June | 2010

Winston Churchill Fellowship Report

Samuel Murray

Attitude is a little thing that makes such a great difference

– Sir Winston Churchill –

"…what you leave behind is not what is engraved in stone monuments, but what is woven into the lives of others..."

- Pericles -

Ancient Greek Politician, General and Statesman, 495 BC-429 BC

The Winston Churchill Memorial Trust of Australia

Post-project report by Samuel Murray – 2009 Churchill Fellow

Project title: *to assess the impact of compulsory registration and accreditation systems of support staff on disability service provision – England, Scotland, Norway, USA and Canada.*

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Signed:  **Dated:** 4th June 2010

“…We shall not fail or falter; we shall not weaken or tire...give us the tools and we will finish the job…”

- Sir Winston Churchill -

BBC radio broadcast, Feb 9, 1941

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Acknowledgments

It goes without saying that this project was not a singlehanded pursuit on my behalf, nor was the lead up, preparation and sourcing of contacts done alone. As such a number of people must be acknowledged, as without their support, guidance, encouragement and interest in this project it simply would not have happened.

Dr Karen Nankervis, Director of the Centre for Excellence in Behaviour Support at the University of Queensland (former Head of Discipline, Disability Studies, RMIT) – Karen has long been a mentor, inspiration, motivator and friend. It is fair to say that Karen has helped shaped who I am today and the things I do. In fact, Karen was the first to suggest applying for a Churchill Fellowship, and was my project referee on both occasions that I applied. Karen is a constant source of motivation and sage advice. *www.disability.qld.gov.au/key-projects/positive-futures/centre-of-excellence /*

Gary Radler, Clinical Psychologist and Behaviour Specialist. Gary was my personal referee for this Fellowship. But more importantly he is 'the guru' in the areas of interest we both share. As such he has being an exemplary role model for me over the last ten years, and one that has shaped my own practice and approaches and still does to this day. Asked once to whom I aspire to be like, Gary was one of the two people that I found myself naming without hesitation. *www.gradler.com.au*

Andrew Hollo, Director and Principal Consultant (Workwell Pty Ltd). Andrew is a brilliant sounding board and the second of the two people after whom I have tried to model my professional life. Andrew is as smart as he is witty, is as generous with his time as he is thoughtful in his advice giving and is as honest as he is forgiving. Having first met Andrew in a training session many moons ago, I would never have thought we would have the collaborative professional relationship and personal friendship we have today. I am grateful for the opportunities he has presented me and his wise counsel over the years. *www.workwell.com.au*

Karen Woods, my guide, confidante, proof reader and dear friend (oh and most importantly, mother of my gorgeous goddaughter, Georgia – and of course Lucy and Alice too!). Karen has truly been a great support to me over the years not just leading up to this project, even when it was just to be an ear for listening, but also as a very thorough proof-reader for all of my important reports and speeches, including this Behemoth. It is 'i' before 'e' except after 'c', isn't it? Oh, and the final count was 231 hyphens.

Dr Michael Brown, PhD. It was recommended that I meet with Michael in Edinburgh to learn about the disability sector whilst in Scotland. What I didn't get told was that Michael was going to be such an awesome host and guide for my two weeks in town. Michael was adept at coordinating meetings and site visits for me, and was instrumental in connecting new with the right people. It also didn't hurt that our sense of humour was congruent either! *http://www.napier.ac.uk/fhlss/NMSC/Pages/SchoolofNursing.aspx*

Dr Amy Hewitt, PhD and John Sauer. Despite Amy having to skip state not long after I arrived, her initial show of interest and follow-up in connecting me with others was paramount to my time in Minnesota. This leg was critical for the project and without her support it just would not have been the same. John 'my man on the ground' Sauer – never before have I felt so welcomed and supported during such a project. John was not only instrumental in setting up my itinerary for the week, but he selflessly gave up his own

personal time to pick me up from the airport and ensure that not only were my professional needs met, but that I had a social calendar that reflected a 'touch of Minnesota'. Thanks so very much, John. *http://ici.umn.edu/*

Professor Jim Mansell and Dr Julie Beadle-Brown. This is my second visit with Jim and Julie at Tizard, and once again I was welcomed warmly and supported to achieve what I had set out to accomplish during this leg. Thanks to you both for connecting me with service providers, steering me towards (or away from) areas of interest and for the time you gave in your hectic schedules to ensure I was able to make the most of my time in Canterbury and surrounds. *http://www.kent.ac.uk/tizard/*

Associate Professor Robert Davis, thank you Bob for all of your professional support over the years, and for the brilliant connections you passed over for King's College London, the Estia Centre (London), Kerry's Place (Kingston, Canada), Kennedy-Krieger and Johns Hopkins. It should also be mentioned that your ongoing support of McMahens is not only 'above and beyond', it is a genuine reassurance knowing you're there with expert guidance and sage direction. *www.cddhv.med.monash.au*

Yooralla, my thanks also to Bruce Bonyhady AM (Chairman of the Board), Sanjib Roy (CEO), Jennifer Boulton (General Manager), Jane Cusdin (Group Manger: Operational Support) and Sasha Lindsay (Area Manager), for their support of my project by permitting me time away, guidance and mentorship and flexibility. It has most certainly made my absence from Yooralla life for over ten weeks so much easier and less stressful knowing that this support was there. *www.yooralla.com.au*

My awesome team at *The Farm*, it is fair to say that this is the best group of dedicated, committed and enthusiastic individuals I've had the pleasure of working with over the course of my ten years at Yooralla. I wish to thank them all for their contributions, but particularly for their ability to carry on with the work despite my heavy schedule leading up to this trip. Particular thanks must go to Jacquee Alger and Erin Palmer for "holding the fort" with such ease in my absence.

To everyone that gave some of their time to meet with me and explore their working experiences. Too many to name, but certainly a significant facet of this project and without them, there simply would not have been a trip – let alone a successful one.

And to all the fabulously warm and welcoming people along the way that made my life so much easier when travelling away from home for so long, Sally Ann M, Marie A, David M & Benji P, Sam(girl) T, Emma S, Glynn R, Adam M & Hanne (and the entire Oslo crew), Jack W, Marilyn S, Dillon M, Xander E, Max C, and Jeni & Tristan C.

"…in any moment of decision, the best thing you can do is the right thing, the next best thing is the wrong thing, and the worst thing you can do is nothing..."

- Theodore Roosevelt -

26th President of the United States of America

Executive Summary

Churchill Fellow 2009: Samuel Murray, President Australasian Society for the Study of Intellectual Disability (Victoria) and Disability Support Worker, Yooralla. 9 / 8 Avoca Avenue Elwood, Victoria 3184

Project title: *to assess the impact of compulsory registration and accreditation systems of support staff on disability service provision – England, Scotland, Norway, USA and Canada.*

Overview

- In the absence of a professional body for the DSW workforce, it is not unexpected that the standard of these supports is widely variable.
- Some research reports that almost half of all disability support workers (DSW) are semi literate. Yet, DSWs are charged with the awesome responsibility of ensuring that people with a disability receiving formal supports lead the lives they want to lead. Often amongst competing complexities such as challenging behaviour, complex communication, significant health and medical needs, mental illness and / or intellectual disability.
- Staff in these roles do not just 'care' for people with a disability, they must be overtly familiar with legislation, government and organisational policy, technical and therapeutic guidelines and behaviour management plans.
- However, despite the significant expectations of the role, the DSW is not required to have any compulsory education level, seek to develop themselves professionally over the course of their employment, or practice to a prescribed code of ethics.
- The role of the DSW is no less complex or reliant on currency and execution of technical and sophisticated skills than that of teachers, nurses, allied health professionals and therapists. Yet, the DSW is not required to have and maintain registration akin to these similar fields.
- In the United Kingdom, under the Care Standards Act (2000), these areas are addressed through compulsory registration of all social care workers, and at the heart of this registration is a requirement of a minimal standard of education and an ongoing commitment to professional development on behalf of both the employee and the employer. No registration = no employment.
- The United States of America has moved towards formalising the workforce to 'professional'. The College of Direct Support and the National Alliance for Direct Support Professionals are two ways they have achieved this.
- A hybrid version of the two models examined would bring about changes to the way we see the DSW workforce and the responsibilities they are charged with performing.

Recommendations

- That further investigation be undertaken locally to ***assess unmet skill needs*** amongst the DSW workforce.
- That government invests in a feasibility ***study of the impact of formal professionalisation*** of the DSW workforce.
- That ***current legislation is reviewed*** to bind these needs within law, not just organisational policy.
- That a ***professional association be established*** for DSWs.
- That the current ***Code of Ethics be further developed*** for both employees and employers.
- That a robust ***review of curriculum for certificates courses*** be undertaken, so that knowledge and skill development is directly matched to job function, and assessed by observation not verbal / written examination.
- That ***'complex service' teams be further developed***, with the same intensity they face when providing supports.
- That the funding allocation to service providers ***training budgets be reviewed.***

Travel itinerary and Programme

Jan 11th

DEPART: *Melbourne, Australia*

Jan 12th – Feb 2nd

England: *London and Canterbury*

Feb 2nd – Feb 16th

Scotland*: Edinburgh, Glasgow and Dundee*

Feb 16th – Feb 22nd

Norway: *Oslo and Lillehammer*

Feb 22nd – March 8th

United States of America:
Minneapolis (MN), NYC (NY), Albany (NY), & Baltimore (MD).

March 8th – March 12th

Canada*: Montréal, Kingston, and Toronto.*

March 12th – March 24th (Recreation leave)

United States of America: *New York City (NY), Baltimore (MD) and Washington (DC).*

March 24th

DEPART*: Washington DC*

March 26th

ARRIVE*: Melbourne, Australia*

Date	*Organisation*	*Place*	*Contact/s*
14th -15th Jan	General Social Carer Council (GSCC)	London, UK	*David Rowland*
18th-21st Jan	Estia Centre, and King's College	London, UK	*Steve Hardy & Eddie Chaplin,*
19th Jan	Lambeth Behavioural Support Service	London, UK	*Naomi Mackenzie-Davies & Annie Parris*
20th Jan	Guy's Hospital	London, UK	*Dr. Jean O'Hara*
21st Jan	The Bethlem Royal Hospital	Beckenham, UK	*Steve Hardy,& Dr Shaun Gravestock*
26th – 29th Jan	Tizard Centre at the University of Kent	Kent, UK	*Prof Jim Mansell and Dr Julie Beadle-Brown*
28th Jan	Home Farm Trust (HFT)	Kent, UK	*Jonathan Coady-Mayall & Nigel Horne*
29th Jan	The Avenues Trust	Hythe, UK	*Jayne Kilgallen & Carol Davies*
2nd Feb – 13th	Napier University & National Health Services (NHS)	Edinburgh, UK	*Dr Michael Brown*
2nd Feb	University of Edinburgh	Edinburgh, UK	*Marilyn Sangster*
3rd Feb	Specialist Behavioural Unit (NHS)	Edinburgh, UK	*Kirsty Kelly*
4th Feb	Scottish Parliament	Edinburgh, UK	*Ryan Gunn*
4th Feb	Community Learning Disability Nurses (NHS)	Edinburgh, UK	*Alistair Littlejohn*

5th Feb	Edinburgh City Council	Edinburgh, UK	*Tom Frank*
9th Feb	Sense Scotland	Glasgow, UK	*Paul Hart & Ian Noble*
10th Feb	South East Scotland Learning Disability Managed Care Network	Edinburgh, UK	*Tom Hammond*
11th Feb	Murray Park Learning Disability Services Unit @ Corstorphine Hospital	Edinburgh, UK	*Wendy Dewar*
12th Feb	University of Edinburgh	Edinburgh, UK	*Marilyn Sangster, PhD Candidate*
12th Feb	Scottish Social Services Council (SSSC) – Workforce Development Team	Edinburgh, UK	*Kathryn Strong, Alison Harold & Frances Scott*
17th Feb	HiAK and affiliated program sites	Oslo, Norway	*Ass Prof Tete Kobla Agbota & Sigmund Eldevik*
18th Feb	Skedsmo Metropolitan/City Council	Oslo, Norway	*Ass Prof Tete Kobla Agbota*
19th Feb	Lillehammer University College	Lillehammer, Norway	*Dr Ole Petter Askeim*
23rd – 26th Feb	University of Minnesota	Minneapolis, USA	*John Sauer*
23rd Feb	Friendship Ventures – Howard County	Annandale, MD	*Laurie Tschetter*
23rd Feb	University of Minnesota	Minneapolis, USA	*John Sauer & Dr Amy Hewitt*
24th Feb	College of Direct Support (CDS)	Minneapolis, USA	*Nancy McCollugh*
24th Feb	University of Minnesota – Institute on Community Integration (ICI)	Minneapolis, USA	*Dr Sheryl Larson*
24th Feb	National Alliance for Disability Support Professionals (NADSP)	Minneapolis, USA	*Lori Sedlezky*
25th Feb	University of Minnesota	Minneapolis, USA	*Derek Nord*
25th Feb	DCI - Brookview	St Paul, USA	*Brenda Mohrland*
26th Feb	Opportunity Partners	Minneapolis, USA	*Sue Fries and Sally Stromquist*
26th Feb	University of Minnesota – Faculty meeting	Minneapolis, USA	*Dr Charlie Lakin*
26th Feb	University of Minnesota – Active Support Research Team	Minneapolis, USA	*Susan O'Nell*
2nd – 3rd Mar	Common Ground	New York, NY	*Anna Demmler & Vanessa Miller*
4th March	New York State Assoc. of Community & Residential Agencies (NYSACRA)	Albany, NY	*Joe MacBeth*
5th March	Kennedy-Krieger Institute - Center on Autism & Related Disorders and Parents & Children Together (PACT)	Baltimore, MD	*Maureen van Stone, PhD*
5th March	John's Hopkins Hospital – Kennedy Krieger Institute	Baltimore, MD	*Christopher Smith, Director*
5th March	P.A.C.T.: Helping Children with Special Needs	Baltimore, MD	*coordinated by Christopher Smith*
10th March	Queen's University (Division of Developmental Disabilities) & Ongwanada Resource Centre	Kingston, Ontario	*Dr Liz Grier & Dr Bill McCreary*
10th March	Kerry's Place Autism Services	Thomasburg, Ontario	*Irene Newman and Randy Wilson*
17th March	Common Ground	New York, NY	*Tim Marx, Exec Director*

Background

Ironically, it was in fact Sir Winston Churchill who said that "*if you change the expectation, you will change the outcome*". And it has long been an issue within the Australian disability sector that those people that are charged with the awesome responsibility of supporting people with a disability have not had any individual or mandated expectations with respect to the quality of the supports they are providing.

