

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

**Inquiry into the provision of supported accommodation for Victorians with a disability
or mental illness**

Melbourne — 5 November 2008

Members

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Ms D. Guppy, assistant state secretary,

Mr P. Nuzum, disability support professional,

Mr G. Doige, mental health practitioner, and

Ms A. Landmann, disability support professional, Health and Community Services Union.

The CHAIR — Welcome. All evidence taken at that these hearings is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearing may not be afforded such privilege. We are recording the evidence, and we provide a proof version of the transcript to each witness at the earliest opportunity. I will get you to make a verbal submission now. Please introduce yourselves, each one of you, and give a brief overview of your organisation and a bit more of the submission.

Mr WILLIAMS — My name is Lloyd Williams. I am the state secretary of the Health and Community Services Union.

Ms GUPPY — I am Denise Guppy. I am the assistant secretary of the Health and Community Services Union. I am a psychiatric nurse and mental retardation nurse.

Ms LANDMANN — I am Angela Landmann. I am a disability services officer and a house supervisor in the eastern region.

Mr NUZUM — I am Patrick Nuzum. I am a disability services support officer and house supervisor.

Mr DOIGE — I am Graeme Doige, a community psychiatric nurse.

Mr WILLIAMS — Thank you, Mr Chairman, for inviting me and my organisation and my colleagues to attend the hearing today. We have brought a number of our colleagues who work directly in the services — it is at the request of the committee the last time that I was here — so that we could have a discussion. I recall the committee was genuinely interested in issues around workforce. Our members here are also able to provide valuable input in terms of the structure of services.

HACSU represents the mental health and disability workforce across Victoria. We are also providing the committee with a written submission, which will go to all of the questions posed by the committee. That submission will be provided shortly. Today's verbal submission broadly focuses on accommodation availability; the issues around individualised funding; workforce; and the balance of service provision between government and non-government providers. Of course we are happy to respond to any questions or any other matters that the committee may choose. In terms of the service system it is important to point out — and I am sure the committee would be aware — that disability and mental health services systems are structured and operate quite separately. Accordingly our discussion today with the committee is going to address mental health first, followed by disability services. Now, if the committee pleases, I would just like to go on to mental health. There is no question that there are serious shortages of accommodation places within mental health services. There are gaps in service delivery and there are serious gaps in workforce capacity. One of the reasons is that services have come off a low base in terms of deinstitutionalisation and the establishment of services in the community. Without adequate accommodation and the right level of support, people with a mental illness cannot move towards recovery and instead can remain trapped in a cycle of poverty and illness. From a service perspective, that cycle leads to increased demand and higher cost in other bed-based services such as acute inpatient units. What this does is it extends waiting times for mental health clients in emergency departments. It contributes to homelessness and places additional stress on our correctional system.

The committee is considering accommodation across a number of sectors. It is worthwhile us taking a brief moment to discuss those different sectors and their roles. Clinical bed-based services such as secure extended care units, known as SECUs, and community care units, CCUs, are operated by public area mental health services. These focus on treating and managing a client's clinical symptoms, including a small group of people who for various reasons do not respond to standard treatments. The structure and staffing of these services is also designed to manage behavioural problems such as those who have repeated self-harm issues, ongoing substance abuse and aggressive behaviour.

Non-clinical accommodation services — the resi rehab services, as we call them — are provided by the PDRS sector, the non-government service providers. They are not staffed or structured to manage the behaviours that clinical bed-based services deal with — that is, self-harm issues, substance abuse and behavioural issues. PDRS focus on managing disability, assisting residents with community and social integration, and promoting recovery. Clinical inputs to these clients in the PDRS sector is done on an in-reach basis from the area mental health services.

Area mental health services and PDRS also in partnership operate what is known as prevention and recovery care services — PARCS. These are sub-acute services working with people in crisis whose level of risk is such that they do not necessarily require immediate access or admission to an acute inpatient bed.

The private sector provides accommodation with minimal support. This form of accommodation is generally of low quality in the SRS area, and there have been a number of reports in terms of the supported residential services provided by the private sector, but we will not go to those today.

