Emerging identities:
Practice, learning and professional development of
home and community care assessment staff

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Abstract

This thesis argues for greater recognition of assessment staff in community care/home and community care (HACC) and a more comprehensive and considered approach to preparing such a workforce. By offering deeper insights into the practice of assessment and the individuals employed in these positions, the thesis makes the case that these are emerging identities: a new specialism in the emergent space of community care. This specialism has arisen to fill the gap which has developed as a result of changing socio-cultural practices in relation to care for the frail aged and people with disabilities, and the inability of established disciplines to keep pace with the new demands of the contemporary world.

The study employed a qualitative methodology using in-depth interviews with key informants with various stakeholder interests and expertise in the area of assessment and home and community care, and workers employed in assessment roles in HACC services in Victoria. The conceptual framework is represented as theoretical perspectives from current adult educational scholarship that focus on professional disciplines (including multidisciplinary/interprofessional perspectives), those that focus on communities of practice, and those that focus on the workplace.

The thesis shows that HACC assessment workers are a product of contemporary workplaces and systems of health and community care. The nature of their practice derives substantially from the local contexts in which they work; there is no single profession or discipline-based narrative that drives their practice. Instead they draw from a diverse range of knowledge sources including their embodied practice. In this way, it is argued that they are emergent practitioners, whose practice and identities share many elements with traditional professions in comparable work contexts (similar levels of autonomy, reflective practices, and development and application of ‘know how’ and tacit wisdom). The case is put that their embodied practice is the site of a robust professionalism which can provide the foundation for new approaches to the education, training and development of this increasingly important and growing occupational group. A model of learning is proposed which builds on authentic learning attained in daily work activities with clients, in the workplace as a social setting, and developing the self as a resource for practice. This model is based on a hybrid approach that builds on the learning strengths of both educational institutions and the workplace.
Declaration

This is to certify that

(i) the thesis comprises only my original work towards the PhD

(ii) due acknowledgement has been made in the text to all other material used

(iii) the thesis is less than 100,000 words in length, exclusive of tables, bibliographies and appendices.

Melissa A. Lindeman
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(i) Denise Taylor for her constant support, patience and encouragement during this project.

(ii) My first supervisor, Associate Professor David Beckett, who seemed to know exactly the right thing to say at the right time and who was always accessible, and my second supervisor, Associate Professor Elizabeth Ozanne, whose suggestions were always pertinent and helpful. I thank them both for their interest in this project, and ongoing support, encouragement and guidance. Their extensive knowledge of their respective fields was invaluable to me, as were their considered content and editorial suggestions.

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Conference Presentations

The following conference presentations were made during my candidature:

(i) **Assessment of client need in HACC services: workforce development issues in Victoria;** Poster presentation at the International Federation on Ageing 6th Global Conference, Perth, 26-29 Oct. 2002. Content from this presentation is included in Chapter Four, and in Section 7.2.4.

(ii) **Assessment staff in home and community care: issues of learning and professional identity;** Paper presented at the International Federation on Ageing 7th Global Conference, Singapore, 4-7 Sep. 2004. Content from this presentation is included in Chapters Four, Five and Six.
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Part I: Locating the field of inquiry

1. Introduction

This thesis is a study of a group of workers in aged and community care: those who are responsible for assessing individual clients’ needs for services. The types of services include home care (such as cleaning or shopping), home maintenance, personal care, social support, day activities/day care, other forms of respite, delivered meals and community transport. The function these individuals undertake in community care (that is, assessment of need for services) is explicitly described in the relevant policy frameworks and in research studies focused on the processes and outcomes of community care. However, the workforce itself has not been considered as a group before. In fact, apart from the function of assessment itself, there is little information available in the sector that apparently unifies this workforce.

This would seem to be problematic from several perspectives. Firstly, without an understanding of who these workers are, how do we know how they are, and should be, prepared for undertaking this function? For this reason, part of the thesis reports on what essentially amounts to a mapping exercise to locate and define this workforce and its contexts. Secondly, without an understanding of what these individuals bring to the task, and what they learn from the doing of the task, it is difficult to construct a meaningful explanation that may assist in answering this question. Thirdly, without an evident collective identity, how do we understand what their knowledge claims and learning needs are and how these claims and needs are regarded (by themselves and by others) in practice? This thesis is essentially about making such ontological and epistemological characteristics explicit. These new understandings will enable these individuals to keep pace with an increasingly professionalised workforce in the sector. More broadly, it may assist to enable better preparation of, and support for, the community care assessment workforce.

1.1 Context

Australia, along with other developed nations, is experiencing a rapidly ageing population. This trend is strongly associated with increasing pressure on existing services and systems of support and the resulting need for new and flexible ways to
meet those needs. Modern notions of citizenship and consumerism, have led to community demand for alternatives to residential care, and a greater reliance on informal supports. In recent years, greater emphasis has been placed on community care as the primary model of care available for those requiring assistance. The cost of residential care is also a significant factor in the shifting balance of care evident in service systems throughout Western democracies. The need and demand for community care, as alternatives to residential care options, is therefore, increasing exponentially. Polices of deinstitutionalisation and improved technology which enable people with disabilities to be cared for at home, is also placing pressure on the established systems of support.

These changes are occurring against the backdrop of shrinking resources and newly developed marketisation and commodification of welfare and basic social services. Well-educated citizens, faster information flows and access to knowledge, diverse social landscapes in which populations can be both sparsely and densely located, multi-agency responsibilities taking over from traditional ‘providers’ of welfare supports, and a changing labour market, also contribute to the complex contexts in which the system of care for older people and people with disabilities is situated.

With such complexities contributing to the contexts of practice of workers in this sector, there is a need for greater recognition of assessment staff in community care and a more comprehensive and considered approach to preparing such a workforce. Deeper insights into the assessment function and the individuals employed in these positions, are, I believe, of paramount importance as a strategy in improving standards and systems of care.

The ‘occupation’ of assessment has arisen to fill the gap which has developed as a result of changing socio-cultural practices in relation to care for the frail aged and people with disabilities, and the inability of established professional categories to keep pace with the new demands of contemporary approaches and systems of health and community care.
1.2 Rationale

The initial stimulus for this research has come from my personal experiences as a worker in a range of settings in the aged and disability services sector since the early 1990s. My interest in this topic was first aroused during my involvement in coordinating the implementation of the Client Information and Referral Record (see table 1 in 1.3.1) as a State Government employee in Victoria, Australia. Training was provided to assessment staff working in Home and Community Care (HACC) organisations widely throughout the sector to assist implementation, with mixed results. Workers in some areas were willing to implement the tool, and in other areas implementation rates remained low. The reasons for these differences remained puzzling to me for a number of years.

Later, working in aged and community services research, I had the opportunity of exploring many issues related to assessment (such as designing assessment tools, and developing service system approaches to assessment and care planning), and became interested in the personnel employed in assessment roles. Their diversity, coupled with shared values, commitment and knowledge, caught my attention. The quality of assessment and care planning had continued to be a focus for reforms from funding bodies, but little of the focus of the reforms had been directed at the workers themselves or their education needs. There was an implicit assumption that the market would deliver the improvements to assessment practice (and by implication, the personnel). I then co-developed a workshop training program to try to meet some perceived gaps in preparing staff for the assessment role in HACC which had become very obvious to me and other colleagues. The training I was involved in developing, although a modest program, and only available at the time in Victoria, was successful in that demand was constant and feedback from participants was positive. However, there was clearly a need for more (or different) learning opportunities for these workers, as the service environment and the policy context continued to change.