This does not take away the many achievements made by direct support staff, it is merely a statement of fact that there are pockets of excellence operating at times solely on their own self-determination and motivation, and at the same time there are other areas of inadequate or less than average supports resulting in a wide variability.

Failing to recognise the great work people being done right now and in the past would be remiss, and would certainly not serve any purpose other than to alienate, an already undervalued workforce. It is however, regrettable that the expectations of that role regrettably have been left unchecked, unmonitored and at times uninspired for a long period of time.

Organisations are required both by law and through their funding agencies to comply with standards and conform to regulations. There is no doubt that this is necessary and forms the basis of quality for service providers. However, what has been left out is the need to establish a professional body for disability support workers. A regulatory body that can not only set the standard for supports provided, and monitor it within the workforce, but also to provide ongoing review of these supports over time to meet changing needs.

A recent statement was issued by the National Disability Services (NDS) stating that a minimum mandatory qualification be set for disability support work of a Certificate IV (Disability Studies). This alone does not ensure a minimum standard of quality in supports being provided, let alone one that is a gold standard. Nor is it an adequate response to professionally developing the sector – for two very critical reasons.

Firstly, the current syllabus of this qualification is not at all adequate for the skills sets required to undertake this role. The course is also being 'churned out' to many disability supports workers through Recognition of Prior Learning (RPL) that does not adequately assess the soft skills of this role, or the candidate's ability to perform in situ.

And secondly, organisations providing support to people with a disability are not suitably funded to pay staff at this level. Most agencies unit cost is calculated at Grade 2, Year 2, and this move will shift all staff to a minimum of Grade 4. A financial burden, that government will expect to be worn by agencies, without any additional funding dollars.

Bill Shorten, Parliamentary Secretary for Disability and Children's Services, said during the opening keynote address, at the DSW09 Conference at Melbourne University:

> *"…it takes a kind of creative sympathy, an empathetic focus, that one finds in the army in wartime, the comrade you must fight alongside, the big battles you need to win. No one here will call this easy. No one here will say their first day at work went swimmingly. No one here has not felt helpless at times, felt that they reached the point where there was nothing more they could do. No one here has not felt the frustration and anger that comes with fighting the good*

> *fight but feeling you are fighting in vain…The work that you [DSWs] do is not simple supervision or guardianship, but an effort to connect with a person whose abilities are different to your own and to lift them out of themselves and beyond their impairment. To be done well this work requires emotional involvement. It can not be mechanised or outsourced. It needs a genuine human connection. I think it is fair to say that in this society we generally reward people whose jobs require physical or intellectual skills. What we do not do well is reward people whose job requires similar emotional skills and involvement."* [1]

I too, have tried to fight the good fight at the ground level, but quickly realised that improvements in only small areas do not focus on the broader issues that must be addressed. However, the significant impact of supporting the supporters well has been seen time and time again in my experience over the last decade as a disability support worker. What I have found though, is every time one brushfire is put out, once one area of excellence is shared with the broader sector, once there is an improvement in the quality of life of an individual with a disability, I find more of these examples surfacing.

The time to consolidate, collaborate and champion the rights of the disability support worker are upon us. I took on this challenge to bring about changes to the workforce so that the DSW is better supported to do the 'supporting' we know must be done. For it is true, that if we get this right, then people with a disability are placed at the best advantage to lead the lives they want to lead.

This report aims to give a clear and comprehensive record of the Winston Churchill Memorial Trust Fellowship study tour I embarked upon in Jan-March of this year. It is a thorough account of some of the critical elements that I believe can be transposed into a local context, to bring out significant positive changes in the lives of people living with a disability in Australia. I hope that you agree.

Who is the Disability Support Worker?

The DSW workforce in Australia comprises of approximately 237,000 paid DSWs (ABS, 2002[2]). Interestingly, this was an increase of 58% from the previous census in 1996. Population growth, changes to the age structure of the population, greater emphasis on care within a community environment rather than in an institutional settings and also the increasing number of women in the workforce are all factors expected to affect the future demand for community services and impact on the workforce of this sector. Estimations based on trends will see well in excess of 500,000 disability support workers in five years time.

Demographically, DSWs are predominantly (87%) made up of female staff, aged 35 - 54 years of age with an educational average of high school graduate. Work settings vary from supported accommodation settings, to recreation services, day services, therapy services and respite services, amongst other diverse situations.

Most importantly however, are the functions the DSW workforce are charged to perform, sometimes working under demanding conditions, such as the presence of challenging and aggressive behaviour, complex communication, significant health and medical needs and/or

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[1] The Hon Bill Shorten's full keynote address can be found at: http://assid.org.au/ConferencePapers/tabid/59/Default.aspx

[2] Australian Bureau of Statistics, 2003, *Disability, Ageing and Carers Australia: Summary of Findings 2003*, Cat. No. 4430.0, ABS, Canberra, ACT.

mental illness. DSWs are there to provide support to people with a disability to lead the lives they want to lead. This requires the application of technical skills and sophistication in order to support people in the main life areas: (a) to be active members of their community, (b) develop and/or maintain relationships with friends and family, (c) build skills and develop competence, all the while (d) respecting and encouraging decision making and choices, and (e) within a paradigm of respect and dignity.

Intellectual disability: *referred to as 'learning disability' in the UK, 'developmental disability' in the USA, and other similar variations in other parts of the world.* These terms are used extensively throughout this document. The widely accepted clinical definition, was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD), as being a condition that is identified by three main elements: *below average intelligence*, *limitations in adaptive behaviour, all manifesting before age 18.*

I mention this diagnostic definition, not just to give clear definition, but also to give greater context to this project and its goals. As it was back in early 1980's that Marc Gold, in his *Try Another Way* approach, said of this definition of intellectual disability, that it is actually a condition that requires ***above average training procedures***, ***superior assets in adaptive behaviour on the part of society***, ***manifested throughout the person's life***.

To be clear, this project seeks to address the current training and development procedures of disability support staff to increase the participation of people with a disability in their home and community lives; better appreciate the way we utilise the DSW as an asset within the sector, and to bring about long term systemic changes that will endure long after this report is written. The bottom line is that a paradigm shift establihsing a professionalized workforce is fundamental to any guarantee of change.

What does it mean to professionalise?

"**Professionalisation**" **of the DSW**, is not merely about setting a mandatory qualification and applying it to the workforce. Being a professional DSW indicates "an ethical commitment to a client and to a field of action. Doctors commit themselves to the patient, and to the practice of healing. Lawyers commit themselves to the accused or aggrieved, and to the practice of law. Being a professional indicates that the relationship is of a certain kind. It is not a personal relationship, or a commercial one, although aspects of both of these may be implicated. It is at core an ethical relationship, limited in scope (lawyers don't do brain surgery) but open-ended in the commitment to the client[3].

Being a professional is at its core, all about integrity and competence. To achieve this end, the following has been determined as the critical features that define *any* professionalised workforce[4 5 6 7]:

- **Skill based on theoretical knowledge**: Professionals are assumed to have extensive theoretical knowledge and to possess skills based on that knowledge that they are able to apply in practice.

[3] Sercombe, H. (1997). *The youth work contract: professionalism and ethics.* Youth Studies Australia **16**(4): 17-21.
[4] Perks, R.W.(1993): *Accounting and Society*. Chapman & Hall (London)
[5] Keith M. Macdonald, *The Sociology of the Professions*, London: Sage Publications Ltd, 1995
[6] P. C. S. Lian & A. W. Laing, *The role of professional expertise in the purchasing of health services,* Health Services Management Research, 17.2, 1 May 2004, pp.110-120.
[7] Merle Jacobs and Stephen, E Bosanac, *The Professionalization of Work,* Whitby, ON: de Sitter Publications, 2006

- **Professional association**: Professions have professional bodies organized by their members, which are intended to enhance the status of their members and have carefully controlled entrance requirements.
- **Extensive period of education**: The most prestigious professions usually require at least three years at university.
- **Testing of competence**: Before being admitted to membership of a professional body, there is a requirement to pass prescribed examinations that are based on both theoretical and practical knowledge.
- **Institutional training**: In addition to examinations, there is usually a requirement for a long period of institutionalised training where aspiring professionals acquire specified practical experience in some sort of trainee role before being recognized as a full member of a professional body. Continuous upgrading of skills through professional development is also mandatory these days.
- **Licensed practitioners**: Professions seek to establish a register or membership so that only licensed individuals are recognised as bona fide.
- **Code of professional conduct or ethics**[8]: Professional bodies usually have codes of conduct or ethics for their members and disciplinary procedures for those who infringe the rules.
- **Self-regulation**: Professional bodies tend to insist that they should be self-regulating and independent from government. Professions tend to be policed and regulated by senior, respected practitioners and the most highly qualified members of the profession,
- **Exclusion, monopoly and legal recognition**[9]: Professions tend to exclude those who have not met the requirements and joined the appropriate professional body. This is termed *professional closure,* and seeks to bar entry for the unqualified and to sanction or expel incompetent members.
- **Control of remuneration and advertising**: Where levels of remuneration are determined by government, professional bodies are active in negotiating remuneration packages for their members.
- **High status and rewards**: The most successful professions achieve high status, public prestige and rewards for their members. Some of the factors included in this list contribute to such success.
- **Legitimacy**: Professions are seen as adding legitimacy to a wide range of related activities.
- **Indeterminacy of knowledge**: Professional knowledge contains elements that escape being mastered and communicated in the form of rules and can only be acquired through experience.
- **Mobility**: The skill knowledge and authority of professionals belongs to the professionals as individuals, not the organisations for which they work. Professionals are therefore relatively mobile in employment opportunities as they can move to other employers and take their talents with them.

These elements clearly outline the current gaps within the Australian DSW workforce that have the greatest potential to bring about solid, consistent change that will enhance the supports being provided to people with a disability.

This report aims to highlight, just some of the ways that international associations and organisations have embraced this framework, to bring about this change.

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[8] Bayles, Michael D. *Professional Ethics.* Belmont, California: Wadsworth, 1981.
[9] Gerald Larkin, *Occupational Monopoly and Modern Medicine*, London: Tavistock, 1983

Main areas of study

The following is an overview of the critical areas of the study tour. The report tries to capture the essence of each of the particular areas and how they impact on the objectives of the overall project. They are chronologically ordered and provide, where necessary, background to each area to give the reader a fuller understanding of the research gathered.

Care Standards Act (2000)

With many vast and varied areas of enquiry to cover in this trip, I started off in the United Kingdom, examining the framework surrounding social care staff. One of the most significant factors in recent times for the disability and social care sector in the UK was the introduction of the Care Standards Act in 2000.

Regrettably, the Care Standards Act (CSA) was enacted partly in response to criticisms in the late 1990s of social services in Britain, in particular the prolific case of Victoria Climbié, a young girl who was abused and ultimately killed by her relatives in north London despite having been known to local social services. The CSA established a major regulatory framework for social care to ensure high standards of care and will improve protection of vulnerable people. Implementation led to the establishment of the independent National Care Standards Commission (NCSC).

The Commission was abolished post Fellowship project (on 31 March 2009) and its responsibilities in England broadly subsumed by the Care Quality Commission.

The CSA provides for the administration of a variety of care institutions, including children's homes, independent hospitals, nursing homes and most relevant to the project: residential care homes. The CSA, was enacted in April 2002 and replaces the *Registered Homes Act 1984* and parts of the *Children's Act 1989,* which pertain to the care or the accommodation of children. The aim of the legislation is to reform the law relating to the inspection and regulation of various care institutions and to ensure quality standards are being met by employers and agencies through the provision of supports by staff.

Taken from the CSA:

> *"…In November 1998 and March 1999, the Government published two White Papers on its proposals for social services in England and Wales. Detailed proposals for the regulation of private and voluntary healthcare in England and for the regulation and inspection of social care and healthcare services in Wales were set out in consultation documents issued in 1999. The Government's proposals for the regulation of early years education and day care were set out in a consultation document issued in 1998. The recommendations and proposals for the Children's Commissioner for Wales were set out in Sir Ronald Waterhouse's Report Lost in Care, and in the report of the Health and Social Services Committee of the National Assembly for Wales on a Children's Commissioner. This Act implements the main proposals in these documents that require primary legislation…"* [10]

[10] *Care Standards Act* 2000, British Parliament (2000). Retrieved May 19, 2010, from http://www.opsi.gov.uk/acts/acts2000/ukpga_20000014_en_1

To summarise, this Act intends to:

- *establish a new, independent regulatory body for social care and private and voluntary healthcare services ("care services") in England to be known as the National Care Standards Commission;*
- *provide for an arm of the National Assembly for Wales to be the regulatory body for such services in Wales;*
- *establish new, independent Councils to register social care workers, set standards in social care work and regulate the education and training of social workers in England and Wales (later to be named the General Social Care Council);*
- *establish an office of the Children's Commissioner for Wales;*
- *reform the regulation of childminders and day care provision for young children;*
- *provide for the Secretary of State to maintain a list of individuals who are considered unsuitable to work with vulnerable adults.*

…the main purpose of the Act is to reform the regulatory system for care services in England and Wales. Care services range from residential care homes and nursing homes, children's homes, domiciliary care agencies, fostering agencies and voluntary adoption agencies through to private and voluntary healthcare services (including private hospitals and clinics and private primary care premises). For the first time, local authorities will be required to meet the same standards as independent sector providers..."