HACSU submits that the present number, range and level of supported accommodation for people with mental illness is inadequate. The supported accommodation system is an interdependent system where both action and inaction in one sector will always impact on another sector and beyond in terms of the broader community. Clinical and PDRS services in particular serve quite specific and unique roles. Whilst these roles are overlapping, they are quite different but complementary in terms of their function. It is therefore vital that these services have the capacity and are able to fulfil those intended roles. If one of the services is clogged, then the other services will not be able to fulfil their functions effectively. In other words, there needs to be the capacity in each component of the services I have just described in order to ensure the free flow of clients as their clinical, recovery and rehabilitation needs change. This can only happen when each service is operating effectively.

The impact of blockages and undersupply is seen in a variety of settings. On an informal but very real basis there are waiting lists for community care units, secure extended care units and all types of residential rehabilitation beds. People end up waiting in emergency departments for acute admission because of the blockages in terms of throughput because there are waiting lists in these other services. People are being held in police cells, accessing homeless shelters and also living in substandard accommodation — living on the streets, for example — when there is an inadequate level of accommodation.

Those informal waiting lists I referred to are quantified in a Department of Human Services report entitled *An Analysis of the Victorian Rehabilitation and Recovery Care Service System for People with Severe Mental Illness and Associated Disability*. I have a copy of that report for the committee to refer to — you probably already have it. Importantly, within that report it states that on average, for each secure extended care unit — and there are seven — eight people are waiting for admission at any

given time. Half of these are in acute inpatient units. In terms of CCUs, the report also states that an average of six people are on the waiting list for each CCU vacancy. One-third of those were unnecessarily taking up an acute inpatient bed and 13 per cent were taking up a secure extended care unit bed. So you can see that, as I said earlier, where blockages occur in one there are downstream impacts which have a profound impact on the service system.

I would just like to take the committee to secure extended care units, in terms of the availability of beds. Secure extended care beds, as I said, are designed for patients exhibiting behavioural disturbance which poses significant risk either to themselves or to the community. They require extended management in a restricted environment. They also provide appropriate accommodation for patients whose mental illness has been significantly complicated by other conditions such as intellectual disability, acquired brain injury and misuse of alcohol and other drugs.

Secure extended care beds are concentrated mainly in the metropolitan area. We have three secure extended care units with a total of 71 beds across metropolitan Melbourne. There are a further 32 beds across regional and rural Victoria; however, these are often not able to be utilised to their full capacity because they are not secure enough. Given the waiting lists and the importance of these facilities for individual and community safety, we need to expand and extend secure extended care beds in Victoria.

Part of the solution has already been established by the Victorian government. The 2006–07 budget allocated \$9 million for stage 1 planning of an extended care clinical facility on the former Heidelberg Repatriation Hospital site. HACSU considers it absolutely imperative that construction of this facility be given a high priority to meet the shortage of secure extended care unit accommodation and urges bipartisan political support for the Heidelberg project.

Community care units, on the other hand, are also clinical-based services like secure extended care units. The two key features of CCUs are their clinical capacity to manage complex behaviours, including concurrent substance abuse, and to apply and closely monitor the responses to different psychological, behavioural and pharmacological treatment approaches. As discussed earlier, there are also waiting lists for CCU beds. CCUs play a vital role in terms of recovery and step-down facilities for patients from secure extended care units and forensic services and for those awaiting discharge from acute units.

We are concerned about the blurring of roles and the loosening of boundaries between CCUs and PDRS services, the residential rehabilitation services. Currently the Shepparton-Goulburn Valley area has been denied a CCU. Other than Mildura, Shepparton and the Goulburn Valley community is the only community in Victoria that does not have access to its own CCU beds. The state government announced funding for a 10-bed CCU in Shepparton in the 2006 budget. HACSU welcomed that announcement, as it was an important and necessary development. However, that promise of a CCU has unfortunately not been delivered. Instead the Shepparton-Goulburn Valley community has been given a relocated residential rehab service that was first established in 2002 and then rebadged as a CCU.