Yet, there remained for me, further unresolved problems. How can the demand for assessment staff, in terms of increasing numbers that will be required to work in these roles, be met in the sector? How will the sector respond to the continued requirement for quality assessment practice and how should assessment staff be prepared for these roles? I felt that strategic workforce planning could not occur adequately without an
answer to these questions. There was also the pervasive debate between medical and social models of care, in which any practitioner in this sector would have participated at one time or another. I then commenced the current study with the realisation that this was an inquiry that should cross disciplinary boundaries.

As will be evident by now, I am not a dispassionate observer in this project. I acknowledge in the methodology chapter that I am engaged reflexively throughout. This is a topic of personal interest to me from my professional involvement in service development, policy, research and training. However, I have not practised as an assessor in aged and community care. Therefore I do not bring the personal perspective that might be expected of someone who had undertaken the work they were researching others practising; I did not commence this study favouring a particular practice style, certain worker backgrounds, or approaches to developing workers. Thus, a level of bias that may have been present had I worked in such roles, is not present.

The timeliness for this research is evident from the investment governments have made into policy and service development to improve assessment practice (see 1.3.1) within the broader service system context, and in the recent calls for major reform of the workforce and related education and training systems (Australian Government Productivity Commission, 2005; Duckett, 2005). It is also evident to me from the reactions and feedback I received during the course of my research from participants in the study and from colleagues. And, as will become clear from the literature review, assessment is a hot topic and widely acknowledged as central to the whole system of service delivery.

1.3 Policy and conceptual framework

HACC is a funding program of the Commonwealth (also known as federal) and State governments in Australia which supports the vast majority of community care service providers. Access to services in the HACC Program is based on the assessed needs of individuals seeking assistance to remain at home in the community. In this section I outline the key policy initiatives that have focused on the assessment function at both the Commonwealth and Victorian State levels (1.3.1). This serves three main purposes. First, it condenses the initiatives to those most directly impacting on assessment and the workers who perform the function and presents them in chronological order for ease of
reference. Second, it demonstrates the commitment of governments to reform the area of assessment. Third, it defines the policy context within which this thesis is located and introduces many of the terms/initiatives that are referred to throughout the thesis.

After presenting the policy framework for HACC assessment, I then introduce the theoretical perspectives that inform the research approach which comprise the conceptual framework for the thesis. The conceptual framework draws initially on the theoretical perspectives that have informed the development of assessment in community care. This represents theoretical perspectives from disciplines such as nursing and social work which have contributed substantially to the policy rationale for health and social services in Western democracies. The conceptual framework also draws on the field of adult education philosophy which provides the foundation for critical analysis of the data and future directions.

1.3.1 Policy framework for HACC assessment

HACC is jointly funded by Commonwealth and State and Territory governments; the Commonwealth government contributes 60% of funds and States/Territories contribute 40%. Auspice agencies and client fees contribute to the overall funds available for the delivery of services (Department of Human Services, 1998a). State/Territory governments are responsible for administering the program and they develop their own policies to guide service delivery within the broad policy framework provided by the Commonwealth. The stated aims of the HACC Program are:

- to provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers; and
- to support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care (http://www.hacc.health.gov.au/).

1 Throughout this thesis I use the term “client” to refer to the target population of home and community care services. Other terms commonly used particularly in Program documents (the grey literature) are “service user” or “consumer”. The latter terms, I believe, mask the true nature of their engagement with services. Payne adopts a similar position: “service user” suggests an empowered user, and “consumer” suggests a user with real market choice Payne, M. (1995), Social work and community care, London, Macmillan Press.. In the context of the realities of HACC service delivery in Australia, both are somewhat spurious terms in my view.
The policy framework for assessment in the HACC Program is outlined in the HACC National Program Guidelines, and focuses largely on the procedures of practice. In summary, the key principles guiding assessment in HACC are that assessment:

1. should be broad and involve the individual client and their carer or advocate in decisions
2. should be defined as being “service specific” (referring to ascertaining clients’ requirements in relation to particular services) or “comprehensive” (referring to assessment which is consumer focused, independent of service provider perspectives and broader in scope and orientation than a general or service specific HACC assessment)
3. makes available information for consumers about assessment processes and outcomes
4. is flexible to enable appropriate service responses
5. incorporates provision for different levels of assessment for clients according to individual needs
6. should be ‘needs led’ rather than ‘service led’ so that clients are individually assessed for all their care requirements rather than for one particular service
7. should be coordinated locally and regionally to avoid multiple assessments and/or the duplication of services for clients
8. incorporates information about avenues for appeal and complaint
9. incorporates use of a common client data and referral form (the Client Information and Referral Record)
10. data is collected and collated at a regional level
11. incorporates the eligibility, targeting and priority of access guidelines
12. models developed regionally are efficient and effective
13. practices should protect clients' privacy and confidentiality (Australian Government Department of Health and Ageing, 2002)

The HACC National Service Standards is a major component of a quality framework developed for HACC service providers aimed at ensuring services are of high quality and consumer rights are upheld. The Standards consist of seven main objectives that are applicable across all HACC services. Two of these objectives directly relate to the assessment process:
Objective 1: Access to services (to ensure that individuals’ access to a service is decided only of the basis of relative need):

Objective 4: Coordinated, planned and reliable service delivery (to ensure that each consumer receives coordinated services that are planned, reliable and meet his or her specific ongoing needs)(Commonwealth Department of Health and Aged Care, 1998).

In short, HACC assessors are required to meet certain standards of practice in areas such as developing cooperative relationships with other providers, collecting basic client data on a common referral form, assessing certain domains, involving the client and carers in the process, and developing care plans. Policy documents also imply that HACC is not ‘medicalised’ in the sense that specific health conditions should not automatically indicate need for services and that each individual should be assessed on their particular circumstances:

“HACC assessment is function, not diagnosis driven, and must reflect the level of maintenance/support required, the extent of capacity to undertake activities of daily living and the level of risk of inappropriate admission to long term residential care” (Department of Human Services, 2003, p.17).

A number of reforms have occurred in the HACC program both at a Federal level and at the Victorian State government level designed to improve the function of assessment, which provide important context for the current study. Some of the key developments in the HACC program in relation to assessment are presented below (Table 1).

