# National Aboriginal Community Controlled Health Organisation Integrated Care Training Needs Analysis

January 2026

NACCHO Workforce & Training

CSWA Community Skills WA

# Acknowledgement of Country

NACCHO acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners of the lands where we live, where we work, and across Australia. NACCHO recognises and pays respect to Elders past, present and emerging across Australia and thanks them for their continuing care and custodianship of land, sea, culture and community.



**A note on language**

While this report refers to Aboriginal people, this phrasing is intended to encompass the feedback and experiences of both Aboriginal and Torres Strait Islander people who participated in consultations.

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# Acknowledgement of Contributions

In genuine partnership, many individuals and organisations have contributed their time and expertise to the Training Needs Analysis. Consultations for this report were undertaken with Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations. We thank participants from the following organisations for sharing their experiences, expertise and time with us as we developed this report.

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- Bendigo & District Aboriginal Co-operative (BDAC) – Bendigo, VIC
- Broome Regional Aboriginal Medical Service (BRAMS) – Broome, WA
- Carbal Medical Services – Toowoomba City, QLD
- Dandegong & District Aborigines Co-operative
- Danila Dilba Health Services – Darwin, NT
- Dolphin Aged Care Services – Forster, NSW
- Galambila Aboriginal Health Service – Coffs Harbour, NSW
- Katherine West Health Board – Katherine, NT
- Kimberley Aboriginal Medical Services (KAMS) – Broome, WA
- Kimberley Stolen Generation Aboriginal Corporation – Broome, WA
- Miwatj Health Aboriginal Corporation – Nhulunbuy, NT
- Moorditj Koort Aboriginal Corporation – Perth, WA
- Njernda Aboriginal Corporation – Echuca, VIC
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- Puntukurnu Aboriginal Medical Service – Newman, WA
- Riverina Medical and Dental Aboriginal Corporation (RivMed) – Wagga Wagga, NSW
- Rumbalara Aboriginal Co-operative – Shepparton, VIC
- South Australian West Coast ACCHO Network (SAWCAN) – Adelaide, SA
- South West Aboriginal Medical Service (SWAMS) – Bunbury, WA
- Sunrise Health Service Aboriginal Corporation – Katherine, NT
- Sydney Region Aboriginal Corporation – Penrith, NSW
- Tamworth Aboriginal Medical Service – Tamworth, NSW
- Tasmanian Aboriginal Health Service – Hobart, TAS
- The Purple House (Western Desert Nganampa Walytja Palyantjaku Tjutaku AC) – Alice Springs, NT
- Tullawon Health Service – Yalata Community, SA
- Ungooroo Aboriginal Corporation – Singleton, NSW
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Aboriginal Health Service – Melbourne, VIC
- Wathaurong Aboriginal Co-operative
- Yadu Aboriginal Corporation – Ceduna, SA
- Yokai – WA Stolen Generations Aboriginal Corporation – Perth, WA

CommunitySkills WA

NACCHO acknowledges Community Skills WA who authored this report. CSWA provides a forward thinking leadership role within the Community Services, Health, Education, Sport, Fitness and Recreation Sectors (the sectors), supporting and developing workforce capacity and capability, now and into the future. As the Western Australia industry training council they provide strategic industry advice to the State Training Board and the Department of Training and Workforce Development on behalf of the sectors.

# Glossary

| | |
|---|---|
| ACAT | Aged Care Assessment Team |
| ACCO | Aboriginal Community Controlled Organisation |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACCHRTO | Aboriginal Community Controlled Health Registered Training Organisation |
| ACQS | Aged Care Quality Standards |
| ADLO | Aboriginal Disability Liaison Officer |
| BSB | Business Services Training Package |
| CHC | Community Services Training Package |
| CHSP | Commonwealth Home Support Programme |
| COPD | Chronic Obstructive Pulmonary Disease |
| CSWA | Community Skills WA |
| DEWR | Department of Employment and Workplace Relations |
| DoHDA | Department of Health, Disability and Ageing |
| ECC | Elder Care Connector (also used in some contexts for Elder Care Coordinator) |
| ECS | Elder Care Support |
| HCP | Home Care Packages |
| HLT | Health Training Package |
| IT | Information Technology |
| JDF | Job Description Form |
| KAMS | Kimberley Aboriginal Medical Service |
| LLN | Language, Literacy and Numeracy |
| LLND | Language, Literacy, Numeracy and Digital |
| MAC | My Aged Care |
| MMM | Modified Monash Model |
| NAIDOC | National Aborigines and Islanders Day Observance Committee |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NATSIFAC | National Aboriginal and Torres Strait Islander Flexible Aged Care |
| NDIA | National Disability Insurance Agency |
| NDIS | National Disability Insurance Scheme |
| NGO | Non-Governmental Organisation |
| PACE | Participant and Claims Experience |
| PD | Professional Development |
| PITC | Partners in the Community |
| RAS | Regional Assessment Service |
| RCC | Remote Community Connector |
| RPL | Recognition of Prior Learning |
| RTO | Registered Training Organisation |
| SAH | Support at Home |
| SEWB | Social and Emotional Wellbeing |
| SEE | Skills for Education and Employment |
| TAE | Training and Education (Trainer and Assessor) |
| TAFE | Technical and Further Education |
| TNA | Training Needs Analysis |
| UoC | Unit of Competency |
| UNDRIP | United Nations Declaration on the Rights of Indigenous Peoples |
| UTI | Urinary Tract Infection |
| VET | Vocational Education and Training |

# Executive Summary

**This Training Needs Analysis (TNA) was undertaken to understand how training can more accurately reflect and support the integrated care workforce operating within ACCHOs. While the findings highlight significant system complexity and workforce pressure, the purpose of this report is not to address all workforce challenges, but to identify how training can be embedded in ways that are meaningful, practical and useful for workers.**

The TNA confirms that the challenges experienced by ECS and ADLO/RCC workers are not due to a lack of capability or commitment. Instead, they arise from training pathways and products that do not align with the realities of integrated care practice. Workers are expected to navigate complex systems, translate deficit-based frameworks into culturally safe conversations, manage emotional and relational labour, and respond flexibly to community needs, yet training often remains narrowly focused or disconnected from this work.

**Across all consultations, workers emphasised the critical, often invisible labour of system navigation, which is not just an administrative function but a culturally sensitive, emotionally complex task that requires deep knowledge of both community and government systems.**

The workforce consistently reported that current pathways into disability and aged care rely on deficit-based assessments, where families are required to articulate what an Elder or child cannot do in order to access support.

This structural requirement was identified as being fundamentally out of sync with Aboriginal worldviews, where describing a loved one through deficits is culturally uncomfortable, often shame-laden, and in some cases completely incompatible with language. Workers in the Northern Territory described that there is no direct Aboriginal word for “disability”, reflecting a worldview that does not separate people based on functional limitation. As a result, families may avoid assessments, decline to articulate “problems,” or disengage from processes that position their children or Elders as lacking. This directly contributes to the under-representation of Aboriginal and Torres Strait Islander people in services they are entitled to.

In this context, system navigation becomes a critical cultural interface role, requiring workers to gently translate deficit-based requirements into culturally safe conversations while protecting dignity, identity, and family cohesion. This work requires nuanced communication skills, high trust relationships, and the cultural and linguistic competency to bridge two very different value systems.

Compounding this challenge is the prevalence of co-morbidities across both disability and ageing. Workers consistently emphasised that Elders and clients rarely present with a single need; rather, they experience intersecting health, disability, cognitive, social, and cultural considerations. This reality aligns naturally with the holistic model practiced by Aboriginal Community Controlled Health Organisations (ACCHOs), where a single, trusted service provides integrated support that acknowledges the interconnected nature of community, Country, physical health, social wellbeing, and cultural identity.

Participants repeatedly stated that this holistic, wraparound, community-centred model is not only culturally appropriate, but also best practice and should inform the broader disability and aged care sector. ACCHO approaches demonstrate that person-centred care is incomplete without being community-centred, acknowledging kinship systems, local governance, cultural protocols, and relational accountability.

This strong focus on place-based approaches must be locally designed, locally delivered, and community informed. Workers stressed that success depends on:




**Figure 1**

**Key components of place-based, community-centred care in ACCHO service delivery**

As current disability and aged care frameworks do not cater well for regional and remote realities, including thin markets, unstable workforce availability, limited assessors, and long travel distances, the burden of adapting, compensating, and problem-solving falls on ACCHO workers. They become the people who:

- bridge service gaps when external providers won't travel or services are simply unavailable,
- constantly follow up assessors who only visit intermittently and lack awareness of factors impacting on the individual within community,
- support Elders through long delays, and confusing and often intimidating processes,
- translate system requirements into culturally safe conversations, and
- ensure Elders aren't left behind simply because systems are rigid and inaccessible.

The ACCHO model is what makes this possible. Its community-led governance, wraparound service structure, and cultural authority provide a protective buffer that enables workers to adapt rigid systems to local needs, maintain continuity of care, and uphold trust. Place-based ACCHO practice aims to address system failures by exploring workable pathways for families however, this critical intervention must be recognised, resourced, and remunerated.

Consultations consistently highlighted that effective learning is grounded in real practice, supported through relationships, and delivered in culturally appropriate ways. Training that reflects lived experience, uses relevant scenarios and is supported by mentoring and peer learning was valued. In contrast, training that is heavily theoretical, overly written or focused on personal care tasks was seen as difficult to engage with and of limited relevance.

The findings also demonstrate that training must better support workers already in the role. Existing workers often carry the greatest responsibility for navigation, advocacy and coordination, particularly in regional and remote settings, yet often have the least access to flexible, role-relevant learning.

## Training that can be undertaken alongside work, delivered in achievable stages and adapted to local contexts was consistently prioritised.

A further key finding is the need for training to explicitly acknowledge the cultural and emotional dimensions of the work. Supporting Elders, people with disability and families through rigid and often culturally unsafe systems places significant emotional and cultural load on workers. Training that does not address difficult conversations, trauma, dementia, mental health and worker wellbeing leaves staff managing these pressures without adequate support.

This TNA identifies skill sets as a practical and culturally appropriate mechanism for workforce development within the ACCHO sector. Skill sets support incremental learning, recognise existing strengths and allow workers to build capability without undertaking full qualifications that may not reflect their roles. Used effectively, they provide flexible entry points and progression pathways aligned with integrated care practice.

The findings of this report directly inform Phase 2 of the project, which focuses on refining existing Elder Care Support resources and developing disability-focused training materials. Priority areas identified include system navigation, communication and documentation, disability and dementia awareness, mental health response and worker wellbeing. These areas reflect where training can most immediately strengthen confidence, effectiveness and sustainability for the workforce.

This TNA should be read as a practical guide for embedding training within Aboriginal community-controlled models of care. It affirms that training is not supplementary to the work of integrated care roles, but central to recognising, supporting and sustaining the culturally grounded practice that underpins effective care across ACCHOs.

## Key Findings

### Systems

- Current pathways into disability and aged care rely on deficit-based assessments, where families are required to articulate what an Elder or child cannot do in order to access support.
- System navigation is a critical cultural interface role, requiring workers to gently translate deficit-based requirements into culturally safe conversations while protecting dignity, identity, and family cohesion.
- Elders and clients rarely present with a single need which aligns naturally with the holistic model practiced by ACCHOs, where a single, trusted service provides integrated support that acknowledges the interconnected nature of physical health, social wellbeing, and cultural identity.

### Workforce

- Workers are often drawn from the communities they serve, bringing with them local knowledge, cultural authority, and established connections with families, elders, and service providers. While many do not hold formal qualifications, their strength lies in their practical experience, empathy, and community trust, qualities essential to delivering culturally safe and responsive care.
- Across all consultation sites, a consistent gap emerged between formal job descriptions and the work performed in practice. As a result, workers routinely absorb responsibilities that sit outside their formal scope but are essential to maintaining culturally safe care. This mismatch is not incidental, but structural, arising from thin markets, system complexity and the absence of alternative services.
- Once workers engage with an Elder or family, community expectation and lack of access to culturally appropriate services mean they remain involved long-term resulting in persistent caseload growth with no handover.
- Role expansion reflects both community need and systemic workforce shortages and contributes to increased emotional load, blurred role boundaries, and higher burnout risk.
- Workers shared commitment and resilience, with many describing their roles as a “calling” grounded in community service and cultural care.
- Attrition is rarely attributable to remuneration, rather burnout and lack of training to ensure clients are kept safe are key factors. Workers are motivated by the opportunity to make a difference not money.
- A place based, locally designed approach to workforce development is key to the delivery of culturally appropriate services and better health outcomes for community members.
- A single, standardised recruitment or training model does not reflect the realities across MMM classifications. Community-led recruitment is not a weakness of remote and regional settings; it is a strength that enables continuity, cultural safety and trust in environments where formal labour markets are thin or absent.

### Training

- Current training system settings do not adequately support established ACCHO workforce development models. This gap is misaligned with the way ACCHOs and related services build and sustain their workforce, through upskilling and formalising the qualifications of existing staff who already have strong community and cultural knowledge.
- In the integrated care workforce, the value of qualifications lies in their ability to support progression, specialisation and formal recognition over time. When accessed at the right point in a worker’s journey, and supported by flexible delivery and appropriate scaffolding, qualifications can strengthen workforce capability while respecting the diverse pathways through which ECS and ALDO/RCC workers contribute to culturally safe, community-led care.
- Current national qualifications fail to capture the skills and knowledge required and training models fail to align with the ACCHO delivery model and integrated approach to service delivery. The Certificate III in Individual Support has a strong emphasis on personal care tasks such as bathing, toileting, and physical assistance and is not appropriate or aligned with many roles. Rather, work is more holistic, preventative, community-based, and centred on social, emotional, and cultural wellbeing. For some Aboriginal community-controlled settings, the personal care components can also raise cultural safety concerns or create barriers to participation and retention.
- Workers consistently called for culturally grounded, context-specific training and nationally recognised pathways tailored to integrated aged care/disability navigation not generic community services qualifications.

- Access to training remains a significant barrier. In remote and very remote locations (MMM6–7), training providers are scarce, travel distances are extensive, and digital connectivity is unreliable. Face-to-face delivery is rarely available locally, while online delivery assumes levels of digital access, confidence and literacy that do not reflect local realities. In regional areas, training availability is often inconsistent or cancelled due to low enrolments.
- Aboriginal and Torres Strait Islander Community Controlled Registered Training Organisations (ACCRTOs) are categorised as private RTOs under ASQA, despite being not-for-profit and community-governed organisations. This classification restricts their access to the larger and more secure public VET funding streams available to TAFEs and other publicly recognised providers. As a result, ACCRTOs face significant constraints in expanding their training scope, even though they consistently achieve stronger outcomes for Aboriginal learners.