In our view the Shepparton-Goulburn Valley community should not be forced into a situation of 'either a CCU or a residential rehab service'. The two, as explained earlier, have very different functions, and the Goulburn Valley region needs access to both of these services. There is a need to clarify and reaffirm the role and function of the statewide community care units, the CCUs, rather than blurring their distinctive

role with that of a resi rehab service. HACSU considers that the Goulburn Valley has a need for a CCU and that a CCU should be provided as promised in 2006.

Finally in terms of accommodation in mental health, in respect of the wider supported accommodation system we argue for the expansion of PARCs. They have been partly rolled out, but we argue that they should be rolled out within in each area mental health service and that residential rehabilitation beds need to be increased. These arguments are detailed in our written submission, which will be provided shortly. Now if I could just take the committee to the mental health workforce: the workforce comments I intend to make later in respect of disability I think apply equally to the mental health workforce. However, before I move into disability services it is important to note that the problems in recruiting and retaining an adequately skilled workforce are already very well known across Victoria. This applies in particular to the staffing of clinical-based accommodation services. Mental health nurses and direct care staff comprise the core staffing component of these services, yet the nursing and direct care workforce is ageing and not being sufficiently replenished with new recruits. Workforce problems are also prevalent in the PDRS sector, where inadequate salary rates, career structures, in-service training and portability of entitlements between service providers make it difficult to attract and keep skilled and experienced workers.

In addition, the inadequate provision of in-service training is exacerbating our workforce problems. There is an urgent need to ensure all staff have ready access to regular training programs related to their work. These programs should enable all staff to keep informed about evidence-based practice and service innovations. HACSU considers that it is absolutely imperative that this training is undertaken on a statewide basis so that staff across Victoria have consistent access to best practice knowledge and skills. HACSU considers that the government needs to commit, and must commit, to a major mental health workforce strategy if this situation is not to deteriorate further. We are pleased that work in this space is currently under way, and we are involved with government in terms of that work.

In concluding on mental health I would like to summarise by saying that in order to meet Victoria's growing population and demand for mental health services the supported accommodation system clearly needs to be expanded. This will also help manage demand for high-cost acute services and reduce the impact on the homeless, the police services and correctional systems, as well as promoting community and individual safety. In addition, an expanded supported accommodation system will promote recovery and support people's participation in their own community. These are the same communities, of course, which members of this committee represent. That concludes my submission around mental health. I will now move to disability services, unless the committee wishes to go to any questions before I go to disability.

The CHAIR — We will go to questions at the end.

Mr WILLIAMS — In terms of this space, in and around disability, I want to discuss three key areas: workforce and training, supply of accommodation, including models and quality, and balance of service providers. Firstly I will discuss workforce and training. The disability workforce is facing major retraction, retention and skills-growth problems, and without some major and industry-wide policy and funding intervention we do not see the situation improving and believe that service provision, reform and change may stagnate as a result.

Sound workforce capacity and skills underpin any quality and productive service system. There are no short-term quick fixes to development and repairing workforce problems, particularly where there have been periods of workforce neglect and

cost-cutting over previous years — such as the 90s, which effectively saw 10 years of cuts to training and a real and genuine breakdown of professional career structures. Every level of government and non-government service provider has a major attraction, retention and skills issue facing them; however, problems are particularly chronic in the non-government disability sector. The government sector has fared better since 2000, due mainly to the better leverage of a single workforce, greater capacity of a single management and greater ownership and investment by government as the employer.

By contrast the government service providers have not leveraged funding models that provide for capacity building around workforce and skill development. Nor have the non-government service providers been collectively pure in passing on government funding to deal with some of these problems. There has been a pattern of many of the smaller CSOs not passing on wage growth to employees, and this is exacerbating workforce attraction and retention problems in the sector and expanding the wage disparity problems that currently exist across the sector.

