2018

Direct Client Care and Support

INDUSTRY REFERENCE COMMITTEE
INDUSTRY SKILLS FORECAST

SKILLSIQ

CAPABLE PEOPLE MAKE CLEVER BUSINESS

Contents

Skills Forecast

Name of IRC:

Direct Client Care and Support

Name of SSO:

SkillsIQ Limited

About SkillsIQ:

SkillsIQ supports 18 Industry Reference Committees (IRCs) representing diverse 'people-facing' sectors. These sectors provide services to people in a variety of contexts such as customer, patient or client. The IRCs are collectively responsible for overseeing the development and review of training package products, including qualifications, serving the skills needs of sectors comprising almost 50% of the Australian workforce.

Our qualifications deliver skilled people that are valued and make a difference to others.

- Cross Sector Skills Committee, February 2018

Executive Summary

Direct Client Care and Support workers care for and support people who are in vulnerable situations such as those in aged or home care, or living with a disability, mental illness, dementia, a chronic condition, terminal illness or an alcohol- or drug-related problem. The Industry Reference Committee (IRC) is responsible for ensuring that nationally recognised qualifications deliver the skills and knowledge required to equip the sectors under its remit with a highly skilled workforce.

The National Schedule details the training package review and development work commissioned by the Australian Industry and Skills Committee (AISC). The National Schedule is informed by this Industry Skills Forecast which outlines the proposed timing for updating existing training package products. This Forecast has been informed using many sources, including a range of literature and databases, IRC member input and expertise, public consultation feedback, and an industry analysis of both new and emerging workforce skills needs within the Direct Client Care and Support sub-sectors.

Workers within the remit of this IRC make up a large part of the health and community services workforce. Due to Australia's ageing population, and through the implementation of the National Disability Insurance Scheme (NDIS), and Consumer-Directed Care (CDC), it is anticipated that the workforce will need to grow significantly to accommodate predicted demand (support worker-related jobs being expected to grow by 40% over the next five years).

Currently, the sector is experiencing a number of challenges and opportunities impacting the workforce, as follows:

- **Regulation** – with the implementation of the NDIS and CDC, workers within the sector will need to adhere to a certain set of standards to deliver safe and appropriate person-centred care
- **Wages and conditions** – which continue to be an ongoing issue for workers within this sector
- **Quality issues** – relating to the workforce being understaffed in terms of the demand for services. There is also concern that care may be compromised in terms of quality due to insufficient numbers of workers within the sector
- **Rural and remote communities** – given that attracting and retaining workers in these areas continues to be an issue for the sector
- **Abuse in aged care and disability** – which requires the workforce to be equipped to recognise signs of abuse and to know how to support people who are victims/survivors of domestic/family violence
- **Digital health** – which means that the workforce will need the required skills to adapt to the changes as technology becomes further integrated into health service delivery.

The Direct Client Care and Support IRC has identified **Health Assistance, Health Support Services** and **Individual Support and Ageing** qualifications as requiring updates in 2018–19 to fill gaps in knowledge and skills for workers within the Direct Client Care and Support sub-sectors. Using and implementing technology; recognising and responding appropriately to abuse; and providing person-centred customer service are skills that workers within the sector need now and will need in the future. Developing stronger cultural awareness and competency to interact with and support the Aboriginal and Torres Strait Islander community, people from Culturally and Linguistically Diverse (CALD) backgrounds and the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ) communities, is also important for workers within this sector.

The remaining qualifications within the remit of this IRC, including Leisure and Health, Mental Health and Health Services Assistance, are proposed to be updated in 2019–20, along with the cross-sectoral units of competency that form part of the greater *HLT Health and CHC Community Services Training Packages*. Industry also notes the continued need to allow for the proper implementation and testing of training products within the system, prior to any further review work.

Sector Overview

The Direct Client Care and Support IRC is responsible for national training package qualifications relevant to aged and home care, disability, mental health, alcohol and other drugs, leisure and health, allied health assistance, and health services assistance.

People who work in this sector care for others. They may be looking after someone who is frail and aged, or living with a disability, mental illness, dementia, a chronic condition or acute illness, terminal illness or an alcohol- or drug-related problem. Every direct client care situation is different and unique to the individual who is the service recipient.

Direct Client Care and Support workers:

- provide support and assistance:
  - with a range of care tasks, including personal daily activities such as bathing, dressing and personal care, as well as other routine requirements associated with meals, community participation and social support
  - in the provision of counselling, psycho-social support, information services, case management, and services related to clients with issues relating to mental health, alcohol or other drugs, homelessness, family welfare and family violence
- require the appropriate skills and knowledge relating to their relevant area to be able to support their clients in accordance with the relevant codes of conduct, standards of practice and legislation
- work directly with individuals to support a variety of services in a range of settings.

Recipients of these services are often vulnerable and in need of advocacy for their rights, as well as needing assistance in accessing entitlements or appropriate support. Ensuring the safety and wellbeing of highly vulnerable consumers, many of whom may be residents in shared facilities or in receipt of services in their own homes, is essential and is a key driver of policy settings and the need for regulation within the sector.

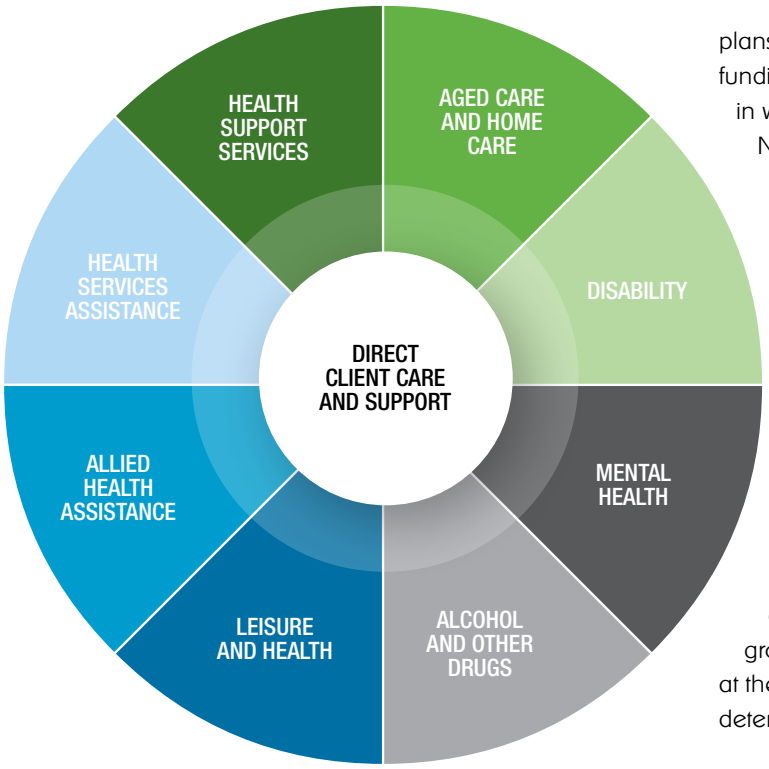
It is difficult to calculate the number of people employed across the sector. However, it is acknowledged that these workers make up a significant proportion of the health and community services workforce, which is estimated to employ over 1.6 million workers (13% of the total workforce) and which has accounted for 25% of new jobs during the five years to November 2017.[1]

Businesses across this sector are predominantly government and not-for-profit organisations. However, the move to consumer-directed funding models may represent a transition for providers towards a more contestable and competitive market. This has been driven in part by federal government policy as highlighted in the Productivity Commission's report titled *Introducing Competition and Informed User Choice into Human Services*.[2] This shift has prompted speculation that there may be an increase in for-profit operators entering the market, including multinational health and community service providers.

The labour market in this sector is affected by broader government policies which determine how, and on what basis, services are provided. There are shared responsibilities between the federal and state and territory governments, while implementation is at a community level and can involve local government.

The Direct Client Care and Support sector plays a critical role in enabling vulnerable individuals to function in life and has a direct impact on the quality of their lives. The services the workforce provides are not merely transactional. An element of humanity and the importance of interpersonal connection must be acknowledged at the outset of any consideration of the sector.

The sub-sectors of the Direct Client Care and Support sector can be seen on the following page.



Australian communities are increasingly diverse and this is reflected in the range of people in need of the services provided by this sector. For example, there are people of all ages from diverse backgrounds such as those who are Culturally and Linguistically Diverse (known as the CALD community), the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/Questioning (LGBTIQ) community, and Aboriginal and/or Torres Strait Islander peoples. There are groups of people whose life experiences have caused them to suffer post-traumatic stress and who are in need of support services with specialised expertise. These groups include war veterans, refugees, and victims of family violence or child abuse. Workers in the Direct Client Care and Support sector need the skills to empathise and connect, and to understand the many layers of influences which affect the recipients of their services.

The Direct Client Care and Support sub-sectors are not mutually exclusive in the services they provide, and increasingly the collaboration of people across sub-sectors is a critical element in individual care and support plans. Major policy changes and limited categorical funding can create challenges in terms of the ways in which services are coordinated, and the current National Disability Insurance Scheme (NDIS) implementation is an example of this. It is critical to have people working in these sub-sectors who are skilled in navigating complex bureaucratic processes and translating entitlements into meaningful services to meet the appropriate care and/or support needs of individuals.

The Direct Client Care and Support sector is subject to a range of policy settings across federal, state, territory and local government levels. Data predicting the demand and need for services must be up-to-date and reliable; equitable funding systems need to balance access and affordability of services across different population groups and geographic areas; and implementation at the community level must be effective and reflect self-determination on the part of the service recipient.

Aged Care and Home Care

This sub-sector includes Residential, Retirement and Home Care.

- **Residential aged care:** This is for older people who can no longer live at home and need ongoing help with everyday tasks or health care, either on a permanent basis or via short-term care with help available 24 hours a day. Short-term care in an aged care home is called **residential respite care**. Privately funded aged care services and housing options fall under the category of **retirement villages**, and are **not** approved providers of aged care services funded by the Australian Government.

  According to the Property Council of Australia, there were more than 2,300 retirement villages in Australia in 2014 and around 184,000 seniors living in retirement villages. However, that figure is expected to double, with some predicting that as many as 382,000 people will be living in retirement villages by 2025.

  It is noted that a number of young people with severe disabilities may be placed in residential aged care

facilities when there is a lack of other supportive accommodation. Data from the Young People in Nursing Homes National Alliance shows that, as far back as 2010, there were around 6,500 people aged under 65 living in residential aged care. Over 100 of these were aged younger than 39.[3]

- **Retirement villages with home care services:** These are for people living in a villa or independent living unit, but many retirement villages also offer access to a range of home care services such as help with domestic work and transport to appointments.
- **Retirement villages with residential aged care:** Some retirement village developments now have integrated levels of care and offer residential care accommodation for people who already live in the community - for example, partners who wish to stay close to each other if one has complex needs or couldn't otherwise continue to live in his or her own home.
- **Home care:** The Australian Government's Home Care Packages Program helps older people who would prefer to remain independently at home as they get older to live independently in their own homes for as long as they can.

Workers in all these areas take a person-centred approach and use individualised planning to assist clients in their day-to-day living. Roles are available as support workers in a variety of contexts. Personal care attendants can also provide support with food services and transport.

New reforms have been announced and include a new national independent Aged Care Quality and Safety Commission to commence operation from 1 January 2019. The reforms are in response to a review which found that the current aged care regulatory framework is fragmented and does not adequately provide the assurance the community expects.[4]

As the shift to a consumer-directed care model underpins current policy, there is a greater need for a focus on providing information to both consumers (with consideration for people from CALD backgrounds, particularly older people, who may have difficulty understanding and navigating systems to access information if they are not proficient in English) and also to providers on what quality care means for an individual; how to exercise individual and human rights; and how to improve the effectiveness of accreditation and compliance monitoring.

Elderly citizens living in care facilities, many of whom acquire disabilities and dementia associated with ageing, are especially in need of protection.[5] According to Alzheimer's Australia in 2016, just over half of the people living in residential aged care facilities had dementia. It was also estimated that over 400,000 people were living with dementia in Australia in 2016.[6]

The Aged Care Workforce Strategy Taskforce, formed in 2017, has been instructed to "develop a strategy for growing and sustaining the workforce providing aged care services and support for older people, to meet their care needs in a variety of settings across Australia." [7] This reflects the critical importance of the people-facing aspect of the provision of aged care services and the equal importance of access to a skilled workforce in providing quality service.

The Taskforce is focusing its efforts around five strategic imperatives, including the importance of the aged care sector to the broader community; industry leadership and accountability within the aged care sector; current and future workforce organisation and skills; the attraction and retention of workers within the aged care sector; and new models of care and practice based on research and technology. The Taskforce recently released 15 strategic recommendations aimed at driving transformational change within the aged care sector through shifting attitudes towards ageing and dying, reforming access to aged care services, and enhancing life through a suitably skilled workforce. The work of the Taskforce is expected to be completed by mid-2018.

Disability

The disability sub-sector provides a range of options to support people with disability in a variety of settings. The focus of this sub-sector is to offer support to ensure independence and provide a person-centred approach to planning. There are several essential roles within the sub-

sector, including personal care, employment support and social support. In addition to skills, knowledge and attitudes in respect to disability, workers also require attributes in high-level and targeted communication, and must be responsive to the needs and wishes of individual people with disabilities.