<table>
<thead>
<tr>
<th>Year commenced</th>
<th>Level of government initiating</th>
<th>Title of reform</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>Commonwealth government</td>
<td>Client Information and Referral Record (CIARR)</td>
<td>The CIARR was a common document for HACC, and other, agencies to record client data collected during assessment. To be used in referral to minimise duplication in assessment. The CIARR was also client held. (Brian Elton and Associates &amp; Department of Human Services and Health, 1995)</td>
</tr>
<tr>
<td>1996</td>
<td>Victorian State government</td>
<td>HACC Best Practice projects</td>
<td>Informal coalitions of HACC and other service providers supported with small amounts of State government funds to develop protocols of assessment and service coordination, with</td>
</tr>
<tr>
<td>Year</td>
<td>Government</td>
<td>Area</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1998</td>
<td>Commonwealth government</td>
<td>National framework for comprehensive assessment of the HACC program</td>
<td>Arising from earlier reviews of the HACC program, this consultancy developed a framework for independent comprehensive assessment in HACC, including discussion of assessor competencies for comprehensive assessments (Lincoln Gerontology Centre, 1998).</td>
</tr>
<tr>
<td>2000</td>
<td>Victorian State government</td>
<td>Primary Care Partnerships (PCP)</td>
<td>Formal coalitions of service providers to create an integrated primary care service system that assists providers and professionals to coordinate their work. Development of assessment documents for mandatory use by all State Government funded primary care services: Initial Needs Identification (INA), now known as Service Coordination Tool Template (SCTT) (Department of Human Services, 2000a; Department of Human Services, 2000b).</td>
</tr>
<tr>
<td>2001 - 2006</td>
<td>Commonwealth government</td>
<td>Community care needs assessment project</td>
<td>A series of projects aimed at achieving a national needs assessment system for community care consistent with other types of assessment. Includes development of a broad policy framework encouraging (amongst other things) shared definitions and approaches to assessment across all community care agencies (including HACC) (Australian Government Department of Health and Ageing, 2004). A major focus is the development of detailed functional screening and assessment tools to standardise information collection at assessment (Owen et al., 2005).</td>
</tr>
<tr>
<td>2005</td>
<td>Victorian State government</td>
<td>Strategic directions in assessment in HACC</td>
<td>Broad directions for the development of an assessment framework in the HACC program over 3 year time frame. Recommends series of structural and procedural reforms including new policy guidelines (including selecting a suite of common assessment tools), designation of agencies to undertake assessment, and professional development for assessment staff (Howe &amp; Warren, 2005).</td>
</tr>
</tbody>
</table>
The most significant recent policy reform impacting on the practice of assessment is occurring through the Victorian State Government’s Primary Care (PCP) strategy. This aims to create an integrated primary care service system that assists providers and professionals to coordinate their work for clients they have, or may have, in common (Department of Human Services, 2000b). The Strategy has a large emphasis on the process of assessment and information management systems to assist coordination between service providers. HACC agencies including local government are a key part of the PCP strategy, alongside Aged Care Assessment Services (ACAS), community health services, primary mental health, alcohol and other drug services and Divisions of General Practice (Department of Human Services, 2003).

Central to the PCP reforms are the definitions of separate assessment functions: initial contact, initial needs assessment, specialist assessment and comprehensive assessment. For the purposes of the present study, the focus does not encompass assessment at specialist or comprehensive levels, which would most usually be carried out by ACAT (see below) staff or specialist staff in other HACC agencies (for example, Division 1 nurse in a District Nursing agency; Occupational Therapist in a Community Health Centre).

The present study is concerned with the staff involved in the initial identification of clients’ needs, who are employed in assessment roles in HACC-funded agencies. Staff in these roles are most usually clients’ first point of contact with the service system, and is a critical stage in clients’ engagement with community care services. In my view, this area has received too little attention in terms of workforce planning and development, and is addressed more fully in the literature review in Chapter Two.

1.3.1.1 Aged Care Assessment Teams (ACAT)

Aged Care Assessment Teams (ACAT), also known as Aged Care Assessment Services (ACAS) in Victoria, require some explanation at this point. Originally established in Australia in the 1980s (and then known as Geriatric Assessment Teams) as a reaction to the considerable growth in nursing home expenditure at the time, they had a major brief to prevent inappropriate admission to nursing home care (Clark, 1998). ACATs remain responsible for determining eligibility for admission to aged care facilities (low care - hostels and high care - nursing homes). They also determine eligibility and allocation
of Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages (intensive forms of home based support available to people assessed as being of similar dependency levels as people in residential facilities). As such, they essentially act as gatekeepers to residential and other high care options.

ACATs may also recommend a range of HACC services, including the Community Options Program (known as Linkages in Victoria) which is targeted at people with high or complex needs, although they do not determine eligibility for such services (Australian Institute of Health and Welfare, 1995). ACATs are multidisciplinary, with the range of staff generally including a medical practitioner, nurse, social worker, and other specialist allied health or medical practitioners. ACAT staff are employed according to professional discipline to provide a clinical assessment service. Although ACATs are involved in community care assessment, they are outside the scope of the present study. To reiterate, the present study is focused on the staff involved in initial needs assessment, where the greatest volume of assessments take place, which at this stage is with HACC providers.

1.3.2 Conceptual framework

Epistemology is concerned with the nature and sources of knowledge, and the assumptions upon which knowledge is based. Ontology is concerned with the nature of reality, and the filters through which the world, including the self, is experienced. In traditional approaches to education, epistemology precedes ontology. That is, formal knowledge is ‘front loaded’: the practitioner enters their field of practice with universalised, highly valued, and internalised, discipline-based knowledge, and their perceptions of knowing flow from this. In much contemporary adult education philosophy, ontology precedes epistemology (Usher et al., 1997, p.204). This means that what is taken to be the nature of reality in particular socio-cultural contexts precedes practitioners’ knowledge claims (for example, knowledge that is rational, positivist, discipline-based). Such perspectives acknowledge the diversity of worker contexts and experiences and recognise that these will affect worker identities in different ways and that knowledge claims will emerge from such diversity. Similarly, I argue that, for the community care assessor, the experience of being an assessor is more likely to be the source of their identity than anything else.
Professions such as social work, nursing and the allied health professions, key players in community care, are embedded in long-established industrial labour relations, and traditional approaches to education. Such approaches are constructed from universalised knowledge claims that assume certainty, where technical rationality is privileged in the nature of practice. However, for some contemporary theorists uncertainty, fragmentation, and local and contingent knowledge (Camilleri, 1999), and openness to knowing, are central (Garrick, 1998). Knowledge is valued for its ‘performativity’, not for legitimating universal or ‘grand’ narratives, as in more traditional approaches (Usher et al., 1997, p.13). Practical performance is valued as central in the formation of adult identity, and which is constructed in adults’ everyday actions, rather than identity being a prior ontological state which is ‘brought in’ to those everyday actions by virtue of possession of a ‘body’ of universal knowledge (Morris & Beckett, 2004).

Community care - HACC - assessment workers are a product of contemporary workplaces and systems of health and community care. The nature of their practice derives substantially from the local contexts in which they work; there is no single profession or discipline-based narrative that drives their practice. Instead they draw from a diverse range of knowledge sources including their embodied practice. Thus, the ontological is a feature, and I argue that their practice, identity, and epistemology share many elements with traditional professionals in comparable work contexts (similar levels of autonomy, reflective practices, and development and application of ‘know how’ and tacit wisdom). I develop the case that their embodied practice is the site of an emerging, but potentially robust, professionalism which can provide the foundation for new approaches to the education, training and development of this increasingly important, and growing, occupational group.