What are the drivers around disability workforce attraction and retention? They are varied and very much interrelated. In terms of attraction and retention we identify a number of areas: wages are poor, particularly in the non-government sector, but also in the government sector, and this is primarily because of low recognition and the valuing of care work. Care work is not seen as part of the productive economy, and as a result carers do not leverage higher pay. Working arrangements, rosters, are not family friendly. Work is modelled around people's primary care needs, and that by definition means in the morning, in the afternoon, in the evenings, nights and on the weekends. So our members are at work when their families are at home. Again, that is not an attractive proposition for many people wanting to enter this field. Care work is predominantly part time. There is high casualisation within the sector and flat career structures offer poor development opportunities for staff.

In terms of training and skills growth, both on and off-the-job training is of fundamental importance within the disability sector. Training and skills development impacts on quality outcomes for service users, work culture, career development and retention. The research report *Identifying Paths to Skill Growth or Skill Recession — Decisions for Workforce Development in the Community Services and Health Industries*, commissioned by the Industry Skills Council — and I will provide a copy of that report to the committee — argues that broadly speaking employers in this sector generally have little incentive to train their employees as it is in their interests to keep costs down. If they train people, they have to pay for that training and then they have to increase employees' pay in acknowledgement of that training.

The report argues and identifies the preconditions which lead to either skills growth on the one hand or skills atrophy on the other. Skills atrophy is different to skills recession, of course, which is failing to attract people to train at the entry level. Skills atrophy is a continual decline in those workers who are currently working in the system. We would argue that skills atrophy is of particular salience to the disability workforce, and in particular the CSO sector. In our view the preconditions that lead to skills atrophy exist within Victorian disability services, particularly within the CSO area. The elements that the report identifies and the pathways to skills atrophy are: funding models do not support in-service training — so there is low investment around in-service training; ownership and capacity — larger organisations have more scope to train than smaller organisations, and also competitive pressures between service providers puts pressure on those smaller organisations and increases their incapacity to deliver on training; employment structures impact — hours of work and

working arrangements in disability services make it difficult to release staff for skills training, one of the major hurdles being that organisations do not give skills growth a high enough priority and the funding models do not support giving skills development a high enough priority.

Job design, perceptions at work and the value of work are extremely important.

Caring roles are not seen, as I said before, as part of the productive economy, reflecting a low skill set expectation and career pathway within the industry.

Incentives to train are extremely restricted. Restricted career pathways, no funding for promotion or recognition of skills enhancement and work intensification combine to create disincentive to train.

There are also the perceptions of customer need. The move to focus on the new individualised funding model is problematic, in our view, for skills growth. Training is not a factor in the individualised funding approach, and there is little work being done, in our view, to ensure that the individualised funding model does not create disincentives to invest in skills — i.e., people purchase low-skill services, and that of course will impact on quality and increase risk for those clients who are accessing support through the individualised funding model.

In short, these attraction, retention and training issues combine, resulting in the disability services sector not being seen as a career of choice. HACSU submits that there is a need to further increase funding and tie such funding to training outcomes in the sector. A major disability workforce and training strategy needs to be developed, funded and implemented to arrest the current skills and workforce problems.

If I could just take the committee to the issue of supply of accommodation, including some models and quality, I think it is beyond question that there are insufficient supported accommodation places within the state. The most recent data states that unmet demand for accommodation places is around 1370 people, or 30 per cent, with demand increasing by about 4 to 5 per cent annually. Those figures are stated in the Victorian Auditor-General's report *Accommodation for People with a Disability 2008*. The demand for, and high cost of, accommodation has resulted in the government moving to alternative funding models, including individual packages, as a service diversion strategy. Since 2003 all new funding has been in the form of individual packages, most of which are not at a level which can support people in greatest need. We believe this strategy fails to address the issue of the increasing demand for accommodation places and has diverted attention away from the issue. In the last five years there has been no funding allocated to increase community residential unit stock, which continues to be identified by families as their preferred option, particularly where clients have ageing parents.