> ***Summary:*** *the enactment of the CSA has cemented a process to establish a framework to set a standard of care for all employers and employees to abide in order to either (a) employ staff into the sector; or (b) enter the DSW workforce and maintain employment. The Australian disability sector does not have such a framework, and the absence of a set of standards to ensure quality has resulted in wide variability of quality across the country.*

Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator of health and social care in England. The CQC regulate care provided by the National Health Service (NHS), local authorities, private companies and community service organisations. The CQC aim to ensure that better care is provided for people with a disability (and other groups) - in a variety of settings including hospitals, care homes and people's own homes. They also have a remit to protect the interests of people whose rights are restricted under the Mental Health Act.

Currently, the CQC is working to a five-point priority plan specifically basing priorities on an equality and human rights framework, with particular attention given to the needs of people in more vulnerable situations, the following excerpt on the five priorities has been taken directly from the CQC website [11]:

1. Making sure that care is centred on people's needs and protects their rights

We want people to be able to shape their own care.

[11] http://www.cqc.org.uk/aboutcqc/whatwedo.cfm

2. Championing joined-up care

We will look at how well health care and social care services work together.

3. Acting swiftly to eliminate poor quality care

People have a right to expect that, if a service falls below essential standards of quality and safety, this is identified and acted on quickly.

4. Promoting high quality care

Where we see that care is improving, we will tell other organisations that provide or buy care so they can learn from what is working well.

5. Regulating effectively, in partnership

We will work with other organisations to improve the quality of life for communities and local people.

The main area of activity of the CQC that is of interest and relevance to this project is the registration and the enforcement of policies. The monitoring of essential standards of quality and safety is paramount to supporting vulnerable populations and from April 2010 new essential standards of quality and safety were introduced in stages across all health and adult social care services in England. THE NHS FOUNDATION TRUST hospitals are the first to come into the new system starting in April 2010, with social care staff not scheduled until 2012. Important to note that the following areas of regulation within this system are all bound by law.

This new system will ensure the following[12] :

- *check on the actual quality of the care people experienced, not just on systems and processes.*
- *monitor whether providers are meeting essential standards of quality and safety today and tomorrow, not in the past.*
- *take into account the voices of people who experience treatment, care and support and want them to have a bigger say in how we assess and judge health and adult social care providers.*
- *have a wider range of stronger enforcement powers to take swift action if we find that standards aren't being met, ranging from warning notices and fines to closure.*

Summary: *From 2010, the cornerstone of CQC's regulatory activity is the new system of registration. It means that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. This is reinforced by a legal framework that demands that assessment of outcomes is based on actual experiences, not just on systems or processes.*

[12] taken from: http://www.cqc.org.uk/aboutcqc/whatwedo/monitoringessentialstandardsofqualityandsafety.cfm

General Social Carer Council (GSCC)

The GSCC is a non-departmental public body that has responsibility for registering and regulating Social Care Workers in England (approximately 500,000). Its responsibilities include setting and promoting high standards of social care, and ensuring that all workers in the Social Care sector adhere to high professional standards.

It is an arm's length body sponsored by the UK Department of Health. It has three sister organisations which have similar responsibilities in the other parts of the United Kingdom; these are the **Scottish Social Services Council** (SSSC), the **Care Council for Wales** (CCW), also known locally as *Cyngor Gofal Cymru (CGC)*, and the **Northern Ireland Social Care Council** (NISCC).

The GSCC was set up in 2001 as a part of the CSA implementation. The GSCC inherited the mantle of the Central Council for Education and Training in Social Work (CCETSW), a previous body that had responsibility solely for managing and funding Social Work education. The GSCC was given a broader remit to take a lead not only in education but in the strategic development and promotion of the whole social care sector in Britain.

A major responsibility of the GSCC and other councils is the maintenance of a professional register of Social Workers, with Social Care Workers to follow in the coming years. From 1 April 2005 it became a criminal offence to claim to have the title Social Worker without proper qualifications. Social Workers are required to renew their registration every three years, and to undertake a certain amount of professional training and learning during each three-year registration period. In this way the GSCC hopes to raise the standards and reputation of the social carer in the United Kingdom workforce.

GCSS Codes of Practice: the GCSS Codes of Practice (CoP) were the first ever UK-wide regulations for social care workers and employers providing a clear guide for all those who work in social care, as well as setting out the standards of practice and conduct workers and their employers must meet. The GCSS registrants are required to comply with these codes as a condition of ongoing registration, failing to do so can result in sanctions and de-registration – and without registration one cannot practice.

There are two GCSS Codes of Practice:

> **Code of Practice – Employees:** In short the CoP for Employees states that social care staff must:
>
> - Protect the rights and promote the interests of service users and carers;
> - Strive to establish and maintain the trust and confidence of service users and carers;
> - Promote the independence of service users while protecting them as far as possible from danger or harm;
> - Respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people;
> - Uphold public trust and confidence in social care services; and
> - Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.

Code of Practice – Employers: In short the CoP for Employers states that all employers of social care staff must:

- Use the code for employers as a 'tick list' for a comprehensive audit of their organisation's policies.
- Make sure relevant senior colleagues such as their HR manager, training manager and the elected members or board are aware of the codes and their potential impact on the organisation. In smaller organisations, make sure all senior colleagues are aware of the codes and their potential impact.
- Ensure that staff are familiar with the codes, and try to have a session where the issues can be discussed.
- Introduce the codes to new staff at induction and have a discussion with them then about what they mean. The codes contain nothing that cannot be put into practice straight away.
- The codes can be used in the performance appraisal process as a measurable target for staff and managers. Incorporating the codes into people's work plans and objectives will be a good way of getting them to think about the codes.
- Get staff to carry their credit card-sized codes around with them and ask staff to explain to service users what the codes are, at an appropriate moment.
- Provide access to the codes to all people who use services. These are available for download from the GCSS website [13].

The GSCC had, at the time of meeting with them, received and investigated approximately 100 complaints. Exact data was not available, however the three main courses of action, other than to dismiss without prejudice, are to *admonish*, whereby registrant receives a formal warning; to *suspend* from register for a period of time; and to *deregister* the individual from the register so that they can no longer practice in a social care setting.

> ***Summary:*** *enacted from the CSA, the GCSS and affiliates, are charged with the oversight and development of social carers across the United Kingdom. This includes the establishment of a Code of Practice for Employees and Employers, as well as a register of all social care staff. The strength of the GCSS register is the compulsory component of ongoing professional development of the workforce to maintain registration.*

Scottish Social Services Council (SSSC)

Refer to the General Social Care Council (GSCC) section, as there are only subtle differences between the two councils in their policy and practice.

It was important to meet with SSSC however, as the two councils are somewhat closer to the registration of direct support staff than their sister associations.

[13] http://www.gscc.org.uk/codes/

National Vocational Qualification (NVQ)

NVQs are a work based award system in England, Wales and Northern Ireland that are achieved through assessment and training. In Scotland they are known as SVQs (see section below) and do not differ greatly from the NVQ.

Typically the NVQ, and SVQ, are similar to a Certificate course program structure in TAFE setting within an Australian context. To achieve an NVQ, candidates must prove that they have the ability (demonstrated through assessment of competence) to carry out their job to the required standard. NVQs are based on National Occupational Standards that describe the 'competencies' expected in any given job role. Typically, candidates will work towards an NVQ that reflects their role in a paid or voluntary position. Typically the NVQ for DSWs is within the Health and Social stream.

There are five levels of NVQ ranging from *Level 1* focussing on basic work performance, through *Level 5* for senior managers.

Level 1
Competence that involves the application of knowledge in the performance of a range of varied work activities, most of which are routine and/or predictable.

Level 2
Competence that involves the application of knowledge in a significant range of varied work activities, performed in a variety of contexts. Collaboration with others, perhaps through membership of a work group or team, is often a requirement.

Level 3
Competence that involves the application of knowledge in a range of varied work activities performed in a variety of contexts, most being complex and non-routine. There is considerable responsibility, autonomy and guidance of others is required.

Level 4
Competence that involves the application of knowledge in a broad range of complex, technical or professional work activities performed in a variety of contexts and with a substantial degree of personal responsibility and autonomy. Responsibility for the work of others and the allocation of resources is often present.

Level 5
Competence that involves the application of a range of fundamental principles across a wide and often unpredictable variety of contexts. Very substantial personal autonomy and often significant responsibility for the work of others and for the allocation of substantial resources features strongly, as do personal accountabilities for analysis, diagnosis, design, planning, execution and evaluation.

Summary: *NVQs are the standardised qualification for social carers and the key to distinguishing between each of level is the assessment of competence. Rigorous assessment of actual competence is the core means of attaining the qualification.*

Scottish Vocational Qualification (SVQ)

Refer to the National Vocational Qualification (section above), as there are minimal differences between the two qualifications.

Summary: *refer to NVQ section above.*

Learning Disability Services in South London

A full week was spent with the expert teams at King's College London, the South London and Maudsley NHS Foundation Trust, the Estia Centre. King's College London alone boasts:

- Being in the Top 25 Universities in the world
- Three of the UK's leading NHS Foundation Trusts:
  - Guy's and St Thomas',
  - King's College Hospital and
  - South London and Maudsley NHS Foundation Trust
- Seven hospitals and over 150 community-based services, serving over two million 'clients' each year
- 25,000 employees and 19,500 students
- £2 billion annual turnover

Dr Steve Hardy introduced me to three main program areas that I was able to examine:

Estia Centre & NHS Foundation Trust: South London and Maudsley (SLaM)

The Estia Centre, part of South London and Maudsley NHS Foundation Trust (SLaM), runs a well-established training programme for health professionals working with people with learning disabilities and mental health problems.

The Estia Centre is also an academic section of the Health Service and Population Research Department at the Institute of Psychiatry. It is based at the Guy's Hospital campus in the heart of London, near London Bridge. The Centre conduct research into the needs of people with learning disabilities and mental health problems and shares the results of their studies through their training programmes.

The work conducted by the Estia Centre acts as the research base for SLaM, the Lambeth Behavioural Support Services and The Bethlem Royal Hospital – Dual Disability Assessment and Treatment Unit.

Lambeth Behavioural Support Services

I spent an afternoon with Naomi Mackenzie-Davies & Annie Parris, two lead behaviour support specialists with the Lambeth Behaviour Support Services team. Their experience is not dissimilar to that of Behaviour Intervention Support Teams (BIST) here in Australia.

The overwhelming commonality, is the shared experience of trying to get the balance right between outside professional interventions and the implementation by staff support teams. With no managerial role or responsibility in their support, even the most well-crafted and meaningful invention plans are all but dead-in-the-water if they are not implement fully by staff support teams. The other issue lies in the need for accurate data to firstly ensure an accurate assessment and to inform the intervention, but secondly to review any implemented plans to ensure that outcomes are being met, and if they are not being met then appropriate adjustments can be made.

Bethlem Royal Hospital – Dual Disability Assessment and Treatment Unit

The Unit is based on The Bethlem Royal Hospital site in Beckenham, which is the perfect therapeutic environment, set within 270 acres of green space. The facilities include nature walks, a gym and swimming pool, and an onsite art gallery. An extensive occupational therapy programme includes activities like computing, creative art, sewing and textiles, aikido, drumming, drama, gardening, community art projects, woodwork, digital photography, karaoke, an organic kitchen garden, and pottery. Patients also have the use of the community centre, chapel and museum.

Our core clinical team includes a consulting psychiatrist, 18 nurses (both general registered and learning disability nurses), 12 social workers, two psychologists, 1 occupational therapist, 1 speech and language pathologist and 2 medics, who bring together a range of skills that benefit each individual patient. All patients have:

- *Support from an allocated team involving all professionals.*
- *Individual care from a named key nurse.*
- *A named care co-ordinator.*
- *Therapeutic psychiatric intervention.*
- *Regular physical health checks, as needed.*
- *Opportunities to see additional therapists as identified in individual care plans.*

The site visit to this Unit emphasised a number of areas where staff were in need for professional development of staff. Particularly in light of large amounts of money being spent on sophisticated new facilities and programs.

Observations included:

- One young lady constantly hitting the staff duress alarm to gain attention throughout the course of my visit. The apparent reason being that it was in response to not being able to have another cigarette.
- Three young people sitting staring in the common area, when the activity board indicated that set activities were going on. One staff member was present but they were drinking coffee and watching television whilst seated at the rear of the room.
- A distinct medical model approach was evident throughout the visit and it was clear who were staff and who were the 'patients'.
- Another older lady had reportedly engaged in aggressive behaviour earlier in the day, including throwing her own faeces at staff. Apparently as a result of being told that she would not be able to go to the "community centre", due to a limited number of staff. Despite, an abundance of staff on shift at the time of request.