This case is therefore a contrast to the assumptions underpinning traditional education systems. These are that there are two major approaches to the education and training of people in any setting: knowledge-based approaches and competency-based training (CBT) approaches, or in other words, the general education / training dichotomy. In ‘traditional’ adult education discourse, ‘education’ is content based (often associated with a future role) and ‘training’ is process based (usually associated with the individual’s current job). Further, education is usually associated with schooling and higher education, and training is often associated with vocational education and
training. Although not rigid categories, these dichotomies in practice are contested. ‘Lifelong learning’ or simply ‘learning’ are terms often adopted to represent a more inclusive view of the different forms of education/training/development that can occur both formally and informally in a person’s life and work: “an integrated view of knowledge rather than a disciplinary-based one” (Jarvis et al., 2003, p.43). The conceptual framework I develop is represented as theoretical perspectives from current adult educational scholarship, based on a notion of learning rather than ‘education and training’ as defined under more traditional approaches to education.

I have loosely grouped these into three areas, although there are many overlaps and shared assumptions between them. All have developed from newer understandings of ‘traditional’ education philosophies, in the light of an inability to adequately explain practice and its relationships to epistemology. The three major theoretical perspectives I address are those that focus on professional disciplines (including multidisciplinary/interprofessional perspectives), those that focus on communities of practice, and those that focus on the workplace:

- **Professional discipline/inter-disciplinarity** theories examine the development of professional disciplines and challenges to the traditional assumptions underpinning discipline-based knowledge and practice. In particular, discipline-based professionals create new forms of knowledge and expertise and exercise judgements (wise action) based on their own embodied experience of practice. The self as a source of knowledge and the fluid ‘boundaries’ of discipline-based professions are major themes. I also include a discussion on interprofessional/interdisciplinary learning which is gaining much currency in professional education and which is particularly relevant for the community care context.

- **Communities of practice** theories are social theories of learning which have developed to explain how workers in general (not limited to professionals) learn from social interactions where there is a shared interest or aspects of shared practice. They have been applied mostly in staff development contexts, and also informally in workplace settings. However, they offer a model for analysis of the various ‘communities’ available to diverse practitioners such as HACC assessors.

- **Workplace learning** theories encompass explanations of all types of learning at the workplace including formal, informal, and incidental. The historical interest
on ‘competency’ (with its roots in behaviorism) has kept the focus of these theories mostly relating to ‘vocational’ (as opposed to professional) jobs, and the critique of these forms of ‘training’. Newer developments in the literature focus on judgements, and the development of expertise, and demand a broader conception of competence: one which acknowledges the embodied, situated and holistic, and interrelated nature of practice, learning and identity.

Identities are framed and reframed by different workplaces and contexts and identity claims for professions and professionals need to be analysed from these multiple perspectives. Taken together these perspectives will contribute to understanding the HACC assessment workforce; their practice, learning and identity, and future possibilities for their development and support are all underpinned by such perspectives.

### 1.4 Aims

As will become apparent in the next chapter, little is reported in the literature about the profile of the assessment workforce in community care, although the general lack of clarity about the appropriate qualifications, experience and competency required by assessors has been noted. In contrast, HACC program policy requires these workers to meet certain standards of practice in areas such as developing cooperative relationships with other providers, collecting basic client data on a common referral form, assessing certain domains, involving the client and carers in the process, and developing care plans, all of which are skills claimed by several professions. Further, there are certain generic skills and knowledge that are ‘above and beyond’ professional discipline and are required for any individual undertaking assessment in community care. HACC agencies are expected to provide access to ongoing training that meets the needs of their staff, including in-service and registered vocational training and a variety of modes of delivery (Department of Human Services, 2003). They also have a responsibility to ensure that “staff have the relevant qualifications to undertake the activities that they are allocated to” (Department of Human Services, 2003, p.51). However, little is available to assist service providers in determining the most appropriate training for their assessment staff.

Importantly, HACC assessors have not previously been seriously regarded as a group with a distinct role and identity. The function of assessment in HACC Victoria has been described in detail (see for example, Holten et al., 1992; Howe & Warren, 2005;
National Ageing Research Institute, 2001b; Prideaux et al., 2004), and in the oversees literature from a broader (that is, non program-specific) perspective (such as Parry-Jones & Soulsby, 1999; Stanley, 1999; Stewart et al., 1999; Vernon et al., 2000; Worth, 1998), but the embodiment of this function, that is, in the workers themselves, has not. Chapter Two (part one) reviews the references to assessment workers in the literature and builds the case for advancing our understanding of the community care assessment workforce undertaking initial needs assessments. This study seeks to address this gap by identifying, in particular, the typical professional and educational backgrounds of the staff, the kinds of workplace contexts they work in and how these influence their practice, the skills and knowledge they need and how they develop these, how they make decisions and judgements, the knowledge and experience they draw upon, and how they are supported in their roles.

Therefore, the study is essentially concerned with the epistemological and ontological of community care assessment, and how such understandings can assist the sector to better prepare and support the assessment workforce. I also draw some conclusions about potential new approaches to the education and training of staff involved in client assessment for community care. In short, the thesis aims to consider how, and to what extent, workers can be better prepared as assessors in community care.

1.4.1 What the thesis does not do

In the next chapter I review the literature to introduce the main issues and trends in the sector which have led me to focus on the assessment workers. However, the thesis itself does not present a detailed account of the function of assessment, community care assessment policy and the various models and approaches to assessment. A large body of material is already available that provides this level of detail (some examples referenced immediately above). To offer more detail about assessment itself would necessarily take the study towards a critique of these areas, and away from the workers themselves which is where I want to remain focused. To this end, I have described these aspects of assessment only to the extent required to build the understandings (first asked in the introduction), of the workers and their practices as these contribute to workers’ learning, identities and professional development.
It is well known the ‘care’ workforce is a gendered one with women predominating in both ‘hands on’ care roles and in more professional roles (see for example, Baines, 1998; Finch & Groves, 1983; Meyer, 2000). However, a gender analysis per se of the assessment workforce is unlikely to add new understandings to the body of material already available that deals with the gendered nature of the ‘caring’ workforce, and is thus not a major focus of the current study beyond identification of the gender of the research participants.

1.4.2 Research questions

Five research questions are posed:

1. Who are the workers that undertake assessment of client need in HACC and what is the range of contexts in which they are employed?
2. What preparation (including formal education and training) and support do they receive?
3. What relationship does the workplace context have to the skills and knowledge required and acquired, and vice versa?
4. What is the relationship between the professional identity of assessment staff, and their practices, knowledge and expertise?
5. How, and to what extent, can workers be better prepared and supported as assessors in community care?

I return to these questions in the conclusion (Chapter Nine).

1.5 Methodology

This study employs a qualitative methodology, which draws substantially from an interpretivist-constructivist paradigm. The methods used included in-depth interviews with two groups of 12 participants each, conducted in two stages. The first 12 participants (Stage One) were key informants with various stakeholder interests and expertise in the area of assessment and home and community care. These participants were purposefully selected for the critical perspectives they could offer on the topic. Data from this set of interviews were used to finalise the approach used in Stage Two.
In Stage Two, the 12 participants comprised randomly selected workers employed in assessment roles in HACC services in Victoria. A stratified sampling technique was used to ensure that representation from different organisational types, as well as rural and metropolitan areas, was included in the study.