## Key Recommendations

1. Delivery of the training by ACCRTOs, to ensure training is culturally appropriate and customised to reflect a place-based approach.

2. Consistent national funding for skill sets for new and existing workers which support a staged and achievable approach to learning that recognises the diverse needs, experiences and starting points of learners. By breaking training into smaller, clearly defined segments, skill sets allow workers to undertake learning without being overwhelmed by the volume or duration typically required for full qualifications. This approach supports early achievement and confidence building, while still providing skills and knowledge that are directly relevant to the workplace.

3. Investment in mentoring and buddy systems are essential for effective learning and are particularly important in culturally grounded, community-based roles. Mentors support learners to interpret training content, apply skills in real work settings, build confidence and manage cultural and emotional load. Mentoring also enables learning to be paced according to individual need and allows workers to step in and out of training in response to cultural obligations, family responsibilities or community priorities.

4. Design and development of ACCHO specific flexible training pathways, staged and grounded in real work. Skill sets, mentoring and place-based delivery provide practical mechanisms to support workforce entry, upskilling and progression while recognising lived experience and cultural knowledge. Training must also explicitly address system navigation, disability and dementia awareness, mental health response, difficult conversations and worker wellbeing to support workforce sustainability.

5. Delivery of training in place-based settings wherever possible. Learning that occurs on Country or within community-controlled environments is more meaningful and accessible than delivery in unfamiliar or institutional settings. Place-based delivery allows training to incorporate local language, cultural protocols, community priorities and service pathways, ensuring learning is grounded in the realities of where people live and work.

6. Development and delivery of evidence-based, non-accredited community-led adult literacy campaigns designed specifically for Aboriginal people.

7. Inclusion of ACCRTOs in state and national workforce development strategies. Their inclusion will ensure delivery models and sector needs are included in funding design and policy reform processes.

# Training Needs Analysis Scope

**This TNA focused on ACCHOs' integrated non-clinical care workforce, specifically the ECS and ADLO/RCC roles, and sought to identify the skills, knowledge and training requirements necessary for the development of an integrated aged care and disability navigation training pathway.**

This includes:

- Understanding why people are attracted to and remain in these roles.
- Examining the actual duties performed across these roles compared with perceived scope outlined in job descriptions.
- Identifying skill and knowledge requirements for entry level, existing workers and to support career progression and how they varied between locations.
- Identifying transferable skills between aged care and disability functions to support career progression and the realities of intersectionality particularly in regional and remote locations.
- Identifying entry pathways including accredited and non-accredited pathways such as skill sets, courses and qualifications.
- Understanding preferred modality of training delivery and once again the impact of learning capacity and location.
- How cultural integration can be achieved
- Current training gaps
- Understanding the advantages and challenges experienced by ACCHOs that have integrated these roles.

The TNA required consultation with ACCHOs using surveys, interviews, workshops and other consultation methods. Findings from the TNA will inform the next stage of the project (Phase 2), which involves refining existing ECS training resources and developing resources for up to two Units of Competency (UoC) and associated accredited training and assessment materials. This work will support the development of a national Integrated Care certified training pathway.

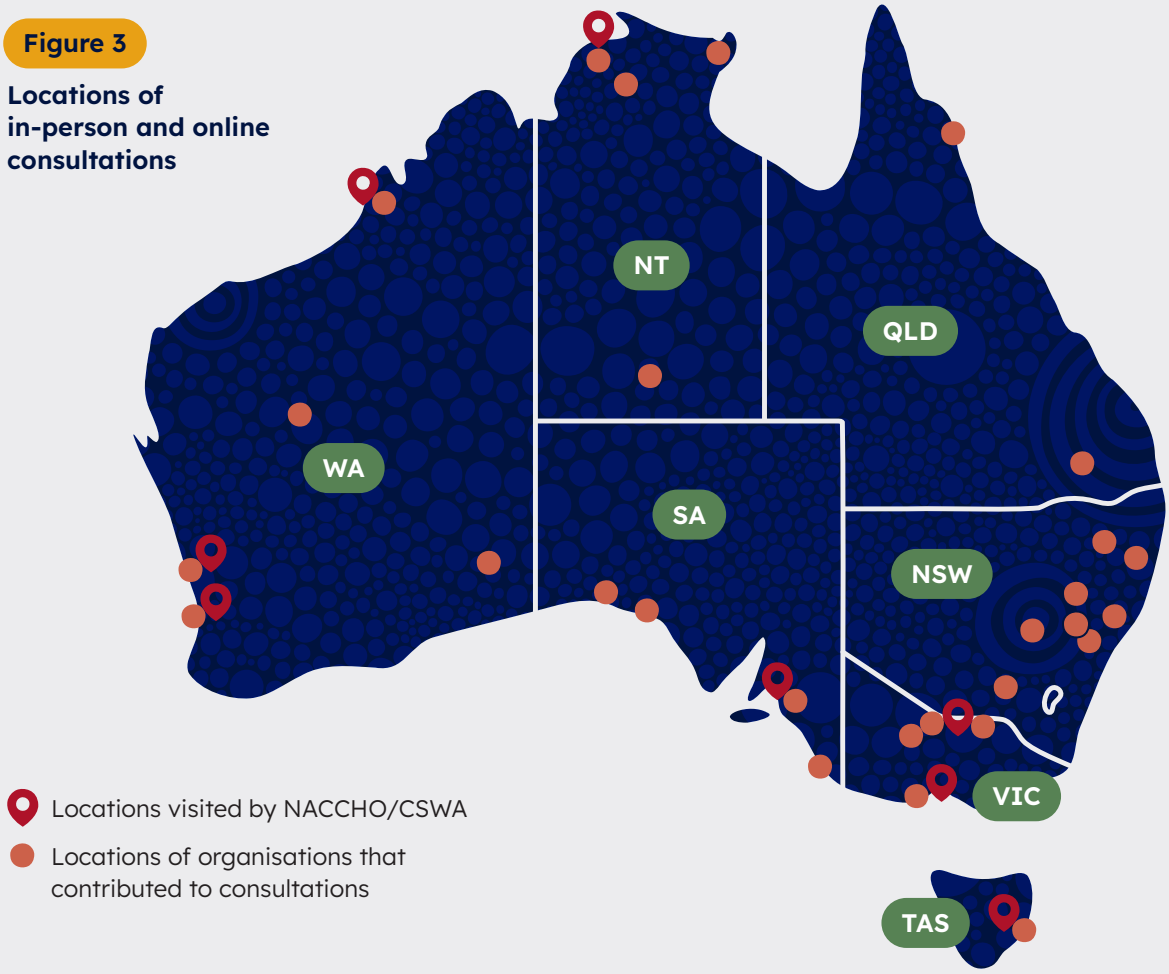
**Figure 2**

**Scope of the Training Needs Analysis for the ACCHO integrated care workforce, showing the roles examined, key areas of analysis, and the link to Phase 2 of the project**



**Figure 3**

**Locations of in-person and online consultations**




## Consultation process

Across all engagement activities, participants were open, genuine, and willing to share their perspectives. They demonstrated strong passion for their work and a deep commitment to their communities, consistently emphasising the importance of these roles in supporting Elders, people with disability, and families.

Consultations were delivered through a combination of in-person sessions, online meetings, and written feedback opportunities. In-person consultations were held in Broome, Perth, Bunbury, Adelaide, Darwin, Shepparton, Melbourne, and Hobart, ensuring broad geographic representation across jurisdictions. All participants were also invited to complete feedback surveys, resulting in 41 workforce respondents (ECS and ADLO/RCC roles) and seven manager respondents.

Workshops were conducted using collaborative group discussions and structured brainstorming activities. Participants were invited to contribute ideas, identify challenges, and articulate training needs on paper. Where numbers allowed, workers were divided into role-specific groups, such as ECS and ADLO/RCC to capture the unique perspectives and responsibilities associated with each role.

Following each session, the consultation team reviewed all on-paper outputs, grouping similar ideas and identifying recurring themes, shared issues, and variations across roles. These insights were then triangulated with survey data and key points raised during conversations, enabling a robust synthesis of qualitative and quantitative evidence. This mixed-method approach ensured the TNA was grounded in the lived experiences of the workforce, accurately reflecting their priorities, strengths, and capability development needs.

As part of the TNA process, preliminary findings were presented at the NACCHO Conference held in Sydney in December 2025. This presentation provided an opportunity to share emerging themes and early insights with NACCHO member services and stakeholders working across integrated care. As part of the presentation, a feedback session was facilitated to source additional stakeholder insights. The information gathered through this session was documented and has directly informed the development and refinement of the TNA, ensuring it reflects sector priorities, community expectations and the lived experience of the workforce.

# Integrated Care

**NACCHO is the national peak body for 148 ACCHOs, which deliver culturally safe primary health care as well as aged care, disability, early childhood intervention and psychosocial services to Aboriginal and Torres Strait Islander people across urban, rural and remote communities. This work is grounded in an integrated model of care that brings together health, specialist and social supports to meet community needs holistically.**

As part of this approach, key navigation and coordination positions help community members navigate the complex support and service systems across aged care and disability. Several roles are delivered through NACCHO programs, including the Elder Care Support (ECS) roles of Elder Care Connector (ECC) and Elder Care Coordinator (ECC), and the Aboriginal Disability Liaison Officer (ADLO) role. The NDIA also directly fund Remote Community Connector (RCC) roles in ACCHOs/ACCOs and these have been included here as the remote counterpart to the urban/regional ADLO workforce.

These roles sit within multiple overlapping policy and funding systems that are highly regulated, compliance-driven and largely designed around mainstream service assumptions (described in **Attachment A**).

The roles themselves are complex and multifaceted, requiring staff to support individuals and families to navigate the often confusing NDIS and My Aged Care (MAC) systems, coordinate care across multiple providers, advocate for culturally appropriate services, and build trust with clients who may have experienced systemic barriers or service gaps.

Together, these positions operate in a wide range of settings, from large metropolitan ACCHOs to small, remote community-controlled services. They must adapt to differing local needs, workforce capacity, service availability and community expectations. Given the majority of these roles sit within an ACCHO that delivers primary health care, workers are already recognised within community as coming from a position of trust and understanding. This helps ensure ECS and ADLO/RCC roles provide essential, culturally grounded support that strengthens the ability of ACCHOs to deliver truly integrated care for Aboriginal and Torres Strait Islander people.

Core Roles of the Integrated Care Workforce detailed in **Attachment B**

**Figure 4**

**Key responsibilities of ADLO/RCC and ECS staff demonstrating the breadth of their roles in integrated care delivery**



## Workforce overview

The integrated care workforce is community-based, relationship-driven, and shaped by lived experience. Workers are often drawn from the communities they serve, bringing with them local knowledge, cultural authority, and strong interpersonal skills that enable them to connect with families, elders, and service providers. While many do not hold formal qualifications, their strength lies in their practical experience, empathy, and community trust, qualities essential to delivering culturally safe and responsive care. The majority of workers involved in consultations were Aboriginal however, there were some workers from other backgrounds each of whom had strong ties to the Aboriginal community in which they worked.

- Entry-Level Workers: Typically recruited locally, these workers are motivated by community wellbeing and guided by cultural responsibility. Their pathways into the role often emerge organically through volunteering, caring responsibilities, or informal advocacy.
- Experienced Workers: Long-serving staff who understand both local community dynamics and the complexities of government systems. They often take on mentoring responsibilities and act as the link between ACCHOs, government programs, and other service networks.
- Senior/Coordinator Roles: Oversee day-to-day operations, reporting, compliance with programs such as MAC and NDIS, and provide supervision and workforce development support across multiple sites.

Across all levels, the Job Description Forms (JDFs) differ substantially from the actual scope and nature of the work performed. In practice, many workers operate far beyond administrative or navigational duties, managing complex cases, supporting family crises, and bridging service gaps created by fragmented systems. This role expansion reflects both community need and systemic workforce shortages but contributes to increased emotional load, blurred role boundaries, and higher burnout risk.

Consultations and program evaluations indicate that retention improves where ACCHOs have strong local governance, peer supervision, and access to ongoing training and support. However, workforce sustainability becomes more challenging in remote or under-resourced areas, where limited staffing, geographic isolation, and high service demand compound workload pressures.

Despite these challenges, workers demonstrate strong commitment and resilience, with many describing their roles as a “calling” grounded in community service and cultural care. The reasons workers were attracted to and remain in these roles were clear and are reflected in Figure 5 below.

**Strengthening training pathways, improving role clarity, and aligning JDFs with on-the-ground expectations will be essential to sustaining this critical workforce.**

**Figure 5**

**Workforce motivations and values shaping Integrated Care practice**



## Impact of remoteness

The workforce profile across the integrated care roles varies significantly depending on location, as defined by the Modified Monash Model (MMM). Differences between metropolitan, regional, rural and very remote settings have a direct influence on recruitment approaches, role design, skills required and the they operate in practice, and workforce sustainability.

In major cities and large regional centres (MM1-2), such as Adelaide, Melbourne, Perth, Darwin, Hobart, Bendigo, Shepparton and Greater Western Sydney locations including Penrith, recruitment is generally more formalised. These locations offer access to larger labour markets, established training providers and broader service networks. Recruitment processes in these settings are more likely to involve advertised positions, formal selection criteria and qualification-based requirements. Workers in these locations may enter roles with prior experience in health, community services or administration and have greater access to structured induction, supervision and external training opportunities. While community connection remains important, it is often balanced with formal workforce systems and compliance requirements.

In regional centres such as Broome, Bunbury, Wagga Wagga, Orange, Coffs Harbour, Tamworth, Mount Gambier, Toowoomba and Katherine (MM3-5), recruitment models are more mixed. In these locations, organisations often rely on a combination of formal recruitment and community-led identification of suitable workers. Candidates may be known to the organisation or community prior to employment, with cultural knowledge, relationships and lived experience valued as highly as formal qualifications. Roles in these settings tend to be broader responding flexibly to service gaps. Workforce availability is more constrained, increasing reliance on existing staff to expand scope and build capability over time.

In remote and very remote locations (MM6-7), including Yalata Community, Ceduna, Nhulunbuy, Alice Springs, Tjuntjuntjara, Newman and some parts of the Kimberley and Northern Territory, recruitment is predominantly community led. In these settings, workforce supply is limited and continuity of care depends heavily on employing local community members. Recruitment is often informal and relational, with workers transitioning into roles through volunteering, family caring responsibilities, cultural leadership or community advocacy rather than through formal career pathways. Formal qualifications are less common at entry, and skills are developed through on-the-job learning, mentoring and lived experience.