The *National Disability Insurance Scheme* (NDIS) is designed to change the way that support and care are provided to people with permanent and significant disability (i.e. a disability that substantially reduces an individual's functional capacity or psychosocial functioning). The NDIS is being rolled out across Australia and is the most significant reform for the sub-sector in decades. At full implementation, approximately 475,000 people with disability will receive individualised supports, at an estimated cost of $22 billion in the first year of full operation.[8] The NDIS is based on the premise that individuals' support needs are different, and that scheme participants should be able to exercise choice and control over the services and supports they receive.

Since the NDIS aims to provide more individualised support for people with a disability, demand for workers and the overall workforce is forecasted to increase significantly in order to meet participant intake volumes, as well as the need to provide more personalised services. According to the Productivity Commission 2017 report, *National Disability Insurance Scheme* (NDIS) Costs, the number of full-time equivalent staff will need to double, or in some areas, triple, to meet demand. Other estimates, however, indicate that the increase may be instead between 60% and 80%. Whilst the need for the workforce to increase dramatically has been raised as a key issue to be addressed in order to meet the number of participants in the Scheme, the speed at which this needs to happen is also an issue that the government and sector both face.[9]

The knowledge and skills to access specialist and generic community organisations are significant requirements where workers operate as sole providers, and some marketing knowledge and other small business skills are relevant.

Mental Health

The mental health sub-sector is made up of clinical staff and people who work in support roles in a variety of organisations across government and community-managed organisations.

A focus on recovery orientation in mental health support is underpinned by national and state activity. Workers need a solid understanding of mental health, the principles of recovery and trauma-informed care, and access to specialist and generic community services to meet the identified needs and aspirations of people with mental health issues. Collaborative planning and effective high-level communication skills are required to work effectively with a range of community stakeholders.

The Mental Health peer workforce is a growing segment of the sector's labour force. The peer workforce refers to people employed because they have 'lived experience' of a mental health condition. A peer worker may be an individual who has a lived experience of a mental health condition personally, or may be a family member or carer of a person who has a lived experience of a mental health condition. The term 'peer workforce' is used to refer to a diverse range of consumer worker and carer worker job roles in Australia (for example, peer support worker, consumer advocate, consumer consultant, carer representative, carer advocate, consumer or carer team leader/manager, consumer/carer educator/trainer, consumer/carer researcher/evaluator, etc.).

A capable and compassionate workforce is required to deliver services to people living with a mental illness, their families, carers and support people. An increased focus on the inclusion of people with mental health issues in the workforce has been evident in recent advertising campaigns and programs to increase awareness in the broader community. Awareness can be the initial step in developing skills to work in an inclusive manner towards supporting individuals in their communities.[10]

Alcohol and Other Drugs

Alcohol and Other Drugs workers work in a range of services, predominantly within the health sector. They

provide health interventions to those affected by alcohol and other drug dependence or experiencing harm from the use of alcohol and other drugs. These roles range from case managers, counsellors, clinicians, coordinators, residential and community support workers, recovery workers and outreach workers.

Service provision is underpinned by national and jurisdictional strategies (e.g. the National Drug Strategy, the National Alcohol Strategy, and the National Tobacco Strategy, etc.). Work is undertaken within a harm minimisation framework. There is a well-established peer workforce drawn from people with lived experience of alcohol and other drug dependence and engagement with treatment services. Support services include case management and broader psychosocial support, including a focus on client complexity (for example, where people also experience poverty, homelessness, family violence, gambling problems, mental health issues, etc.).

Alcohol and Other Drugs workers require skills in working with specific groups within the community who have higher rates of use or dependence, such as young people, people from CALD communities, and Aboriginal and Torres Strait Islander communities. Developing an understanding of evidence-based treatment and the changing patterns of use of known and emerging synthetic substances is also important. For example, recent attention has focused on methamphetamine use and its harms in regional communities.[11] However, there is an overemphasis on methamphetamine use when compared to the impact of tobacco, alcohol and cannabis, each of which has a higher burden of disease than methamphetamine alone.

Leisure and Health

Workers in leisure and health have traditionally held roles in aged care services (in either aged care facilities or community care). With reforms occurring in the manner in which services are delivered (in line with other aspects of community services sector work) a more individualised approach to meeting the leisure and health needs of individuals is evident. This work continues to be important in aged care facilities. However, the demand for services from other groups is evidenced in an increased range of activity choices in gyms and aquatic and fitness facilities in communities. Direct client care and support workers are undertaking leisure and health planning and implementation programs in inclusive recreational activities, to enhance programs for people of all ages with disabilities, mental health or alcohol and other drug addiction issues.[12]

Allied Health Assistance

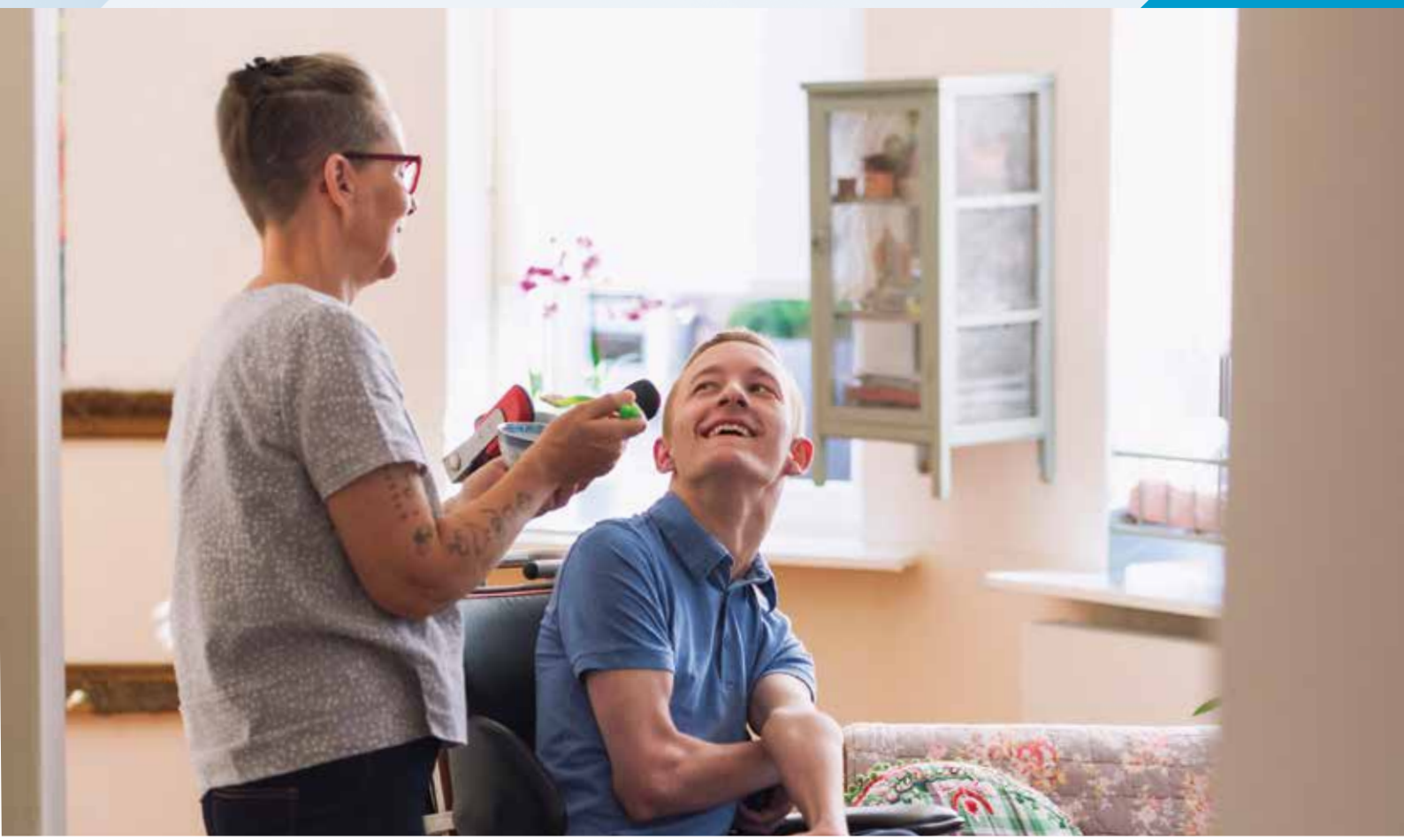
The allied health assistance workforce is an essential component of the broader health workforce, and the demand for allied health services is expected to increase with the growing burden of chronic disease, an ageing population, an increased focus on prevention and rehabilitation, increasing expectations in terms of the delivery of multidisciplinary care, and increasing consumer knowledge and expectations.,[13,14] In response to these challenges, governments across Australia have recognised the importance of developing the allied health assistance workforce.[15]

An allied health assistant has been defined as 'a person employed under the supervision of an allied health professional who is required to assist with therapeutic and program-related activities. Supervision may be direct, indirect or remote and must occur within organisational requirements'.[16] Allied health assistants work to support allied health professionals, undertaking less complex tasks across a range of disciplines, settings and program areas.[17] Allied health assistants may work within a single allied health discipline or may work across more than one allied health discipline. The scope of practice for assistants is guided by the employing organisation and professional associations/regulatory bodies.[18]

Allied health assistants' training and skills development needs to keep pace with the growing range of service roles of health professionals within new models of health care delivery.

Health Services Assistance

Assistants and support workers use a range of factual, technical and procedural knowledge to provide assistance to health professional staff, such as registered



nurses, for the care of clients. These assistant roles involve the provision of direct client care under the supervision and delegation of a registered health professional, who, in the majority of cases, is a registered nurse with overall responsibility for the assistant worker. The assistant remains responsible and accountable for his or her own work within prescribed parameters.

Health Support Services

Individuals working in health support services assist in the effective functioning of the health system and are critical to the overall standard of care provided. Their roles include those relating to food services, cleaning, laundry, transport, administration, grounds and general maintenance. Although workers will most likely work in hospitals, many of these services may be contracted out to other providers.

Appropriately skilled and qualified workers are required to undertake these roles. These workers often have highly transferable skills and may perform a range of functions. For example, depending on the shift, work may include elements of cleaning duties, patient transfers, or the transport, provision and delivery of supplies. The breadth of these roles can be highly dependent on the employing organisation and the coordination of work at a facility.

Nationally Recognised Direct Client Care and Support Qualifications – as at June 2018

The VET qualifications that cater to this sector are:

- CHC33015 Certificate III in Individual Support
- CHC43015 Certificate IV in Ageing
- CHC43115 Certificate IV in Disability
- CHC43215 Certificate IV in Alcohol and Other Drugs
- CHC43315 Certificate IV in Mental Health
- CHC43415 Certificate IV in Leisure and Health
- CHC43515 Certificate IV in Mental Health Peer Work
- CHC53215 Diploma of Alcohol and Other Drugs
- CHC53315 Diploma of Mental Health
- CHC53415 Diploma of Leisure and Health
- HLT23215 Certificate II in Health Support Services
- HLT33215 Certificate III in Health Support Services
- HLT33015 Certificate III in Allied Health Assistance
- HLT33115 Certificate III in Health Services Assistance
- HLT43015 Certificate IV in Allied Health Assistance.

The qualifications can be mapped to job roles as follows, to indicate the diversity of settings and breadth of these support services:

CODE	QUALIFICATION TITLE	JOB ROLES
CHC33015	Certificate III in Individual Support	**Support workers** – work with a person-centred approach to provide support, predominantly supporting the aged or people with disability. Depending on the sector, work may be undertaken in a residential, retirement, home or community/clinical-based environment
CHC43115	Certificate IV in Disability	
CHC43015	Certificate IV in Ageing	**Assistants in nursing** – provide assistance to health care professional staff for the care of clients in an aged care, clinical or acute care setting
CHC43215	Certificate IV in Alcohol and Other Drugs	**Drug and alcohol workers** - provide services and interventions to clients with alcohol and/or other drugs issues and/or implement health promotion, prevention and early intervention services. Work is undertaken in contexts such as health services, non-government and private organisations, delivering withdrawal services, residential rehabilitation, harm reduction and community-based services that deliver strategies ranging from abstinence to controlled usage
CHC53215	Diploma of Alcohol and Other Drugs	
CHC43315	Certificate IV in Mental Health	**Mental health workers** - support people with mental illness in community participation, working to prevent relapses and promoting recovery through programs such as residential rehabilitation, and/or work in clinical settings, in home-based outreach and/or centre-based programs delivered by community-based non-governmental organisations. Work may also involve supported employment and programmed respite care
CHC53315	Diploma of Mental Health	
CHC43515	Certificate IV in Mental Health Peer Work	**Peer support workers** - have lived experience of mental illness as either a consumer or carer and work in mental health services to support consumer peers or carer peers. Workers are employed in government, public, private or community-managed services
CHC43415	Certificate IV in Leisure and Health	**Diversional therapy assistants** - assist in the design, implementation and evaluation of health and leisure activities for clients. This can include encouraging clients to take part in activities, assisting in their social development, and promoting a sense of wellbeing. These assistants work in residential facilities or in community settings, as well as day centres
CHC53415	Diploma of Leisure and Health	
HLT33015	Certificate III in Allied Health Assistance	**Allied health assistants** – provide therapeutic and program-related support to allied health professionals. These workers may be engaged to work in speciality areas (physiotherapy, podiatry, occupational therapy, speech pathology, community rehabilitation, nutrition and dietetics), or generically across the organisation in the delivery of allied health services
HLT43015	Certificate IV in Allied Health Assistance	
HLT23215	Certificate II in Health Support Services	**Health services support workers** - provide support for the effective functioning of health services. Workers complete tasks under supervision in collaboration with others in a team environment. These workers do not deliver direct care to clients
HLT33215	Certificate III in Health Support Services	
HLT33115	Certificate III in Health Services Assistance	**Health services assistants** – workers who use a range of factual, technical and procedural knowledge to provide assistance to health professional staff for the direct care of clients under supervision.