All interviews were conducted at the place of each participant’s choice, were transcribed and signed off by participants. There was a high level of willingness to participate, and a high level of interest in the focus of the study, from both groups of participants.

A detailed account of the methodology (and methods), including a rationale, is provided in Chapter Three.

1.6 Thesis structure

The thesis is divided into three parts, each containing three chapters.

Part I
Part I locates the field of inquiry. This introductory chapter (Chapter One) has outlined the context, my interest in the topic, and introduced the policy and conceptual framework for the study, and the research question and methods.

In Chapter Two the literature is reviewed and is divided into two parts. Firstly, community care/assessment literature is reviewed to establish what is currently known about the community care assessment workforce and how they are prepared for the role. I draw on both the grey literature (see glossary) from Australia (where many policy initiatives and research on community care service delivery is reported) and on peer reviewed literature. Definitions of community care (including the HACC program) and assessment are provided. This is the service provision context in which these workers operate. Issues arising in the literature relating to training needs are identified, and some generalisations are drawn that point to the need for a more detailed understanding of these factors.

The second focus for the literature review chapter is the field of adult educational philosophy which provides a theoretical framework for the thesis. I present each of the
following theoretical perspectives as useful to assist an analysis of the HACC assessment workforce: theorising focusing on professional disciplines (including interprofessional and multidisciplinary learning); communities of practice; and workplace learning. I map out the theoretical terrain for each perspective, and consider to what problem is this theoretical perspective the answer, and how explicable the phenomenon (of the HACC assessment workforce) becomes as a result of this theoretical perspective.

Chapter Three articulates the methodology (and methods) in detail.

Part II

Three chapters of findings and analysis are presented in Part III (Chapters Four, Five and Six). The focus of Chapter Four is the organisations and personnel involved in assessment based on the findings of the interview data. Specific areas reported include perceptions of the professional identities of staff, of work contexts, and of workforce trends. Some implications of these findings are also introduced.

Chapter Five describes the practice of assessment, focusing on broad approaches and processes utilised by participants, as well as some of the judgements and decision-making that they are required to make. It also introduces the personal attributes, technical skills and knowledge required, and reports influences on particular approaches to assessment as identified by participants.

Chapter Six presents findings in relation to the professional backgrounds of assessment staff, the types of education and training that are currently available, and the processes of learning about assessment roles.

Part III

The discussion is presented in Part III (Chapters Seven, Eight and Nine). Chapter Seven is devoted to a detailed discussion of worker professional identities and the nature of practice. The chapter focuses initially on these emergent practitioners and locates their professionalism in the ontological and epistemological base of their practice. Inherent tensions between, on the one hand, ‘traditional’ accounts of professionalism, identity and practice, and on the other hand, those of HACC assessment in contemporary workplaces and systems of health and community care.
The implications of these tensions are pointed out and an argument for new perspectives on how this occupational group should be regarded is presented.

In Chapter Eight, a model of professional learning is offered which, it is argued, will help to address both the equity issues evident for community care assessment workers, and provide a rigorous approach to preparing and developing this group of workers to maintain quality practice in a growing and increasingly important field of work.

The final chapter (Chapter Nine) concludes the discussion and summarises the central findings. I return to the research questions and summarise the findings and discussion for each of them. Limitations of the research approach are also outlined. The major theme of the thesis is articulated: that new approaches to preparing and developing HACC assessment staff are required, and that such new approaches should be inextricably linked to new ontological and epistemological understandings of practice and worker identities.
2. Literature review

The literature review is divided into two parts. The first part addresses issues in community care and assessment relevant in scoping the current study. The second part reviews the adult education scholarship, which, essentially, provides the conceptual framework for the thesis.

2.1 Issues in community care and assessment

An exact definition of community care is difficult to find because definitions tend to be historically located (Beresford & Trevillion, 1995; Marr, 1998). A broad general consensus is that it relates to provision of care in settings other than residential institutions (such as hospitals and nursing homes) and relies on a system of both formal and informal care (Beresford & Trevillion, 1995; Bland, 1994; Bulmer, 1987; Marr, 1998). Most usually provided by women, community care, both formal and informal, can involve physical tending, material and physiological support, as well as general concern for the welfare of others (Bulmer, 1987). Community care in developed nations now tends to be enshrined in legislation which makes explicit the desired shift away from expensive residential care towards a greater range of service options to enable people to remain living in their own homes as long as possible.

The delivery of community care services for the aged and disabled has been a growing trend in Australia and overseas for many years (Gibson, 1998; Ozanne, 2001). In many ways this trend parallels the gradual shift away from universalist (state) welfare provision towards the marketisation of welfare and community services (Baldock & Evers, 1992; Dominelli, 2004, pp.149-152; Payne, 1995; Seed & Kaye, 1994), a trend which also fits with the ideology of economic rationalism and ‘new managerialism’ (Chevannes, 2002; Ife, 1997). Responsibility for care for frail older people and people with disabilities now rests with a diversified range of community providers. Choice and flexibility of service delivery are said to be fundamental to community care, as is the provision of collaboration (Beresford & Trevillion, 1995; Marr, 1998; Payne, 1995).

The HACC program provides funding for the vast majority of community care services in Australia. The introduction of the HACC program in 1985 signalled both the decentralisation of service provision to a broad range of local service providers, and
recognition of community demands for greater choice and flexibility about care options. It also fitted with the increasingly dominant ideologies of the time that valued individual independence, consumerism and the primary role of (women) family/informal care (Beilharz et al., 1992; Dominelli, 2004). The Program rhetoric is that HACC services support people who live at home and whose capacity for independent living is at risk or who are at risk of premature or inappropriate admission to long term residential care (Australian Government Department of Health and Ageing, 2002). HACC is now a vast program providing funds to well over 3,000 organisations, with over 750,000 individuals receiving some form of community care service provided by the HACC program each year (www.health.gov.au/internet/wcms/publishing.nfs/content/hacc-index.htm, Australian Government Department of Health and Aged Care website, accessed 15 September 2005).

The critical role that HACC services play in the health maintenance of an ageing population is well recognised (Vecchio & Jackson, 2002), so it can be expected that the importance and size of the HACC program will increase along with our rapidly ageing population. Policies of deinstitutionalisation and improved technology also mean that people with disabilities (including children) are more likely to be cared for at home. So, as the provision of community care continues to increase in size and significance, it is therefore of strategic importance that the workforce is well equipped to deal with the increasing number, and levels of need, of older people (Wheeler, 2002) and younger people with disabilities requiring care in the community.

2.1.1 Community care service system

Whilst collaboration is a theme for community care, in Australia, community care is delivered in an increasingly complex funding and program environment. In fact, fragmentation and poor coordination have been said to characterise the system of aged and community care (Fine, 1999; McDonald & Zetlin, 2004). Good collaboration is hampered due to structural or funding issues which contribute to a lack of cohesion and integration in the service system (Fabri & Southwell, 2003). Although HACC is the main funding program of community care, other programs have developed that have similar aims and target groups (including “respite for carers”, ACAT, and a variety of brokerage programs). Within HACC, there is a diversity of service types and organisations involved in delivering services, many of whom will share the same clients
in local areas. And within the broader service system, collaboration (and coordination) is required between community care agencies and hospitals, GPs, rehabilitation facilities and residential care, and the network of disability-funded organisations. The service system dynamics provide important context for understanding the personnel who are the focus of the present study.