Across MMM6–7 locations, roles are inherently expansive. Workers frequently perform navigation, advocacy, education, transport coordination, crisis response and cultural brokerage functions simultaneously. Travel distances, thin markets, limited visiting services and high community demand require workers to operate with significant autonomy and adaptability. In these contexts, rigid role definitions and qualification-based recruitment are unrealistic, and workforce sustainability depends on recognising community knowledge, cultural authority and informal capability development.

The consultation locations illustrate this national variability clearly. Workers in metropolitan Adelaide, Melbourne and Perth described more structured recruitment and clearer role delineation, while those in places such as Broome, Katherine, Ceduna, Yalata, Nhulunbuy and Tjuntjuntjara described pathways into roles that were grounded in community trust, cultural responsibility and necessity rather than formal workforce pipelines. Regional centres such as Bendigo, Echuca, Shepparton, Bunbury, Wagga Wagga and Orange sat between these models, drawing on both formal and community-led approaches depending on workforce availability.

This variation has important implications for workforce development. A single, standardised recruitment or training model does not reflect the realities across MMM classifications. Community led recruitment is a strength of remote and regional settings that enables continuity, cultural safety and trust in environments where formal labour markets are thin or absent. At the same time, workers recruited through community pathways require access to flexible, scaffolded and culturally appropriate training that supports progression without undermining local models of care.

Understanding the interaction between MMM classification, location and recruitment approach is essential to accurately interpreting workforce capability and training needs. Workforce strategies that fail to account for these differences risk privileging metropolitan assumptions and overlooking the strengths, realities and constraints that shape integrated care roles across Australia.



Rumbalara Aboriginal Co-operative, Bendigo & District Aboriginal Co-operative, Njernda Aboriginal Corporation, Community Skills WA & NACCHO Integrated Care consultation hosted at Rumbalara Elders Facility in Shepparton VIC.

## Workforce strengths

Consultations highlighted a consistent and distinctive set of strengths across the integrated care workforce. These strengths reflect Aboriginal community-controlled ways of working and underpin the workforce's ability to deliver culturally safe, high-quality aged care and disability navigation across diverse urban, regional and remote settings:

### 1 Strong community connection and cultural authority

- Deep trust-based relationships with Elders, families and community members.
- Strong cultural authority derived from lived experience, kinship connections and local standing.
- Detailed knowledge of family systems, community histories and local dynamics.
- Ability to uphold and navigate cultural protocols, including Sorry Business and men's and women's business.
- Capacity to support sensitive conversations about ageing, disability and care without shame or disengagement.

These strengths enable workers to act as trusted intermediaries between community and complex service systems.

### 2 Holistic and integrated care practice

- A whole-of-person approach that recognises physical, social, emotional, cultural and spiritual wellbeing.
- Natural alignment with integrated ACCHO service models rather than siloed program delivery.
- Ability to respond to co-morbid and intersecting needs through wraparound support.
- Strong collaboration across ACCHO programs, enabling coordinated and continuous care.
- Support for Elders ageing with disability and families navigating multiple systems simultaneously.

This holistic practice was consistently identified as culturally appropriate and effective.

## 3 Advanced system navigation and advocacy skills

- Practical, experience-based knowledge of MAC, NDIS, assessments, reviews and complaints processes.
- Ability to translate complex, deficit-based system language into culturally safe and understandable explanations.
- Strong advocacy skills when engaging with assessors, providers and government agencies.
- Informal networks with local services that support problem-solving and access.
- Capacity to persist through system delays, service gaps and bureaucratic barriers.

This navigation work is a skilled and critical function rather than an administrative task.

## 4 Relational, trauma-informed and person-centred practice

- High levels of empathy and respect when supporting Elders and families.
- Strong capability in managing grief, loss, trauma and distress.
- Ability to de-escalate conflict and manage difficult conversations safely.
- Long-term relationship building that supports trust and engagement over time.
- Commitment to protecting dignity, identity and cultural safety in all interactions.

These relational skills are central to effective engagement and service uptake.

## 5 Flexibility, adaptability and problem-solving

- Ability to adapt roles and approaches in thin markets and under-resourced settings.
- Creative problem-solving when services are unavailable, delayed or fragmented.
- Use of alternative communication methods to address language, literacy and digital barriers.
- Willingness to operate across broad scopes of practice to maintain continuity of care.
- Responsiveness to changing community needs and system conditions.

This flexibility enables ACCHOs to function effectively despite systemic constraints.

## 6 Strong commitment, resilience and motivation to remain in role

- Deep commitment to community wellbeing and cultural responsibility.
- Strong sense of purpose in supporting Elders, people with disability and families.
- High levels of resilience despite emotional load and system barriers.
- Greater retention where workers feel culturally safe, supported and valued.
- Desire to mentor others and contribute to long-term community capacity building.

This intrinsic motivation is a critical workforce asset.

## 7 Informal learning, peer support and knowledge sharing

- Skills developed through on-the-job learning, mentoring and shadowing.
- Strong peer support within ACCHO teams and across communities.
- Informal supervision and shared problem-solving in complex cases.
- Learning that is highly contextualised to local, cultural and geographic realities.
- Knowledge transfer between experienced workers and new entrants.

This informal learning ecosystem, while often invisible, plays a central role in workforce capability.

**Together, these strengths demonstrate a workforce that is culturally grounded, highly capable and deeply committed. They also reinforce that the challenges identified elsewhere in this report are structural and systemic in nature, rather than reflective of workforce deficits.**

## Workforce challenges

Consultations highlighted a consistent set of challenges affecting workers' ability to deliver culturally safe, high-quality support across aged care and disability systems. These challenges reflect both the unique context of Aboriginal community-controlled service delivery and structural barriers within the broader service environment.

### 1 Role clarity, scope, and job design issues

Across all consultation sites, a consistent gap emerged between formal job descriptions and the work performed in practice.

- Workers undertake tasks far beyond their role scope, including crisis response, case management, transport coordination, system navigation, brokerage, and advocacy across both aged care and disability.
- This role stretch is driven by the absence of local services, high community need, thin markets and underfunding, particularly in remote areas.
- Inconsistent interpretation of role boundaries leads to confusion, variable expectations, and inconsistent supervision.
- Job titles often fail to reflect the responsibility, skill, and emotional load of the role.

Workers report compromised professional identity and increased emotional fatigue when performing duties well outside their official remit. Workers routinely absorb responsibilities that sit outside their formal scope but which are essential to maintaining culturally safe care. This mismatch is not incidental, but structural, arising from thin markets, system complexity and the absence of alternative services.

The differences between JDF descriptions and practice are outlined for select roles in **Attachment C**

### 2 Workforce capability, training gaps, and language, literacy and numeracy

While cultural knowledge and community connections are strong, significant gaps exist in technical and administrative capability.

Key capability gaps:

- System navigation for MAC, NDIS, Commonwealth Home Support Programme (CHSP)/ Home Care Packages (HCP), and foundational supports.
- Documentation, case notes, evidence collection, compliance reporting.
- Digital literacy, including online portals and record-keeping systems.
- Advocacy and communication skills, especially when dealing with government agencies and external providers.
- Leadership and supervision capability for coordinators and senior staff.

LLN challenges:

- Some workers struggle with complex forms, online reporting, or technical writing.
- Workers often feel "self-taught" in digital systems due to limited structured training.
- Elders and clients often struggle to understand letters or communication from government systems, requiring workers to interpret and translate information.
- These challenges increase time pressure and emotional load.

Workers consistently called for culturally grounded, context-specific training and nationally recognised pathways tailored to integrated aged care/disability navigation rather than generic community services qualifications.

## 3 Burnout, emotional load, and limited support structures

Burnout is widespread across roles and regions, driven by high emotional and workload pressures.

- Workers support Elders and clients through complex issues: declining health, disability progression, grief, family stress, financial pressure, and systemic barriers.
- They regularly manage difficult conversations, such as explaining delays or service shortages after helping someone sign up for support. When services do not arrive, workers often absorb Elders' frustration or blame.
- Caseloads rarely decrease because there are few other services to transition clients to, especially in remote areas.
- Workers feel "always on," as community members often seek help outside work hours due to cultural expectations and trust.
- Limited access to supervision, debriefing, and reflective practice heightens risk of vicarious trauma.
- In small teams or single-position roles, workers carry full responsibility without backup.

Without structured wellbeing supports, these pressures contribute to high burnout risk and reduced workforce retention.

## 4 Persistent caseload growth

A major challenge is that clients remain on caseloads indefinitely.

- Chronic and progressive conditions require long-term ongoing support.
- System-level issues—delayed assessments, cancelled services, long waitlists, NDIS plan changes—prevent discharge.
- Once workers engage with an Elder or family, community expectations mean they remain involved long-term.
- Caseloads grow continuously, reducing the ability to:
  - Complete reflective practice
  - Provide proactive support
  - Attend training or professional development
  - Travel into community as often as needed

This entrenched caseload pressure impacts both service quality and worker wellbeing.

## 5 Recognition, status, and career progression challenges

Despite the complexity, responsibility, and cultural importance of these roles:

- Workers feel undervalued, with skills not reflected in pay scales or qualification frameworks.
- Career progression pathways are unclear, inconsistent, or unavailable.
- Workers want pathways that recognise cultural authority, lived experience, and on-the-job expertise as equivalent to formal qualifications.
- Short-term funding cycles and a lack of structural investment undermine job security and workforce retention.
- Workers aspire to roles such as coordinator, assessor, NDIS specialist, governance positions, or broader aged care/disability leadership, but feel the pathways are blocked or poorly defined. In addition, if the worker is looking to pursue an Allied Health pathway there is limited access to these study options in regional and remote communities.

## 6 Geographic, remote, and thin-market barriers

Workers operate across large and often isolated geographic regions, creating major limitations on service delivery. Key barriers include:

- Significant travel time across long distances in extreme conditions.
- Limited on-the-ground aged care and disability service availability, especially in thin markets where providers visit infrequently or inconsistently.




Tasmanian Aboriginal Centre & NACCHO Integrated Care consultation hosted at Tasmanian Aboriginal Centre in Hobart TAS.

- Difficulty coordinating services when assessors, allied health, Regional Assessment Service (RAS)/ Aged Care Assessment Team (ACAT) teams, and NDIS providers attend only intermittently or cancel due to travel constraints.
- Reduced access to training, supervision, and professional support, often delivered online in areas with poor connectivity.
- Clients being approved for services but unable to receive them because the market cannot meet demand, creating risk and frustration for Elders and families. Works cited this placed them in a confronting position whereby they are creating expectations which are unable to be met.
- Workers frequently needing to "fill gaps" left by unavailable providers, leading to role stretch and burnout.
- The impact of Sorry Business, which occurs frequently in regional and remote communities. Workers must take time away for cultural obligations and grieving, reducing workforce capacity, especially in small teams with no backfill, which creates backlogs and emotional strain upon return.

As a result, workers often become the default point of contact for multiple systems, despite limited resources and systemic constraints.

### 7 System complexity, fragmentation, and constant change

Workers must navigate multiple, disconnected systems (NDIS, MAC, Foundational Supports), each with different requirements.

- Constant reforms, including aged care changes (e.g., Support at Home (SAH)), NDIS PACE rollout, and shifting eligibility rules, create uncertainty and confusion.
- Workers often lack role-specific training to interpret new guidelines and changes.
- Clients fall between systems, requiring workers to translate complex policies into plain language and advocate across departments without formal authority.
- The administrative burden reduces time for meaningful client support and increases stress.

## Attraction and retention

Across the Integrated Care workforce, the challenges are not about motivation or capability, they are about structure, recognition, and support. Workers consistently demonstrate flexibility, cultural leadership, and commitment, however the systems around them have not yet caught up (MAC, NDIS).

The sector confirmed attraction, and retention of this workforce will require:

| Attract | Retain |
|---|---|
| Remuneration and salary packaging including culturally informed leave | Remuneration and entitlements including culturally informed leave e.g. a nominated day of paid leave to attend community event during National Aborigines and Islanders Day Observance Committee (NAIDOC) week |
| Increase staff numbers so people have backup for leave and professional development (PD) | Backfilling the role when on leave |
| Scaffold responsibilities – don't overload people | Opportunities to inform strategic direction and progress with leadership roles within organisation |
| Culturally safe inclusive workplace | Engagement with organisations to broaden experience and PD opportunities |
| Mental health, strong and staff wellbeing | Flexibility in what work looks like |
| Employment opportunities and support for partners and families | Peer Support |
| Role stability | Individual flexible learning pathways |
| Career development opportunities | Try before you buy opportunities – Skillsets that support existing staff to try something new. |
| Prioritise trainer wages and recruitment | Continue support for Training and Education (TAE) (Funded educators who can support new and existing learners |
| Greater ability to offer place-based training and specialisation | |
| Staff training | |

## Career aspirations

When asked about future directions and where they saw themselves progressing, respondents described a range of career aspirations that reflected both professional growth and a continued commitment to community. Many identified aspirations to move into roles such as Aboriginal Health Practitioner, Aboriginal Support Coordinator or assessor roles within aged care and the NDIS, where they could apply their lived experience and system knowledge in more formalised capacities. Others expressed interest in allied health pathways, including professions such as occupational therapy, as well as complex case management and coordinator roles that involve higher levels of responsibility and system leadership. A number of respondents also spoke about advocacy roles, including roles within government, and broader leadership positions, reflecting a desire to influence systems and decision-making in ways that improve outcomes for Aboriginal people and communities. Collectively, these aspirations highlight the integrated care workforce as a key pipeline into specialist, coordination, advocacy and leadership roles across health, disability and community services.

**Figure 6**

**Participant feedback received during national consultations**

**"Connector to coordinator to leadership – people do move through these roles."**
— WA Consultation

**"Connectors have transitioned into trainee AHPs."**
— NT Consultation

# Skills and Knowledge Requirements

**Defining clear and consistent skills and knowledge requirements for the ECS and ADLO/RCC workforce is complex. Although these roles share common purposes, supporting Elders, people with disability, families and communities, the way they operate varies significantly across organisations.**

Each ACCHO structures its programs differently, assigns responsibilities based on local needs, and develops expectations shaped by community context, funding arrangements, workforce availability and historical practice. As a result, the capabilities required at “entry,” “existing” and “senior” levels are not uniform across the sector. In some locations, entry-level workers perform highly advanced tasks due to limited staffing, while in others the same tasks sit with coordinators or specialists. Some organisations provide intensive induction programs, while others rely heavily on on-the-job learning and community knowledge. High levels of cultural responsibility, geographic challenges, thin markets, service gaps and diverse local governance arrangements further influence what workers must know and be able to do.