Registered Training Organisation Scope of Registration

The following table (Table 1) indicates the number of Registered Training Providers (RTOs) with Direct Client Care and Support qualifications on scope. This data is current as at June 2018, per the listing on the National Register of VET (www.training.gov.au).

Table 1 Number of RTOs by nationally recognised qualifications on scope – Direct Client Care and Support Training Package Products

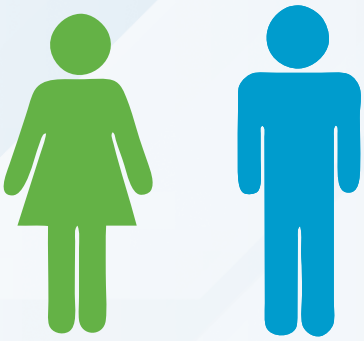
Qualification Code	Qualification Title	No. of RTOs with Qualification on Scope
CHC33015	Certificate III in Individual Support	506
CHC43015	Certificate IV in Ageing	274
CHC43115	Certificate IV in Disability	232
CHC43215	Certificate IV in Alcohol and Other Drugs	49
CHC43315	Certificate IV in Mental Health	95
CHC43415	Certificate IV in Leisure and Health	96
CHC43515	Certificate IV in Mental Health Peer Work	24
CHC53215	Diploma of Alcohol and Other Drugs	32
CHC53315	Diploma of Mental Health	43
CHC53415	Diploma of Leisure and Health	18
HLT23215	Certificate II in Health Support Services	57
HLT33215	Certificate III in Health Support Services	27
HLT33015	Certificate III in Allied Health Assistance	57
HLT33115	Certificate III in Health Services Assistance	96
HLT43015	Certificate IV in Allied Health Assistance	63

Source: Training.gov.au. RTOs approved to deliver this qualification. Accessed 21 June 2018.

2016 ENROLMENT SNAPSHOT

DIRECT CLIENT CARE AND SUPPORT TRAINING PACKAGE PRODUCTS

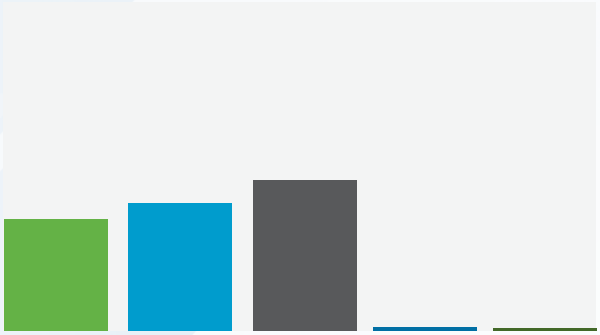
GENDER



80% 20%

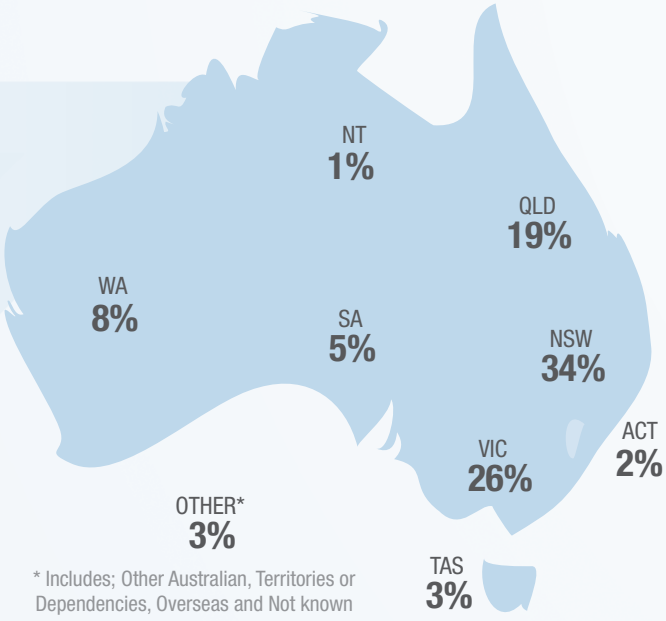
AGE

Percentage Years of age



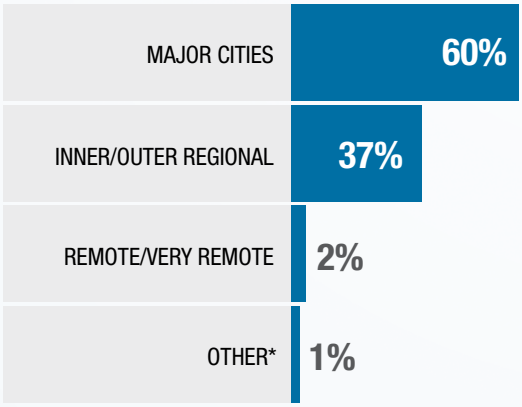
29%	33%	38%	<1%	<1%
UNDER 25	25 – 39	40 – 64	65 and over	Not known

STATE/TERRITORY OF RESIDENCE



* Includes; Other Australian, Territories or Dependencies, Overseas and Not known

STUDENT REMOTENESS REGION (2011 ARIA+)



* Includes; Outside Australia and Not known

Source: NCVER VOCSTATS (Program enrolments 2016 by various breakdowns)
Base count n = 70,728

General notes on statistics

1. Enrolment data is sourced from NCVER VOCSTATS (Program enrolments 2016), accessed November 2017.
2. It is important to note that not all training providers are currently required to submit enrolment data, and some figures presented may therefore under-represent the true count of enrolments for a qualification. From 2018, all training providers will be required to submit data, and current discrepancies noted in the national NCVER figures versus actual attendance should therefore be minimal in future releases. The data presented in this report is shown for indicative purposes.
3. Figures reflect public and private RTO data.
4. 'E' represents Enrolment.
5. Superseded qualifications and their respective enrolment data are not tabled.

All Student Programs – Enrolments

Table 2 details enrolment figures for the year 2016. This data has been sourced from the National Centre for Vocational Education Research (NCVER).

Table 2 - Total number of enrolments (Total VET Activity [TVA]) by nationally recognised qualifications on scope – Direct Client Care and Support Training Package Products, 2016

QUALIFICATION	2016
CHC33015 - Certificate III in Individual Support	35,180
CHC43015 - Certificate IV in Ageing Support	7,465
CHC43115 - Certificate IV in Disability	5,698
CHC43215 - Certificate IV in Alcohol and Other Drugs	1,404
CHC43315 - Certificate IV in Mental Health	3,336
CHC43415 - Certificate IV in Leisure and Health	1,284
CHC43515 - Certificate IV in Mental Health Peer Work	367
CHC53215 - Diploma of Alcohol and Other Drugs	618
CHC53315 - Diploma of Mental Health	1,090
CHC53415 - Diploma of Leisure and Health	261
HLT33015 - Certificate III in Allied Health Assistance	1,998
HLT33215 - Certificate III in Health Support Services	133
HLT33115 - Certificate III in Health Services Assistance	8,542
HLT43015 - Certificate IV in Allied Health Assistance	3,323

Source: NCVER VOCSTATS, accessed November 2017.

Stakeholders

National Peak Bodies and Key Industry Players

The following list represents a range of organisations that perform a variety of key roles in this sector. These organisations and their networks are well placed to offer industry insights at the time of training package review. Engagement and consultation activities will include a broad range of industry stakeholders beyond those included in this list.

- **Federal, state and territory government departments and agencies**
  - Department of Health
  - Relevant state and territory government departments
- **Peak and industry associations**
  - Aged and Community Services Australia
  - Australian Community Workers Association
  - State and territory Alcohol and Other Drugs agencies
  - Allied Health Professionals Australia
  - Carers Australia
  - Community Mental Health Australia
  - Diversional Recreational Therapy Association
  - Leading Age Services Australia
  - Mental Health Australia
  - National Disability Services
- **Employee associations**
  - Australian Nursing and Midwifery Federation
  - Australian Services Union
  - Health Services Union
  - United Voice
- **Regulators**
  - Aboriginal and Torres Strait Islander Health Practice Board
  - Australian Aged Care Quality Agency
- **Registered training organisations both public and private**
- **Large and small private employers across metropolitan, regional, rural and remote areas.**

Sector Overview

The health services sector in Australia includes a range of health services and facilities. According to the IBISWorld Industry Report *Health Services in Australia (2017)*, Australia's age profile and private health insurance coverage are expected to continue rising over the next five years, which should strengthen demand for most health services. The report covers related sectors including 'providing other allied health care services' and 'providing specialist medical services'. Health services revenue is expected to grow at an annualised 2.8% over the five years from 2017–18 to 2022–23, supported by rapidly increasing patient volumes. This result includes forecast growth of 2% in the current year, to a total of $124.5 billion.[19] There is also anticipated growth in employment in the health services industry. This is elaborated later on in the Employment and Skills Outlook - Labour Force Data section of this document.

When looking at the aged care sub-sector in particular, revenue is expected to grow at an annualised 6.4% over the five years from 2017–18, to $22.2 billion. The IBISWorld Industry report, *Aged Care Residential Services in Australia (2017)*, states that the 'Aged Care Residential Services industry is forecast to continue growing over the next five years. Australia's ageing population and the growing need for age-appropriate accommodation are expected to drive the sector's performance over the period.'[20] This will also likely impact the workforce of people providing services to older Australians such as allied health assistants and other health support workers. The major companies within the aged care space are Bupa Aged Care Holdings, which has a market share of 3.3%, and Regis Health Care Limited with a market share of 2.7%. The remaining 94% of the market is made up of other smaller organisations.[21]

Providers of other community services such as disability, mental health, health and leisure support and alcohol and other drugs agencies offer services based in the community using generic and specialist community organisations or a combination of both. The community services sector's not-for-profit and private enterprises are expected to have raised $50.6 billion in revenue in 2016–17, derived from government funding, donations and private income. This sector is expected to grow at an annualised 7.8% over the five years from 2016–17, including anticipated growth of 7.6% in the current year.[22]

The support services sector provides community and support services to disadvantaged individuals including children, young people and people who are ageing. Many users of the sector's services are enduring economic hardship, and others have long-term disabilities. Community, welfare and health services include those designed to assist people with a disability, people who are ageing who require support, and people with mental health issues, in accordance with contemporary legislation and community perspectives within community settings. Other services involve health education and promotion, early intervention services, preventative programs, crisis responses and various types of counselling interventions.

The industry is dominated by small, non-profit social service organisations that have traditionally relied on government funding and volunteers to operate. In recent years, however, Australian community services organisations have shifted to encompass business model characteristics for a range of reasons, including the need for governance and transparency in maintaining public trust and consumer confidence.

Welfare providers in Australia have benefited from high levels of government funding over the past decade, as spending on support services has grown significantly. Industry revenue is expected to grow by an annualised 7.8% over the five years from 2016–17, to total $15.5 billion. This includes expected growth of 8.6% in 2017. Industry growth has been assisted by the introduction of the National Disability Insurance Scheme (NDIS).[23] However, it is worth noting that many sectors are not funded to meet demand. There are shortfalls in capacity within the alcohol and other drugs, mental health, housing and homelessness, disability, aged care, family violence, child protection and support services sectors.

Challenges and Opportunities

Regulation

Aged Care, Disability and Elder Abuse

My Aged Care came into effect in February 2017 and was part of an important set of reforms designed to enable people with complex and multiple ageing-related needs to access home-based care and support services. This in turn allows them to live safely and well in their own homes. Having access to fully portable home care packages means that ageing people are able to exercise greater choice, not only in regard to the mix of services they wish to receive, but also in terms of choosing the service provider.