The need for collaboration and cooperative working relationships is underpinned by the (negative) experiences of clients trying to negotiate a complex and confusing system. The onus is now more clearly on the service system to improve this situation, and efforts have often focused on the introduction of systems for sharing client information, either through shared documentation or meetings to discuss clients in common, or both (see Table 1 in section 1.3.1). Collaboration at this level requires organisations to negotiate categories and meanings of data, develop practical systems and protocols, and consider the various ethical and ‘professional boundary’ issues that inevitably arise (Allison & Ewens, 1998). Organisations can have significant influence on formalising collaborative relationships, and varying degrees of commitment to doing so.

However, collaboration is also dependent to a certain extent on trust (McDonald & Zetlin, 2004). Trust between organisations has been said to primarily depend on the interactions between individuals (Walker & Adam, 2000, p.7). This, in turn, is influenced both by the “psychology of individuals” employed within the different agencies, and the degree of competitiveness of the system of funding in which the organisation is operating (Walker & Adam, 2000, p.3). Having “confidence in what others are doing and the recommendations they make” (in relation to assessment decisions) may be required to establish trust in the practice of other organisations (National Ageing Research Institute, 2001b, p.61). According to Helling, many service system reforms to encourage greater collaboration and service system improvement require individuals and organisations to engage in a learning process, and which in turn is reliant on “respect, trust and openness (to) enable learning to take place” (Helling, 2002, p.98).

Networking (social liaison between personnel from the different services) has become critical in the current environment of community care (Beresford & Trevillion, 1995; Fine, 1999). Networking can be informal, or more formalised through the use of structured opportunities for liaison. Fine (1999) notes that regular meetings, such as
HACC forums and area-based interagency meetings (often convened for general business such as service planning) are part of this process. He also notes that there are increasingly numerous “network-based” meetings such as care coordination forums (Fine, 1999, p.78). A small study conducted in 2001 reported that “networking had ‘gone out of fashion’ for while, with some organisations only now recognising the need to establish more formal networks to facilitate the contact required between workers in different organisations” (National Ageing Research Institute, 2001b, p.40). This was possibly as a result of a culture of competitiveness in the service environment (Lehmann, 2005; Place, 2005), as well as competing priorities faced by individual staff. Particular skills and personal attributes, such as networking and interpersonal communication, are crucial for effective working in community care. The existence or otherwise of networks, and the nature of these networks, in turn, impacts on the degree of peer support and social interaction to which individual workers have access.

2.1.2 Assessment of client needs

Assessment represents the client’s access (or otherwise) to a system of care. Put simply, assessment is a process of developing an understanding of client capabilities and needs for assistance and planning to meet those needs (Hughes, 1995; Seed & Kaye, 1994). Or in other words, assessment involves “gathering, synthesizing and evaluating pertinent information to design an appropriate intervention strategy” (Ivry, 1992, p.3). Kane (cited in Butler et al., 1998), defines assessment as a decision-making tool which aims to collect, weigh and interpret information about the client, and which is part of a process of delivering care to a client. Assessment in community care is said to occur along a spectrum of ‘domains’ or areas of need that are the focus of the assessment process, ranging from clinical/medical areas to social areas (Butler et al., 1998). A range of disciplines have very strong traditions in client (or patient) assessment: medicine, nursing, social and welfare work, and allied health professions such as occupational therapy and physiotherapy all claim assessment as central to their practice expertise.

The HACC program guidelines define assessment as a systematic way of establishing the type and extent of consumer support needs and following on from this, the identification of a range of appropriate home and community care services to meet those needs (Australian Government Department of Health and Ageing, 2002). Assessment is
also said to promote more efficient and effective targeting of resources, more equitable access to HACC services on the basis of relative need as well as identifying areas where needs are not being met. The assessment process encompasses a range of functions including screening for eligibility, determining needs and priorities, targeting, referral and coordination, monitoring and review, and data collection (Australian Government Department of Health and Ageing, 2002).

The importance of assessment lies in the fact that this is clients’ first point of contact with the service system and that it is multifunctional. Assessment determines not only whether a person is eligible and will receive services, but also the type and quantity of services that the clients will receive. The outcome of a needs assessment depends essentially upon the quality of that assessment (Hughes, 1995; Worth, 1998). As Hughes (1995, p.69) says: “poor, limited, superficial assessments results in partial, inadequate or unsuitable responses to users and carers”. Assessment staff are critical in shaping the quality of assessments.

2.1.2.1 Models of assessment in community care

The models for assessment and service delivery for aged and disability services provided in the community is an important contextual consideration for this study. Owing to the importance of assessment in the system of community care it is an area that has often been targeted for reform by governments, both here and overseas. A number of models have been proposed for client assessment in community care ranging from multiple entry points (where assessments are undertaken by a range of staff in a range of organisations) through to single entry points (where organisations are established with the sole function of undertaking assessments for the full range of community care service providers). The type of model used for assessment for clients has important implications for the staff employed in these roles, and the approaches they can adopt in their work. Some early models of needs-based assessment in community care in this country used highly flexible, multidisciplinary teams (Errey et al., 1986) or trialled using ACATs to assess all community care clients (Caban, 1993; Robertson, 2001). However, the rapid proliferation of home and community care services, and the ever increasing demand on them, meant that these models were too costly to implement.
One of the most significant trends in community care assessment models is the adoption of a “needs led”, as opposed to a “service led” approach to assessment and care planning. A considerable amount of material is available that details the reasons for this trend, the various approaches to enacting this philosophy, and which articulates and critiques the issues arising in implementation (mostly from the UK) (Bland, 1994; Butler et al., 1998; Challis, 1999; Lewis et al., 1995; Parry-Jones & Soulsby, 2001; Seed & Kaye, 1994; Stanley, 1999; Worth, 1998). In brief, the trend has developed in response to the perceived poor quality of assessment decisions that related primarily to the availability of particular services, rather than on the assessed needs of individuals. In service led assessments client’s ‘authentic’ needs were unlikely to be identified and met. It was therefore assumed that if assessment of need was separated from service delivery then assessors were much more likely to be objective in their judgements about need and recommendation for services. The approach was also said to enable more accurate data collection about need for community care to assist planning and service development. It also fitted with the economic rationalist agenda which favoured a marketised approach to service delivery. In the UK, this philosophy has been enacted in legislation and there is now a sophisticated service system based on the separation of assessment and service delivery and which also requires an integrated approach to assessment of ‘health and social care’ needs. In Australia, ACATs perform a similar function but are only accessed by people with high or complex needs. The vast majority of assessments for community care still occur in the HACC system where ‘needs led’ assessments are regarded as an ideal.