The work that the ECS and ADLO/RCC workforce undertakes relies heavily on soft skills rather than technical skills. Communication, empathy, professionalism and person-centred support are consistently identified by workers and managers as essential. These skills underpin quality and safe supports but are not always clearly taught or assessed in current training pathways.

Specialty skills remain critical for the workforce, particularly in areas related to system navigation, culturally safe communication, trauma-informed practice and supporting people with intersecting disability, ageing, health and social needs. The TNA identifies significant gaps in training related to navigating the NDIS and MAC systems, managing complex and co-morbid needs, trauma-informed and culturally grounded practice, mental health and psychosocial disability, advocacy, de-escalation and crisis response, digital literacy, documentation and governance requirements.

Workers also identified a lack of culturally appropriate training that reflects place-based realities, thin markets, remote service delivery, and the cultural and emotional labour involved in supporting Elders, people with disability and families through rigid, deficit-based systems.

This diversity means that the skillsets outlined in this report represent the common capabilities identified across all consultations, not a one-size-fits-all model. Instead, they reflect the shared themes, expectations and core competencies that emerged from listening to workers, managers and community members from organisations with vastly different structures.

**The findings of this TNA therefore aim to honour this diversity while providing a consolidated, sector-wide view of the essential skills and knowledge and attributes required across each role and career stage.**

## Workforce knowledge requirements

| | |
|---|---|
| **Elder Care Connectors – Entry Level** | • Basic aged care knowledge (MAC, CHSP, HCP)<br>• Safety policies for home visits<br>• Case noting / acronyms<br>• Community presence and ability to build trust through relationships<br>• Cultural awareness and community understanding<br>• Polite, respectful communication and rapport/trust building<br>• Ability to code-switch<br>• Basic Information Technology (IT) skills and administration essentials (entering notes, registration, reporting)<br>• Confidence driving long distances and transporting Elders<br>• Understanding cultural protocols (men's/women's business, Sorry Business)<br>• Professional boundaries<br>• Lived experience and understanding of "why" the work matters |
| **Elder Care Connectors – Existing Workers** | • Strong understanding of aged care pathways and provider systems<br>• Trauma-informed practice and understanding of Elders' lived experiences<br>• Complex case management capability<br>• Ability to reframe government language in culturally safe ways<br>• Managing expectations when Elders wait long periods for services<br>• Conflict resolution / de-escalation<br>• Understanding chronic conditions and their impact<br>• Strong local service networks (who to contact, referral pathways)<br>• Ability to support Elders through systemic delays and confusion<br>• Ability to advocate effectively for Elders across agencies<br>• Case documentation, reporting accuracy, system navigation<br>• Ability to run and organise community/Elder outings or events<br>• Understanding of dementia and the impacts on the Elder |
| **Elder Care Coordinators – Entry Level** | • Strong communication and writing skills<br>• Time management<br>• Community connections and local knowledge<br>• Thick-skinned and able to stand firm when needed<br>• Empathy, respect, and self-awareness<br>• Understanding needs vs wants<br>• Basic system knowledge<br>• Self-care and boundary management<br>• Initiative and proactive learning<br>• Early ability to problem-solve and follow guidelines |
| **Elder Care Coordinators – Existing Workers** | • Skilled at difficult conversations and managing distressed Elders/families<br>• Managing grief, loss, and mental health concerns<br>• Knowledge of aged care funding streams<br>• Strong care planning and assessment skills<br>• Coordinating rosters, accounts, and logistics<br>• Collaborating with other ACCHO programs<br>• Maintaining strong relationships with ACAT, GPs, nurses |

| | |
|---|---|
| **Aboriginal Disability Liaison Officers – Entry Level** | • Basic understanding of NDIS and Partners in the Community (PITC)<br>• Cultural awareness and local community knowledge<br>• Empathy, communication, and forward thinking<br>• Lived or caring experience (disability, aged care, family services)<br>• Knowledge of disability and service systems<br>• Community and cultural knowledge<br>• IT skills, note-taking, document management<br>• Networking and relationship building<br>• Ability to walk alongside clients through evidence collection<br>• Foundational knowledge of access, planning and reviews |
| **Aboriginal Disability Liaison Officers – Existing Workers** | • Ability to explain NDIS reviews, access, and decisions<br>• Maintaining relationships with PITC, specialists, and providers<br>• Supporting clients with NDIS evidence, reports, and appeals<br>• Liaising with GP/specialists for assessments<br>• Explaining government concepts in culturally safe ways<br>• Managing complex disability situations, shame, stigma, confusion<br>• Supporting families to understand rights and entitlements<br>• Building local disability support networks |
| **Remote Community Connectors – Entry Level** | • Basic understanding of NDIS<br>• Knowledge of local providers, ACCHOs, stakeholders<br>• Understanding different disabilities and functional needs including psychosocial and neurodiversity<br>• Cultural awareness specific to region/community<br>• Knowing key contacts and local leaders<br>• Language centre knowledge; respecting community protocols<br>• Understanding scope of practice and ethical boundaries<br>• Using hard-copy resources when digital tools are unreliable |
| **Remote Community Connectors – Existing Workers** | • Understanding medical reports and evidence for NDIS access<br>• Navigating NDIS systems, pathways, and documentation<br>• Case noting and documentation competency<br>• Managing expectations and resolving conflicts<br>• Navigating complex health systems<br>• Governance knowledge, including complaints<br>• Teaching families how to navigate systems<br>• Creating culturally appropriate visual/alternative learning tools<br>• Adapting communication without deficit language |

## Training gaps

For roles aligned with both the aged care and disability sectors the following key themes emerged around the skills and knowledge required, regardless of tenure and geographical location. It is however acknowledged the depth of knowledge and skill required will vary dependent on these factors.

Across all groups common themes emerged highlighting where the most significant training gaps existed and areas of commonality between aged care and disability.

### Areas of commonality

- **System navigation** – MAC and the NDIS are rapidly changing and complex landscapes and understanding how best to navigate these systems for clients was identified as critical. This includes systems, pathways and documentation and how to build evidence to support access.
- **Case notes** – this specifically related to the development of case notes which supported the provision of holistic care by ensuring key knowledge of the individual and their circumstances was made available to all involved in the individual's care. In addition, it was highlighted that specific language use in notes and reporting greatly enhanced the chance of securing funding.
- **Dementia awareness** – while dementia awareness is historically aligned with aged care supports, the higher incidence of early onset dementia amongst Aboriginal communities ensured this was raised as a potential gap. Additional knowledge around signs, referral pathways and engagement in conversations with individuals and family members is sought.
- **Difficult conversations** – workers are increasingly required to navigate conversations shaped by MAC and NDIS system language, which is often deficit-focused and misaligned with cultural perspectives. Interpreting and explaining this language, while gathering required information, requires strong communication skills and the ability to engage respectfully and effectively with individuals and families through complex and sometimes challenging discussions.
- **Mental health response** – in addition to understanding psychosocial disabilities, the ability to respond appropriate to individuals and family members experiencing mental health concerns was frequently raised.

**Aboriginal Mental Health First Aid training was cited as being of significant value.**

### Disability

Specific gaps were identified by the ADLO/RCC workforce:

- **Disability awareness** – an awareness of the different forms of disability, signs, impacts and required referrals is sought to enable the best advice and support to be provided. In particular, greater awareness of psychosocial and neurological conditions is required due to both complexity and prevalence.

### Ageing

- **Case notes** – in addition to the skills identified above, ECS workers identified the need to better understand how to document signs of ageing, chronic health conditions and potential elder abuse.
- **Dementia awareness** – in addition to the skills identified above, ECS workers specified the need to understand the impact of dementia on members of the Stolen Generation. Care for Aboriginal people living with dementia must be grounded in strong cultural understanding and an awareness of how trauma can resurface as cognitive decline progresses. For members of the Stolen Generations in particular, dementia can erode the coping mechanisms and protective strategies that have supported them throughout their lives, allowing memories of removal, institutionalisation and the loss of family, language and culture to re-emerge.

  Care for Stolen Generations people living with dementia cannot be separated from culture, history or lived experience. Trauma, identity and health are deeply interconnected, particularly where there has been forced removal, institutionalisation and cultural loss. When care is delivered by a workforce that understands these experiences and responds in culturally grounded, trauma-aware ways, the risk of traumatisation is reduced and people's dignity, emotional safety and cultural identity can be upheld across the lifespan.
- **Difficult conversations** – in addition to information described above, ECS workers identified the language about acceptance of care in a home environment and/or the transition into residential care requires conversations that may not be welcome, may elicit fear and are misaligned with cultural ways.
- **Signs of ageing** – an awareness of the different signs of ageing, risks and required referrals is sought to enable the best advice and support to be provided. In particular greater awareness of dementia, Urinary Tract Infections (UTI), Chronic Obstructive Pulmonary Disease (COPD) and how these present vs detailed clinical knowledge is required.

# Proposed Training Resource Priorities for Phase 2

**To address the most critical and common capability gaps across the integrated care workforce, clear priorities for Phase 2 resource development have been identified. These priorities are grounded in workforce evidence and align with both disability and aged care system demands, while remaining adaptable to place-based delivery.**

The proposed training resource priorities for Phase 2 are:

- NDIS system awareness and navigation, including access, planning, reviews and evidence requirements
- Communication and reporting skills, including culturally safe documentation, case notes and difficult conversations with individuals, families and service systems
- Disability awareness, including understanding different types of disability, functional impacts and referral pathways
- Dementia awareness, including early onset dementia and trauma-informed responses for Stolen Generations people
- Mental health response capability, including psychosocial disability and crisis response
- Worker wellbeing, self-care and managing personal stressors in high-load, community-based roles

**These priority areas reflect the intersectional nature of the work and the need for training that supports both technical competence and cultural safety, while recognising the emotional and relational labour carried by workers.**

The first of the two units recommended for resource development to support the workforce is:

**CHCDIS020 / Work effectively in disability support**

This unit is well suited as an entry point into the ACCHO disability workforce. CHCDIS020 focuses on working effectively within disability support roles, emphasising person-centred practice, rights-based approaches, communication, ethical responsibilities and collaboration with others involved in support. Importantly, it does not assume a narrow personal care role. Instead, it supports workers to understand disability in a broader social and rights-based context, which aligns strongly with Aboriginal community-controlled models of care.

CHCDIS020 provides a foundation for integrated care work by building understanding of disability support principles, professional boundaries, and effective engagement, while allowing practice to be contextualised to local cultural and community realities.

As an entry-level unit, CHCDIS020 can be delivered in culturally grounded ways, using scenario-based learning, role plays and community-relevant examples. It can be undertaken by workers with limited prior formal training and can be supported through mentoring and on-the-job learning, making it appropriate for early workforce entry in regional and remote contexts.

To strengthen this unit as part of an entry-level skill set, it could be paired with a complementary unit that supports communication, safety and culturally responsive practice. Suitable options for the second unit of competency therefore include:

**CHCCOM005 / Communicate and work in health or community services**

This unit builds foundational communication skills, professional conduct and teamwork across community-controlled settings

**or**

**CHCLEG001 / Work legally and ethically**

This unit will support workers navigating consent, information sharing, confidentiality, mandatory reporting and boundaries in their daily activities.

Together, CHCDIS020 and one of these units form a coherent disability-focused skill set that prepares workers for entry into ACCHO disability roles without requiring premature specialisation or personal care competencies.

**This combination would support early workforce participation, build confidence and capability, and create a clear stepping stone into further training, including additional disability, mental health or integrated care skill sets, or progression into Certificate II or higher qualifications as appropriate.**

### CHCDIS020 / Work effectively in disability support

This unit describes the performance outcomes, skills and knowledge required to work effectively within the ACCHO integrated care sector, supporting communities through culturally safe, holistic, and community-led health and social care. The unit focuses on meeting role requirements, complying with organisational and governance obligations, and working within the integrated primary health care context that brings together health, social, and community support services.

This unit applies to individuals working across ACCHO services in a range of integrated care settings, including primary health care, social and emotional wellbeing, disability, aged care, family support, and community programs. Work is undertaken using culturally responsive practice, professional judgement, and an understanding of community priorities, and is carried out under regular direct or indirect supervision in accordance with organisational policies and community expectations.

### CHCCOM005 / Communicate and work in health or community services

This unit describes the performance outcomes, skills and knowledge required to communicate effectively and work collaboratively within health and community services environments. It focuses on clear, respectful communication, teamwork, documentation, and working within legal, ethical and organisational frameworks.

This unit applies to individuals working across integrated health, social and community service settings, including ACCHO services. Work is undertaken using professional communication skills, ethical practice and an understanding of service delivery contexts, and is carried out under direct or indirect supervision in line with organisational procedures and community expectations.

### CHCLEG001 / Work legally and ethically

This unit describes the performance outcomes, skills and knowledge required to work within legal and ethical frameworks in health and community service environments. It focuses on understanding and applying relevant legislation, duty of care, confidentiality, consent, and ethical responsibilities while supporting individuals, families and communities.

This unit applies to individuals working across integrated health, social and community service settings, including ACCHO services. Work is undertaken using professional judgement, ethical decision-making and an understanding of organisational governance and accountability, and is carried out under direct or indirect supervision in accordance with organisational policies, legal requirements and community expectations.

# Types of Training

**Accredited training**

Also known as nationally recognised training, accredited training leads to formal vocational qualifications or credentials that are recognised across Australia. It is delivered by registered training organisations, listed on the national training register, and regulated to ensure consistent standards for course content, assessment and quality. Accredited training results in qualifications, skill sets, units of competency or statements of attainment that are portable across employers, industries and jurisdictions.

The main benefits of accredited training are national recognition, transferability of skills and clear career pathways. It provides a consistent benchmark for competence, supports workforce mobility and professional identity, and can be publicly subsidised, making it more affordable. However, accredited training can be time-consuming and inflexible, may not always reflect current workplace practice, and can involve significant indirect costs for employers such as supervision, administration and backfilling shifts.

**Non-accredited training**

This refers to training that does not lead to nationally recognised qualifications and is not regulated under the formal vocational education system. It is commonly used to meet specific workplace or organisational needs and includes induction programs, short courses, workshops, in-house training and professional development.

Non-accredited training is valued for its flexibility, speed and responsiveness. It can be tailored to local, cultural or role-specific needs and often focuses on practical, hands-on learning. However, it is not nationally standardised or formally recognised, meaning skills are not easily portable between employers, and training is often duplicated when workers change jobs. Over-reliance on non-accredited training can limit workforce professionalisation and transparency.

**Development or informal learning**

This type of training sits outside both accredited and non-accredited training and focuses on learning that occurs through everyday work and relationships. It includes coaching, mentoring, supervision, peer learning, shadowing and reflective practice.