- Lastly, the previously mentioned "community centre", was another building on hospital grounds frequented only by hospital patients, not others from the community.

In fairness, this is a very new facility and the team is still adjusting, as would any team in such new surrounds and within new protocols. This aside, the impact of closer staff supervision and development would be profound even in a short period of time.

Summary: *King's College London and the Estia Centre are world leaders in the research field of intellectual disability and mental health. The academic support they provide to SLaM, Lambeth Behavioural Support Services and The Bethlem Royal Hospital – Dual Disability Assessment and Treatment Unit are of a superior quality. The need to complement these supports with a more robust 'research into practice' model, that includes superior assets in staff supervision, professional development and coaching/mentoring, would lead to more positive outcomes for service users*

Home Farm Trust (HfT)

HfT is a nationwide not-for-profit disability service provider. I was able to visit a number of their residential sites to explore regional variance in supports, individualised funding models and complex behaviour supports.

With a broad push towards the implementation of new funding models such as individualised budgets, personal budgets and direct payments (see text box below: *What are direct payments, personal budgets & individual budgets?*) for people with a disability, it was interesting to see two different models of support side by side and the variance in quality between the two versus the actual intention.

HfT supports a number of people on one of its residential sites in Kent, southeast of London. Formerly, a small institutional setting made up of dormitories and shared bathroom/toilet facilities, with large common areas; the site has been redeveloped in the last seven years to provide a more personal and socially acceptable model of support. The changes made to the facility were in the form of redeveloping the large setting into individualised one bed 'studio apartments' with approximately 30 people being supported in this less 'communal' support environment.

It is could be easily argued that this model is the preferred and more widely accepted approach as the people supported have a greater level of privacy, the ability to express greater levels of choice and express individuality. However, without the right kind of supports this model can also lead to isolation, depression, a loss of skill and at times challenging behaviour. This accommodation model, without the right ratios of staff does not lend itself to the appropriate levels of support required to afford people living in these settings the quality of life outcomes intended.

Alongside this newly developed building, were two other accommodation settings on this site. One is a six-bed long-term accommodation service, supporting young people with autism and significant challenging behaviour under the newer "direct payments" model. The other is a less accepted model in today's trends, a semi-congregate care setting under the old funding arrangement – bulk funding to an organisation to provide services.

What are direct payments, personal budgets & individual budgets?

Direct payments *are cash payments given to service users in lieu of community care services they have been assessed as needing, and are intended to give users greater choice in their care. The payment must be sufficient to enable the service user to purchase services to meet their needs, and must be spent on services that users need. Like commissioned care, they are means-tested so assume that, in many cases, people will contribute to the cost of their care.*

Personal budgets *are an allocation of funding given to users after an assessment that should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment, or - while still choosing how their care needs are met and by whom - leave councils with the responsibility to commission the services. Or they can have some combination of the two.*

As a result, they provide a potentially good option for people who do not want to take on the responsibilities of a direct payment.

Individual budgets *differ from personal budgets in covering a multitude of funding streams, besides adult social care: Supporting People, Disabled Facilities Grant, Independent Living Funds, Access to Work and community equipment services.*

The government has only called for the rollout of personal budgets - not individual budgets. The latter were piloted in 13 areas until the end of last year and an evaluation on the pilots is due out this summer.

The interesting difference between the two settings was the staff training model, whereby the service with direct payments had less individualised, service-specific training and support for staff than the older model setting, whereby staff receive ongoing service-centric training and support based on the needs of individuals.

It was argued by staff I met with, that the direct payments model was the way forward and was far superior to that of the 'traditional' funding model as it afforded the service user the ability to pay their own bills "*as you or I would*" and that this is "*everyone's right to be able to pay your own bills…it's normalisation*".

What was actually observed over the course of several hours was that the quality of supports was the only tangible difference between the two settings, regardless of how the

funding was structured. I can only surmise that this was indicative of a robust training and development program, not that of funding arrangements.

Why? It was in fact the 'traditional funding' model setting that had far superior supports during my observation. Service users were engaged fully in a variety of age appropriate and well-planned and executed activities and tasks. Staff ratios were not great however multi-tasking appeared seamless as staff supported more than one individual at the same time.

Conversely, where the model was supposedly far superior to that previously observed and where the staff ratios were better, there were high levels of disengagement and service users spent most of their time pacing, wandering the halls, and engaged in self-stimulatory or aggressive behaviours. During the entire observation period, there were zero instances of staff engaging and supporting service users in meaningful activity other than personal care tasks and meal assistance.

> ***Summary:*** *individualised/personal budgets are seen as the next model of best practice with significant application across the UK in recent times. However, wide variability in the quality of the actual application of these is apparent at a number of service support settings. It is ever present that in services where the staff are supported well, through training and professional development, that the supports being provided will be far superior.*

The Avenues Trust

I visited a number of support settings in Hythe, managed by England's largest not-for-profit service provider, The Avenues Trust. There were no significant observations of supports made at these accommodation settings that could not be witnessed at local services back in Australia.

The model of supervision of staff however was varied, in so much as the Team Leader, or House Supervisor works 90%-100% of their roster completing administrative tasks with responsibility over two or three services, not just the one. The next line down is Senior Support Staff who are charged with the modelling and direct supervision of staff.

Does this model work? Reports from those I spoke to say it does, however they do not have a point of difference to compare with. The predominant model in Australia, has the frontline supervisor working most of their rostered hours 'hands-on', with the expectation to role model performance, coach and mentor staff on shift and then complete administrative tasks during a small allocated period each week. This model is not without its flaws, and by no means is it the ideal scenario for the needs of both leading teams and completing the administrative requirements.

One significant observation that was made relates to the fabric of the accommodation settings. Many buildings in the UK are quite old, and the houses I visited were no different. As a result there were significant issues with old and close to 'run down' elements of some of the settings. Further to this, many sites visited were double story occupancy and this had clear issues of occupational health and safety risk given the needs and support requirements of the service users, whether it is behavioural issues or those relating to physical disability. To remedy this across the entire sector would be a massive investment and somewhat prohibitive, but all the while necessary.

Summary: *formal day-to-day support for people with a disability does not vary widely from one local or national area to another. What does often vary however, is the attitudes of staff in the role of DSW, and this it has been seen makes all the difference. Models of funding, or interpretations of them are not the sole factor in great supports being provided, it is the role that staff play within these settings that is the deciding element.*

National Health Service (NHS) – Community Learning Disability Nurses (CDLN)

To summarise the Edinburgh leg of the tour would take as long as the actual visit, however there was one significant finding that is worthy of discussion.

Given that people with an intellectual disability (commonly referred to as learning disability in the UK) often have a wide range of physical and mental health conditions, greater than that of the general population, it stands to reason that there be a specialist approach to supports to ensure that specific needs are met.

Recent reports by the Disability Rights Commission and Mencap have re-emphasised the need to tackle health inequalities for people with an intellectual disability. By promoting access to mainstream health services and providing direct specialist support as required, learning disability nurses can work to reduce barriers and support the person to pursue a fulfilling life.

Community Learning Disability Nurses (CLDN) in the UK, and specifically observed in Edinburgh, work in partnership with people with an intellectual disability, their family and carers, to provide specialist healthcare.

Their main aim is to support the well-being and social inclusion of people with a learning disability by improving or maintaining their physical and mental health; by reducing barriers; and supporting the person to pursue a fulfilling life. For example, teaching someone the skills to find work can be significant in helping them to lead a more independent, healthy life where they can relate to others on equal terms.

Learning disabilities nursing supports are provided in a range of settings such as adult education, residential and community centres, as well as in the person's own home, workplace or school.

CLDNs can specialise further into areas such as residential, education, sensory disability or the management of services.

One initiative set up by the NHS FOUNDATION TRUST in Lothian, was the appointment of one fulltime CLDN to each of the major hospitals to act as a liaison, an educator and a support person for both people with a disability accessing medical services, as well as for hospital staff in preparation for supporting a person with a disability (either for planned admissions or during emergency consults). Some of the specific services provided by CLDNs are:

- one-to-one case-load working
- health promotion clinics
- epilepsy awareness / rectal diazepam training
- healthy eating groups
- body care awareness groups

- sexual health clinics
- lead on Valuing People health focused projects
- nurses relating to sexual health and epilepsy
- links and training to non learning disability trained and experienced staff within acute primary and mental health care

Summary: *The normalisation movement has created a redundancy of specialist support services for people with a disability over the years, with a push towards accessing typical generic services. With best intentions in mind, the specific needs of people with a variety of disabilities can often be lost amidst this generic environment. The implementation of CLDN teams in the UK bring about changes to redress this gap in service.*

Høgskolen Akershus (HiAk) – Akershus University College

HiAk is located in Lillestrøm, approximately 25 kilometres northeast of Oslo. HiAk has over 3900 students and 300 staff members all within the grounds of the relevantly newly developed buildings. Of the four other faculties within HiAk (Product Design. Health, Nutrition & Management; and Technical & Vocational Teacher Education), it was the Faculty of Behavioural Science that was to be the focus of interest to the program tour. Students and graduates from this discipline can be found in numerous placements within the sector, mostly in behaviour support roles.

It can be said that attitudes all start with language and context – HiAk certainly are aware of this and as such they draw heavily of the research and development program within the college as the basis of their teachings. Specifically, the work conducted by Research on Learning in Complex Systems, or RoLCS (locally we would refer to this field as either intellectual disability or challenging behaviour depending on the context of the discussion). The view at HiAK, and specifically with RoLCS, is that when supporting people either with an intellectual disability, or those that display challenging behaviour, the focus needs to shift away from the actual individuals and any deficits, perceived or otherwise, and back to the broader environment they are in and the positive impact that can be made when focusing on these changes.

Taken from the HiAK RoLCS webpag:

> *"…in a world where the potential for interaction between individuals has increased dramatically, we must manage complexity. Human behaviour and learning happens in complex, changing systems. With a combination of complexity research and behaviour analysis, the Master program Learning in Complex Systems is designed for students who want to make a difference in processes of change, both at an individual level and at a level of systems. The program adds value to the professional repertoire of change agents in public service, education and health care..."*[14]

It is this unorthodox approach that I believe sets up for real positive change in approaches to support. Far too often we focus on the person "owning" their disability, or their behaviours,

[14] http://www.hiak.no/index.php?ID=1475

so much so that we often see years of effective and positive supports lost, as support staff cannot grasp that they play the most critical role in the person's life. We do not expect a person with a physical disability to carry a ramp with them everywhere they go so they can access building, transport etc. Nor do we expect someone with a sensory impairment to be able to see or hear – instead we provide the right environment to match their own abilities in order for them to function within a typical society. Yet, we all too often expect a person with an intellectual disability who presents challenging behaviour to be the sole person responsible for changing those behaviours. The approaches by HiAK RoLCS certainly turn that theory into a reality with the program they offer and the people they have working in the community, as outlined below with the stories of Asma and Mani.

> ***Summary:*** *HiAK provide an innovative curriculum that is not only contemporary and well-founded by a strong evidence based, but importantly has real outcomes for people with a disability in the community as witnessed during site visits where students and graduates were placed.*

Asma & Mani

There is a brief personal account in the web-blog section (*Appendix 1*) of my time spent with Asma and Mani at their kindergarten setting, however there are some clear lessons to be considered.

Both of these young people, Asma and Mani are being supported with their development and education utilising an Applied Behaviour Analysis (ABA) approach. Regrettably, this approach is not as widely applied as it could be due to the intense time required to make it effective – which typically translates to significant expense.

What can be seen though, when this approach is effectively applied, is significant changes in the quality of life and overall potential of the person being supported.

With Asma and Mani, they would have had very different lives if these supports were not being given. This is not to say they may not have led lives of despair and neglect by any means. However, it is fair to say that their development (in such a short period) has been the result of significant ABA supports. These supports have resulted in acquisition and development of language, ability to request or deny, recognition of sharing, turn taking and eye contact, amongst other vital life skills.

The ABA supports are overseen by lead staff at HiAk and executed by graduates of the programs (Faculty of Behavioural Science and Head of Social Education Program) or those trained by graduates.

> ***Summary:*** *the impact of ABA interventions as a means of supporting young people with autism can never be overemphasised. Where educational and support settings utilise external mechanisms to develop people under an ABA framework, greater evidence is seen of people acquiring or further developing important life skills that lead to quality of life improvements in the short and long term.*

University of Minnesota (UMN):

This leg of the tour was one of the most anticipated in respect to diversity of experiences to explore and examine within the one area, and the calibre of the research team I was to spend time with. The following sections all fall under the umbrella of the UMN, however not all of these contacts have direct affiliation with the university.

Institute on Community Integration (ICI)

The Institute on Community Integration (ICI) at the University of Minnesota (UMN) is a federally designated University Centre for Excellence in Developmental Disabilities (UCEDD), part of a national network of similar programs in major universities and teaching hospitals across the country.

ICI believe all persons with developmental and other disabilities should live as valued members of local communities. Through their collaborative research, training, and information sharing, ICI improves policies and practices across the sector in order to ensure that *all* people with disabilities are valued by, and contribute to, their communities of choice.

Dr Amy Hewitt, Dr Sheryl Larson and ICI Director Dr Charlie Lakin are at the forefront of research into practice for disability across the USA, and indeed the worldwide disability community.

Amy Hewitt, has in recent times visited Australia to conduct workshops and present at numerous conferences and symposia. Amy, who is a Senior Research Associate at ICI, was instrumental in the development of the Australasian Society for the Study of Intellectual Disability (ASSID) Disability Support Worker Code of Ethics. Amy has a keen interest and considerable expertise in the area of recruitment and retention of DSWs, and it was from this experience that I was hoping to glean information and guidance for this project.