The most common model for assessment in HACC currently is for staff to be employed within individual service provider agencies to be responsible for assessing clients, although HACC policy has encouraged broader identification of needs, beyond the focus of the service/s provided by the individual agency, in line with the philosophy of ‘needs led’ assessment (Leigh Naunton and Associates, 1997; Lincoln Gerontology Centre, 1998). Every agency receiving HACC funding is expected to provide assessment and care planning as part of their service. Prior to receiving services, a person will normally be assessed by one or more organisations that may be involved in the person’s care. Staff employed in HACC organisations, in roles that include assessment of clients’ needs, determine what services clients will receive and how the services will be delivered. At this stage, most services that have clients referred to them will undertake their own needs assessment although they may vary in breadth (range of
domains included in the assessment) and depth (level of specialist assessment within particular domains). Some domains may not require reassessment if a referral from another agency is accompanied by data on a common data form and there are service system protocols in place to allow for this sharing and transfer of client data.

2.1.2.2 Compulsory Competitive Tendering

In Victoria, unlike other Australian States, local governments play a prominent role in HACC providing both the largest range and size of HACC services, and also contributing (rate-payer) funds to their own HACC services. One important occurrence that needs to be mentioned here is the implementation of Compulsory Competitive Tendering (CCT) for Local Government Authorities (as well as other providers). This was a State Government of Victoria policy introduced in the 1990s to achieve greater cost efficiency and quality service provision based on the assumption that this could be achieved through competition in the ‘market’ (Ernst & Glanville, 1995). The CCT policy has relevance for HACC assessment because some local governments chose to put their HACC services out to tender during this period. Many saw this as an opportunity to enact the philosophy of ‘needs led’ rather than ‘service led’ assessment for community care, by separating their HACC assessment function from their service delivery function (purchaser/provider split). The local government could tender for their own service/s, but faced competition from other providers. The result was that some local governments won both tenders (for assessment and service delivery), and others lost one or both tenders (Haralambous, 2003; National Ageing Research Institute, 2001a). This becomes important context for some of the findings reported in Part II (chapter 4).

2.1.3 Targeting and prioritisation

Assessment is most commonly concerned with access to services, with targeting identifying the population that is to receive a particular mix and amount of services (Lincoln Gerontology Centre, 1998). Prioritisation is concerned with determining relative need within the target population. As a result of the general increase in demand for aged and disability services there is a growing importance placed on client assessment and targeting due to current concerns for cost containment and equity both here and overseas (English & Mykyta, 2002; Gibson, 1998; Stewart et al., 1999).
Although HACC began as a universally available service, targeting and prioritisation are now major preoccupations of HACC policy and service delivery (Ozanne, 2001) first emerging as an issue for the program in the late 1980s (Howe, 1997). In a system now so weighted towards targeting (and rationing), power more clearly rests with the assessment workers rather than with the client (Chevannes, 2002; Gibson, 1999) and the skill of the worker in enabling client participation therefore becomes more critical (Richards, 2000).

Butler et al. (1998) report that needs identification and resource allocation are pervasive themes throughout the literature on community care assessment. These themes are closely connected to one another, particularly as needs identification loses much of its meaning if there is insufficient resource allocation (Branch, 2000; Butler et al., 1998). Following trends in the UK where there has been a shift of focus from assessment of need to rationing (Marr, 1998; Parry-Jones & Soulsby, 2001), assessment in community care in Australia is now often concerned with determining priority of access. The impact of rationing on the assessment process may constrain assessors to the point where, for example, they acknowledge that a client may need daily personal care but the service may only be able to respond twice a week (Branch, 2000). Monitoring the affects of such unmet need on individual clients thus becomes important for assessors (Branch, 2000; Hughes, 1995). In the absence of prescriptive guidelines for prioritisation, assessors face the dilemma of judging whether lower level resources are best directed to the many, or higher level resources are best concentrated to the smaller number of people with the highest needs. Essentially, this is a debate about how thinly resources should be spread amongst the target population and what proportion of those resources should be directed to people with high or complex needs.

Attention has been focused on understanding the impetus for this trend and in developing more consistent approaches to targeting and prioritisation (Black & Buckley, 2003; National Ageing Research Institute, 2001a; National Ageing Research Institute & Bundoora Extended Care, 1999). Some effort has also focused on understanding the impacts on clients (Lindeman, 1997; Turvey & Fine, 1996). However the impacts of targeting and prioritisation on the assessment staff, although reported as profound (White & Harris, 2001), in my view, remain little understood. Gibson notes, “the more stringently services are targeted, the more emotionally difficult become the decisions about boundary cases, and the more dire the consequences for
those who fall outside the boundary” (Gibson, 1999, p.5). As the expectations of the function of assessment are shifting as the demands on the system continue to increase and the nature of the service system changes, it is not unreasonable to assume that the demands and expectations on assessment staff will also be changing with flow-on effects for their practice, identity, values and learning.

2.1.4 Documentation and tools in assessment

Assessment documents can be represented along a continuum of ‘highly formal’ to ‘highly informal’, represented in diagram 1 (below). At the highly formal end of the continuum are the standardised tools that are norm referenced and which have been subjected to extensive field testing and statistical analysis. These tools are said to rate highly in terms of reliability (they will elicit the same results despite who is administering the tool) and validity (they measure what they are supposed to measure). Examples of standardised tools include those that test for dementia, such as the Mini Mental State Examination, or for functional capacity for activities of daily living, such as that included in the InterRAI suite of assessment tools (Lincoln Centre for Ageing and Community Care Research, 2004) (www.interrai-au.org/suite.htm). Standardised assessment tools are commonly used in health (The Royal College of Physicians of London & The British Geriatrics Society, 1992) and allied health professions such as occupational therapy (Cramer & Bartholomew, 2000; Eakin & Baird, 1995; Vertesi et al., 2000) and less frequently in social work (Ivry, 1992). It is assumed that professionals are competent to administer standardised tools due to their professional training. However, it is also fair to say that in general, medical/health professions tend to favour standardised assessment as a mark of their professionalism, and social welfare professionals tend to favour non-standardised assessment (judgement approaches) as a mark of their professionalism. The use of standardised assessment tools is relatively uncommon in HACC (Howe & Warren, 2005) but very common in ACATs (Lincoln Centre for Ageing and Community Care Research, 2004).

Further along the continuum, are highly codified documents which assist workers to formulate judgements but which are not necessarily standardised. In community care, some falls risk assessment tools (Hill et al., 2001) often fall in this category, and the tool to assist workers judge need for personal alarms (see glossary) (Mayhew-Rankcom et al., 2001) also fits here. Further along still are more simple tools designed to assist
assessors to judge whether an issue requires monitoring, a special service response, or referral to a specialist assessor. The HACC nutrition risk assessment tool (Wood, 1998) is an example of this which is designed for application by any HACC assessor.

At the end of the continuum are assessments which are highly informal. These may simply be lists of domains (or headings, such as “mobility”) with free text space allowing for the assessor to record any information they feel is pertinent.