This type of learning builds capability over time through experience, feedback and reflection and is highly relevant to real work contexts. It is particularly effective for developing interpersonal skills, cultural capability, leadership and judgement. However, it is often invisible, inconsistently supported and not formally recognised, and its quality depends heavily on the skills and availability of supervisors or mentors.

**The importance of informal learning and non-accredited training cannot be undervalued for this workforce. However, findings from the TNA highlighted a particular need for accredited training and this is explored further below.**

## Accredited training overview

### Skill Sets

Skill sets are nationally recognised groupings of units of competency that focus on specific skill and knowledge areas required for particular job functions or workforce contexts. They are drawn from existing training packages or accredited courses and are designed to address clearly defined areas of practice rather than the full scope of a qualification.

Their use is particularly relevant in workforces like integrated care where roles are broad, non-linear and shaped by local need, and where workers may not follow a single, standardised qualification pathway.

Skill sets support a staged and achievable approach to learning that recognises the diverse needs, experiences and starting points of the integrated care workforce. By breaking training into smaller, clearly defined segments, skill sets allow workers to undertake learning without being overwhelmed by the volume or duration typically required for full qualifications. This approach supports early achievement and confidence building, while still providing skills and knowledge that are directly relevant to the workplace.

The Community Support Skill Set (WA State ID AF008) has been used in Western Australia to provide entry pathways in remote communities that are achievable for learners with limited formal education, while still equipping them with essential skills to enter the workforce safely and effectively.

Flexibility is a key feature of skill sets. They enable training to be aligned to community need, role focus or a worker's stage of career development - building specialist capabilities or exploring new areas of practice. Skill sets can also be used as stepping stones toward full qualification attainment. The Integrating Mental Health Practice Skill Set (WA State ID AE439) supports workers to strengthen their understanding of mental health challenges and respond more effectively to community members without undertaking the full Certificate IV in Mental Health. Where learners later choose to pursue that qualification, the completed units can contribute toward it, supporting progression over time.

Many skill sets can be completed within relatively short timeframes enabling workers to undertake training alongside employment and community responsibilities and allowing services to respond to workforce development needs in a timely way.

Key characteristics of skill sets in the integrated care context include:

- achievable segments of learning that support confidence and participation
- capacity to be used as entry points, stepping stones or targeted upskilling
- flexibility to align training with role focus, client cohort and community need
- shorter timeframes that support participation without disrupting service delivery

Together, these features make skill sets a practical training option for supporting workforce participation, skill development and progression across integrated care roles.

Identified Skill Sets are described in **Attachment D**

## Qualifications

Qualifications continue to play an important role in supporting the ECS and disability workforce. They provide nationally recognised frameworks that establish foundational knowledge, support workforce credibility and enable portability of skills across settings and jurisdictions. For some workers, particularly those seeking progression into coordination, leadership or allied health pathways, qualifications remain a valuable option to support career progression. Undertaking a qualification can also hold value in its own right, providing workers with increased confidence, formal recognition of their skills, and a stronger sense of professional identity, even where there is no intention to progress to further study.

Qualifications are particularly valuable where roles involve regulated tasks, structured service delivery or progression into supervisory or coordination functions. They also support pathways into further education and training, including allied health and tertiary study, aligning with career aspirations identified through the TNA.

However, the findings of this TNA indicate that qualifications alone do not consistently align with the realities of integrated care roles within ACCHOs. Many qualifications are broad in scope, assume linear learning pathways and require sustained study commitments that are difficult for existing workers to undertake alongside work, family and community responsibilities.

For this reason, qualifications are best positioned as part of a broader, flexible training framework rather than as the sole mechanism for workforce development.

**When combined with skill sets, mentoring and place-based delivery, qualifications can support structured progression while ensuring learning remains relevant to practice.**

In the integrated care workforce, the value of qualifications lies in their ability to support progression, specialisation and formal recognition over time. When accessed at the right point in a worker's journey, and supported by flexible delivery and appropriate scaffolding, qualifications can strengthen workforce capability while respecting the diverse pathways through which ECS and ALDO/RCC workers contribute to culturally safe, community-led care.

A range of qualifications were identified through consultations as either already held by respondents, of interest for future study, or as qualifications that should be considered for the role. Collectively, the identified qualifications listed below reflect the varied entry points, role focuses and levels of responsibility that exist across integrated care roles within ACCHOs.

| |
|---|
| Certificate II Community Health and Wellbeing |
| Certificate II Community Services |
| Certificate III Individual Support |
| Certificate III Community Services |
| Certificate III Allied Health Assistant |
| Certificate IV Ageing |
| Certificate IV Disability |
| Certificate IV Allied Health Assistant |
| Certificate IV Community Services |
| Diploma Community Services |
| Diploma of Leisure and Health |

Outlines detailed in **Attachment D**

**Note:** All of the skill sets and qualifications listed above will be impacted by the review of the Aged Care and Disability qualifications currently being undertaken by HumanAbility. Insights gained through this TNA process will be provided via NACCHO Industry Advisory Group membership and CSWA Technical Committee Membership.

## Benefits of accredited training

Nationally accredited training plays a critical role in strengthening the ACCHO workforce and is most effective when delivered in ways that align with community-controlled values, integrated care models, and Aboriginal ways of learning. When appropriately designed, accredited training provides a structured, achievable pathway into and through the workforce while supporting long-term workforce sustainability.

A key benefit of nationally accredited training is that it is achievable because it can be scaffolded. Skills and knowledge can be built progressively, allowing learners to start with foundational capabilities and develop confidence over time. This is particularly important for Aboriginal learners who may be returning to study, balancing cultural, family, and community responsibilities, or entering training through employment rather than traditional education pathways. Scaffolding reduces the risk of learners becoming overwhelmed and supports steady progression, completion, and confidence in practice.

Nationally accredited training also integrates effectively with on-the-job learning through traineeship models. Traineeships enable learners to earn and learn simultaneously, applying new knowledge directly in workplace settings while completing formal training. This approach strongly aligns with Aboriginal learning practices which value observation, relationships, and learning through doing. Training delivered in this way is grounded in real community contexts and reinforces practical skill development that is immediately relevant to service delivery.

Mentoring and buddy systems are central to the success of both scaffolded training and traineeship models. Feedback from participants consistently highlighted that mentoring and buddy systems were highly valued and seen as essential to learning and workplace confidence, making it easier to ask questions, practise skills safely, and understand expectations without fear of judgement. Importantly, participants emphasised that mentoring is most effective when time is formally allocated and when engagement is regular and intentional, rather than informal or ad hoc. Where mentoring was rushed or treated as an extra task, its benefits were reduced.

Within training environments, mentoring supports learners to bridge the gap between formal learning and practical application, particularly in integrated care settings where roles are complex and culturally grounded. In workplaces, mentoring and buddy systems reduce isolation, support wellbeing, recognise cultural load, and contribute to workforce retention. They also enable the transfer of cultural knowledge, community context, and professional practice from experienced workers to new and emerging staff.

Nationally accredited training further enables ACCHRTOs to access sustainable and recognised funding streams. This funding supports the delivery of qualifications, traineeships, and workforce development initiatives, strengthening organisational viability and reducing reliance on external training providers. Importantly, access to sustainable funding allows mentoring and supervision to be properly resourced and recognised, including supporting supervisor time, mentor capability, and structured engagement.

Taken together, nationally accredited training, when scaffolded, delivered through traineeships, and supported by strong mentoring and buddy systems, provides a culturally appropriate, sustainable, and effective workforce development model for the ACCHO sector. This approach supports learner completion, workforce retention, service quality, and the ongoing strength of Aboriginal community-controlled health and integrated care services.

# Accredited VET Training Pathways

## Current training pathways

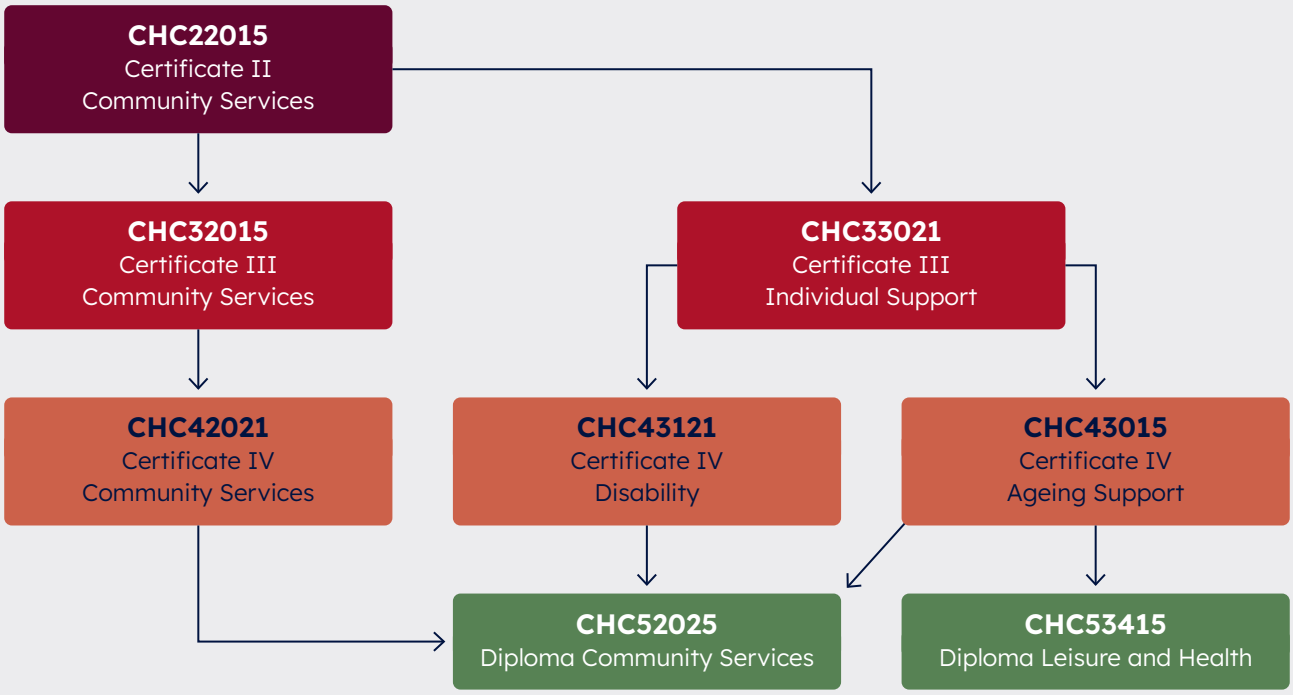
The current training pathways reflect a common progression model within the Community Services Training Package, as outlined in Figure 7 below. These pathways are well established across the Community Services sector and are often used by learners and employers to build a progressively skilled workforce capable of supporting people across disability, ageing, health, and community service contexts.

In practice, however, the use of Certificate III in Individual Support as the primary entry point presents challenges for the integrated care sector. While the qualification is designed to be broad, it has a strong emphasis on personal care tasks such as bathing, toileting, and physical assistance. Feedback from services indicates that this focus is not appropriate or aligned with ECS, ADLO/RCC or many other roles, where work is more holistic, preventative, community-based, and centred on social, emotional, and cultural wellbeing rather than routine personal care. For some Aboriginal community-controlled settings, the personal care components can also raise cultural safety concerns or create barriers to participation and retention.

Despite these limitations, the Certificate III in Individual Support continues to be used as a gateway into higher-level qualifications because of the lack of alternative entry-level pathways that better reflect integrated care models. Learners often move from Individual Support into Certificate IV Disability or Ageing Support to specialise, and then into Diploma of Community Services to develop broader case coordination, advocacy, and service delivery skills. While these pathways are logical on paper, they can result in learners completing content that is not directly relevant to their intended roles before reaching qualifications that better align with ACCO service models.

**Figure 7**

**Community Services training pathway from Certificate II to Diploma-level qualifications**



This misalignment highlights a structural issue within the current pathways. For the ACCO sector, there is a clear need for pathways that foreground culturally safe practice, mentoring, community engagement, prevention, and integrated care from the outset. Without this alignment, services risk reduced engagement, lower completion rates, and the ongoing use of qualifications that do not fully reflect the scope, values, or realities of Aboriginal community-controlled health and social care.

The following model is proposed as an alternative to this noting it includes skill sets and qualifications that utilise national recognised units of competency but may not appear as qualifications and skill sets in the current CHC training packages.

## Proposed training pathways

Consistent with the findings of the TNA, skill sets provide a practical, culturally appropriate and achievable entry point into the integrated care workforce, as outlined in Figure 8.

Skill sets such as the Community Support Skill Set are well suited to this role and can operate as the first formal step into employment for people entering through community-led pathways. This approach recognises that many workers are recruited based on cultural authority, community trust and lived experience rather than prior qualifications, particularly in regional and remote contexts.

**Figure 8**

**Suggested pathways for Community Health and Wellbeing training pathways**

| Introduction Skill Set | Certificate II and Skill Set | Certificate III and Skill Set | Certificate IV, Diploma and Skill Set | Degree |
|---|---|---|---|---|
| Community Support Skill Set | Certificate II Community Health and Wellbeing Traineeship | Certificate III Allied Health Assistance | Certificate IV Allied Health Assistance | Registered Nurse |
| | Certificate II Community Services | Certificate Ill in Aboriginal and/or Torres Strait Islander Primary Health Care | Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care Practice | Occupational Therapist |
| | Course in the Early Years | Certificate III Community Services | Certificate IV Communitv Services | Speech Therapist |
| | Awareness of Alcohol and Other Drugs (AOD) Skill Set | Certificate III Health Services Assistance | Certificate IV Mental Health | Social Worker |
| | | Certificate III Individual Support | Certificate IV Alcohol and Other Drugs (AOD) | |
| | | Certificate III Indigenous Environmental Health | Diploma of Nursing | |
| | | Integrating Mental Health Practice Skill Set | Integrating Mental Health Practice Skill Set | |
| | | | Alcohol and Other Drugs (AOD) Skill Set | |

The Community Support Skill Set equips entry-level workers with foundational capabilities that are immediately relevant to integrated care roles, including safe work practices, communication in health and community services, and first aid. These skills align with the early responsibilities of ECS, RCC/ADLO roles, which focus on engagement, relationship building, basic system navigation and safe community-based work rather than direct personal care. As a result, this skill set supports workforce entry without imposing inappropriate personal care competencies or high literacy demands that can act as barriers to participation.