Amy has some very strong, and well-founded, views on why DSWs choose to work in the field; stay in the field; and importantly, leave the disability field. Without wanting to over simplify Amy's extensive research in this area of study, it can be boiled down to: *professionalise the workforce*.

Interviewed recently, Amy said: "*If I had only one sentence, this would be it: Direct support work is a highly skilled job*." So why is it we are still not moving toward, or have indeed established this workforce as a professional workforce?

One reason, according to Amy is that "*…it's not viewed that way by society – or, frankly, by many employers [or government] – but not everybody can do this job. You have to be smart; you have to be able to problem solve; you have to be flexible and a quick thinker. You also need patience and empathy and creativity. We're not going to get anywhere in terms of policy advocacy or getting the supports we need in place without clearly articulating that this is a highly skilled job.*"

Amy has found that "*…the quality of people's lives is directly related to the quality of the support that they get, and that support is provided by direct support workers, so a lot of our work is in trying to understand workforce challenges – and, more importantly, trying to develop tools and resources for community providers, to help them improve their retention rates and the competence of their workers.*

More importantly, Amy noted that although it is an obvious commentary, the research she has been involved in shows that, "*…direct support work is not just about keeping people clean and fed and safe. It's about helping them make friends; helping them evolve relationships; helping them decide what activities in the community they're interested in and connecting them to those supports. It's about helping them have a life.*"

These are highly sophisticated responsibilities that are regrettably not instilled within the workforce as a whole here in Australia, and in fact globally. There are certainly pockets of excellence, however variability is as wide as it is profound, with the majority of supports being provided at a less than average level to achieve positive outcomes for people with a disability receiving supports.

Amy is very clear that to resolve the issues of wide variability of supports and in turn improve people's lives (both that of the service users and the staff member), the sector must reduce staff turnover, bolster supports to foster retention and ensure that skills are matched to needs.

In the absence of a professional body, clear systems of regulation and a competency-based curriculum that does not currently cultivate strong hands on supports, it is clear that we are strides away from achieving this.

This is further supported by the work of ICI and recent research of theirs that tells us that the workforce is based on "*the premise that people's lives are better if they have a well-trained and stable workforce, so if you can reduce turnover you can improve lives,"*

In reference to a particular piece of research conducted by ICI, Amy said of the study that it *"…showed that people who received care in organisations with higher rates of turnover had worse outcomes…."*

Further support to this was gathered from the work of Sheryl Larson, a colleague of Amy's at UMN. Sherri conducted a decisive longitudinal study of DSWs involving interviews of staff at the point of hire and then again over the course of a year to learn why so many left their jobs within three to six months.

Common (ranked) reasons for departure:

1. Limited, nonexistent or inefficient supervision;
2. Conflicts with co-workers; and
3. Not having understood what the job entailed when they signed on or not being supported through development of skills to complete the work.
4. Poor wages and benefits;

It is important to note that 'wages' ranks 4th after areas that can be influenced both effectively and immediately at a much lower cost to organisations and government.

So in order to bring about change, Amy said that employers need to focus on the factors that can be influenced in the short and mid term, "*…wages and access to benefits really matter. We would be remiss not to say that, BUT that said, there really are things that organisations can do differently now, without more money, just using the resources they have more wisely, that can change the turnover outcomes*

within their workforce. That's often very hard for providers to accept, that they create environments in which workers feel devalued, feel incompetent, feel disrespected, and there are things they can do to improve."

Strategies recommended by Amy and supported by ICI research, include:

- *How to identify and hire the right people for the job, rather than hiring "whoever walks through the door";*
- *Realistic job previewing, a technique designed to ensure that people know what the job entails before signing on to do it;*
- *Effective supervision, through the use of the coaching supervision model and other strategies; and*
- *Empowering direct support workers by including them more in decision-making.*

Summary: *Despite the common misnomer that if you pay enough you'll find the right people for the job, ICI research to date shows us this is not true. Critical in the findings is that to ensure quality outcomes for people with a disability receiving supports; there must be a stable and consistent staffing team. To achieve this, organisations must (a) hire the right people, not just the first to walk-in; (b) robustly induct staff into the role; (c) provide ongoing mentoring and supervision and (d) equip staff with the skills and knowledge to achieve job role outcomes.*

College of Direct Support (CDS)

It is not at all easy to briefly describe the awesome capacity the College of Direct Support (CDS) has to implement widespread and effective change for DSWs with respect to ongoing support and development. In fact, the half-day I spent with Nancy McCollugh, was not nearly enough to get a full comprehension of this system of staff development.

CDS is an Internet based curriculum for the DSW workforce, currently supporting almost half of the States within the USA. The CDS training curriculum is permeated with a set of values and skill standards to train all skill levels of DSWs and their supervisors and managers as they support people with a disability in community-based settings. Values such as inclusion, rights, leading self-determined lives and ethical, values-based treatment, among others, are at the core of the CDS online program.

> *"The College of Direct Support was created by some of the leading experts in the field and is built on established and validated skill sets. This curriculum comes as a result of requests made by Direct Support Professionals, provider agencies, and counties for training that is practical, user-friendly and flexible… By providing this training opportunity, the Office of Mental Retardation hopes to demonstrate its commitment to addressing the recruitment and retention issues faced by the Commonwealth."*[15]

[15] excerpt from The Family Forum, April 2004 (a publication of Mental Retardation Services, City of Philadelphia)

Although the CDS is a user pays curriculum (based on the number of people served by an agency), it is apparent that this expense could in fact save disability service providers significant money in the long term through pay-by-the-minute training versus bulk backfill, more effective and timely induction, lower rate of staff attrition, subject-specific development such as disability awareness, complex health and challenging behaviour that can lead to a reduction in workplace incidents, amongst many other savings.

All of the modules are extensive and well researched *(authored by academic staff at UMN as well as other institutions, complemented by input from direct support staff, disability service providers, advocacy groups, government and NGO departments, allied health professionals and of course people with a disability, their families and carers)*.

The grand design of the CDS lies in the three-part approach to 'training'.

1. ***Online tutorials*:** the internet based classroom, whereby by 'students' take on a module and go through the lesson via a multimedia platform incorporating text, voiceover instructions, video clips and additional resources. Each module has a quiz that must be passed at a set grade in order to move on. Quizzes are randomly selected from a broader pool of questions to minimise falsification of answers.

2. ***On-the-job training* (OJT):** each module has an OJT component whereby the DSWs direct line manager assesses their competence based on a set criteria. The fidelity of this lies in the requirement for assessment to be taken in situ, not based on RPL (see boxed text *"The major flaw in Recognition of Prior Learning"*) or verbal response.

3. ***Portfolio*:** *staff are required to keep a record of achievements, record of how they have overcome any barriers, workplace assessments and associated results to establish an evidence base to their competence. By keeping a portfolio staff can clearly demonstrate their actual ability to perform certain job roles if they were to apply for senior positions or other roles within their organisation or further afield.*

A demonstration of the site can be found at http://info.collegeofdirectsupport.com/go/about/demo_site/?phpMyAdmin=3e8c4b06eae1t56d768ec

Summary: *Although not a panacea for staff development, the CDS provides a comprehensive and thoroughly researched curriculum that will develop DSWs into professionals if utilised as advised and in conjunction with other important aspects of development such as supervision and mentoring supports.*

The major flaw in Recognition of Prior Learning

Recognition of Prior Learning (RPL) has done the same for the disability support workforce as the diploma mill institutions have done for tertiary degrees. Privately operating Registered Training Organisations (RTO) and even some TAFE programs have become reliant on the funding associated with graduating students on RPL alone. With the ever-growing demands to make money over producing quality results, these operators are tainting the industry by failing to establish competence in graduates of their programs.

The result is a diluted workforce of 'qualified', yet limited skilled workers providing at times less than adequate supports to people with a disability.

Known euphemistically as 'tick-and-flick', one can receive the full award, in this case a Certificate III or IV in Disability within weeks, having never sat in a class or having completed an assignment, based on RPL alone – often without any on-site observations by an assessor either. In the absence of a rigorous assessment of actual competence, we are failing the sector. This equates to poor quality of life outcomes at times for people with a disability.

One well-known and respected institution said this about the advantages of RPL:

> *"…RPL is a way that you can take advantage of your previous experience to "fast-track" your acquisition of a competency-based qualification. RPL will save you both time and money; you may get a qualification virtually straight away and for a fraction of the cost and effort it would otherwise have taken…"*

This same institution does not demonstrate anywhere within their RPL literature, or when enquiring on the phone, that on-site, competency-based assessment would be required to gain the qualification.

After an extensive analysis of the RPL assessment and its disadvantages, Smith (2004) concludes that effective RPL 'requires experienced professional assessors able to make informed professional judgments'. Indeed the importance of truly 'professional' assessors is a recurring feature of Smith's case studies and he argues that an important focus of RTOs and the system should be to confirm 'the capacity of the assessors to make credible industry-supported judgments'. The expressed view is that current arrangements are attempting to provide 'quality control for assessors who do not have the professional competence to make valid professional judgments', and in so doing, are actually 'undermining the capacity of good providers to conduct RPL in a highly valid and cost- effective way'.

Bowman et al. (2003), in their review of RPL implementation, confirm the findings of Smith (2004) and Blom et al. (2004). In this report, a critical issue for RTOs was that of the skills of assessors conducting RPL, especially related to their ability to make judgments based on diverse evidence.

16 17 18

[16] Smith, L. (2004), *Recognition of prior learning: Selected case studies of Australian private providers of training*, NCVER, Adelaide. http://www.ncver.edu.au/research/proj/nr2030.pdf (accessed May 2010).
[17] Bowman, K., Clayton, B., Bateman, A., Knight, B., Thompson, P.L., Hargreaves, J., Blom, K. & Enders, M. (2003), *Recognition of prior learning in the vocational education and training sector*, NCVER, Adelaide.
[18] Blom, K., Clayton, B., Bateman A., Bedggood M. & Hughes, E. (2004), *What's in it for me? Recognition of prior learning in enterprise-based registered training organisations*, NCVER, Adelaide.

National Alliance for Direct Support Professionals (NADSP)

I spent an afternoon with Lori Sedlezky from the National Alliance for Direct Support Professionals (NADSP) to examine their DSP credentialing program. The NADSP's mission is to promote the development of a highly competent human services workforce which supports individuals in achieving their life goals.

The NADSP has developed a national credentialing program for Direct Support Professionals (DSP) working in community human services. The purpose of this program is to provide national recognition for the contributions and competence of DSPs who apply for and meet the credentialing standards.

The NADSP affords DSPs the opportunity to commit to the profession of direct support through its three-tiered credential program:

- The DSP career path begins with the *Direct Support Professional - Registration (DSP-R)* level.
- As a DSP-Registered, the candidate will then be eligible to complete expert training in the key competencies of empowerment, communication, planning, ethical practice and advocacy that leads to the *Direct Support Professional – Certified (DSP-C)*.
- The third level, *Direct Support Professional - Specialist* (DSP-S) recognises DSPs who have obtained specialised training and have competence in providing specialised support to individuals with disabilities. There are currently four specialist areas at this level:
    - *DSP Specialist in Inclusion (DSP-S-I)*
    - *DSP Specialist in Health Support (DSP-S-HS)*
    - *DSP Specialist in Positive Behaviour Support (DSP-S-PBS)*
    - *DSP Specialist in Mentoring and Supervision (DSP-S-MS)*

The following is the list of fifteen competency areas that have been approved by the NADSP Executive Committee. Each competency area has corresponding skill statements that describe the knowledge and skills DSPs must have to demonstrate competency in each area. The detailed list of each areas skill statements can be found on the NADSP website.[19]

Area 1: Participant Empowerment

The DSP enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.

Area 2: Communication

The DSP should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.

Area 3: Assessment

The DSP should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.

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[19] http://www.nadsp.org/credentialing/competency.asp

Area 4: Community and Service Networking

The DSP should be knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.

Area 5: Facilitation of Services

The DSP is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.

Area 6: Community Living Skills & Supports

The DSP has the ability to match specific supports and interventions to the unique needs of individual participants and recognises the importance of friends, family and community relationships.

Area 7: Education, Training & Self-Development

The DSP should be able to identify areas for self improvement, pursue necessary educational/training resources, and share knowledge with others.

Area 8: Advocacy

The DSP should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.

Area 9: Vocational, Educational & Career Support

The DSP should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.

Area 10: Crisis Prevention and Intervention

The DSP should be knowledgeable about crisis prevention, intervention and resolution techniques and should match these to particular circumstances.

Area 11: Organisational Participation

The DSP is familiar with the mission and practices of the support organisation and participates in the life of the organisation.

Area 12: Documentation

The DSP is aware of the requirements for documentation in his or her organisation and is able to manage these requirements efficiently.

Area 13: Building and Maintaining Friendships and Relationships

Support the participant in the development of friendships and other relationships.

Area 14: Provide Person-Centred Supports

The DSP provides support to people using a person-centred approach, modifies programs to ensure they are person-centred, challenges co-workers and supervisors to use person-centred practices, is knowledgeable about person-centred planning techniques and assists individuals in developing person-centred plans.

Area 15: Supporting Health and Wellness

The DSP promotes the health and wellness of all consumers.

The real strength of this credentialing program is in how it can positively impact on recruitment by disability service providers. Too often we take on face value the years of experience an applicant holds when they apply for a position. However, it is clear that years of service do not necessarily mean quality in support.