There are also reforms in aged care in line with the *Review of National Aged Care Quality Regulatory Processes* which found that the current aged care regulatory framework is disjointed and does not provide the community with the guarantees it expects.[24] The rationale for the regulation of residential aged care quality is that the market is an inadequate mechanism to ensure the safety and wellbeing of highly vulnerable residents. Elderly citizens living in care facilities, many of whom suffer from disabilities and dementia associated with ageing, are especially in need of protection.[25]

There is a concern in industry regarding the abuse of patients in aged care and community homes. There have been reported instances of abuse by family members and/or the decision-makers of care recipients, other residents and paid care workers.[26] The Australian Institute of Family Studies notes that it is likely that between 5% and 10% of older Australians experience elder abuse in any given year, and the prevalence of neglect may be higher. The evidence suggests that most elder abuse is interfamilial and intergenerational, with mothers most often being abused by sons, but with abuse by daughters also being common, and with fathers also as victims. The study found that financial abuse toward elderly people (often associated with psychological mistreatment) is the most common form of abuse they experience.[27] People from CALD communities are particularly vulnerable to elder abuse due to generally lower levels of English proficiency, and their dependence on family members for care and support.

According to the peak body advocacy group People with Disability Australia (PWDA), in 2011 a quarter of rape cases reported by females in Australia were perpetrated against women with disability. PWDA also highlights that financial abuse is an issue that people with disability face and that mainstream services are not equipped to support people with disability escaping abuse.[28]

Mental Health Services

Mental health services are guided by the National Standards for Mental Health Services ('the Standards'). These Standards focus on how services are delivered, whether they comply with policy directions, whether the standards of communication and consent are met, and whether procedures and practices are set in place to oversee particular areas, especially those that may be associated with risk to the consumer, or which involve coercive interventions.[29] The Standards are intended to be applied comprehensively across mental health services, including bed-based and community mental health services, those in the clinical and non-government sectors, those in the private sector, and those in primary care and general practice.[30]

Other

While other sectors within health care are also regulated, one of the main concerns is that many non-governmental organisations (NGOs) are accredited under existing standards (The Australian Council on Healthcare Standards' Evaluation and Quality Improvement Program) as well as the International Organisation for Standardization (ISO) and others. This can be confusing from a consumer perspective, and there remains an opportunity for a whole-of-sector approach.

There is considerable potential for systemic accreditation across service boundaries in respect to minimum standards and safeguards for vulnerable groups that policy is intended to protect. The consumer-directed care reforms are an opportunity to consider a whole-of-sector approach.

Workforce

Consistency in Planning and Development Frameworks

There are joint roles and responsibilities between the federal government and state and territory governments relating to the health workforce and its education and training requirements. While the National Law has an objective 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce', there is no shared documented vision regarding what such a workforce would look like for allied health professionals and direct client care workers. Also, currently there is no national consistency in education and training requirements for the direct client care support workforce, while workforce needs are state-based due to largely state-controlled health care organisations.[31] The National Qualification Framework does, however, support the mobility of the workforce between states.

Wages and Conditions

Wages in the health and community services sector have been, and remain, relatively low and are an ongoing source of discontent for both employees and the sector more broadly. Other identified workforce issues consist of the need for practical education and training. There is concern expressed by the sector about the suitability of entry level qualifications, the role of ongoing education and training in preserving skills and providing career pathways, and the performance of some training providers. The situation regarding pay and conditions was one of the key themes discussed in the recent Senate Inquiry into the Future of Australia's Aged Care Sector Workforce.[32] It remains to be seen what action will be taken as a result of this.

Rapid change in the sub-sectors can result in complications involving worker entitlements and engagement models. There have been recent reports of this in the NDIS sector. Workforce engagement models in the sector are being tested under new policy settings, and traditional standards and regulations regarding work rates and conditions may need to be updated to ensure that minimum entitlements are clear. Consumers can access services independently or through an agency, for example, and this can impact employment rights and responsibilities.

The introduction of individualised funding for disability services under the NDIS has led to in increased demand for self-employed support workers.[35] This is consistent with the worldwide trend towards self-employment across a range of industries, as noted in the 2015 Committee for Economic Development of Australia (CEDA) report, *Australia's Future Workforce*.[36] Under a consumer-directed care (CDC) system, independent contracting of home care workers is feasible, and as a result there has been an rise in the number of alternative online platforms that permit care workers to be engaged independently by numerous consumers to provide more personalised services.[37] However, this is less likely to work with direct client care and support staff compared to allied health professionals setting up in private practice. There is also the fear of uncertain employment outcomes for less skilled workers in setting up their own practices.

A consumer who directly engages a care worker—when the intent of both parties is a flexible contracting arrangement—could also potentially be interpreted under existing laws to be creating an employment relationship subject to existing industry award conditions, which may have implications in the industrial relations arena. This is a common problem across disruptive industries, and determining the status of workers as either employees or independent contractors is being worked out on a case-by-case basis.[38]

Industry notes that casualisation, as well as frequent turnover of staff, can impact a worker's ability to establish productive working relationships with people they support. It can also have a negative effect on the recipients of care who face uncertainty of access to quality care along with a lack of opportunity to build long-term relationships with their carers. This is more apparent in the disability sector workforce which has a more casualised workforce, which in turn leads to a high turnover rate of staff.[39] This in turn can result in workers and organisations not investing in training and education, which can ultimately lead to weak career pathways.

Education and Training Needs

The Living Well Living Longer reforms within NSW Health have paid particular attention to the mental health sector workforce and found that workers within this area wanted more training and support to respond to situations in

a more appropriate way.[40] With regards to this, the sector needs to take the lead, in collaboration with the vocational education and training and higher education sectors, to ensure education and training is responsive to the mental health sector's needs.

The prevalence of dementia is expected to increase over the next 40 years. Alzheimer's Australia has predicted that in 2056 there will be over one million people living with dementia. Dementia is a greater risk for Aboriginal and Torres Strait Islander communities than it is for non-Indigenous people. In CALD groups, one in five people has dementia.[41] The increasing number of people with dementia is placing pressure on care and support services provided both through informal care arrangements in the community and within formal residential aged care facilities, as these people tend to have higher care needs than those without dementia. Along with the anticipated increase in people with dementia, and with over half of the consumers in residential aged care already having dementia,[42] it is imperative for care workers that relevant dementia training and education be received to enable them to provide a person-centred service.

According to the *Sustainable Health Review 2017* interim report to the Western Australian Government, there is also support for the exploration of contemporary, multidisciplinary models that would utilise the broad skills and experience of the professions employed within the health system. Submissions to the Review indicated that these changes could potentially facilitate better outcomes for patients, enhance productivity and add value for money for health services. To ensure training requirements for health care workers are reached both currently and in the future (including the ability to work in an interdisciplinary team), partnerships between training providers, including universities, TAFEs and medical colleges, are required.[43]

Importance of Aboriginal and Torres Strait Islander Peoples in the Health Services Workforce

Aboriginal and Torres Strait Islanders experienced a burden of disease that was 2.3 times the rate of that of non-Indigenous Australians in 2011,[44] and yet Aboriginal and Torres Strait Islander people are significantly under-represented in the health workforce. This potentially

contributes to reduced access to health services for the Aboriginal and Torres Strait Islander population.[45] With the health challenges facing the Aboriginal and Torres Strait Islander community the health workforce needs planning for now and the future.

Culture and identity are central to Aboriginal and Torres Strait Islander perceptions of health. This has seen the Aboriginal and Torres Strait Islander Health Worker workforce evolve into a more culturally comprehensive service provider that meets the need to provide culturally safe clinical and primary health services to Aboriginal and Torres Strait Islander people whose health care needs have traditionally not being met by mainstream services.[46]

Broader Needs for a Diverse Workforce

Another identified challenge in the aged care sector is appropriate service delivery to CALD communities. The proportion of older Australians from CALD backgrounds is growing, and these older adults use aged care services differently to other aged care service users.[47]

Members of the LGBTIQ community also require consideration in how they access and use aged care services. It is important that both older CALD and LGBTIQ communities be taken into account in the planning and delivery of appropriate aged care services.[48]

These challenges indicate that a diverse workforce is an important consideration in meeting the needs of service recipients. In 2016 a significant proportion of aged care workers were born overseas (32% and 23% in residential and home care respectively). However, Aboriginal and Torres Strait Islanders made up only 2% of the aged care workforce.[49]

It is also important for the workforce to have skills in cultural competence to be able to best support and care for people from these diverse communities and in these specific groups.

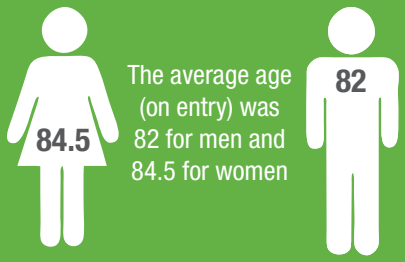
The Demand-side Driver for Aged Care

The key driver of the demand for aged care is demographic change. Australia, like most developed nations, is experiencing a long-term ageing of its population. The 2015 Intergenerational Report (IGR) shows that both the number and proportion of Australians aged 65–84 and 85 years and over are projected to grow substantially. In 2015, approximately 3 million people, or 13% of the population, were aged 65–84, and 500,000 people, or 2% of the population, were aged 85 years and over. By 2054–55, the cohort aged 65–84 is projected to be around 7 million people, or just under 18% of the population, and the 85 years and over cohort is projected to be around two million people, or 5% of the population.[50] With these changing demographics comes an increasing demand for, and use of, health and aged care services. This most recent IGR (2015) projected that, as a result of these demographic changes, government spending on aged care services is likely to almost double, from less than 1% of gross domestic product (GDP) in 2014–15 to 1.7% of GDP in 2054–55.[51]

Statistics

6.4% of Australians over the age of 65 live in an aged care facility

On 30 June 2016, **175,989** people were living permanently in an aged care facility



The average age (on entry) was 82 for men and 84.5 for women

The average length of time in an aged care home was **34.7** months

50% or more of residents in an aged care home have been diagnosed with dementia

On June 30 2016 there were **2,669** aged care homes in Australia.[52]

Quality Issues Within the Sector

Allocation of Resources

In many aged care facilities, Personal Care Attendants (PCAs) provide direct care. Residents' wellbeing depends on PCAs not only having the requisite skills, but also enough time to deliver genuine person-centred care. Where there are sufficient numbers of appropriately skilled PCAs on duty, residents are far more likely to receive person-centred care that meets their needs. Stakeholders note that insufficient numbers of PCAs on duty can lead to care becoming task-oriented and often rushed as those on duty strive to meet the needs of all residents in the timeframe provided. It is further noted that PCA training is variable. A 2013 Australian Skills Quality Authority (ASQA) review found that many training programs were too short and provided inadequate time to enable the proper development of all the competence and skills required to work in an aged care home.[53] In some aged care homes, PCAs receive additional on-the-job training. Employing organisations have a significant role in training PCAs, and increasingly casualised or fragmented work arrangements can have an impact on an organisation's willingness to invest in some aspects of on-the-job training.

There is a perception that residents have a better quality of life and improved health outcomes when registered and enrolled nurses are on duty in an aged care home. The Australian Nursing & Midwifery Federation (ANMF) National Aged Care Staffing and Skills Mix project found that care for elderly residents in aged care should be provided by a mix of nurses and carers to in order to optimise care. The skills mix recommended through this project was 30% Registered Nurses and 20% Enrolled Nurses, with the bulk of services (50%) being provided by carers. Registered and enrolled nurses ensure that residents receive suitable nutrition and hydration, managing challenging behaviours such as dementia and supporting residents in their final weeks of life due to their knowledge and expertise.[54] For care workers within this sector, registered and enrolled nurses provide supervision and support in delivering care to the frail and elderly. It is therefore important, in order to maintain quality of care, that residential aged care facilities continue to employ registered and enrolled nurses to work in conjunction with other care workers.

It is imperative that workers in this sector have opportunities to pursue training and skills development, in order to ensure an adequate supply of skilled staff to deliver quality, person-centred care.

The National Disability Insurance Scheme (NDIS)

The NDIS represents a major, complex national reform and the following predictions have been made in relation to its implementation:

- It will increase funding in the sector from about $8 billion per year to $22 billion in 2019–20
- It will involve assessing the reasonable and necessary needs of about 475,000 people
- It will require about 70,000 additional disability support care workers (or about 1 in 5 of all new jobs created in Australia over the transition period).[55]

There is no question that the disability sector faces an enormous challenge to develop a workforce of the scale and scope required to meet the predicted demand for support services. This challenge is exacerbated by the speed at which the growth will be required. Disability support workers will also require more diverse skills, as the range of individualised supports required by people living with disability increases and broadens.

Several policy changes have been recommended to alleviate the potential workforce shortage over the short term. These include:

- Meeting the desire of many existing workers—who are qualified and experienced, and usually work part-time—to work additional hours
- Trialling different approaches to help fund volunteer organisations to provide participant supports
- Allowing for skilled migration where residual shortages remain persistent.[56]

There must also be consideration of the interaction of the NDIS with other health and community service sectors. There is currently significant debate regarding the NDIS interface with health. It is important to understand the relative roles and responsibilities of each sub-sector, and how staff can work together to maintain a person-centred model of care where it is important that there be a shared care model.

Quality and Safeguarding Framework

Quality and safety for those engaging with the NDIS is also critical in ensuring that the rights of people with disability are not infringed.