From this initial entry point, workers can progress into the Certificate II in Community Services as their confidence, capacity and role scope develops. The Certificate II can then function as a consolidation step, formalising foundational skills and supporting transition into broader responsibilities. Importantly, this pathway does not need to be linear or uniform. Depending on the client cohort, community need and role focus, workers may instead move between targeted skill sets as stepping stones, building specific capabilities required at different stages of their work. For example, workers supporting clients with higher psychosocial, mental health or disability-related needs may undertake additional skill sets early in their employment to strengthen their practice. Others working predominantly with Elders may prioritise skill sets focused on dementia, trauma-informed care or complex needs.

**This flexible, modular approach reflects the realities of integrated care practice, where roles evolve over time and differ significantly by location and community context.**

Workers may also undertake selected skill sets alongside, before or after completing the Certificate II, allowing skills to be built incrementally without overwhelming learners or disrupting workforce participation. This approach supports retention, reduces training attrition and aligns with Aboriginal ways of learning that value observation, practice and gradual skill development supported by mentoring and supervision.

## Case study in career development

KAMS implemented an innovative pilot program in 2023 to address critical shortages in allied health services across the remote Kimberley region. A partnership arrangement between a private RTO, the local Technical and Further Education (TAFE) and KAMS supported twelve existing Aboriginal employees, including Family Support Workers (FSWs) undertaking a comparable role to RCCs, to complete the Certificate IV in Allied Health Assistance. These workers were already embedded in local communities and brought cultural knowledge, strong relationships, and frontline experience, making them ideal candidates for formal allied health career pathways. Training was delivered through a culturally safe block release model, supported by funded travel, accommodation, and embedded literacy and numeracy support.

The pilot demonstrated that investing in the existing workforce delivers immediate and sustainable workforce gains. Participants remained employed while studying, employers retained essential staff, and communities experienced continuity of care. Graduates have already expanded the capacity of allied health teams, increased service reach, and reduced reliance on costly and culturally less effective fly-in fly-out models.

One student enrolled to explore advanced career opportunities within Allied Health after working as an administrative assistant within an allied health team. Another student transitioned into the role of Aged Care Community Connector at BRAMS Service following her training. She now provides culturally grounded support to older community members, conducts welfare checks, and advocates for elders navigating aged care systems.

These student journeys demonstrate the transformative impact of upskilling existing workers which includes improving social mobility and income uplift. By enabling Aboriginal staff to gain formal allied health qualifications while remaining connected to their communities, the KAMS model strengthens cultural safety, expands clinical support capacity, and builds long term workforce sustainability. This evidence strongly supports the need for dedicated funding to upskill existing workers, allowing other regions facing critical shortages to replicate the proven success of the KAMS approach.

# Training Enablers

**Whilst training products can be made available which align with skill and knowledge requirements and job roles for training, to support learner success and build workforce capacity there are a number of considerations which have been demonstrated to best support success across ACCHOs.**

## Culturally appropriate delivery

Delivery of training by ACCRTOs provides a guarantee that delivery will be culturally appropriate and more likely to be customised to reflect a place-based approach.

The First Nations Health Worker Traineeship Program demonstrates the effectiveness of training delivered by ACCRTOs. As at 31 December 2025, the program has achieved 599 enrolments and 155 completions nationally, demonstrating strong interest and engagement from learners. The current withdrawal rate is tracking at approximately 15–18 per cent. National data suggests that around 50% of learners withdraw from qualifications. The program's strong level of enrolment and retention indicates that the program is resonating with its target audience and that culturally appropriate and place-based solutions are achievable in regional and remote locations.

While ACCRTOs are not always available in thin market areas, the provision of other training enablers, and partnerships with non-Aboriginal RTOs can ensure culturally integrity of training and a culturally safe environment for students to learn in.

## Language, Literacy and Numeracy support

Levels of English literacy among Aboriginal and Torres Strait Islander adults are very low. Research from the Literacy for Life Foundation (LFLF) estimates that between 40 and 65 percent of Aboriginal adults are functionally illiterate in English. Low English literacy can make it difficult for a person to find and access education, training and employment opportunities. It also presents a practical impediment to growing the local workforce. However, non-accredited training, such as community-led LLND training, is extremely valuable in improving people's agency, participation and wellbeing and interconnects with social determinants of health to improve access to life opportunities. As an accessible entry-point, non-accredited LLN training plays an important role in building people's confidence and starting or resetting their relationship with training.

## Mentoring and buddy systems

Mentoring and buddy systems are critically important in training and workplaces across the integrated care sector and are strongly aligned with findings from the TNA. These approaches reflect culturally grounded ways of learning that prioritise relationships, shared responsibility, observation, and learning through doing. Participants consistently described learning as most effective when it occurs within trusted relationships, supported by guidance from experienced workers who understand both the role and the community context.

From a TNA perspective, this feedback reinforces that mentoring and buddy systems should be embedded as core components of both training delivery and workforce development. Allocating time, recognising mentoring responsibilities, and valuing these roles formally supports knowledge transfer, cultural safety, and workforce sustainability.

## Training modality

Training delivery for the integrated care workforce must be responsive to individual learner needs and capable of being contextualised to ensure cultural relevance within local communities. Learners enter training with different levels of language, literacy, digital access, confidence, prior education and lived experience. Training modalities must therefore be flexible, adaptive and learner-centred, rather than standardised or one-size-fits-all. Place-based delivery is central to this approach, ensuring training reflects local community contexts, cultural protocols, service realities and workforce conditions.

**Face-to-face delivery is the most appropriate mode for entry-level training and aligns strongly with best practice approaches for Aboriginal learners.**

This mode supports relationship building, trust and cultural safety, particularly when delivered by Aboriginal trainers or co-facilitated with respected local workers, Elders or community members. Face-to-face delivery should incorporate role plays, yarning circles, storytelling and group discussion, enabling learners to connect new knowledge to lived experience and local practice. Assessment strategies at entry level should minimise written requirements and prioritise observation, demonstration, verbal explanation and practical application, recognising strengths in oral learning and learning through doing.

Role play is a critical modality across both entry-level and existing worker training. Role play allows learners to practise difficult conversations, system navigation, advocacy and culturally safe communication in a supported environment. Role play should be locally contextualised and reflect real situations encountered in community, reinforcing relevance and confidence while supporting skill transfer into the workplace.

Training should be delivered in place-based settings wherever possible. Learning that occurs on Country or within community-controlled environments is more meaningful and accessible than delivery in unfamiliar or institutional settings. Place-based delivery allows training to incorporate local language, cultural protocols, community priorities and service pathways, ensuring learning is grounded in the realities of where people live and work.

Online classroom and online self-paced delivery models have a more limited but still important role. These modes are highly dependent on individual learner language, literacy and digital capacity, as well as access to devices and reliable Wi-Fi. As such, they are more suited to upskilling existing workers who already have foundational knowledge and confidence in their roles. Online delivery is most effective when facilitated, supported and flexible, rather than fully self-paced, and when complemented by opportunities for discussion, reflection and follow-up support.

Across all delivery modes, training must be underpinned by structured mentoring and support. As indicated above, mentoring and buddy systems are essential to effective learning and are particularly important in culturally grounded, community-based roles. Mentoring enables learning to be paced according to individual need and allows workers to step in and out of training in response to cultural obligations, family responsibilities or community priorities. These roles should be formally recognised and resourced within both training and workplace structures.

Blended delivery models that combine face-to-face learning, supported online components, place-based activities and ongoing mentoring are recommended wherever possible.

**This approach supports cultural safety, individual learner needs, flexibility and experiential learning, while responding to workforce pressures and geographic constraints.**

Overall, training modalities should prioritise place-based delivery, cultural safety, learner-centred design and practical relevance. Approaches that value lived experience, community knowledge and relational skills as strengths, and that embed mentoring and support throughout the learning journey, are most likely to support meaningful participation, skill development and workforce sustainability across integrated care roles.

# Systemic Barriers to Training

**Systemic barriers to training for Aboriginal people are experienced across remote, regional and metropolitan contexts, although their impact varies by location. The TNA confirms that workforce capability challenges are not driven by a lack of motivation or commitment, but by structural barriers embedded within training design, funding arrangements and policy settings. These barriers place a disproportionate burden on ACCOs and their workforce, particularly those delivering integrated care.**

Access to training remains a significant barrier. In remote and very remote locations (MM6–7), training providers are scarce, travel distances are extensive, and digital connectivity is unreliable. Face-to-face delivery is rarely available locally, while online delivery assumes levels of digital access, confidence and literacy that do not reflect local realities. In regional areas (MM3-5), training availability is often inconsistent or cancelled due to low enrolments. Regional workforces can be expected to travel to capital cities to undertake training however this fails to recognise the caring responsibilities that workers have in their families, often it is impractical for a worker to be away from their home for a period of time. Even in metropolitan areas (MM1-2), where providers are more numerous, Aboriginal learners face access barriers linked to cost, transport, competing responsibilities and the absence of culturally safe learning environments.

Limited access to culturally appropriate training is a barrier across all locations. The number of ACCRTOs is small relative to demand, particularly outside capital cities. Mainstream training is often delivered using deficit-based frameworks and generic content that does not align with Aboriginal worldviews, community-controlled models of care or the relational and holistic nature of integrated care roles. This places the responsibility on learners and organisations to adapt training content themselves, rather than being supported through culturally safe delivery.

Funding and incentive structures further constrain participation. Entry-level qualifications that align with integrated care, navigation and coordination roles are often not fee free, or are excluded from priority funding lists because they do not fit traditional personal care or clinical job classifications. Existing workers are frequently ineligible for subsidies that prioritise new entrants, despite the reliance of ACCOs on upskilling their current workforce who already hold cultural authority, community trust and lived experience.

## The cost of training, loss of income during study, and lack of paid study time discourage participation across all settings.

These funding issues are particularly pronounced in allied health and specialist pathways. While some qualifications are subsidised for new students, existing workers are required to pay full fees, making ongoing participation financially unviable. Traineeship incentives are often tied to job titles that do not reflect integrated care or navigation roles, excluding many workers from eligibility. Rigid funding models also limit opportunities for recognition of prior learning, forcing workers to repeat content rather than focus on genuine skills gaps.

The suitability of training products themselves is another systemic barrier. Many qualifications are not designed as effective entry pathways for learners with limited LLN capacity. Heavy reliance on written assessments, academic language and digital platforms disadvantages learners whose strengths lie in oral communication, relational practice and practical problem-solving. Without embedded LLN support and culturally appropriate assessment methods, learners are more likely to disengage or struggle.

There is also a persistent misalignment between training pathways and actual job roles. Many Aboriginal workers are directed into qualifications such as Certificate III Individual Support that emphasise personal care, despite their roles focusing on navigation, advocacy, coordination, prevention and community engagement. This mismatch reduces the relevance and perceived value of training and, in some contexts, raises cultural safety concerns where personal care components are inappropriate.

Pathways beyond vocational education are limited. Clear and supported articulation into tertiary education, including allied health, nursing and social work, is inconsistent and often unrealistic for workers in regional and remote areas who would need to move away to study. Even in metropolitan areas, Aboriginal learners report difficulties navigating tertiary systems that lack cultural safety and meaningful recognition of prior learning, restricting career progression and contributing to workforce attrition.

Finally, training systems do not adequately recognise prior experience and lived experience. Aboriginal people often enter roles through community leadership, caring responsibilities, volunteering or informal advocacy. These capabilities are rarely credited within formal training systems, which prioritise certificates over experience. Recognition of prior learning processes are complex, costly and poorly funded, making them inaccessible in practice. These barriers are compounded by inflexible training structures that fail to accommodate cultural obligations, Sorry Business, caring responsibilities and broader social pressures.

Taken together, these systemic barriers undermine workforce development and shift the burden of adaptation onto individual learners and organisations. Addressing them requires structural reform to training design, funding models and delivery approaches so that pathways are culturally safe, flexible, properly resourced, aligned to real job roles, and grounded in recognition of lived experience across remote, regional and metropolitan contexts.

## Constraints on ACCRTOs

These access and cultural safety issues are compounded by structural constraints affecting ACCRTOs themselves.

| | | |
|---|---|---|
| 1 | **Funding and classification barriers** | ACCRTOs are categorised as private RTOs under ASQA, despite being not-for-profit and community-governed organisations. This classification restricts their access to the larger and more secure public VET funding streams available to TAFEs and other publicly recognised providers. As a result, ACCRTOs face significant constraints in expanding their training scope, despite consistently achieving stronger outcomes for Aboriginal learners.<br><br>Instead, they must compete for limited and less stable funding pools, creating financial uncertainty and limiting their ability to invest in infrastructure, qualified trainers, assessment systems, and compliance requirements necessary to add new qualifications. |
| 2 | **Limited Inclusion in Government Skills Planning** | Evidence indicates that ACCRTOs are frequently overlooked in state and national workforce development strategies. This exclusion means their delivery models and sector needs are often absent from funding design and policy reform processes.<br><br>For instance, the Western Australian Skills and Workforce Action Plan did not reference ACCRTOs, despite broader commitments to working in partnership under Closing the Gap.<br><br>Without meaningful involvement in skills planning, ACCRTOs have fewer opportunities to influence qualification development, secure targeted funding, or align their training scope with identified workforce priorities — all of which restrict scope expansion. |

| | | |
|---|---|---|
| 3 | **Gaps in Infrastructure, Capital and Specialist Resources** | Many ACCRTOs lack access to the capital investment, facilities, technology, and specialised training environments required to deliver certain qualifications — particularly in health, community services, and emerging industry sectors.<br><br>Government reviews acknowledge the need for accelerated infrastructure and asset upgrades to strengthen ACCRTO capability, highlighting that current resource limitations are a major constraint on growth.<br><br>These infrastructure gaps also make it challenging to satisfy ASQA's evidence requirements when applying to extend scope. |
| 4 | **Trainer and Workforce Capacity Constraints** | The sector faces ongoing shortages of qualified trainers and assessors, particularly Aboriginal trainers who hold both VET credentials and relevant industry experience.<br><br>National workforce strategies identify the urgent need to grow the Aboriginal health and community services workforce, reflecting broader capacity shortages that also affect ACCRTOs' delivery capability.<br><br>Without sufficient qualified personnel, ACCRTOs are unable to demonstrate the delivery capacity required by ASQA to add new qualifications to their scope. |
| 5 | **Limited Recognition of Culturally Responsive, Place-Based Models** | ACCRTOs provide culturally safe, community-designed and place-based training approaches, yet these models are often undervalued or insufficiently supported within mainstream VET systems. Workforce planning frameworks that prioritise TAFEs over ACCRTOs marginalise culturally responsive delivery models, contributing to structural inequities in accreditation and qualification development processes.<br><br>This systemic imbalance restricts ACCRTOs' ability to introduce new qualifications that reflect community-identified needs. |
| 6 | **Challenges of Remote and Regional Delivery** | Many ACCRTOs operate in rural and remote communities where learners face complex social and economic barriers. These conditions also create additional challenges in meeting regulatory requirements. Research demonstrates that RTOs in remote areas encounter difficulties in maintaining industry engagement, sourcing work placement opportunities, accessing reliable local data, and recruiting qualified staff. These factors make it harder to meet ASQA standards related to resourcing, supervision, and industry currency when seeking to expand scope. |
| 7 | **Administrative and Compliance Pressures** | While regulatory obligations apply across the VET sector, ACCRTOs are disproportionately affected due to:<br>• Smaller administrative and compliance teams<br>• Reliance on competitive and short-term funding<br>• The need to balance culturally appropriate delivery with rigid regulatory frameworks<br><br>These pressures limit organisational capacity to prepare comprehensive scope-addition applications, including detailed mapping, resourcing documentation, and trainer capability matrices.<br><br>These structural constraints on ACCRTOs directly affect the availability, cultural safety and suitability of training pathways for Aboriginal learners across all settings. |

In order to overcome these constraints, NACCHO has developed a *10-year ACCHRTO Capacity Building Implementation Plan*[1] to strengthen training and development efforts across the sector. This plan identifies areas where ACCHRTO capacity building is needed to ensure ACCHOs can meet the growing demand for services, particularly in rural and remote areas. There is a strong focus on building a sustainable pipeline of qualified professionals by expanding training opportunities and developing career pathways for Aboriginal and Torres Strait Islander people within the healthcare system.