Take for example, the *Direct Support Professional - Specialist* (DSP-S) credential when recruiting for roles in challenging behaviour services, complex health/medical services, and for role of leadership such as House Supervisor. Would you rather rely upon the good faith of a reference check and the persons ability to answer questions relating to the role, or would you be more reassured and confident having an applicant present a credential that has been independently assessed for competence? We don't ask other teachers, therapists and other professionals to merely be interviewed for a job, we seek to have verification of actual skill through their respective industry credentialing programs

The NADSP has had a relatively small number of 'graduates' to date with a few internal and external factors contributing to the slower than expected uptake. That is not a reflection at all on the intent, content or outcomes of such a credentialing program and should not be seen as a failing. What is required is greater collaboration perhaps with sector leaders to support their own staff to drive this further. It is an echo of the common theme over the course of this trip, that in order to support the supporters we need to look more holistically at how all key stakeholder, including the actually DSWs can drive this to the next level of professionalisation.

> ***Summary:*** *the NADSP provide, amongst other services and supports, a DSP credentialing program to not only increase the knowledge and skill base of direct support staff, but to provide the sector with a benchmark standard by which they can recruit.*

Dakota Communities Incorporated (DCI) - *Brookview*

Brookview is one of approximately thirty residential services managed by Dakota Communities Incorporated (DCI) in the Twin Cities. This particular house is home to four older people with varying disabilities. Interestingly, the mandated maximum number of residents for long-term supported accommodation is four people, in most parts of the USA (some states in the south still support congregate care settings). This compares to an average of 5-6 here in Australia.

A visit to a community residential unit was a great way to see how the CDS works 'on the ground' and to further examine on-site supports within community settings.

I spent several hours with the Brookview Team Leader, Brenda Mohrland as she walked me through the DCI approach and their application of the CDS. In short, their use of the CDS is thorough and comprehensive. There is no doubt that they are using this resource to its fullest potential. This is well evidenced in the supports I witnessed being provided. Staff were well informed of day to day issues as well as broader sector matters relating to their role. The level of knowledge was superior to what I've seen where there is an absence of such resources, and this translated fluidly into real and natural supports that were fostering engagement and participation in all aspects of life for the people being supported at Brookview.

The staff support within DCI is to be applauded, Brenda as the leader uses the book, "*First, Break All the Rules: What the World's Greatest Managers Do Differently*" [20] as the foundation of her management approach. This style certainly does reflect in the impact this team has on the lives of the people being supported.

This service is so well-developed in their person-centred thinking that they have supported the resident group to charter their own *Resident Bill of Rights,* outlining the expectations of each of the residents in respect to the way they wish to be supported and what they value in life. No mean feat of accomplishment given that the client group have moderate to profound intellectual disability and complex communication needs.

Some of the ways the CDS is being utilised to develop staff at Brookview, outside of just completing the learning modules are:

- ***Staff induction**: a 60-day induction occurs at all CDS sites. The DCI induction is not class based at all. This solely online induction appears thorough and effective to properly initiate new staff into the service they will be working. There are milestones to accomplish after the first day, the first three days, the first week, the first month and then the first two months. These include mandatory modules on the CDS as well as organisational and service-centric online tutorials all with quizzes to test understanding.*
- ***Service-centric and organisational alerts**: the CDS acts as an email alert system for all affected staff in the event of a crisis, outbreak, emergency or change to supports. Situations such as medical needs relating to an individual, through to preparation for pandemics are all captured in this function. Again, all alerts have the capacity to require a quiz be taken to check for understanding. The system also registers that the person has read it, giving another layer of record for the organisation's Quality Assurance (QA).*
- ***Memorandums and policy changes**: as with the previous use, this feature allows the organisation to send out broad alerts to changes in policy or general memos to all or selected staff. In essence, it acts as an online communication folder with the inclusion of tests to ensure the information is translated correctly to the staff member.*
- ***CDS Module allocation:** the assigned 'training manager' in most case the service supervisor or team leader, can allocate modules to team members for staff development. In line with the individual's Development Plan, the modules can ensure that staff develop at the pace best suited to them, while still meeting the needs of the service.*
- ***Training alerts:** the CDS alert function serves as a reminder alert system for training events and periodic renewals such as first aid, fire safety and the like. The alert email goes to the site administrator as well as the staff member, and as such staff can be booked in online*

[20] further information on the book: "*First, Break All the Rules: What the World's Greatest Managers Do Differently*" (1999), can be accessed from: http://www.managementhelp.org/guiding/motivate/basics.htm

at the point of alert by their supervisor. Reports can also be generated at administrator level and up as another QA measure.

- ***Admin resource to monitor development**: linked to staff's own professional development plans, the CDs can be used effectively to ensure staff are constantly being challenged and developed throughout the course of their employment.*

- ***Desktop team meetings:** at times it is not practical to get ALL staff together at the same time to meet, yet the need for regular time together to discuss issues is imperative to a well-functioning team. Brookview use the CDS as a means of having desktop team meetings, where staff can contribute to agenda items in the lead up to it and then 'attend' a discussion platform with each of the subjects covered in an online format at the earliest availability. His is also registered when competed so staff are recorded as having 'attended'. The CDS also has capacity to print name badges, agendas and staff attendance sign on record for the face to face meetings*

- ***Annual staff opinion survey:** one other effective resource being used at DCI with the CDS is the annual staff opinion survey. These are conducted online and can be made service-centric where required. Return rates for the online survey for DCI since using the CDS is greater than 75%, in comparison to lower than 20% in the previous paper-based format.*

***NB/** it is important to reinforce that the CDS is lay person friendly. Although it is an online resource and requires some level of computer literacy, it is designed to be used by even the earliest of computer users. The functions and navigation are specifically designed for maximum ease for all learners. It is effectively a "point and click" program.*

In contrast, it is important to discuss the impact of poorly applied use of the CDS. I was able to visit another residential service in the Twin Cities (not operated by DCI), one that was comparable in many aspects to Brookview with respect to client population and staff team. It was evident from the limited supports, lack of clear evidence of real resident choice and the 'old style' of support being provided that this team are not being effectively supported and developed to meet and maintain a standard of performance and conduct. At this service, some staff were not even aware of the CDS at all (even after three years at the service), and those that were had limited knowledge of its function. This organisation spends the same amount of money in licensing fees and support for the CDS, yet there is clearly no value in this expenditure. DCI may spend a little more in terms of resource to make use of the CDS to its full potential, however the cost to benefit impact was profoundly positive.

***Summary:** DCI provides the closet thing to 'textbook perfect' support and supervision of their staff teams, with all staff enthusiastic and motivated to further developed themselves as professionals. The result is a well-functioning team that provide exceptional supports to the people they serve.*

Common Ground

Common Ground is a New York City based not-for-profit organisation that creates and manages affordable, supportive housing and employment programs for homeless, disabled, elderly, low-income people and people living with HIV/AIDS.

Founded by Rosanne Haggerty back in 1990, Common Ground has been a genuine pioneer in the development of supportive housing and other research-based practices that work towards bringing about an end to homelessness. Common Ground's network of well designed, affordable apartments — linked to the services people need to maintain their housing, restore their health, and regain their economic independence — has enabled more than 4,000 individuals to overcome homelessness in the States of New York and Connecticut.

Common Ground purchased their first major property, the Time Square Building back in 1990's during the Mayor Rudolph Giuliani's wide sweeping zero tolerance [21] and broken windows movement [22]. Common Ground saw an opportunity to have an impact on the lives of people living on the very fringe of society.

Common Ground's strategy has three components:

1. **Affordable Housing.** We build and operate a range of housing options for homeless and low-income individuals – housing that is attractive, affordable, well-managed and linked to the services and support people need to rebuild their lives.

2. **Outreach.** We identify and house the most vulnerable: those who have been homeless the longest, have the most disabling conditions, and are least likely to access housing resources. These individuals typically spend years cycling between emergency shelters, hospitals, and jails.

3. **Prevention.** We strengthen communities and prevent homelessness by addressing the multiple factors that cause individuals and families to become homeless.

I met with Executive Director Tim Marx and he reflected that some of the key milestones of Common Ground during his tenure are:

- Last year, Common Ground opened their *3,000th unit of permanent and transitional housing* in New York City, Connecticut, and upstate New York. *The Hollander Foundation Center* (70 units) and *The Brook* (190 units), are the latest of these projects in Connecticut. With *The Schermerhorn* (217 units) and *The Andrews* (146 units), the most recent in NYC. The goal is to create *4,000 additional units of housing for the homeless by 2015*.

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21 Kelling, G.L., Julian, M. and Miller, S., (1994) *Managing 'Squeegeeing': a problem solving exercise*, New York: NYPD.
Ming-sum Tsui "The harm reduction approach revisited: An international perspective" *International Social Work* 2000, 43, p243

22 George Kelling and Catherine Coles (1997). *Fixing Broken Windows: Restoring Order and Reducing Crime in Our Communities*, ISBN 0-684-83738-2

- *Common Ground costs are the lowest in the sector: approximately $36 per night to operate* – considerably less than public expenditures:
    - *$54 for a city shelter bed,*
    - *$74 for a state prison cell,*
    - *$164 for a city jail cell,*
    - *$467 for a psychiatric bed,*
    - *$1,185 for a hospital bed.*
- And the ground-breaking *Street to Home* program, that supports people living on the street to move directly into homes, has *reduced street homelessness by 87% in the 20-block Times Square neighbourhood*, and by 43% in the surrounding 230 blocks of West Midtown.

A couple of weeks before meeting with Tim, I was fortunate enough to be given a guided tour through The Prince George building (416 single occupancy units) in Midtown Manhattan (*see Photo 1*). The Prince George is home to a mix of low income working people, the formerly homeless and people living with HIV/AIDS. The deliberate mix is aimed at reducing the stigma of HIV/AIDS by not 'segregating' the housing. Each apartment is partially furnished when a new resident moves in (see Photo 3).

Photo 1: The exterior of the Prince George Building in Manhattan, New York

The Prince George building was a US$40 million project. A former luxury hotel built in 1904, it ran into disrepair and became a serious drug den and squat, until it was literally cleared out and refurbished in 1999.

Some key points about The Prince George:

- a range of on-site social services provided by Common Ground's social service partner, the Centre for Urban Community Services (CUCS). CUCS provide individualised support services to help tenants put their lives back on track and manage their housing, employment, and health-related needs.
- the building also has two large open garden spaces, including the rooftop garden that is home to 11 community garden plots through a collaboration with the New York Horticultural Society and the Green Team Project.
- the project received a coveted World Habitat Award in 2003

A really exciting project that coincided with the redevelopment of the Prince George was the restoration of the hotel's former Grand Ballroom (*see Photo 2*). Common Ground launched an ambitious project to restore the 460 m^2 ballroom and adjacent former Hunt Room. The project presented an opportunity to offer vital training and jobs. Common Ground, working with four other not-for-profit groups, arranged for at-risk youth, high school students interested in restoration arts, architectural students, and individuals with HIV/AIDS to work on the renovation - together.

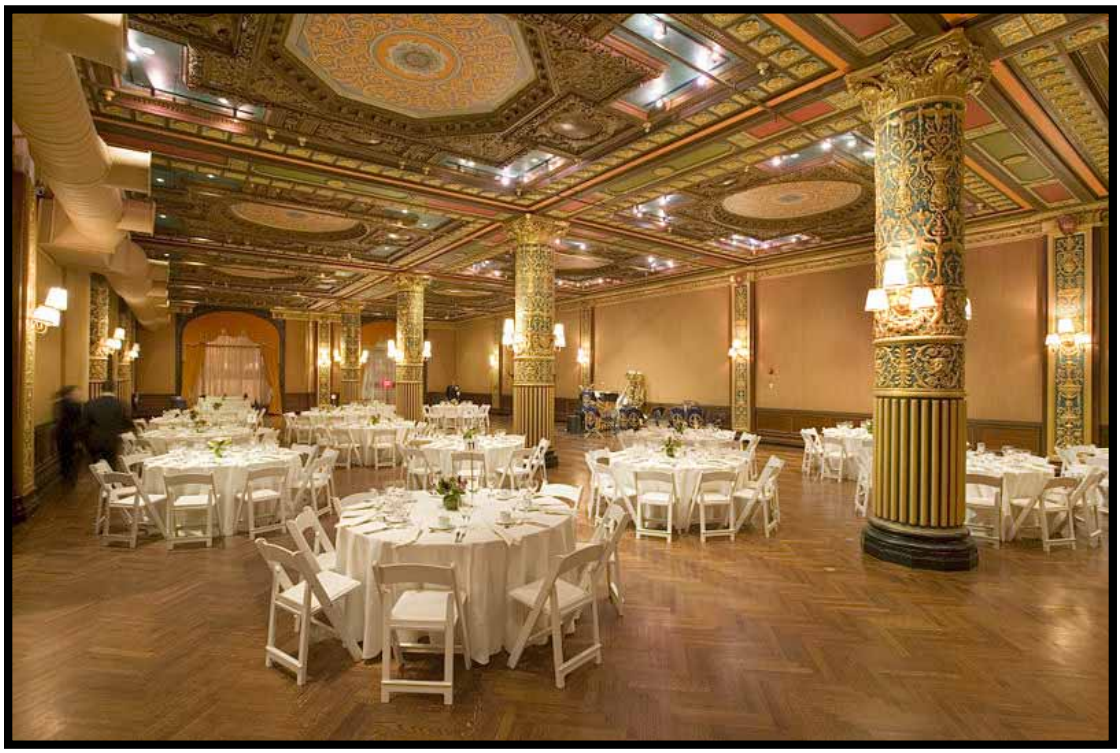

Photo 2: The Grand Ballroom @ The Prince George

Students at the Parsons School designed and built an entry foyer and gallery space in what had been the Hunt Room. Faced with an area that was beyond restoration, the students developed an airy, modern space that is now the World Monuments Fund Gallery [23], which serves as a special exhibition and events space. The Grand Ballroom was fully restored to its former luxurious and stunning glory, and has even featured in the television series "*Gossip Girl*" and has maintained its heritage listing.