The NDIS Quality and Safeguarding Framework ('the Framework') includes a Code of Conduct; provider registration, including quality assurance; a complaints handling system; reportable incident notification; behaviour support and restrictive practice oversight; investigation and enforcement; and nationally consistent worker screening. From 1 July 2018, the Code of Conduct will be overseen by the NDIS Quality and Safeguards Commission, which was announced by the Commonwealth Government on 9 May 2017. Where providers or workers have acted inappropriately towards residents, the Commission will have the authority to enforce action.[57] The Framework will help to ensure that the provision of services is safe and adheres to the principles of ethical service delivery. People who work in the sector will need to be aware of the quality standards set out by the Code of Conduct and of their role and responsibilities in respect to its application.

Concerns have been raised about the NDIS and its impact on people with pre-existing arrangements in terms of addressing their needs. Prescriptive formulas and checklists may have a role in establishing safeguards and parameters. However, the personal perspective of the service remains a critical factor in the service recipient's experience.[58] An appropriate balance is needed to ensure individual needs can be met.

Rural and Remote Communities

Access

Due to factors such as a lack of economic opportunity, geographical isolation and harsh climate, it is difficult to establish a primary health care (PHC) workforce in rural and remote areas. A lack of training options often also exists in rural and remote areas, as it is simply not viable in terms of costs for Registered Training Organisations (RTOs) to deliver in these areas. Also, given the lack of population density in these communities, it is problematic to support sustainable health services, which in turn leads to difficulties in attracting and retaining PHC workers.[59] This limits the choice of providers in a rural/remote setting and challenges the basic premise of consumer choice regarding providers that is incorporated in models such as the NDIS. This can be even more challenging for Aboriginal and Torres Strait Islanders and CALD communities that need culturally appropriate services.

Contributing Factors to Individual Health

There are contributing factors relating to the health of people in rural and remote communities in Australia, particularly higher mortality rates and lower life expectancy; high reported rates of elevated blood pressure, diabetes and obesity; higher death rates from chronic disease; a higher occurrence of mental health problems; alcohol and other drug issues; gambling addiction; poorer dental health; a high rate of sexually transmitted infections; a higher incidence of poor ante-natal and post-natal health; and a higher occurrence of babies being born with low birth-weight.[60]

Aboriginal and Torres Strait Islanders, as previously stated, are more burdened with health issues than non-Indigenous Australians. The life expectancy of Aboriginal and Torres Strait Islanders has improved slightly in recent years but progress will need to accelerate if the 2020 Council of Australian Governments' (COAG) target to

close the gap in life expectancy by 2031 is to be met.[61] For health planners delivering PHC this has been, and remains, one of the greatest challenges they face as they try to ensure adequate and equitable health care services for residents in rural and remote areas.

Allocation of Resources

Measures and tools (such as the Accessibility and Remoteness Index of Australia, ARIA+) for the planning and allocation of health resources in rural and remote areas can be challenging, and it is necessary to improve the directing of resource allocation and the planning of PHC services. For those in rural and remote areas, health service planning strategies built on inadequate measures of access risk continuing, or even worsening, existing inequities in access to PHC services.[62] There is an ongoing need to review and update the measures which are applied and their relevance to targeted programs.

Attraction of Staff

Many workers in health care, as well as other industries, show a preference for living in metropolitan or regional areas due to the greater range of opportunities available. In response, a range of programs has been instigated to motivate workers to practice in remote and rural areas. These programs encourage students through scholarships and access to bonded places, early practice and specialist training through pre-vocational and rural and remote health placements, and by return of service commitments and established practitioners via a range of incentive programs.[63] In many very remote areas there is an opportunity to build capacity through the use of a localised workforce, such as training local people in a broad range of skills to meet local demand for services and support specific to their environment.

Industry feedback has suggested a generic health sector Certificate III, with streaming options at Certificate IV level (similar to the current *Certificate III in Individual Support* qualification) could potentially allow students more flexibility regarding job options. This is important in smaller communities where there may only be one or two positions in each speciality. It could also allow students to gain employment and then progress to Certificate IV once a speciality is identified.

Mental Health

In Australia over 2 million people received Medicare-subsidised mental health-specific services in 2015–16, with $8.5 billion spent on mental health-related services and 7.8% of total health expenditure spent on mental health-related services and programs in the 2014–15 period.[64] Mental illness affects many Australians and it can take a toll on families and the community. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity, and homelessness.

'At-Risk' Groups

Among the different groups within Australian society, those who identify as LGBTIQ have disproportionate experiences of mental health problems and mental illness. Rates of major depressive episodes in the LGBTIQ community can be four to six times higher than the general population. Psychological distress rates are reported as being twice as high, and suicide rates are higher than those for any other group in the Australian population.[65]

At-risk groups who have higher rates of suicide than the general population also include recent war veterans. Risks to this group generally occur once they leave the service, with men who have served being 14% more likely to commit suicide. This increases for males 18–24, who are **twice** as likely to take their own lives as the same demographic who are **not** in the Australian Defence Force.[66]

Aboriginal and Torres Strait Islander people are more likely to have higher rates of mental illness and suicide, higher rates of substance use, and rates of psychological distress more than twice those of the general population. Triggers for this stress include discrimination, racism and social exclusion; grief and loss; the removal of children; economic and social disadvantage; family and community violence; incarceration; substance use; the impact of colonisation, transgenerational trauma, and physical health problems.[67]

There is a higher burden of mental illness for people who live in rural and remote Australia due to a number of factors. While the prevalence of illness in rural and remote Australia is similar to that in major cities, the impact of mental illness is much greater. Mental health

professionals are in short supply, with rates declining markedly with remoteness. 88% of psychiatrists and 75% of psychologists are employed in major cities, with only three psychiatrists per 100,000 population and 30 psychologists per 100,000 population employed in remote and very remote areas.[68] The incidence of suicide is 30% higher in regional/rural areas and **twice** as high in remote areas, while mental health hospitalisations are higher by at least 10% and intentional self-harm and drug and alcohol issues are up to double when compared to the rate of incidence in major cities. Many people are not able to access prevention, primary health care and early intervention services due to the lack of availability. Being unable to seek advice at the appropriate time leads to late diagnosis, meaning patients are often at a more advanced stage of illness, with corresponding various related and unrelated physical conditions.[69]

People who suffer from dual diagnosis (when a person is affected by both a mental illness and alcohol and/or drug misuse) are more likely to have more serious adverse effects.[70] Recovering from mental health issues is difficult and more challenging for people with dual diagnosis, and they are more likely to relapse. [71]

According to the Royal Australian and New Zealand College of Psychiatrists (RANZCP), 'people with serious mental illness typically live between 10 and 32 years less than the general population. Around 80% of this higher mortality rate can be attributed to the much higher rates of physical illnesses, such as cardiovascular and respiratory diseases and cancer experienced by this population.' The issue of mental illness along with other chronic diseases is a major challenge to the health system in Australia and New Zealand.[72]

Trauma in childhood plays a significant role in a person having mental health issues later on in life. There is evidence that shows that childhood trauma affects all socio-economic, ethnic and cultural groups[73] and as such the mental health workforce must be able to interact across all these groupings. To understand the issue of trauma of Aboriginal and Torres Strait Islander people, an understanding of their experience through events such

as colonisation, the Stolen Generation, etc., is needed. This needs to inform practice on how best to support this community. Trauma-informed care and practice services and systems need to emphasise the potential risk of re-traumatisation for Aboriginal and Torres Strait Islander people, particularly in acute mental health settings which, in some cases, don't reflect Aboriginal views or sufficiently support cultural safety. Aboriginal and Torres Strait Islander cultural safety is a practice and service framework that is designed to provide a positive and emotionally safe experience for Aboriginal people in normal service delivery.[74]

Those who suffer child abuse trauma are more likely to have poor mental health outcomes and poor physical health. According to the Mental Health Coordinating Council's position paper *Trauma-Informed Care and Practice: Towards a cultural shift in policy and reform across mental health and human services in Australia*, 'Child sexual assault is associated with two and a half times the rates of mental disorder, including being two to three times more likely to have an anxiety, mood or eating disorder; four times more likely to attempt suicide, and sixteen times more likely to have a sleep disorder.' The *Royal Commission into Institutional Responses to Child Sexual Abuse* recommends that services offer a trauma-informed approach which incorporates understanding of the widespread impacts of trauma and its effects.

In Australia, people with mental illness have access to a variety of mental health care services provided by various health care professionals in different care settings. Health care professionals providing mental health care and support include general practitioners (GPs), psychologists, psychiatrists, nurses, occupational therapists, social workers, and peer workers. In some jurisdictions, such as Western Australia, there is increasing alignment between mental health and alcohol and drug services through bodies such as the Western Australian Mental Health Commission, implying potential integration of qualifications across these two domains. Potentially, qualifications under the direct client care and support portfolio may help to address some of the service access issues for mental health clinicians as stated above, with training of peer support and other frontline workers (mental health nurses, for example) to provide brief interventions.

At a more general level, there are recent initiatives to raise awareness and encourage the general community to consider the experience of marginalised groups of Australians. For example, the ABC program You Can't Ask That is a series where people ask questions of Australians including recent war veterans, refugees, transgendered people, suicide attempt survivors, 'ice' users, and people who have a disability.[75] The questions are those that may be seen as awkward, inappropriate or uncomfortable, meaning ones that people are usually too afraid or embarrassed to ask, which perpetuates misunderstanding within the general public.

Family Violence and Elder Abuse

In 2015 the Victorian Government established a Royal Commission into Family Violence. The establishment of the Royal Commission was an acknowledgement of the seriousness of the issue. The Commission's undertaking was to identify more effective ways to prevent family violence; improve early intervention so as to ascertain those at risk; support victim-survivors; make perpetrators accountable; develop and refine systemic responses to family violence; better coordinate community and government responses to family violence; and, finally, to evaluate and measure the success of strategies, frameworks, policies, programs and services introduced to stop family violence.[76] Other states have also recognised the importance of this issue, such as Queensland, which has established the Special Taskforce on Domestic and Family Violence in Queensland ('the Taskforce'). The Taskforce's role has been 'to define the domestic and family violence landscape in Queensland, and make recommendations to inform the development of a long-term vision and strategy for Government and the community, to rid our state of this insidious form of violence'.[77]

It is noted that whilst these initiatives were taken by the Victorian and Queensland Governments, other jurisdictions have also done work in this space, and the findings are applicable nationally in terms of looking to address family violence issues.

Community service providers and health professionals, due to the nature of their work, are often in a position to identify and respond to family violence. Workers within a range of health services interact with people experiencing family violence, including general practitioners, pharmacists, ambulance officers and individuals working within hospitals, maternal and child health services, mental health services and drug and alcohol services. There are many reasons for health professionals failing to inquire about family violence, or lacking the confidence to respond to disclosures. A lack of family violence training and awareness, inadequate referral options, and time pressures can all contribute to missed opportunities to intervene and offer support to victim-survivors.[78]

The Commission made a range of recommendations to improve health sector responses, from strengthened screening and risk assessment procedures and greater workforce training and development to better coordination and information-sharing between different parts of the health care system.[79] This should be reinforced by clear political and professional leadership to ensure that awareness of, and the ability to respond to, family violence are central components of comprehensive patient care. At the time of writing, the recommendations outlined by the Victorian Royal Commission are being initiated and are still coming into effect. It will take some time before these recommendations are fully realised.[80]

As stated previously, there is concern in the sector regarding abuse of patients in aged care and community homes. The Australian Institute of Family Studies 2016 Report, *Elder Abuse: Understanding Issues, Frameworks and Responses*, identified the importance of a National Plan in relation to elder abuse. While national plans or frameworks exist for issues related to elder abuse such as the *National Plan to Reduce Violence Against Women and Their Children, 2010–2022*, it is acknowledged that

elder abuse cannot simply be incorporated into family violence prevention strategies.[81] It is therefore important to fill the gaps in existing frameworks to include elder abuse. The Disabled People's Organisations Australia (DPO Australia), in its Submission 360 recommended that the 'National Plan must intersect and build on the approaches not only in relation to family violence, but also in relation to disability, the NDIS, and its quality and safeguarding Framework'. Carers NSW added that, from the perspective of carers, a National Plan would provide 'a good opportunity to consider the convergence of issues and strategies regarding abuse, neglect and exploitation in ageing, disability and carer contexts'.[82] Elder abuse is a serious issue and one of which the direct client care and support workforce must be aware, and have the skills and capabilities to address appropriately when faced with it.

Digital Health

Digital health looks to integrate technology into health care. Digital health technologies have the potential for improving the capture of information and access to health and medical care. These technologies may effectively provide information, support and social networks for health consumers and improve health care access and delivery.