This approach directly aligns with the Closing the Gap Priority Reforms, which emphasise the growth of the Aboriginal community controlled sector and the need to strengthen Aboriginal leadership and workforce capability.

## Building ACCHO worker capability

This TNA highlights that while ACCHOs play a vital role in delivering culturally safe, community led social assistance and allied health services, the current vocational education and training system does not sufficiently align with how ACCHOs and ACCOs grow and sustain their workforce. These organisations rely heavily on upskilling, supporting, and formalising the qualifications of existing staff who already hold deep cultural knowledge, trusted relationships, and an understanding of community priorities. However, the existing training landscape often lacks the flexibility, cultural relevance, and accessibility needed to meaningfully support this approach.

Embedding workforce training and capability development directly within Aboriginal community controlled and led organisations would address these system gaps. By shifting away from reliance on external training providers and instead strengthening internal capability, this initiative would enable ACCRTOs, ACCHOs and ACCOs to design and deliver training models that reflect Aboriginal ways of learning, are responsive to local needs, and are structured around the realities of community based workforces. This would operationalise broader reforms in a practical and sustainable way, creating training pipelines that are culturally anchored, community governed, and fit for purpose.

**More fully integrating ACCOs into formal vocational education and training pathways would also create stronger, more reciprocal connections between the Aboriginal community controlled sector and the broader training system.**

This integration would improve workforce planning across the sector, support alignment of qualifications with actual job roles, reduce duplication of effort, and increase training completion rates by providing culturally appropriate learning pathways. Over time, this approach would support a more stable, skilled, and culturally informed workforce, ultimately strengthening service delivery and improving outcomes for Aboriginal communities.

1 ACCHRTO Implementation Plan – A 10 year strategy

# Additional Findings

**This report acknowledges all factors which influence the development of this workforce however, the focus of the TNA is most specifically how training can support the future and existing workforce to undertake these critical roles. Remuneration, entitlements and culturally and mentally safe environments are key themes, as is the importance of training and career development.**

As such the following recommendations are provided for consideration:

- Clarifying role expectations and aligning JDFs with real practice.
- Embedding structured supervision and peer networks.
- Expanding culturally relevant training pathways and qualifications and ensuring the provide flexibility and accessibility.
- Reforming program design to allow flexibility and fair resourcing in regional and remote areas.

Aboriginal Health Council of South Australia, Aboriginal Family Support Services, Nunkuwarrin Yunti, Community Skills WA & NACCHO Integrated Care consultation hosted at Aboriginal Health Council of South Australia in Adelaide SA.



# Conclusion

**This TNA confirms that the integrated care workforce within ACCHO plays a critical role in supporting Elders, people with disability, families and communities to navigate complex and often culturally misaligned service systems.**

ECS and ADLO/RCC roles operate at the intersection of community, culture and mainstream aged care and disability frameworks. Together, these roles form a multi-layered workforce model that positions trusted community members within ACCHOs to deliver integrated, person-centred care. This model emphasises cultural safety, flexibility and local responsiveness, ensuring services remain culturally appropriate and grounded in community need.

**The findings demonstrate that the challenges faced by this workforce are structural rather than individual. Workers routinely operate beyond formal role descriptions in response to thin markets, system fragmentation and unmet community need.**

While cultural capability and commitment are strong, training pathways have not kept pace with the realities of integrated care practice. Existing qualifications and learning models often fail to reflect the navigation, advocacy, coordination and emotional labour that define these roles in practice.

This TNA highlights the need for training that is flexible, staged and grounded in real work. Skill sets, mentoring and place-based delivery provide practical mechanisms to support workforce entry, upskilling and progression while recognising lived experience and cultural knowledge. Training must also explicitly address system navigation, disability and dementia awareness, mental health response, difficult conversations and worker wellbeing to support workforce sustainability.

Progressing to the next phase of work is critical to translating these findings into practical outcomes for the workforce. Phase 2, which focuses on refining existing Elder Care Support training resources and developing disability-focused training and assessment materials, provides the mechanism to embed the TNA findings into training that reflects how work is actually undertaken within ACCHOs. Without this next phase, the misalignment between training and practice identified in this report will remain.

Taken together, the findings position training as a central lever for strengthening the integrated care workforce. Advancing Phase 2 will enable the development of culturally grounded, role-aligned and accessible training resources that support workers to continue delivering effective, culturally safe and community-led care across aged care and disability systems.

Attachment A

# Policy Landscape

**These roles sit within multiple overlapping policy and funding systems that are highly regulated, compliance-driven and largely designed around mainstream service assumptions.**

While each framework is intended to improve accountability, safety and outcomes, many have been developed with limited consideration of Aboriginal worldviews, community-controlled service delivery, collective approaches to care, or the strengths and efficiencies of ACCO-led models. This creates additional navigation, advocacy and translation work for staff supporting Aboriginal clients and families.

| | |
|---|---|
| **National Disability Insurance Scheme Act** | The NDIS Act establishes the legislative basis for disability supports in Australia, focusing on individualised funding, eligibility based on permanent and significant disability, and market-based service provision. Recent reforms have aimed to improve sustainability, reduce fraud, and tighten eligibility and planning decisions. Changes have included increased scrutiny of evidence, more constrained definitions of 'reasonable and necessary' supports, and a stronger emphasis on functional capacity assessments. For Aboriginal and Torres Strait Islander clients, this framework often clashes with cultural understandings of disability, which are more holistic and relational, and with community based approaches to care. The individualised, transactional model can disadvantage people who rely on shared supports, kinship care, or ACCO-delivered wraparound services. Although the ECS and ADLO programs are block funded, these roles are frequently required to advocate, translate cultural context into clinical language, and manage mistrust stemming from historical exclusion and system harm which is symptomatic of a fee for service model. |
| **National Disability Insurance Scheme Practice Standards** | These standards regulate how providers deliver NDIS-funded supports, covering governance, risk management, worker screening, incident reporting and participant rights. While intended to protect participants, the compliance burden can be significant for ACCOs, particularly smaller organisations. The Standards place a strong emphasis on written policies, formal records and audit evidence as the primary measures of quality and compliance, which can overlook or undervalue culturally grounded, relationship-based and community-accountable ways of working that are central to ACCHO and ACCO models of care.<br><br>Recent regulatory tightening has increased reporting requirements and audit intensity, which can divert resources away from frontline service delivery. Staff working within or alongside ACCOs must balance cultural safety and flexibility with rigid procedural requirements, often without adequate policy recognition of the strengths of Aboriginal community controlled governance models. |

## Aged Care Act

The new Aged Care Act (commenced 1 November 2025) replaces earlier legislation and is framed around a rights-based, person-centred system. It introduces stronger regulatory oversight, new provider obligations, and alignment with the revised Aged Care Quality Standards (ACQS). While there is explicit recognition of diversity, including Aboriginal and Torres Strait Islander people, implementation details remain largely mainstream in design.

There is concern that the Act does not fully embed Aboriginal community control as a foundational principle, instead positioning it as a special consideration, rather than a core system design feature. This risks perpetuating a model where ACCHOs and ACCOs must adapt to the system, rather than the system adapting to the strengths of community controlled models.

## Employment Landscape

Across Australia, the social assistance and allied health workforce has become one of the largest and fastest growing components of the national employment landscape. Growth is being driven by population ageing, rising chronic disease, the expansion of disability and mental health services, and increasing reliance on prevention and community-based care. As demand accelerates, these workforces are no longer growing in isolation; they are operating within a highly competitive labour market where skill are increasingly contested across sectors.

This environment has direct implications for ACCHOs and their integrated care workforce models. ACCHOs deliver holistic, community-led care that integrates primary health, allied health, disability, aged care, social and emotional wellbeing (SEWB) and a wide range of social assistance functions. They workforce reflects this integration, relying on multidisciplinary teams where social assistance and allied health roles are central to service delivery. As these roles expand nationally, ACCHOs are competing with hospitals, non-governmental organisations (NGOs), private providers, NDIS organisations, aged care services and government agencies for the same workers, often without comparable access to funding wages or training incentives.

Within ACCHOs, social assistance and allied health workers are foundational to integrated care. Aboriginal Health Workers and Health Practitioners, clinical health workers, disability and aged care staff (integrated care), youth, family and SEWB workers provide the continuity, cultural safety and coordination that enable clinical services to be effective. These roles support prevention, early intervention and long-term engagement, reducing reliance on acute care and improving outcomes. When these workers are drawn away by better resourced parts of the labour market, the impact is felt across the entire service model, including increased pressure on nursing and medical staff.

Attachment B

# Core roles of the integrated care workforce

| | Role | Core Functions |
|---|---|---|
| **Aboriginal Disability Liaison Officer** | Support families and individuals in understanding, applying for, and accessing disability services through culturally safe navigation and advocacy. | • Navigation and advocacy within disability services<br>• Support with evidence gathering, ID, and service access<br>• Attending appointments and supporting communication<br>• Building trust between mob and mainstream (“white”) organisations<br>• Knowing and walking alongside<br>• Networking internally and externally, supporting wraparound community work |
| **Elder Care Connector** | Assists older Aboriginal and Torres Strait Islander people to access and navigate MAC services, advocating for culturally appropriate support. | • Linking Elders, families, health services, and programs<br>• Assisting with Aged Care sign-ups, referrals, and communication<br>• Advocacy within aged care pathways (MAC, ACAT, health professionals, and internal community programs)<br>• Educating community about available supports<br>• Reducing confusion in the aged care system<br>• Supporting trust and engagement, many Elders are reluctant to seek help due to shame or independence |
| **Elder Care Coordinator** | Provide higher-level oversight, guidance, and case management support within the aged care pathway. They strengthen the link between frontline connectors, service providers, assessors, and community, ensuring Elders receive timely, culturally safe, and coordinated care. | • Supporting and supervising ECC with guidance, mentoring, case advice, and troubleshooting complex issues<br>• Coordinating aged care assessments (RAS/ACAT), ensuring assessors understand cultural protocols, local context, and the needs of the community<br>• Overseeing care planning, helping Elders and families understand assessment outcomes and navigating next steps<br>• Building partnerships with aged care providers, health services, hospitals, and community programs to strengthen service pathways<br>• Monitoring community demand, identifying unmet needs, service gaps, and barriers to support<br>• Educating Elders and families about aged care rights, responsibilities, funding options, and complaint processes<br>• Advocating for Elders when services are delayed, not culturally safe, or do not meet assessed needs<br>• Ensuring cultural safety across all interactions and supporting providers to adjust their approach when working with Aboriginal Elders |

| | Role | Core Functions |
|---|---|---|
| **Remote Community Connector** | Assist Aboriginal people understand disability supports, connect to the NDIS, and stay engaged with services. Their work focuses on early engagement, breaking down barriers, and supporting families in culturally safe ways. | • Community outreach to identify people who may need disability support<br>• Explaining NDIS and disability concepts in simple, culturally relevant ways<br>• Linking people to local providers, ACCHOs and mainstream supports<br>• Helping families understand evidence, reports, and access steps<br>• Using visual and plain-language tools to support learning<br>• Supporting communication between families and services<br>• Networking with local leaders, services, and stakeholders<br>• Promoting disability awareness and reducing shame |



Attachment C

# Comparison of official role descriptions

| Selected integrated care roles | On paper: Official job description | In practice: Actual role in practice |
|---|---|---|
| **Aboriginal Disability Liaison Officer** (ADLO)<br>**Remote Community Connector** (RCC) | Provide culturally sensitive outreach | Act as a cultural bridge managing trust, trauma, and family dynamics. This can lead to cultural burn out |
| | Linkclients to NDIA/PITC and assist with forms | Translate jargon, redo evidence, and chase agencies for progress |
| | Support functional assessments and evidence gathering | Coordinate entire processes including transport, coaching GPs, and emotional support |
| | Support handover to NDIA/ PITC | Repair relationships, advocate for cultural safety, and build trust on both sides. Relationship continues even after client is receiving services |
| | Assist with planning, reviews, and complaints | Act as informal case managers handling crises, appeals, and system gaps |
| **Elder Care Coordinator** (ECC) | Support clients to navigate MAC and assessments | Lead complex case navigation, often resolving systemic issues and long-term barriers for Elders |
| | Provide advocacy to promote cultural safety | Act as cultural governance, challenging unsafe practice and reshaping provider behaviour across the network |
| | Liaise with MAC staff, assessors and providers via the Portal | Continuously chase, escalate and interpret changes, troubleshooting delays and confusion for the whole service |
| | Help clients choose providers and understand contracts and costs | Negotiate with providers, monitor quality, and reconfigure supports when services don't meet Elders' needs |
| | Record local services and maintain data and reporting | Map service gaps, feed into planning and funding advocacy, and support/supervise Connectors under heavy workload |
| **Elder Care Connector** (ECC) | Connect with Elders through outreach | Provide ongoing cultural, emotional, and crisis support – cultural navigation. Deep relational support |
| | Help Elders identify aged care needs | Interpret complex health, cognitive & social needs. Educate community about what they are entitled to. Perform informal case management & advocacy |
| | Support MAC registration & assessments | Manage the full process including delays, forms & portals. Provide emotional support through the process addressing barriers |
| | Organise referrals & appointments | Negotiate with providers, monitor quality, and reconfigure supports when services don't meet Elders' needs |
| | Collect data & participate in training | Handle complex documentation & learn systems on the job |

Attachment D

# Proposed Accredited Training options

## State developed accredited skill sets

### Community Support (WA State ID AF008)

This skill set is designed to provide both new and existing community services and care/support workers with the knowledge and skills to provide care and wellbeing support to individuals in the community service and health care sectors, including aged care and disability.