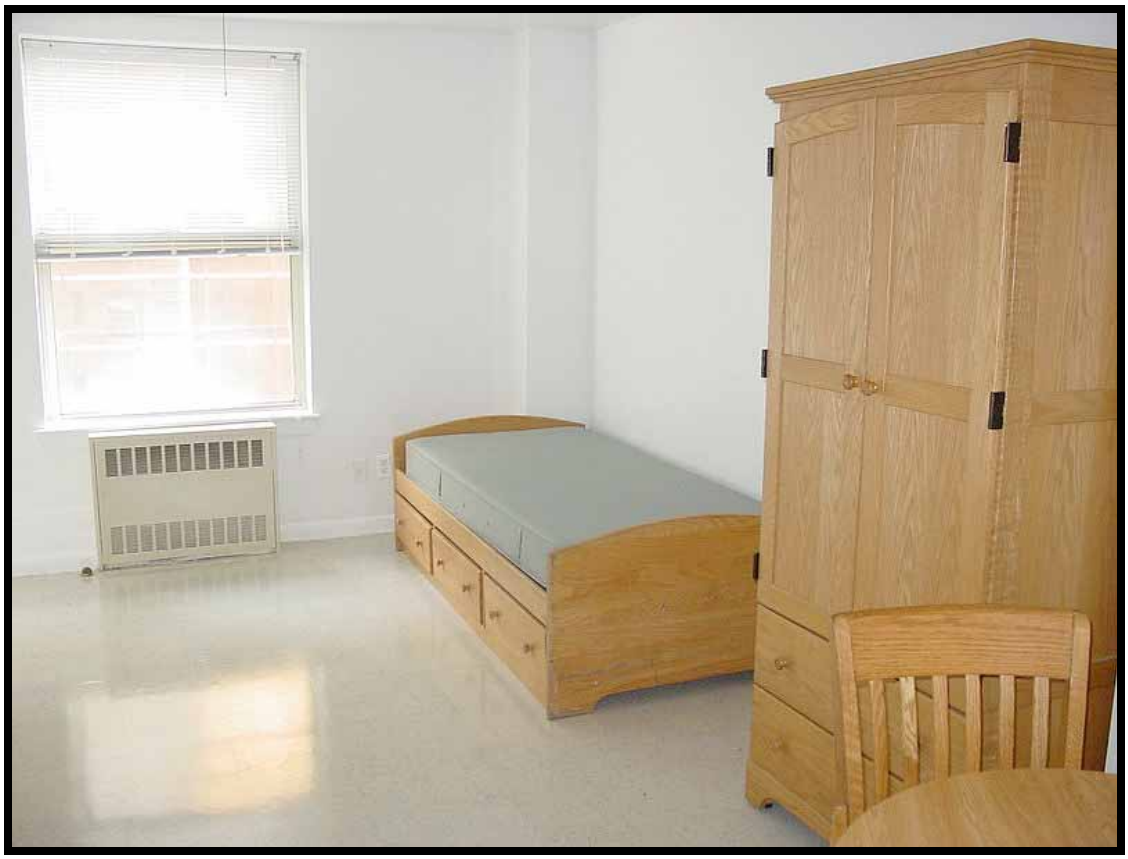

Photo 3: A Common Ground apartment, including the basics that are provided.

Summary: *The visit with Common Ground, although not (a) directly related to the project aims; or (b) directly related to the disability sector as a whole, provided an insight into social housing models that could be effectively implemented within Australian communities to support people living with a disability who may ordinarily find themselves living in a more supported accommodation setting with others as a result of limited resource allocation for more independent living arrangements. The funding agreement alone, as seen earlier in this section, shows that it can be both an effective social project with positive outcomes for all, at the same times as costing less than many other 'traditional' services.*

[23] http://www.princegeorgeballroom.org/world-monuments-fund-gallery/

Kerry's Place (Autism Services) & Ongwanada Resource Centre

I was given a strong recommendation from Associate Professor Bob Davis, Director of the Centre for Developmental Disability Health Victoria (CDDHV) to visit a particular rural residential setting in Ontario, Canada managed by Kerry's Place. The recommendation was that this particular service "kicks goals", but not in the typical and orthodox way in which supports are generally delivered in the disability sector either in Australia or aboard. Particularly, with the selection of the dedicated team of staff that support the service users.

It became quite the adventure getting to this relatively isolated property - be sure to read *Appendix 1 – Around the World in Seventy Days Blog* to discover the $600 taxi ride associated with this leg of the tour). However despite, the amusing travel side of this visit, the observations made were worth any hassle that may have occurred getting there.

The first part of this leg was to meet up with the team of professionals who support the service I would visit later in the day. Most of the dozen or so names in the meeting escape me, however it was lead by Dr Bill McCreary, consulting psychiatrist, and a group of social workers, speech and language pathologists, along with a psychiatrist, a clinical psychologist, a behaviour intervention specialist, a nurse and a consulting physician.

With such an expert team, I as curious as to Bob Davis' definition of 'unorthodox', as although this was not the norm for services globally to have such a professional ensemble of support, it was certainly a desired team for the support of complex behavioural settings.

The meeting with the multidisciplinary team was the perfect opportunity to get a background on both the history of the service I was to visit later on, as well as a chance to get an understanding of the complex needs of the resident group.

One thing that was very clear, and it was resonant of Bob's words back in Australia before leaving, was that I had to wait to meet Irene.

In due course, I made it to the offices of the Thomasburg region of Kerry's Place and was able to meet Irene, the manager of the service I would get to eventually that day.

Irene is an action woman. She fell into the field from an unrelated career about 20 years ago and has never looked back. She has a keen eye for autism and the need to be patient in assessing the purpose of the behaviours being demonstrated by the service users. Never quick to rush in, Irene has an adept way of understanding the intent of the behaviour and then is fast to act in meeting the needs of the resident in order to reduce the maladaptive behaviours.

While we were talking, a young man with came into the office and asked for a drink, Irene said "sure, help yaself to a can of pop" and the young man went over to the fridge, selected a can of fizzy drink and shook the can furiously – no one batted an eye. I was wondering what was to follow. And was preparing to get sprayed along with others. Instead, the young man quickly and deftly opened the can and skolled the entire content in seconds. And with a round of applause, that he gave himself, he walked out of the office saying goodbye to everyone in the room.

The critical part of this story is this: supposedly twelve months earlier the office would have cleared at the mere arrival of this young man, yet now everyone was so calm and relaxed as he went about 'routine'. I felt calm and relaxed too as those around me were. I had no reason to be fearful; I was being well 'supported' by those around me to ensure the best

outcome for this young man. It was to be an early sign of the support at the residential setting I was to go to next.

I eventually found myself at the residential setting I had travelled all this way to see. The resident group (12 young people with autism) are here for a relatively short period of time, approximately 3-6 months, to have their complex needs thoroughly assessed and interventions plans prepared, tested and reviewed. There are two side-by-side buildings on the property, which is situated in a rural location on 100-acres of farming land.

The resident group are not overtly different to any resident population you would find globally, with autism and complex behaviours. What is different though is the support that is provided, and the recruitment of the 'right people' to provide these superior, and natural, supports.

Irene hand-selects all the staff herself and leads her team through action, not through policy or procedure. In fact, this service setting could not be any less bureaucratic if it tried. The only serious paperwork utilised at this setting is the data collection records for the resident behaviour and the plans for interventions. This is not at all orthodox, and would never receive the rubber stamp from government or funding bodies in most other jurisdictions around the world, however it works and works well in this setting.

The staff team is comprised of local welders, plumbers, truck drivers, return to work mothers, retired school teachers and many other wide and wonderful backgrounds. The common attribute they all share is no previous experience in the sector. Irene provides textbook perfect coaching and mentoring to all staff on shift, leads by example, provides regular and robust supervision and performance feedback and encourages all staff to contribute to the team with ideas and comments as long as it can be grounded in observations and data. Nothing is done on a whim.

The result: significant reduction in aggression, greater participation in home and community life, acquisition of new skills and maintenance of others, the establishment and fostering of new and existing relationships, respect for decisions and choices made by residents leading to greater resident contribution to outcomes and an increase in overall quality of life for all residents that are fortunate enough to spend time being supported by Irene's 'expert' team

Summary: *Is Kerry's Place the perfect setting? Could Kerry's Place be replicated with success under similar conditions in other jurisdictions? Would funding bodies support the 'unconventional' style of supports? The answer is probably a resounding no to all of those questions. What I discovered about Kerry's Place is that despite not conforming to the 'norms', and not following the textbook management approaches to service provision, it works. In fact it works really well. Perhaps it is the focus on residents and not administrative outcomes and deadlines that enhance the work being done here and perhaps it could be said that there are issues around 'compliance areas' not being met. However, what is clear is that when everything gets boiled down, as long as there is an established framework of support standards, they are followed up and staff are given the resources to execute them, and it is all conducted in a safe and equitable work environment, then success follows.*

Kennedy-Krieger Institute at Johns Hopkins

Background to this institution: Johns Hopkins University was founded in 1876 by educational pioneers who abandoned the traditional roles of the American college and forged a new era of modern research universities by focusing on the expansion of knowledge, graduate education, and support of faculty research. Its motto in Latin is *Veritas vos liberabit* – "*The truth will set you free*." The name of this institution is interesting in itself, named after philanthropist, Johns Hopkins. His first name is actually the surname of his great-grandmother, Margaret Johns, who married Gerard Hopkins. They named their son Johns Hopkins, and his name was passed on to his grandson, the university's founder.

There have been 33 Nobel Laureates associated with this institution. It is ranked in the Top 20 universities in the world[24] and the hospital was ranked in 2009 as the top overall hospital in the United States for the 19th consecutive year [25]

Photo 4: Johns Hopkins Hospital, Baltimore Maryland

My time with Johns Hopkins was spent meeting with staff at the Kennedy-Krieger Institute, and specifically the Center for Autism and Related Disorders (CARD), a tour of the newly

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[24] *Academic Ranking of World Universities*. Institute of Higher Education, Shanghai Jiao Tong University. http://www.arwu.org/ARWU2009.jsp Accessed May 9, 2010.

[25] *America's Best Hospitals 2008: Johns Hopkins Hospital U.S. News & World Report*, http://health.usnews.com/health-news/best-hospitals/articles/2008/07/10/best-hospitals-honor-roll.html Accessed May 9, 2010.

refurbished hospital and with Director Christopher Smith PhD of the Maryland Center for Developmental Disabilities (MCDD).

The Kennedy-Krieger Institute is a made up of a team of scientists and researchers leading the worldwide effort to prevent and cure disorders of the brain and spinal cord as well as other developmental disabilities. The institute boasts a swift transfer of research into practice establishing itself as a leader in its field.

I met with Maureen van Stone, PhD at the Kennedy-Krieger's main research facility in Baltimore. Maureen was able to give a thorough overview of the research to date and future directions for research in autism spectrum disorders. Most significant in her conversation with me, was the screening tool currently being tested to diagnose autism spectrum disorder in children as young as 9-12 months. The exciting part of this, is that it is proven that the earlier the invention with a diagnosed child the greater the chance of supporting skill development and successful social training.
Christopher Smith, Director of the MCDD, generously supplied a lunch providing a forum where his colleagues were able to share their experiences and knowledge with me, whilst I had an opportunity to discuss my project and the impact it could have back in Australia.

MCDD, another member of the University Centers for Excellence in Developmental Disabilities (UCEDD) has four core functions:

- **Pre-service preparation and continuing education;**
- **Community service;**
- **Research; and**
- **Information dissemination.**

The purpose of these four functions are to increase the community's capacity to incorporate state-of-the-art advances so that people with developmental disabilities can achieve greater levels of independence, productivity, and inclusion in their communities.

One other area of Kennedy-Krieger that is noteworthy is the PACT program: helping children with special needs. This program has multiple elements, however they do run specialist early intervention programs; family support services, parent education, counselling, specialised childcare and professional training. They have five core programs: World of Care, the Comprehensive Therapy Centre, the Inclusive Child Care Training Program, Working Together, and the Therapeutic Nurseries.

Through ongoing staff training and continuous interactions with other providers, PACT keeps up to date with the latest techniques and research for supporting children with special and complex needs. PACT also has taken a lead role in the field in designing and implementing programs not duplicated anywhere in the region.

Summary: *The Kennedy-Krieger Institute, under the auspices of Johns Hopkins, is a very well funded and resourced collaboration of professionals, a fact clearly evident in the quality of the research and practice within its organisation. Drawing on state-of-the-art research and techniques, these collaborations ensure that people with autism are receiving the very best opportunities to develop themselves, allowing them to lead normal lives.*

Conclusion

In summing up the tour, I will echo part of a quote in the opening pages of this report that said, "*…give us the tools and we will finish the job…".* Sir Winston Churchill himself said these words whilst addressing the nation during the war. He was appealing for a call-to-arms from his countrymen and women. It was a time of great fear and uncertainty, what lay ahead could not have been known at that point, but the determination to be well-equipped and prepared to charter that territory was absolute. It could not be predicted if this would succeed, nor were there clear strategies in mind to get through those times ahead. But there was an understanding that if you prepare a nation, or a workforce with the requisite tools, or skills and knowledge, then what lay ahead would be a determined and unconditional commitment to success.