With regard to electronic health records (EHRs) and patient portals, one example is the digital medical record (DMR) which is increasing in its use within the sector. The use of electronic information can help with communication and the development of electronic health records with shared access, to aid continuity in care.[83] Currently there is little uniformity in the electronic clinical information systems being used by health care providers. Patient safety and care is dependent on complete and efficiently captured health information. If the patient's health care records are linked and the information is readily accessible, such as in the case of an EHR, then this would reduce the risk of error or harm. The federal government has approved funding of $485 million to develop a universal online electronic medical record system (My Health Record) and is currently trialling this in the Nepean Blue Mountains and Northern Queensland.[84]

The Australian Digital Health Agency has identified the technological exchange and use of information of clinical data as one of its priority outcomes, with regions in Australia showcasing comprehensive technological use and exchange of information across health service provision by 2022. This will support patient data being collected in standard ways for sharing in real-time with patients and their health care providers. However, most primary health care occurs in general practices and allied health practices operating as private entities. With general practice electronic health records currently unregulated, there are inconsistencies across data and use of clinical terminologies and classifications. Once the lack of standards across electronic health records is addressed, this will ensure the transfer of data between electronic health records for clinical purposes; the enabling of individual health data for integration of care across different sectors of the health care system; and the reliable extraction of patient data for practice improvement and research purposes.[85]

Health technologies should lead to greater sharing of data and information. This is where real value is created for both consumers and their health care providers. Software that links health data across health care and social services, such as the National Disability Insurance Scheme and aged care, will provide greater information for all to provide appropriate health care to connect communities. It will improve care provision and data integration and decrease 'silos'.[86]

Telehealth is also growing in its use due to advances in technology. Telehealth refers to the use of telecommunication technologies and electronic information to promote, support and deliver clinical health care at a distance. Telehealth has been shown to improve access to high quality clinical care, optimise the efficient use of people and physical resources, and improve clinical collaboration.[87]

There are four major modes of telehealth delivery:

- Synchronous live video conferencing – a live, two-way interaction between two sites. This mode is routinely used in the delivery of care from metropolitan-based tertiary/quaternary specialist health services to patients at rural and remote health service facilities. It is also increasingly used to deliver care between metropolitan-based health, disability and aged

care services. Benefits to service providers include more timely and cost-effective care delivery across a greater geographic region. Benefits to consumers include reduced travel time and expense, access to a greater range of speciality services, and improved convenience.

- Asynchronous store-and-forward (S&F) mode – the transmission of video and digital images across secure electronic systems.
- Remote patient monitoring – clinical data from an individual (e.g. blood pressure, heart rate) shared between the individual and a health care service provider. This modality is currently used predominantly in the delivery of care to people with chronic disease but has potential for expansion to other patient groups.
- Mobile health application (M-Health) – smartphone applications that allow the sharing of clinical data in real time between health professionals while meeting patient confidentiality and medical record requirements.

One outcome of the growth in telehealth is that geographical and physical location becomes less relevant in determining access to care, and the same level of care can be provided regardless of the patient's whereabouts.[88] This can be helpful in the Australian context in terms of providing health services to people in rural and remote areas which, as mentioned previously, has been an issue within this sector. Work has been done in this area by the University of Queensland Centre for Online Health who are working with Aboriginal and Torres Strait Islander health services on a telehealth support project that would provide specialist geriatric consultations via videoconference for people with dementia and their carers living in rural and remote areas of Queensland.[89]

The use of telehealth modalities is expected to increase as the NBN rollout progresses and further technological advances improve opportunities for connectivity. However, adoption of telehealth by health service providers and patients is a challenge. To be effective, telehealth solutions must go beyond creating technologically advanced platforms to access information. They must also provide a better user experience for patients and physicians.[90]

There are, however, downsides to the creation of large data banks of personal information. Data security and individual privacy, including the individual's right to choose with whom they share their health records, need to be considered. Currently there is little work being done on the risks and harms associated with data issues. In other spheres such as social media we have seen significant harm done to individuals and the community through the theft or inappropriate accessing of individuals' information. In areas where there is significant social stigma attached to receiving treatment (mental health, alcohol and other drugs, sexual health, sexual assault, family violence) there needs to be consideration of who controls the data, when and how it may be tested by a service user for veracity, when it is deleted/expunged, who has access to it within larger systems, and what the systems are for redress in the event that organisations, individuals or systems fail to protect data.

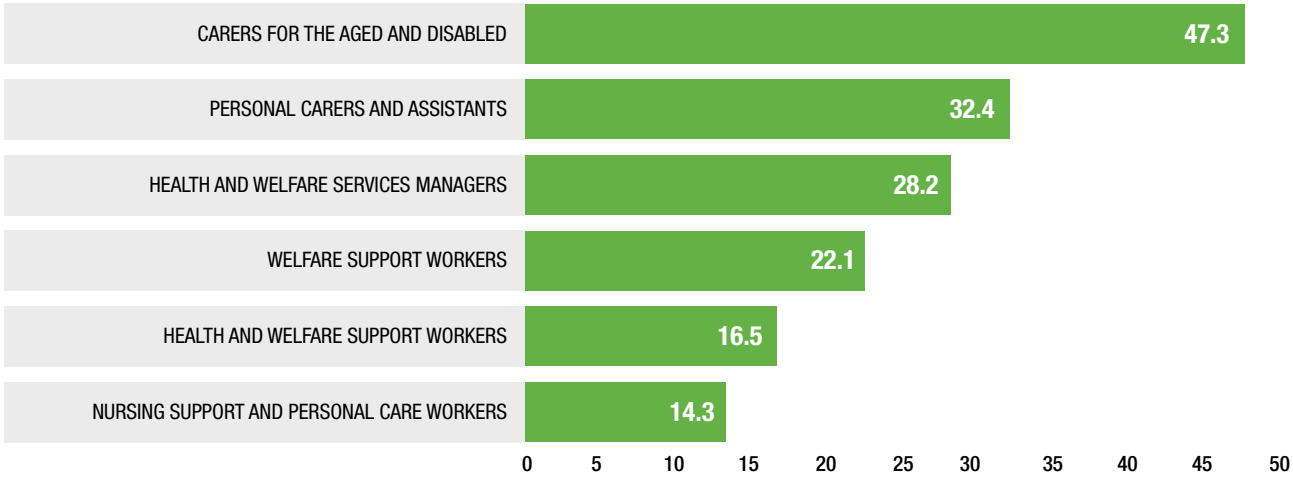
With new technology comes the requirement for training workers to ensure they have the skills to implement the technologies to their full capacity. A study of the effectiveness and efficiency of training in digital health care packages revealed that staff benefit from formal training on new software systems.[91] However, there is a broader need than simply instruction on the use of software packages or systems. The workforce will need to be competent using technologies, adapting to frequent changes in technology, and understanding the clinical, privacy and confidentiality implications of technological tools.

Employment and Skills Outlook

Labour Force Data

Strong growth is projected across the direct client care and support sector over the next five years. The largest growth is for Carers of the Aged and Disabled (47%) and Personal Carers and Assistants (32%). See Figures 1 and 2 below for a full breakdown of future growth and levels of employment.

Figure 1 Projected growth in selected Direct Client Care specific groups 2017-2022 (%)



Source: Australian Department of Jobs and Small Business, 2017 Occupational Projections – five years to May 2022

Figure 2 Employment level of Direct Client Care specific occupations ('000s), 2017

Source: Australian Department of Jobs and Small Business, 2017 Occupational Projections – five years to May 2022

In 2016 the National Aged Care Workforce Census and Survey reported that the number of workers in the aged care industry was approximately 366,000 (with an additional 68,000 volunteers). A further breakdown revealed that 235,764 were estimated to be employed in residential care homes (supported by an additional 23,537 volunteers) of whom 153,854 were direct care workers. Home support and care was estimated to have a workforce of around 130,263 of which approximately 86,463 were direct care roles.[92]

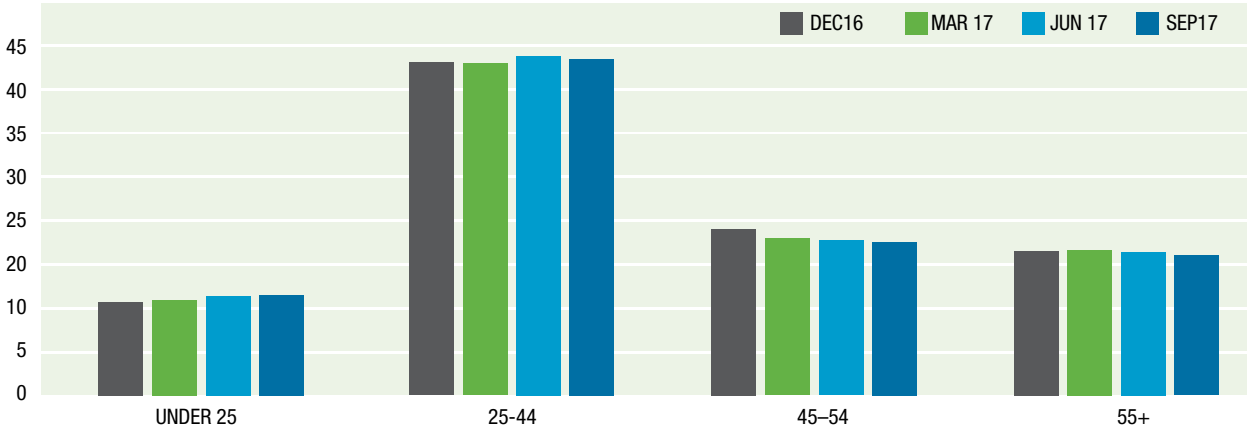
The workforce within the residential care sub-sector has grown over the last four years with most employees increasingly looking to attain more permanent working conditions than in the past where casual or contract employment was more common. In contrast, the home support and home care workforce has experienced a reduction in its paid workforce since 2012, despite a significant increase in the number of consumers during this period. Reasons for this could include the use of temporary or agency staff.[93]

The profile of workers within the aged care sector shows that they are likely to be overseas-born, female and aged over 46. Community care workers who are in aged care roles are less likely to have Certificate III and Certificate IV qualifications than personal care attendants working in residential care.[94]

The size of the disability workforce is hard to determine due to gaps in the data. To overcome this the National Disability Services with funding from the Department of Education and Training commissioned an online tool called Workforce Wizard. This tool is aimed at human resource managers and executives within the disability sector with a view to gaining some insight into the workforce. By May 2017 the Workforce Wizard had collected data on more than 35,000 disability support workers and allied health professionals across Australia. This number is estimated to represent 39% of the total workforce within the sector.[95]

The latest National Disability Services Workforce report (February 2018) shows the breakdown of the disability support workforce within the sector. The biggest cohort was comprised of permanent employees (55%), with casual employment not far behind (42%). The disability support sector has a high proportion of female workers who make up 70% of the workforce. The age of the disability support workforce shows that 44% are aged over 45 years.[96] The disability support sector has an ageing workforce at the same time as there is growing demand for workers. The growth of organisations within the disability sector has been tracked through the Workforce Wizard, which shows the disability support workforce grew by 11% over the two-year period 2016–18. Most of the growth can be attributed to growth in the casual workforce.[97] It is important to monitor the rate of growth of the workforce given the challenges relating to recruitment for this sector.

Figure 3 Age profile of disability support workers (%)



Source: National Disability Services, Australian Disability Workforce Report, February 2018

While the overall trend towards increased casualisation is only slight, when we look more closely at the different organisational sizes in the disability sector, it becomes apparent that small and medium-sized organisations are definitely engaging more casuals. The proportion of casuals among the disability support workforce in small and medium-sized organisations is now greater—or about to become greater—than the share of permanents. Only for large organisations is the gap between the share of casuals and permanents not closing.[98]

From the July 2017 NDS workforce report it was recorded that across the states and territories there were differences in workforce retention. NSW, for example, had lower turnover of casual staff than other states but higher turnover of permanent staff. This could be due to casualisation occurring within the sector due to the uncertainty of funding models. Queensland's turnover of casual staff was higher than in other states, while Victoria was consistently more effective at retaining its permanent staff. Workers in Tasmania tend to be part-time workers, with the casual workforce on par with the national average, as are its turnover rates for both casual and permanent staff.[99]

The mental health workforce within the context of this IRC has limited access to data and statistics on the workforce and therefore estimating its size is difficult. Accordingly, the Australian Institute of Health and Welfare National Mental Non-Governmental Organisations (NGOs) Landscape Survey (2009) and a 2010 workforce scoping survey helped provide some data about the mental health NGO workforce. The surveys estimated that the NGO mental health workforce numbered over 12,000 full- time equivalent (FTE) employees. Of these, the findings indicated that 34% had a Certificate or Diploma-level qualification.[100]

There is an estimated informal mental health carer workforce of 240,000 (informal carers being people such as a family members or friends). This group comprised 54,000 primary carers and 186,000 other mental health carers. Of this cohort over half (54%) were female, of working age (73%), married (54%) and living in a capital city (61%).[101]

Future Skills Needs

Technology

Digital literacy and being competent using different technology platforms will be essential skills in the future. Without basic digital competencies a person will not have the skills to negotiate the digitally connected world which is now the norm.[102] Workers will need the ability to use technology in their jobs to access and use information and digital content; communicate and collaborate through digital technologies; manage their digital identity; develop digital content; and use and protect their digital devices, personal and organisational data, and privacy.[103] For workers within the sectors under the purview of this IRC, digital literacy skills will be important in order to maintain knowledge and skills in an evolving digital age. For example, the analysis of patterns and trends from big data will require more advanced digital literacy skills to interpret and provide information that has a direct impact on the quality of client care.