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **HLTWHS002** | Follow safe work practices for direct client care |
| **CHCCOM005** | Communicate and work in health or community services |
| **HLTAID011** | Provide first aid |

### Integrating Mental Health Practice Skill Set (WA State ID AE439)

The Integrating Mental Health Practice Skill Set is designed to equip the community service and health sectors with the knowledge and skills to respond to and support clients experiencing mental health challenges.

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS003** | Increase the safety of individuals at risk of suicide |
| **HLTWHS006** | Manage personal stressors in the work environment |
| **CHCMHS005** | Provide services to people with co-existing mental health and alcohol and other drugs issues |
| **CHCCCCS019** | Recognise and respond to crisis situations |
| **CHCDIV001** | Work with diverse people |

## National training package skill sets

### CHCSS00089 Service Coordination and Collaboration

This skill set reflects the skill requirements for work in coordinating services for clients including establishing and maintaining working relationships and partnerships with other service providers in the health or community sector.

This skill set has been endorsed by industry as suitable for individuals who:

- hold a qualification at Certificate III level or higher in related field

**or**

- have skills equivalent to the qualification requirement validated through a recognition of prior learning process

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **CHCMGT003** | Lead the work team |
| **CHCPRP001** | Develop and maintain networks and collaborative partnerships |
| **CHCMGT002** | Manage partnership agreements with service providers |

## CHCSS00116 Work with Clients with Complex Needs Skill Set

This skill set provides a set of skills for supporting clients with complex needs.

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS020** | Respond effectively to behaviours of concern |
| **CHCCSM005** | Develop, facilitate and review all aspects of case management |
| **CHCDFV001** | Recognise and respond appropriately to domestic and family violence |
| **CHCMHS005** | Provide services to people with co-existing mental health and alcohol and other drugs issues |
| **CHCMHS007** | Work effectively in trauma informed care |

## CHCSS00123 Dementia Support

A set of skills for work supporting people with dementia.

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **CHCAGE011** | Provide support to people living with dementia |
| **CHCCCS044** | Follow established person-centred behaviour supports |

## CHCSS00114 Entry into Care Roles Skill Set

This skill set addresses the skills and knowledge required to provide entry level support for basic client care for a range of roles and purposes required within the aged care and disability support sectors. The support provided in client care will be predominantly non-direct, with some basic direct client care, in order to maintain the safety of both the learner and client in care.

The units included in this skill set are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS015** | Provide individualised support *(this unit is superseded but remains in the skill set)* |
| **HLTINF006** | Apply basic principles and practices of infection prevention and control |
| **HLTWHS002** | Follow safe work practices for direct client care |

## Accredited course

### Course in the Early Years (52917WA)

The accredited Course in the Early Years (52917WA), like a skill set, comprises two units and could be used in the disability sector if a worker is dealing with parents and children so understand child development at a very basic level.

The course is intended to provide participants with the knowledge and skills to perform the following tasks:

- Support the development of children's learning and development;
- Record and implement appropriate opportunities for learning and development;
- Engage caregivers and families to participate in the program;
- Respectfully collaborate with caregivers and families;
- Identify appropriate referral pathways; and
- Access and understand the organisation's policies, procedures and guidelines.

The two units included in this course are:

| Unit Code | Unit Title |
|---|---|
| **EARENG201** | Engage with caregivers and families of young children |
| **EARSUP201** | Support children's learning and development |

## Qualifications

### Certificate II in Community Health and Wellbeing (52890WA)

This qualification provides basic industry-specific skills and knowledge enabling transition into traineeships in Community Services or Health sectors and entry-level employment in allied health, community health, Aboriginal and/or Torres Strait Islander primary health care.

Packaging Rules / Structure:

- Total of 9 units
- 6 core units
- 3 electives (selected from pathways such as Allied Health or Aboriginal Health).

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **HLTIINF006** | Apply basic principles and practices of infection prevention and control |
| **CHCCOM005** | Communicate and work in health or community services |
| **CHCDIV001** | Work with diverse people |
| **HLTWHS001** | Participate in workplace health and safety |
| **HLTWHS006** | Manage personal stressors in the work environment |
| **HLTAID011** | Provide First Aid |

## Certificate II in Community Services (CHC22015)

This qualification prepares workers for entry-level community services work supporting individuals with immediate needs under supervision.

Packaging Rules / Structure:

- Total of 9 units
- 5 core units
- 4 electives (minimum 2 from listed electives; all must contribute to valid vocational outcome).

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **CHCCOM001** | Provide first point of contact |
| **CHCCOM005** | Communicate and work in health or community services |
| **CHCDIV001** | Work with diverse people |
| **BSBWOR202** | Organise and complete daily work activities |
| **HLTWHS001** | Participate in workplace health and safety |

## Certificate III in Individual Support (CHC33021)

This qualification prepares workers for person-centred support in community, home or residential care contexts under supervision, for people requiring support due to ageing, disability or similar.

Packaging Rules / Structure:

- Total of 15 units
- 9 core units
- 6 electives (at least 3 from Group A or B depending on stream: Ageing or Disability).

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS031** | Provide individualised support |
| **CHCCCS038** | Facilitate the empowerment of people receiving support |
| **CHCCCS040** | Support independence and wellbeing |
| **CHCCCS041** | Recognise healthy body systems |
| **CHCCOM005** | Communicate and work in health or community services |
| **CHCDIV001** | Work with diverse people |
| **CHCLEG001** | Work legally and ethically |
| **HLTINF006** | Apply basic principles and practices of infection prevention and control |
| **HLTWHS002** | Follow safe work practices for direct client care |

## Attachment D

### Certificate III in Allied Health Assistance (HLT33021)

This qualification prepares workers to assist allied health professionals in aged care, disability and other health sectors under supervision with clinical placement requirements.

Packaging Rules / Structure:

- Total of 12 units
- 7 core units
- 5 electives (at least 4 from elective list).

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **BSBMED301** | Interpret and apply medical terminology appropriately |
| **CHCCOM005** | Communicate and work in health or community services |
| **CHCDIV001** | Work with diverse people |
| **HLTAHA027** | Assist with an allied health program |
| **HLTAHA049** | Recognise impact of health conditions |
| **HLTINF006** | Apply basic principles and practices of infection prevention and control |
| **HLTWHS001** | Participate in workplace health and safety |

### Certificate III Community Services (CHC32015)

This qualification reflects the role of entry level community services workers who support individuals through the provision of person-centred services. Work may include day-to-day support of individuals in community settings or support the implementation of specific community-based programs.

Packaging Rules / Structure:

- Total of 12 units
- 5 core units
- 7 elective units

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS016** | Respond to client needs |
| **CHCCOM005** | Communicate and work in health or community services |
| **CHCDIV001** | Work with diverse people |
| **HLTWHS002** | Follow safe work practices for direct client care |
| **HLTWHS006** | Manage personal stressors in the work environment |

## Certificate IV in Ageing Support (CHC43015)

This qualification reflects the role of support workers completing specialised tasks and functions in aged services, planning and delivering individualised supports in residential, home and community environments.

Packaging Rules / Structure:

- Total of 18 units
- Core and elective units tailored to ageing support roles.

The core units (selection) included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **CHCADV001** | Facilitate the interests and rights of clients |
| **CHCAGE001** | Facilitate the empowerment of older people |
| **CHCAGE003** | Coordinate services for older people |
| **CHCAGE004** | Implement interventions with older people at risk |
| **CHCAGE005** | Provide support to people living with dementia |
| **CHCCCS006** | Facilitate individual service planning and delivery |
| **CHCCCS011** | Meet personal support needs |
| **CHCCCS023** | Support independence and wellbeing |
| **CHCCCS025** | Support relationships with carers and families |
| **CHCDIV001** | Work with diverse people |
| **CHCLEG003** | Manage legal and ethical compliance |
| **CHCPAL001** | Deliver care services using a palliative approach |
| **HLTAAP001** | Recognise healthy body systems |
| **HLTWHS002** | Follow safe work practices for direct client care |

## HLT43021 Certificate IV in Allied Health Assistance

This qualification reflects the role of allied health assistants who provide therapeutic and program-related support to allied health professionals under delegation and supervision. To achieve the qualification a candidate must complete at least 120 hours of clinical/work placement as specified in the assessment requirements of the units of competency.

Packaging rules require completion of 18 units:

- Total of 18 units
- 10 core units
- 8 elective units (at least 6 from the elective list, with at least 4 coded HLTAHA).

## Attachment D

The core units (mandatory) included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **BSBMED301** | Interpret and apply medical terminology appropriately |
| **CHCCCS020** | Respond effectively to behaviours of concern |
| **CHCCCS036** | Support relationships with carer and family |
| **CHCCCS038** | Facilitate the empowerment of people receiving support |
| **CHCDIV001** | Work with diverse people |
| **HLTAHA027** | Assist with an allied health program |
| **HLTAHA047** | Engage with clinical supervision and delegation |
| **HLTAHA049** | Recognise impact of health conditions |
| **HLTINF006** | Apply basic principles and practices of infection prevention and control |
| **HLTWHS002** | Follow safe work practices for direct client care |

### Certificate IV in Disability Support (CHC43121)

This qualification reflects the role of individuals in a range of community settings and peoples' homes, who provide support in a manner that empowers people with disabilities to achieve greater levels of independence, self-reliance, community participation and wellbeing. Workers promote a person-centred approach, work according to and may contribute to an individualised plan, and work without direct supervision. They may be required to supervise and/or coordinate a small team.

Entry requirements:

Completion of: CHC33021 Certificate III in Individual Support (Disability)

**or** Completion of: CHC33015 Certificate III in Individual Support (Disability)

**or** Completion of: CHC30408 Certificate III in Disability PLUS the CHCSS00125 Entry to Certificate IV in Disability Support Skill Set.

Packaging Rules / Structure:

- Total of 10 units
- 7 core units
- 3 elective units, consisting of:
  - at least 2 units from the electives listed below
  - up to 1 unit from the electives listed below, or any current endorsed Training Package or accredited course.
  - Units marked with * have one or more prerequisite units. Please refer to individual units for details of prerequisites.
  - All electives chosen must contribute to a valid, industry-supported vocational outcome.

The core units included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| **CHCCCS044** | Follow established person-centred behaviour supports |
| **CHCDIS017** | Facilitate community participation and social inclusion |
| **CHCDIS018** | Facilitate ongoing skills development using a person-centred approach |
| **CHCDIS019** | Provide person-centred services to people with disability with complex needs |
| **CHCLEG003** | Manage legal and ethical compliance |
| **CHCMHS001** | Work with people with mental health issues |
| **HLTWHS003** | Maintain work health and safety |

## Diploma of Community Services (CHC52025)

This qualification reflects the role of community services workers involved in the delivery, management and coordination of person-centred services to individuals, groups and communities. At this level, workers have specialised skills, work autonomously within their scope of practice under broad direction, support people to improve personal and social wellbeing, and may supervise others, undertake case management and coordinate programs. To achieve the qualification, at least 100 hours of work are required as per the units' assessment requirements.

Packaging Rules / Structure:

- Total of 20 units
- 12 core units
- 8 elective units:
  - at least 6 from Groups A–E
  - up to 2 from other endorsed training packages/accredited courses.
  - specialisations can be noted on the testamur if elective selections satisfy case management, social housing, child/youth/family welfare or family violence emphases.

The core units (12 mandatory units) included in this qualification are:

| Unit Code | Unit Title |
|---|---|
| CHCCCS004 | Assess co-existing needs |
| CHCCCS007 | Develop and implement service programs |
| CHCCCS019 | Recognise and respond to crisis situations |
| CHCCSM017 | Facilitate and review case management |
| CHCDEV005 | Analyse impacts of sociological factors on people in community work and services |
| CHCDFV001 | Recognise and respond appropriately to domestic and family violence |
| CHCDIV001 | Work with diverse people |
| CHCDIV002 | Promote Aboriginal and/or Torres Strait Islander cultural safety |
| CHCLEG003 | Manage legal and ethical compliance |
| CHCMGT005 | Facilitate workplace debriefing and support processes |
| CHCPRP003 | Reflect on and improve own professional practice |
| HLTWHS003 | Maintain work health and safety |

Attachment E

# Intersectional workforce development strategies

**The Framework aligns with other relevant strategies and standards that affect older Aboriginal and Torres Strait Islander people, their carers, families and communities, the Aboriginal and Torres Strait Islander aged care workforce and Aboriginal and Torres Strait Islander organisations.**

**These include:**

| |
|---|
| National Agreement on Closing the Gap (and associated strategies and plans) |
| United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) |
| National Aboriginal and Torres Strait Islander Health Plan 2021–2031 |
| National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 |
| Our Care, Our Way, Our Future: 5-Year Plan for Aboriginal and Torres Strait Islander Aged Care (2021–2026) |
| Aboriginal and Torres Strait Islander Cancer Plan |
| National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–23 |
| National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (once finalised) |
| Gayaa Dhuwi (Proud Spirit) Australia Declaration (and associated plans) |
| The New Aged Care Act and Aged Care Quality Standards |
| National Indigenous Languages Report |
| National Dementia Action Plan |
| Aged Care Diversity Framework |
| Australian Government Diversity Action Plan |
| Actions to support Aboriginal and Torres Strait Islander people: a guide for consumers |
| Actions to support older Aboriginal and Torres Strait Islander people: a guide for aged care providers |
| Framework for Governance of Indigenous Data |




Above: Nirrumbuk Environmental Health & Services, Kimberley Aboriginal Medical Services, Broome Regional Aboriginal Medical Service, Kimberley Stolen Generation Aboriginal Corporation, Humanability, Community Skills WA & NACCHO Integrated Care consultation hosted at Nirrumbuk Environmental Health & Services in Broome WA.

Below: Victorian Aboriginal Community Controlled Health Organisation, Victorian Aboriginal Health Service, Wathaurong Aboriginal Co-operative, Dandenong & District Aborigines Co-operative, Community Skills WA & NACCHO Integrated Care consultation hosted at Victorian Aboriginal Health Service in Melbourne VIC.



Nirrumbuk Environmental Health & Services, Kimberley Aboriginal Medical Services, Broome Regional Aboriginal Medical Service, Kimberley Stolen Generation Aboriginal Corporation, Humanability, Community Skills WA & NACCHO Integrated Care consultation hosted at Nirrumbuk Environmental Health & Services in Broome WA.

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