Funding recipients to buy in the support they need to live independently assumes that services exist or will develop in response to the funding model being rolled out. This has major planning, quality, accountability and protection issues for individuals in receipt of packages, in our view. The reality is that the move to the individual planning and support model of funding means that service systems are no longer being strategically planned for — that is, the future need for accommodation is not being strategically planned for.

HACSU contends that in order to address this service shortfall there should be new investment in accommodation stock. The Office of the Public Advocate — OPA — echoes these views. The community visitors report for 2007 recommended, among other things, that the government urgently prepare a strategy to plan and build more disability-specific accommodation of the CRU type, to avoid an escalation of the

crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.

HACSU supports those recommendations. HACSU urges the government to review the existing service options and configurations to expand the model of care beyond a one size fits all. We urge the government to invest in service options and fund the necessary support requirements to deliver quality, individualised service, and we urge the government to provide additional investment to ensure higher levels of training and better resources for staff rostering within services to meet existing client and training needs.

Finally I would like to turn to the balance of service providers. It is our view that both government and non-government services play a vital and different role within the sector. The balance of service is good for the overall quality of service provision within the sector, in our view. We believe the debate about government versus non-government service providers is a distraction. The key issue is that there is simply not enough access to accommodation places and not the workforce available to provide the service.

The state government has a long history in providing services to these citizens who are the most vulnerable and in the greatest need in our society. This focus needs to continue. They are core services that government should provide. We believe the argument that government services have a conflict of interest as funder, service provider and regulator of accommodation support services is wrong. We believe those arguments about a conflict of interest are wrong. There is no empirical evidence of a qualitative benefit to service provision or quality of life for an individual arising from the separation of housing and support provision and/or their management by different entities.

Government is involved in balanced service delivery across a range of core services — for example, education and children's services. This is in the public interest, and we would submit that it is also in the public interest that government maintain its strong presence and investment in the delivery of services to citizens with a disability and with a focus on quality outcomes. It is vital to remain embedded in the service system if there is to be influence and control over such outcomes.

Further, there is greater accountability and a higher level of scrutiny of DHS services than within the CSO sector. The department and the government are subject to freedom of information legislation and to internal scrutiny by the Auditor-General and community visitors, and there is an array of other quality measures and accountability measures. For example, government services are subject to three-monthly quality audits, and regular audits of individual residents' advocacy and care plans are undertaken within the services. In comparison, CSOs are far less accountable. They are neither subject to FOI legislation nor answerable to the Auditor-General. The authority of community visitors was only recently extended to include this sector, arising out of the creation of the new Disability Act, which came into being in July 2007.

This is not to say that there is not a role for CSOs; quite to the contrary, there is. The CSO sector plays a strong role in providing complementary service options. We also note that the period of time which saw competitive tendering for services in the 1990s created a competitive, entrepreneurial culture amongst CSOs, and this has resulted in some interesting growth patterns of organisations, increasing the number of smaller service providers, duplicating effort and duplicating organisational costs, and also, I must say, limiting capacity around some of the workforce training issues that I mentioned earlier. It is questionable whether the number of CSOs involved in the

provision of services remains viable, with the rigours of the new legislation, workforce development capacity and indeed a focus on maximising the quality outcomes required.

Finally, it is our view that it is completely disingenuous of the CSOs and their advocates to argue on the one hand that they can provide services more cheaply by driving down wages and conditions and on the other hand that they need more funding to deal with workforce and training issues. Accordingly we strongly believe that the focus should be on expanding service availability and service capacity across both the non-government and government sectors in a balanced and organised way and that it is only through future investment that we will be able to meet the needs of our most vulnerable citizens in this state. That concludes my submission, and I thank the committee for the opportunity today.

The CHAIR — Thank you.

Ms WOOLDRIDGE — Do you want to hear from any of the others?

Mr NOONAN — I think we should go to questions.

Ms WOOLDRIDGE — Do you want to start?