Other examples of this, previously noted in this document, have been the move to have all medical records accessible via one online portal (My Health Records) and the inevitable rise of telehealth. However, in addition to digital literacy, there are a number of areas where broader STEM skills will be essential in equipping workers for new ways of working. Advancements in assistive technology related to equipment for supporting clients will necessitate additional skills for workers. At present assistive technologies provide support, but are not necessarily designed to address and correct an impairment. However, the assistive technology of the future is increasingly moving towards therapeutic technologies, such as robotic exoskeletons that facilitate movement and the use of functional electrical stimulation to assist in restoring movement.[104]

Interpersonal ('Soft') Skills

While digital literacy skills are critical for future skills needs, interpersonal or so-called 'soft' skills are just as important. Soft/interpersonal skills include things like communication, teamwork, problem solving, emotional judgement, professional ethics and global citizenship. Deloitte Access Economics forecasts that two-thirds of

jobs will be soft skill-intensive by 2030.[105] The need for soft/interpersonal skills is even more important in leadership positions. A survey conducted by Deloitte found that soft/interpersonal skills were more important for determining the success of a leader than technical knowledge.[106] For decision makers, the ability to effectively communicate, solve problems and think critically is important for success.

Credentials for soft/interpersonal skills are beginning to emerge. The benefits to organisations are twofold. Firstly, recruitment processes can be made more efficient as credentials allow recruiters to pre-screen potential candidates for the required soft/interpersonal skills. Secondly, more targeted recruitment for soft-skilled candidates allows businesses to make savings in training and developing their own workforce later on.[107]

As jobs within the direct client care and support sector are highly focused on soft/interpersonal skill requirements, many of the existing units of competency reflect this, with specific reference to the health and community services workplace setting. This specificity and the innate contextualisation of the units of competency help to ensure that graduates have sufficient workplace skills to be able to deal appropriately with at-risk cohorts. This will no doubt help workers within the sector to continue to be equipped with the necessary tools to fulfil their jobs to a satisfactory standard.

The significance of soft/interpersonal skills in a range of contexts and the move towards more client-centred approaches with the advent of NDIS have led industry to consider the role of customer service skills in the direct client care and support sector. Accessibility is also a key consideration here and must be taken into account when dealing with at-risk cohorts and those living with disability. Specific consideration is needed with regard to skills in conflict resolution, problem solving, negotiation and creative thinking within the direct client care and support workforce which focuses on providing sometimes very personal service to people, rather than being merely transactional.

Augmentative and alternate communication (AAC) skills continue to be valued within the direct client care and support sector, particularly when working with new models of care such as the NDIS, and in dealing with the myriad different stakeholders involved in the provision of services, including patients, advocates, parents, people with disability and government. Providing customised support to an individual can involve processes which are difficult to navigate and involve complex networks of health professionals and government agencies. Workers must have not only an understanding of these complexities, but also the requisite communication skills to inform patients and guide them through the process to achieve optimal outcomes.

Cultural competence has been highlighted throughout this Forecast and will continue to be a key requirement for workers in this sector. Dealing appropriately with people from minority backgrounds, such as CALD, LGBTIQ, Aboriginal and Torres Strait Islander peoples and others, requires not only cultural awareness, knowledge and understanding, but also high-level communication skills.

Leadership skills that are contextualised to the direct client care and support sector have been identified as a priority by stakeholders. Increasingly these are skills that can be demonstrated in all roles, as collaboration between support workers and other health professionals contributes to the overall experience of service recipients.

Strengthened communication around formal delegation of duties and instruction, and the awareness of applicable parameters, is particularly important during times of change, such as that experienced in the aged care and disability sectors.

Recognising and Dealing with Abuse

As detailed previously, health and community service workers are often in a unique position to be able to identify and respond to situations of abuse, be it elder abuse, episodes of family violence, child sexual abuse, or other circumstances.

Given that these situations involve highly vulnerable people, workers require the skills to not only identify instances where abuse is taking place, but also the skills to take appropriate action to support the victim. The actions that are to be taken will vary depending on the individual circumstances, but workers need to be able to determine the action that is appropriate and implement this in a manner that is safe for the victim but also does not place the workers themselves at risk.

Linked to this are the skills required by direct client care and support workers to establish and maintain appropriate professional boundaries with patients. Additional knowledge and an understanding of the need to develop professional ethics and adhere to codes of practice are essential to minimising any possibility of poor behaviour in this area.

Service Integration

The collaboration and partnership across a range of services with the advent of NDIS and with new technologies that support the integration of services means that direct client care and support workers will need to develop knowledge and understanding of a diverse range of services and the linkages between them in order to support holistic care solutions for clients. Understanding the specific needs of service recipients and the appropriate means of addressing those needs is critical. Workers must have a deep understanding of the importance of specialisation and its benefits in ensuring patients receive the level and type of care required.

This is increasingly important in dealing with situations such as homelessness and the provision of services to those without fixed accommodation, where there remains a need for individualised programming and care. Another example is aged care, where increasingly workers are dealing with patients with complex care needs, be they cognitive decline, multiple co-morbidity and polypharmacy needs, or social isolation. Workers need the skills and knowledge to develop integrated programs and a deep understanding of referral systems and processes in order to achieve optimal patient outcomes.

Key Generic Skills – Ranked in Order of Importance

Note: The 12 generic skills listed below, including the descriptors, were provided by the Department of Education and Training for the purpose of being ranked by industry representatives. For the 2018 ranking exercise, an 'Other' generic skill option was included in the list to capture any additional key skills considered important for an industry. Please note that, in this case, no other generic skills were identified.

1	COMMUNICATION / COLLABORATION / SOCIAL INTELLIGENCE	Ability to understand/apply principles of creating more value for customers and collaborative skills. Ability to critically assess and develop content with new media forms and persuasive communications. Ability to connect in a deep and direct way.
2	CUSTOMER SERVICE / MARKETING	Ability to interact with other human beings, whether helping them find, choose or buy something. Ability to supply customers' wants and needs. Ability to manage online sales and marketing. Ability to understand and manage digital products.
3	LANGUAGE, LITERACY & NUMERACY (LLN)	Foundation skills of literacy and numeracy.
4	LEARNING AGILITY / INFORMATION LITERACY / INTELLECTUAL AUTONOMY / SELF-MANAGEMENT	Ability to identify a need for information. Ability to identify, locate, evaluate, and effectively use and cite the information. Ability to develop a working knowledge of new systems. Ability to work without direct leadership and independently.
5	MANAGERIAL / LEADERSHIP	Ability to effectively communicate with all functional areas in the organisation. Ability to represent and develop tasks and processes for desired outcomes. Ability to oversee processes, guide initiatives and steer employees toward achievement of goals.
6	TECHNOLOGY AND APPLICATION	Ability to create/use technical means, understand their interrelation with life, society, and the environment. Ability to understand/apply scientific or industrial processes, inventions, methods. Ability to deal with mechanisation/automation/computerisation. computerisation.
7	DESIGN MINDSET/ THINKING CRITICALLY / SYSTEM THINKING / PROBLEM SOLVING	Ability to adapt products to rapidly shifting consumer tastes and trends. Ability to determine the deeper meaning or significance of what is being expressed via technology. Ability to understand how things that are regarded as systems influence one another within a complete entity, or larger system. Ability to think holistically.
8	ENTREPRENEURIAL	Ability to take any idea and turn that concept into reality/make it a viable product and/or service. Ability to focus on the next step/move closer to the ultimate goal. Ability to sell ideas, products or services to customers, investors or employees etc.
9	FINANCIAL	Ability to understand and apply core financial literacy concepts and metrics, streamlining processes such as budgeting, forecasting, and reporting, and stepping up compliance. Ability to manage costs and resources, and drive efficiency.
10	ENVIRONMENTAL / SUSTAINABILITY	Ability to focus on problem solving and the development of applied solutions to environmental issues and resource pressures at local, national and international levels.
11	DATA ANALYSIS	Ability to translate vast amounts of data into abstract concepts and understand data-based reasoning. Ability to use data effectively to improve programs, processes and business outcomes. Ability to work with large amounts of data.
12	STEM (Science, Technology, Engineering and Maths)	Sciences, mathematics and scientific literacy.

The IRC notes that, when looking at generic workforce skills, varying interpretations and definitions are applied. Industry stresses that a common skill may have a vastly different meaning and application to different individuals and organisations. Industry therefore recommends careful consideration when reviewing and determining industry skills priorities.

Key Drivers for Change and Proposed Responses

Drivers for Change and Skill Needs

Industry has identified key drivers for change in the training package products relating to the direct client care and support sector.

Specific areas requiring updates as a matter of priority have been identified in the Health Assistance, Health Support Services and the Individual Support and Ageing qualifications.

The direct client care and support sector has been evolving due to the changes in technology. As more and more processes move to an online capacity, it is important that workers have the skills to be able to use technology when carrying out their duties.

The introduction of new funding models such as the NDIS and My Aged Care will impact how workers interact with clients and the skills and knowledge they require to do so. There is also a need identified by industry for workers across all sub-sectors including disability and aged care (in home and in residential facilities) and in rehabilitation services within acute, sub-acute and community settings to be cross-skilled,

especially in light of the ways in which new funding models will operate.

Workers in areas such as health support services require access to qualifications with a variety of units of competency to build a requisite mix of skills that provide flexibility and transferability. Increasing the cross-skilling of workers will allow the transfer of those workers within different sub-sectors of the health and community services industry, which will be important in addressing workforce shortages in the future. Engagement models are also creating challenges for workers in managing their own entitlements and related processes, and there is therefore a need for business and financial skills and capabilities.

There is a critical need for skills in identifying and responding appropriately to situations of abuse, particularly family violence and elder abuse. Related to this is the establishment of professional boundaries and ethics to ensure the professionalism of the workforce when relating to clients.

Opportunities also exist to develop stronger content around cultural competency, including those competencies required when working with Aboriginal and Torres Strait Islander people and people from CALD and LGBTIQ communities. Workers within the sector will need the skills to meet the demands of consumers in terms of their care.

Customer service skills will also be critical for workers in the direct client care and support sectors. It has been noted that while there are existing units of competency relating to customer service in training packages relating to retail, tourism and others, these are transactional in nature and do not provide the skills in empathy and patient connection required by the health and community service environment. Development of specific training package products that address this need is paramount to providing a high-quality service to care recipients.

A widespread multichannel consultation involving the following stakeholders has been conducted to identify and validate the exact nature of the skills needs in the industry, and the respective training package product update requirements:

- Consultation with the Direct Client Care and Support Industry Reference Committee (IRC) members representing the following key bodies:
  - Department of Health
  - Related state and territory government departments
  - Aged and Community Services Australia
  - State and territory Alcohol and Other Drugs agencies
  - Allied Health Professions Australia (AHPA)
  - Leading Aged Services Australia
  - National Disability Services
  - Australian Nursing & Midwifery Federation (ANMF)
- Online survey conducted in November–December 2017 and distributed to 17,000 stakeholders registered in SkillsIQ's network
- Attendance at industry events, conferences, forums and summits
- Promotion and availability of the draft Industry Skills Forecast and Proposed Schedule of Work for feedback via the SkillsIQ website.

Proposed Response

The Direct Client Care and Support IRC is proposing to update training package products with an initial focus on the impact of the key drivers for change in the priority sub-sectors.

Existing training package products will be updated in light of recommendations of various Royal Commissions and professional organisations. The current recommendations from the Victorian Royal Commission into Family Violence and the Australian Government's Royal Commission into Institutional Responses to Child Sexual Abuse, as well as respected reports and research about trauma and other issues of particular concern and significance to Aboriginal and Torres Strait Islander peoples, all need to be taken into account in updates to training package products and the definition of job roles in the direct client care and support sector.

To address the identified workforce skills needs, an update of the following qualifications and skill sets in the *HLT Health Training Package* and the *CHC Community Services Training Package*, along with the associated units of competency, is proposed.

Qualifications

- HLT33015 Certificate III in Allied Health Assistance
- HLT43015 Certificate IV in Allied Health Assistance
- HLT23215 Certificate II in Health Support Services
- HLT33215 Certificate III in Health Support Services
- CHC33015 Certificate III in Individual Support
- CHC43015 Certificate IV in Ageing Support
- CHC43115 - Certificate IV in Disability.

Skill Sets

- CHCSS00081 Induction to Disability – Disability Skill Set
- CHCSS00097 Individual Support – Ageing Skill Set
- CHCSS00098 Individual Support – Disability Skill Set
- CHCSS00095 Dementia Support – Service Delivery Skill Set
- CHCSS00099 Individual Support – Home and Community (Ageing) Skill Set
- CHCSS00100 Individual Support – Home And Community (Disability) Skill Set
- HLTSS00051 Allied Health Assistance – Community Rehabilitation Skill Set
- HLTSS00052 Allied Health Assistance – Nutrition and Dietetics Skill Set
- HLTSS00053 Allied Health Assistance – Occupational Therapy Skill Set
- HLTSS00054 Allied Health Assistance – Physiotherapy Skill Set
- HLTSS00055 Allied Health Assistance – Podiatry Skill Set
- HLTSS00056 Allied Health Assistance – Social Work Skill Set
- HLTSS00057 Allied Health Assistance – Speech Pathology Skill Set
- HLTSS00061 Food Safety Supervision – Skill Set for Community Services and Health Industries.