The workforce is there primed and waiting. Determined and passionate. Caring and committed. What they need now is to be acknowledged as professionals, for they are not anything less than that. And then to be treated as professionals with full development, support and recognition.

Building a hybrid system of regulation and registration, alongside credentialing and a strengthened program of professional development and education are the exact tools needed to bring about changes in people's lives. At the forefront there is no doubt that it would be enhancing the lives of the DSW workforce as they are better equipped to perform tasks, have a greater level of job satisfaction, reduced rate of stress and an understanding that they are committed to their careers and the changes they can make along the way. This in turn directly translates into quality of life outcomes for people with a disability in supported settings in our community.

It became evident as the Fellowship tour progressed, that where systems were in place which developed staff and had strong practice leadership and mentoring, along with robust systems of assessment of competence, that the lives of the people were supported far better than services where these attributes were not evident. There is no doubt in my mind after this tour that Australia must act, and act now to bring about serious changes to the disability support workforce.

The commitment I pledge, to support these changes based on my finding and experiences are wide and varied. I will use the following forums to 'spread the word':

DSW Conference

ASSID host an annual DSW conference at Melbourne University, a conference that I have chaired for the last three years. This well-established yearly event captures in excess of 600 DSW delegates each year from all around Australia and New Zealand, as well as associated sponsors, exhibitors and presenters. It is the ideal forum to gain feedback on new ideas, as well as share information with the DSW workforce.

DPV workforce professionalisation project

After giving a keynote address at their Annual General Meeting last year, Disability Professionals Victoria (DPV) have already coordinated a number of meetings with me to discuss the tour findings and to also map out a strategic plan for addressing the unmet needs of the DSW workforce across Victoria. Disability Professionals Australasia (DPA), have also attended these meetings and are coordinating the broader response in collaboration with others and myself so that this experience has greater chance of success at a national level, not just locally.

DSW SIG in collaboration with DPV

Further to the systemic changes being reviewed and challenged with DPV (as detailed above), I've also been asked to lead a DSW Special Interest Group (SIG), with their Executive Officer and one of the DPV Board Members. This DSW SIG will be set up with the intent of being self-sustaining and self-governed by the DSW workforce in its earliest stages. The group should not be lead by the sector with DSW involvement, it needs to be a grassroots network with outside supports as they see necessary to address their own recognised needs. With the ever-present lack of 'voice' being heard from this group, the SIG is designed to bring the workforce together to coordinate the DSWs own agenda for professional development, amongst many other issues.

Behaviour Support Network with CDDHV and VALID

Newly returned, and with my overseas experiences still fresh, I was asked to contribute my experience to the establishment of a behaviour support network of sector experts and those with a strong interest that will further examine the lack of resource and funding allocated to services that support people with complex behaviours. Associate Professor Bob Davis of CDDHV, along with Kevin Stone the Executive Officer of VALID[26] are co-leading this initiative with myself.

Summit of key stakeholders

Once there has been some further robust local review into how the tour findings could lead to systemic changes in Australia, it is planned that a summit be called inviting the key stakeholders along to have an open and candid discussion of how this can progress further and what barriers may be faced along the way. Stakeholders from all corners of disability and related sectors will be asked to come along and share their views on the professionalisation of the DSW workforce in Australia. This will then link back to the project with DPV.

Follow up with The Hon Bill Shorten

After the preliminary work has been consolidated and this report submitted, I will take up The Hon Bill Shorten's offer to meet with him again to discuss my tour findings and look at what role he could play in supporting changes.

Chapter in edited book

During the trip, I was asked to author a chapter in an edited book on the history and current trends of the disability sector. Details of the collaboration could not be made publicly available at the time of this report due to discussions still occurring with publishers and the like. However, it is viewed that an early-to-mid 2011 release of the book is expected. The chapter I've been asked to author, will related to DSW workforce professionalisation in the context of the Fellowship findings, as well as broader DSW workforce issues such as stress and burnout, recruitment and retention, training and professional development, and the requisite skills base for support.

Work with College of Direct Support to localise content for Australia

The only limitation that I have identified within the CDS resource, is the significant amount of local US content embedded in the modules. A significant piece of work would be required

[26] Victorian Advocacy League for Individuals with Disability Inc www.valid.org.au

to ensure that this resource would have a greater application within a local context. Some early conversations have already been had to look at how this can occur. Although a more formalised approach, that I am prepared to lend my time and resources to, is required for it to progress further.

Article in IDA

The quarterly IDA magazine, a well respected and widely read disability sector publication invited me to write an article on the Fellowship tour and the key findings and observations of the trip. This has already been submitted to the IDA editor and the published article is due for circulation to the sector in late June 2010.

Commence an Honours year with view to PhD at UQ

Looking at ways to advance this research project so that it can keep the momentum and build on local content, I have enrolled in an Honours degree at the University of Queensland under the supervision of Professor Karen Nankervis, PhD. Karen has a keen interest in DSW workforce issues and has conducted numerous research projects of her own looking at the issues faced by this particular population. The Honours year will be fulltime, and does not officially commence until the second half of 2010, however early planning has established that services supporting people with complex behaviours and the professional development of these staff teams will be the basis of the research project.

Journal article submission

Several professionals and academics in the sector have asked me if I plan to have my findings published as a journal article. I had not intended to do this before or during the tour, however with the strong encouragement of others and the recent enrolment into the Honours degree, it will be a strong consideration at the end of that piece of research. The Fellowship research will certainly complement any work undertaken this year, not just academically but also with the projects mentioned in this section, however the Fellowship findings alone are not in a state to be published without a clear research methodology and ethics approval.

Maintain networks with overseas contacts

Establishing contacts overseas was not an easy task, but the key to longevity with this project is to also maintain this network to draw upon further resources and data over the coming months and indeed years. I have already actively kept in touch with many key contacts and will continue to do so as the longer-term project moves forward.

Recommendations

Throughout the report I have made several recommendations to support the progression of a professionalisation agenda in Australia. Each section of the report has relevance to the recommendations in varied ways, and below is a key summary of the broader recommendations being put forward.

- That government ratify an Act of Parliament akin to the Care Standards Act 2000. Successful change in this instance will be severely truncated if it is not bound in law.

- That an overseeing body akin to the GSCC be established, and with it the establishment of a set of Codes of Ethics for Employees and Employers.

- That the measurement of DSW skill, is based on assessed competence not 'years in the job', or RPL. It is clear that there is a large industry making money whilst diluting the quality of the qualifications within the sector.

- That a review be undertaken of the syllabus currently set as minimum standard, i.e. Cert III/IV. The value of these credentials, if they are seen as a mandatory minimum, must have robust and thorough curriculum based on key competency areas of the actual *hands-on work*. This includes all the soft skills areas and demonstration of these to an independent and comprehensive and work-site based assessor.

- That a professional body for the DSW workforce be established, with a clear mandate to improve on the professionalisation and the development of staff.

- That DHS and funding bodies, review training budget allocation to service providers. The current budget allocation does not even cover annual mandatory training, let alone draw upon service specific development for staff teams to better support people with a disability

- That a thorough review be conducted of the CDS to ensure it is compatible for the implementation within a local context.

- That the sector review its mechanisms in how they incentivise the workforce and stabilise the current issues – such as recruitment and retention, commensurate wages and conditions.

- That disability service providers, both government and community service organisations, review their policies and procedures relating to the assessment of service user outcomes based on actual experiences, not just on systems or processes.

I would like to close with a brief, yet fitting comment that was made to me at the DSW09 Conference I convened at Melbourne University in November of 2009. A DSW who had attended the two-day conference came up to me in the closing hours and gave some very constructive feedback on their views of the sector, and how the conference can better support the workforce. When we were both reflecting on what would be the best way to present information to DSWs in the conference program and who should present it, the DSW remarked, "*the guff and fluff doesn't matter, just show us the best ways we can do our job and we'll get on and do it*". In my experience working side by side with DSWs, this could not be more true.

Glossary

Adult care home: also known as group home, community residential unit. Generally, a community-based long-term supported residential setting for people with a disability. Varying levels of supports, however broadly defined as a home staffed with DSWs.

Applied Behaviour Analysis (ABA): is a system of support based on behaviourist theories, which simply state that behaviours can be taught through a system of rewards and consequences. The Lovaas Institute in California, USA explains the concept in this way:

- **Applied** - principles applied to socially significant behaviour
- **Behavioural** - based on scientific principles of behaviour
- **Analysis** - progress is measured and interventions modified

Arms length body (also known as Quango): an acronym (variously spelt out as quasi non-governmental organisation, quasi-autonomous non-governmental organisation, and quasi-autonomous national government organisation) used notably in the United Kingdom, Ireland, Australia and elsewhere to label colloquially an organisation to which government has devolved power. In the United Kingdom the official term is "non-departmental public body" or NDPB.

Central Council for Education and Training in Social Work (CCETSW): was, from 1971 to 2001, the statutory authority charged with promoting education and training in social work, recognising courses and awarding qualifications throughout the United Kingdom. On 1 October 2001, the CCETSW was abolished and its functions taken over by the GSCC and their affiliate councils.

Coaching Supervision: is (1) a time and space to reflect on ones work either with a senior colleague, in a led group or with peers. The purpose of that reflection is to make greater sense of difficult and complex work situations and to gain more clarity going forward; (2) an opportunity to receive support both practical, in the form of ideas and suggestions and emotional, in the sense of sharing issues and when appropriate reassurance; and (3) supervision that should be a place for ongoing learning and professional development.[27]

Disability Support Worker, Direct Support Professional, Individualised Support Worker and Social Carer/Social Care Worker: acronymistically known as DSWs, this title refers to people working in direct support roles with people with a disability. They are often shift workers working primarily in residential settings, however also in day services, supported employment, private homes, recreation and therapy services and many other disability settings. *Also refer to p.14: "Who is the Disability Support Worker?"*

General Certificate of Secondary Education (GCSE): is an academic qualification awarded in a specified area, generally taken in a number of subjects by students in secondary education in England, Wales, and Northern Ireland. (Scotland, the equivalent is the Standard Grade.) Some students may decide to take one or more GCSEs before or afterwards; people may apply for GCSEs at any point either internally through an institution or externally.

Mencap: The Royal Mencap Society is the UK's leading intellectual disability charity working with people with an intellectual disability, their families and carers. Mencap works collaboratively, fighting for equal rights, campaigning for greater opportunities and challenging attitudes and prejudice. Mencap also provides help and support through

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[27] http://www.pbcoaching.com/article-coaching-supervision.php

supported living, supported employment, respite services, organised activities, systemic and individual advocacy, and outreach support.

National Occupational Standards (NOS): specify UK standards of performance that people are expected to achieve in their work, and the knowledge and skills they need to perform effectively. According to the Sector Skills Development Agency (SSDA, from 1 April 2008 replaced by the UK Commission on Employment and Skills), National Occupational Standards set out measurable performance outcomes to which an individual is expected to work in a given occupation. Developed by employers across the UK, NOS set out the skills, knowledge and understanding required to perform competently in the workplace.

Quango (also known as arms length body): refer to - arms length body

Recognition of Prior Learning (RPL): describes the set of standards and procedures put in place by educational institutions to assign advanced standing to prospective students. Typically referred to as **RPL** or Priior hgvkhgvkhgvkhgvkhgvkhg **PLA** by education professionals, it is most often associated with adult education. The term RPL has been used in two slightly different ways in recent times. Discussion influenced by the Organisation for Economic Co-operation and Development (OECD) and the project of Lifelong Learning, tends to restrict RPL to the recognition of non-formal and informal learning - with the result that the recognition of formal learning is called 'credit transfer'. More traditional educational discussion uses RPL to include credit transfer and sometimes creates different terms for the narrower sense. Prior Learning Assessment is a process that might save a person time as well as money in carrying out a program. It establishes if anything a person has accomplished outside the traditional educational setting qualifies for credit. *Also refer to boxed text: "The major flaw in Recognition of Prior Learning".*

Social carers: disability support workers working in direct support roles, but not excluding some levels of management and social work staff.

University Centres for Excellence in Developmental Disabilities (UCEDD): currently, there are 67 UCEDDs - at least one in every US state and territory - that are in a unique position to facilitate the flow of disability-related information between community and university. Centres work with people with disabilities, members of their families, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing, with a focus on building the capacity of communities to sustain all their citizens. UCEDDs have played key roles in every major disability initiative over the past four decades. Many issues, such as early intervention, health care, community-based services, inclusive and meaningful education, transition from school to work, employment, housing, assistive technology, and transportation have directly benefited by the services, research, and training provided by UCEDDs. *Taken from:* http://www.aucd.org/template/page.cfm?id=667

Valuing People (White Paper): more recently known as Valuing People Now, after its review in Jan 2009. *Valuing People Now* is a United Kingdom three-year strategy that aims to improve the lives of people with learning disabilities, and the lives of their families and carers. It is based on the belief that people with learning disabilities are people first. They have the right to lead their lives like any others, with the same opportunities and responsibilities. Valuing People Now work includes: employment, housing, families, health, workforce issues and other work: that includes advocacy, hate crime and reaching out to culturally and linguistically diverse (CALD) communities.

Appendix 1 – Around the World in Seventy Days Blog

This appendix has been removed solely for the purposes of the Productivity Commission submission, however full access to this material can be downloaded from:

http://www.churchilltrust.com.au/fellows/detail/3369/samuel+murray