Mr NOONAN — Where to start? You have covered a fair bit of territory there. Thank you for that, and to your representatives. I suppose we have heard lots of things about workers. I picked up a note there that the non-government CSOs are not always passing on some government funding for workers to perhaps narrow that gap. Can you expand on that? Is there any evidence that you might be able to submit to the committee? Also, whilst you are going through your notes, you also referenced funding models that might better support training in the non-government CSO sector, about how that might be established in order for what you are putting in relation to the wage funding not being used for other purposes.

Mr WILLIAMS — Just in terms of our experience around salaries and trying to deal with the issue of the disparity in wages, whilst there is a significant disparity between government/public sector disability staff and the non-government staff, the other side of the coin is that the government services staff do not get salary packaging. There is a disparity of the order of around 25 per cent in terms of the salary model. There is a disparity in respect of many allowances, and there is also a disparity in terms of leave and the portability of such leave. Our experience in terms of what we have been able to do in making sure that it does not fall any further, is that when the government funds CSOs every three years, the larger CSOs do the right thing and pass on that 3 per cent funding in the wages so there is not a further falling back. Some CSOs do not pass on all of that funding and continue to pay just the bare minimum award rates of pay, which are again below what many CSOs pay. What we have developing is not just disparity between government services but we have seen developing a disparity between the CSOs themselves. We have some CSOs paying what we call EBA rates of pay which reflect the government funding for additional pay outcomes, but we also have many smaller CSOs simply paying the bare minimum award rates for which I will give you an example. At an entry-level a certificate IV person CSO EBA rate is \$35 064 per annum. The award rate is \$33 623. The government rate is \$42 611, so you can see that there are three variations across the sector. It does not help us when we hear CSOs talking about funding for employment standards and conditions when not all of the CSOs, as I said in my submission, are pure in terms of passing that on.

Mr NOONAN — I suppose the second part — —

Mr SCHEFFER — I just want to follow up on that. When National Disability Services Victoria were presenting this morning they referred to this salary

discrepancy in the context of a larger inequity in resourcing in general. Could you throw light on that at all for us?

Mr WILLIAMS — There are different resourcing levels because the clients who are cared for by the department are clients with very significant needs and by definition there are higher resourcing implications. I did not hear the submission so I cannot respond in detail, but in terms of the price for services I am not sure whether it is the same or different. But I do know that our members work in the department's services and they can actually make some comments themselves in terms of the high need.

Ms LANDMANN — I think definitely, yes, departmental houses tend to support those residents who have the most complex needs that require much higher resources. We have seen evidence of CSOs returning clients to us when they cannot care for them within their resources. We do certainly require a lot more resourcing to deal with the needs of the clients that we have compared with CSOs.

Mr NUZUM — I know of one example from my own region where a CSO handed back a whole house — a whole CRU — to the Department of Human Services because the behaviours of concern were beyond its ability to deal with. I can certainly supply more details of that particular one but I know that I hear regularly stories where complex health care needs or behaviours of concern create problems for CSOs and they are handed back to DHS accommodation services. I do not think you can compare — I suppose it is the old apples and oranges argument. I think on average DHS accommodation services have a much wider range of complexities. Certainly we have a large number of special students who work with people with behaviours of concern who have particular challenges.

Ms WOOLDRIDGE — I think the comments this morning related to facilities and maintenance, and the Office of the Public Advocate said the same thing. Not the mix but if there is maintenance or capital funding to be handed out often DHS gets it first and then the CSOs are required to fundraise to improve their facilities.

Mr WILLIAMS — I think there is no question that there needs to be additional funding and support for CSOs around building fabric, and where we see it is around occupational health and safety standards within those services and units. We would agree there does need to be extra funding for improved stock.

Ms WOOLDRIDGE — I am interested in Tasmania, and it was raised this morning that Tasmania has moved to a system that is provided by the community sector, and you obviously represent the workforce in Tasmania as well. I think it is interesting that they trialled it; their experience has been so positive that they have recently decided to move the whole disability service sector over a transition period to the non-government sector. That experience could inform us in terms of our thinking of the process. I would be interested in your comments in relation to your members' experience of that.