The above training package products require updating to reflect the changing nature of the job roles of direct client care and support staff.

The update will include:

- the development of new units of competency which cover specialist areas noted in the Key Drivers for Change and Proposed Responses section, e.g. recognising and responding to family violence and elder abuse
- updating current units of competency to include new content in some of these specific areas
- the development of new skill sets to address specific areas identified during consultation.

A number of potential risks have been identified and are tabled overleaf should the update of the training package (in line with addressing the skills needs voiced by industry) **not** take place.

STAKEHOLDER	RISK OF NO CHANGE
Employers (i.e. hospitals, aged care facilities, etc.)	• **Risk to patient** of experiencing poor quality care and/or negative effects of treatment are heightened as procedure set-up and support have been conducted by an individual with inadequate knowledge and skills • **Cost implications** include time allocated to conducting in-house training with staff which reduces time for patient treatment and practice management • **Staff turnover** can be further affected by the lack of progression to specialist support roles (due to lack of specialist support skills) • Inability to demonstrate **duty of care** measures due to lack of skills and knowledge in these areas.
Employees (i.e. allied health assistants, aged care support workers, etc.)	• Face **inability to conduct all duties of role** due to insufficient training • **Increase patients' health risks** through inability to perform the role to the required level • **Receive poor and outdated training** by accessing unsuitable training options for client care • **Treat clients in culturally inappropriate ways** due to not having the necessary skills and knowledge • **Risk being victims of abuse** themselves if they do not have the skills and knowledge to establish appropriate professional boundaries.
Students	• **Graduate with insufficient skills** to deal with the evolving and sometimes confronting nature of work within the direct client care and support sub-sectors • Are **unable to gain employment** due to a lack of requisite skills.
Training Providers	• **Training offered does not match** industry needs, and so quality and reputation of course delivery is compromised.
Recipients of Services	• Suffer from feelings of **disempowerment** • Encounter **frustration** due to increasing complexity of consumer choice • **Poor perception** of models designed to improve the health and community services environment • Face adverse **health repercussions** due to lack of skilled support staff • **Disengagement** by those in need of services.

The proposed response aims to ensure that direct client care and support services are delivered by a high quality, trained and skilled workforce.

Impact of Recommended Changes

RTOs

The implementation of new units of competency creates flow-on impacts and costs for RTOs in relation to administrative systems, training resources and assessment materials. In the short term, it is anticipated that there will be an administrative burden on RTOs as they transition to delivery of the new training package products and update their scope of registration, resources and assessment tools. This is, however, unavoidable.

Employers and Service Providers

The use of updated training package products will allow employers and service providers to have access to appropriately skilled workers with the requisite skills and knowledge to provide direct client care and support in accordance with the requirements of contemporary settings and policy frameworks. This will, in turn, increase the effectiveness of services and will ensure employers meet their obligations and duty of care in terms of the services offered.

Students and Workers

Direct client care and support workers will gain better outcomes from training with updated units of competency that reflect current policy frameworks and

recommendations from specialised research, Inquiries and Royal Commissions. This will provide them with increased confidence in their skills and their ability to support people in need of support in a range of circumstances and settings. Transferable skills across a range of roles will enhance employment outcomes and ongoing skills development and expertise in the sector.

Recipients of Direct Client Care and Support Services

Perhaps the greatest impact will be found in respect to recipients of these services, who will benefit from receiving more comprehensive and effective assistance in accordance with their individual needs.

This would be a significant and positive consequence arising from the update of training package products in the direct client care and support industry sector.

Proposed Schedule of Work

2018–19

YEAR	PROJECT TITLE	DESCRIPTION
2018–19	Direct Client Care	The IRC proposes to update the following qualifications and any associated skill sets and units of competency relating to Allied Health Assistance job roles: • HLT33015 Certificate III in Allied Health Assistance • HLT43015 Certificate IV in Allied Health Assistance Health Support job roles: • HLT23215 Certificate II in Health Support Services • HLT33215 Certificate III in Health Support Services Aged Care and Disability Support job roles: • CHC33015 Certificate III in Individual Support • CHC43015 Certificate IV in Ageing Support • CHC43115 Certificate IV in Disability.

2019–20

YEAR	PROJECT TITLE	DESCRIPTION
2019–20	Leisure and Health	The IRC proposes to update the following two qualifications and any associated skill sets and units of competency relating to Leisure and Health job roles: • Certificate IV in Leisure and Health • Diploma of Leisure and Health.
2019¬–20	Mental Health	The IRC proposes to update the following three qualifications and any associated skill sets and units of competency relating to Mental Health job roles: • Certificate IV in Mental Health Peer Work • Certificate IV in Mental Health • Diploma of Mental Health.
2019–20	Health Services Assistance	The IRC proposes to update the following qualification and any associated skill sets and units of competency relating to Health Support job roles: • Certificate III in Health Services Assistance.
2019–20	Cross-sectoral Units of Competency	The IRC proposes to update the remaining cross-sectoral units of competency in the HLT Health and CHC Community Services Training Packages.

2018-19 Project Details

DESCRIPTION	DIRECT CLIENT CARE AND SUPPORT
Rationale:	Training package products need to be updated to ensure they address changes in the skills requirements resulting from: • The impact of new funding models, and the requirement to explain and communicate these impacts with service recipients • An increase in the diversity and breadth of service recipients • Broader holistic approaches to individual plans which can involve features that straddle sub-sectors • An increase in the application of technology in the collection, submission and use of data • The need to consider the recommendations of Royal Commissions into Family Violence and Child Abuse and where additional references may now be required in training package products, such as knowledge evidence in units of competency • The need to consider the impact and recommendations in reforms associated with sub-sectors such as Ageing and the NDIS.
Ministers' Priorities Addressed:	The development of training package products proposed within this Industry Skills Forecast considered opportunities to support the Council of Australian Governments (COAG) Industry and Skills Council and used consultation activities and stakeholder engagement to identify: 1. Opportunities to identify and remove obsolete training package products from the system, by updating these products simultaneously and looking at overlaps and the cross-sectoral use of these training package products 2. Industry expectations for training delivery and assessment (to be documented within the Companion Volume Implementation Guide) 3. Opportunities to enhance the portability of skills from one related occupation to another by looking at similarities across sectors and transferable skills 4. Opportunities to remove unnecessary duplication within the system and create training package products that may have application to multiple industry sectors. Due to the generic nature of the allied health assistant roles, and the use of some HLT Units of Competency not under the remit of this IRC, this may be possible 5. Opportunities for the development of skill sets. This project includes the review of existing skill sets and will explore the potential for the development of new skill sets.
Consultation Plan:	Key stakeholders identified in the list earlier in this document will be consulted. National consultation will be undertaken, including sector-specific forums to ensure differences in requirements can be addressed. Webinars and focus groups will be used to supplement the workshops and ensure accessibility for those in regional and remote areas. The use of the SkillsIQ Online Feedback Forum is well established and will also be used as an opportunity for all interested parties to provide their comments online.
Timing - Estimated Duration of Project and Key Dates:	July 2018, subject to AISC approval. Estimated duration: 15–18 months, due to the large number of stakeholders and the depth of cross-sectoral consultation required.
Training Package to be Revised:	*HLT Health Training Package* *CHC Community Services and Health Training Package*
Qualification/s to be Developed/Updated:	7 Qualifications to be updated: 1. HLT33015 Certificate III in Allied Health Assistance 2. HLT43015 Certificate IV in Allied Health Assistance 3. HLT23215 Certificate II in Health Support Services 4. HLT33215 Certificate III in Health Support Services 5. CHC33015 Certificate III in Individual Support 6. CHC43015 Certificate IV in Ageing Support 7. CHC43115 Certificate IV in Disability

DESCRIPTION	DIRECT CLIENT CARE AND SUPPORT
Unit/s of Competency to be Developed/ Updated:	63 Units of Competency to be updated: 1. CHCAGE001 Facilitate the empowerment of older people 2. CHCAGE002 Implement falls prevention strategies 3. CHCAGE003 Coordinate services for older people 4. CHCAGE004 Implement interventions with older people at risk 5. CHCAGE005 Provide support to people living with dementia 6. CHCAGE006 Provide food services 7. CHCDIS001 Contribute to ongoing skills development using a strengths-based approach 8. CHCDIS002 Follow established person-centred behaviour supports 9. CHCDIS003 Support community participation and social inclusion 10. CHCDIS004 Communicate using augmentative and alternative communication strategies 11. CHCDIS005 Develop and provide person-centred service responses 12. CHCDIS006 Develop and promote positive person-centred behaviour supports 13. CHCDIS007 Facilitate the empowerment of people with disability 14. CHCDIS008 Facilitate community participation and social inclusion 15. CHCDIS009 Facilitate ongoing skills development using a person-centred approach 16. CHCDIS010 Provide person-centred services to people with disability with complex needs 17. CHCHCS001 Provide home and community support services 18. CHCHCS002 Coordinate and monitor home based support 19. CHCPAL001 Deliver care services using a palliative approach 20. CHCPAL002 Plan for and provide care services using a palliative approach 21. HLTAHA001 Assist with an allied health program 22. HLTAHA002 Assist with the application and removal of casts 23. HLTAHA003 Deliver and monitor client-specific physiotherapy programs 24. HLTAHA004 Support client independence and community participation 25. HLTAHA005 Support the delivery and monitoring of physiotherapy programs for mobility 26. HLTAHA006 Assist with basic foot hygiene 27. HLTAHA007 Assist with podiatric procedures 28. HLTAHA008 Assist with podiatry assessment and exercise 29. HLTAHA009 Assist with the rehabilitation of clients 30. HLTAHA010 Assist with the development and maintenance of client functional status 31. HLTAHA011 Conduct group sessions for individual client outcomes 32. HLTAHA012 Support the development of speech and communication skills 33. HLTAHA013 Provide support in dysphagia management 34. HLTAHA014 Assist and support the use of augmentative and alternative communication systems 35. HLTAHA015 Deliver and monitor a hydrotherapy program 36. HLTAHA016 Support the fitting of assistive equipment 37. HLTAHA017 Assist with social work 38. HLTAHA018 Assist with planning and evaluating meals and menus to meet recommended dietary guidelines 39. HLTAHA019 Assist with the monitoring and modification of meals and menus according to individualised plans 40. HLTAHA020 Support food services in menu and meal order processing 41. HLTAHA021 Assist with screening and implementation of therapeutic diets 42. HLTAHA022 Prepare infant formulas 43. HLTAHA023 Support the provision of basic nutrition advice and education 44. HLTAHA024 Work within a community rehabilitation environment 45. HLTAHA025 Contribute to client flow and client information management in medical imaging 46. HLTAHA026 Support the medical imaging professional 47. HLTFSE001 Follow basic food safety practices 48. HLTFSE002 Provide ward or unit based food preparation and distribution services 49. HLTFSE003 Perform kitchenware washing 50. HLTFSE004 Serve cafeteria customers 51. HLTFSE005 Apply and monitor food safety requirements 52. HLTFSE006 Prepare foods suitable for a range of client groups 53. HLTFSE007 Oversee the day-to-day implementation of food safety in the workplace 54. HLTFSE008 Conduct internal food safety audits 55. HLTFSE009 Apply cook-freeze and reheating processes 56. HLTHSS001 Operate an incinerator 57. HLTHSS002 Perform general maintenance and provide assistance to tradespersons 58. HLTHSS003 Perform general cleaning tasks in a clinical setting 59. HLTHSS004 Handle and move equipment, goods and mail 60. HLTHSS005 Undertake routine stock maintenance 61. HLTHSS006 Collect and manage linen stock at user location 62. HLTHSS007 Handle medical gases safely 63. HLTHHS008 Perform routine servicing of plant, equipment and machinery • New Units of Competency - to be confirmed following consultation with industry

DESCRIPTION	DIRECT CLIENT CARE AND SUPPORT
Skill Set/s to be Updated:	14 Skill Sets to be updated: 1. CHCSS00081 Induction to Disability – Disability Skill Set 2. CHCSS00095 Dementia Support – Service Delivery Skill Set 3. CHCSS00097 Individual Support – Ageing Skill Set 4. CHCSS00098 Individual Support – Disability Skill Set 5. CHCSS00099 Individual Support – Home and Community (Ageing) Skill Set 6. CHCSS00100 Individual Support – Home and Community (Disability) Skill Set 7. HLTSS00051 Allied Health Assistance – Community Rehabilitation Skill Set 8. HLTSS00052 Allied Health Assistance – Nutrition and Dietetics Skill Set 9. HLTSS00053 Allied Health Assistance – Occupational Therapy Skill Set 10. HLTSS00054 Allied Health Assistance – Physiotherapy Skill Set 11. HLTSS00055 Allied Health Assistance – Podiatry Skill Set 12. HLTSS00056 Allied Health Assistance – Social Work Skill Set 13. HLTSS00057 Allied Health Assistance – Speech Pathology Skill Set 14. HLTSS00061 Food Safety Supervision Skill Set – For Community Services and Health Industries New Skill Sets - to be confirmed following consultation with industry.

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