Mr WILLIAMS — Our experience there is, I think, the jury is out, and I am advised by our colleagues in Tasmania that the jury continues to be out in terms of the capacity of Able to continue to provide those services. I would not like to make a comment as to whether it is working or not. I would say though that it is off a much smaller base in terms of the need of residents within those services.

Ms WOOLDRIDGE — But the government has clearly had an indication. To have made the decision to go the whole hog, it has obviously taken a call that it is working.

Mr WILLIAMS — Yes. I would respectfully disagree with the Tasmanian government, I think, on that note. One of the concerns that I would have is that, again,

if there is a move to do it on the basis of lowering the dollar and doing it on a cheaper base, I think that is inappropriate.

Mr SCHEFFER — I just wanted to come to individualised funding approaches. I think without exception the witnesses that we have had so far have been supportive of that, and I take it from your remarks that in the broad you are supportive of it as well because of its flexibility. But you did say that there were some issues with that, particularly around the reduction in the capacity to build up a trained workforce. Could you just expand on that? I am not sure I quite understood.

Mr WILLIAMS — I guess it is how it is rolled out. Our concern is the disaggregation of skill set. If you are purchasing services directly, you as an individual become the employer, and your capacity to continue to develop the skill sets of the caring group is much more limited, unless there are some other policy initiatives to support ongoing skill development of workers working directly with individuals and employed by individuals. Whilst we support in principle the notion of individualised funding, we are concerned that if adequate training and capacity issues are not being built in, we will see a decline in the overall skill set of the service provision.

Ms LANDMANN — May I just add there that we are already seeing that due to individualised funding some agencies are having to close down because they cannot provide services any more without having the funding guarantees. We have many residents now who have been left without day placements. There is a small part of it that is showing a funding program that is supposed to increase choice but is actually doing the opposite because of the inability for resources to continue.

Mr NUZUM — The individualised funding model has resulted in in-home support staff who are paid at a lower level than the CSO shared supported accommodation, as well as the government. In fact the individualised model has seen a new class of workers who are getting far worse wages and conditions. You already have problems with the existing services attracting staff and retaining them and making sure they are paid adequately; some of these new individualised funding models have actually seen people go further down.

Ms WOOLDRIDGE — Obviously the pricing review is under way, which a lot of this absolutely addresses. Do you have a position in relation to percentage increase and other changes that need to be reflected out of that pricing review to be able to deliver the training and the support and care and to support the workforce in the way we need to do to achieve the right outcome?

Mr WILLIAMS — The short answer is no. No, we do not have a figure on that. We know the wage disparity is of the order of 25 per cent. That is quite significant in itself, although we do have to add in and do further research about what the salary packaging component of that is. One of the other key issues is the ability for people to move from one CSO to another, who have served eight or nine years, and have their long service leave made portable to another service provider. I think there is a whole range of initiatives that could be implemented in that space. I think also the capacity of CSOs to deliver training outcomes in small areas, particularly rural and regional areas, is extremely difficult. One of the initiatives that we have urged the government to look at is some statewide training capacity for the sector which could be delivered across both the government and non-government services. But the short answer is no, we do not have a number on what we believe the percentage increase should be in the budget.

Ms WOOLDRIDGE — But if the increase reflected an increase in CSO wage rates up to government-provided wage rates, would you be happy for there to be a parity between the salary levels of the two workforces?

Mr WILLIAMS — Absolutely.

The CHAIR — I have one quick question. As an organisation representing members across Australia, how do you rate Victoria compared with the other states in terms of the provision of disability services? Are we on the right path in terms of structures and so on?

Mr WILLIAMS — There is no question that both in mental health and disability services Victoria has led the way for many years. That is not to say that Victoria cannot do better and should not do better — it should — but my experience is that the services in Victoria, whilst they have their problems, overall are of good quality and good structure, particularly our mental health services. The level of community support and structure around those services; and how it is an integrated and connected model is a good model. I think that any report you picked up would say that Victoria is in a better position than the other states to lead further reform and change.

The CHAIR — Thank you very much.

Witnesses withdrew.