**Diagram 1: Continuum of levels of formality of assessment tools**

<table>
<thead>
<tr>
<th>Highly Formal</th>
<th>Highly Informal</th>
</tr>
</thead>
<tbody>
<tr>
<td>(codified)</td>
<td>(less-codified)</td>
</tr>
<tr>
<td>Standardised</td>
<td>Non-standardised</td>
</tr>
</tbody>
</table>

The arguments for use of formal instruments include that they reduce the risk of inconsistency between assessors and enhance the program’s ability to collect reliable data. On the other hand, there are arguments that propose that assessment tools are only as good as their users (Kane & Kane, 2000). In fact, some claim that the assessor’s attitude to their use is more likely to influence the assessment than the instrument itself (Seed & Kaye, 1994). Woods and Baldwin note that while needs assessment processes that include predetermined lists are helpful to ensure that an adequate range of activities is considered for assessment, it cannot substitute for more open-ended techniques. They also note that while all clients share universal needs most clients will have additional specific needs, often relating to religious, ethnic and other cultural factors as well as to specific aspects of their disabilities (Woods & Baldwin, 1998). The implication is that formal (standardised tools) are less likely to capture client diversity than less formalised documentation. Highly formalised documents (including standardised tools) are more likely to be ‘score based’ than less formal documents. Score based approaches give a numeric score to clients based on data collected from them which assists assessors to make comparative judgements and to assess relative need objectively (Seed & Kaye, 1994).

An assessment may include application of a number of ‘tools’ depending on the nature of the referral. There will also usually be a document (or it will be all inclusive) that records other client data important for the provision of services. Informal tools are more often associated with application by non-professional staff, although these are the
tools that rely most heavily on the judgement of the assessor. A lack of integration of ‘health’ and ‘social’ domain groups in community care assessment tools has been reported (Stewart et al., 1999), possibly reflecting the assumption that no one assessment worker can cover both (all) areas sufficiently.

Reforms to community care systems have often focused on the use of assessment documents ostensibly to minimise duplicate assessment of clients shared by more than one agency (so that some questions only need to be asked once), and to improve systems of client data collection (Brian Elton and Associates & Department of Human Services and Health, 1995; Caban, 1993; Helling, 2002). The Client Information and Referral Record (CIARR) (a common information and services record completed at the time of assessment) has been replaced (in Victoria) by Service Coordination Tool Templates (SCTT), and all HACC providers have been required to use these documents since 2002. The SCTT has the same aims as the CIARR: to help improve service coordination and client referral, and reduce multiple assessments of the same person by different agencies but are much more detailed in both scope and depth of assessment domains. This essentially signifies a move towards more formalised documentation which can be common to a range of service providers. This is set to continue to be reinforced as a requirement for HACC services (Howe & Warren, 2005).

Evidence from the United Kingdom suggests that differences in professional backgrounds of staff involved in client assessment presented difficulties when a common assessment form was introduced (Lewis et al., 1995; Vernon et al., 2000). Essentially this was because the information required by the different professions was different, and because it was unclear whether one profession should accept another’s assessment. Similar issues were experienced in Australia in relation to implementation of the CIARR for the HACC program (Brian Elton and Associates & Department of Human Services and Health, 1995). The difficulty of designing a tool to suit the diversity of the aged and community care workforce, despite the range of services having common clients and common objectives, is marked. The influence of the professional background of the assessor in community care is well recognised (Butler et al., 1998; Kane & Kane, 2000). A person with greater expertise in a particular domain is likely to explore that domain in greater detail than someone whose expertise lies elsewhere. Worth refers to research studies that conclude that assessment is seen to be rooted in the professional identity of the assessor, therefore limited in scope with the
assessment style and language profession-specific. The differences between the value frameworks of nursing and social work professions and the resulting differences in practice are cited (Worth, 1998).

In contrast, Hughes refers to research that reported not only differences in the scope and content of assessments performed by different professional categories (social workers, occupational therapists, and home care co-ordinators), but there is often wide variation between people within the same professional category (Hughes, 1995). Similarly, Dill (1993) points out that precisely because of the uniqueness of each assessor (in relation to personal characteristics and approach) as well as each individual who is assessed, needs assessment will vary from case to case regardless of the degree of standardisation of the assessment instruments used (Dill, 1993). Whilst the sector tends to be preoccupied with the influence of individual professions in community care assessment, this suggests that professional background of the assessor only tells part of the story and that a range of other factors may come into play to influence individuals’ approaches to assessment.

A consideration of assessment documentation in needs assessment raises some of the critical tensions that are pervasive in community care. According to Dill,

“the technical superiority of the bureaucratic form derived largely from its ability to rationalise decision-making, replacing personalistic, affective criteria with universalistic, objective means and measures” (Dill, 1993, p.456).

As such, assessment documents that are designed to enable predictability, fairness of decision-making and efficiency fit firmly within a positivist frame. Practitioners are required to uncover essentialised patterns and determine whether they contribute to or hinder functioning (Iversen et al., 2005). Professionals often tend to make extensive use of formal documentation to both assist in their judgements and to justify their decisions.

Yet, while professional (discipline-based) practitioners are encouraged to use formal assessment tools, they are also encouraged to evaluate them from the perspective of the tools’ ability to take into account “each person's unique needs and abilities, as well as the environmental and social factors that may be affecting the clients' performance” (Pollock, 1993). This seems to be at the heart of a tension between the need for service providers to manage the volume of clients presenting for services and to be responsive
to the diversity of clients and contexts. The place of client’s stories, the narrative that should provide the context for assessment judgements, can become secondary through over prescriptive use of some assessment tools (Dill, 1993; Tanner, 2001), and training is their use is recommended to overcome this (Kane & Kane, 2000).

2.1.5 What is known about assessment staff and how they are prepared?

The HACC Program Manual states that it is the service provider’s responsibility to ensure that assessment staff have the “necessary skills, experience and training to deliver a high standard of assessment practice” (Department of Human Services, 2003, p.80). The Manual recommends that staff involved in comprehensive assessment should have some form of professional qualification and specialist knowledge of the HACC consumer group, and apart from specifying that Division 1 Nurses should be involved in assessing clients with unstable health, no further detail is provided about what might be regarded as appropriate qualifications, skills or experience (Department of Human Services, 1998a; Department of Human Services, 2003).

However, throughout the available research documents, little is reported on the profile of the assessment workforce in HACC. One major consultancy on assessment in HACC conducted in 1997/98 found that the skills or educational backgrounds of workers involved in community care or aged care assessment are not covered in policy statements, and found no appropriate training program for HACC assessors (Lincoln Gerontology Centre, 1998). Another research report, focused on local government HACC providers in Victoria, and completed in 2000, reported that assessment officers were a diverse group with a wide range of experience and backgrounds including social work, nursing, health, management, arts, science, and economics. The high turnover of the workforce was also reported as a feature of assessment staff in local government (Howe, 2000, p.100).

More recently, a comprehensive review of assessment practice in HACC (Prideaux et al., 2004) found that 96% of assessment officers in local government had some form of formal post-secondary qualifications, with nursing, welfare or social studies, social work and disability studies accounting for 76%. In non-local government services, all assessment officers had some type of formal post-secondary qualifications, including nursing (64%), allied health (15%) and social work (9%). Others had qualifications in
welfare or social studies, disability studies, and social sciences. Little over a decade
go in the UK, untrained or unqualified assessors were not uncommon in services such
as home care, respite or meals provision (Bland, 1994; Twigg & Atkin, 1994, p.57).
From my own experience in training this group of workers, I know that they can have
backgrounds ranging from no formal qualifications and limited experience in
community care assessment, through to relevant formal qualifications and extensive
experience in community care assessment and case management (Lindeman &
Nankervis, 2000). Given the prominence of assessment in quality community care
service provision, greater knowledge of the assessment workforce is imperative.

The literature reviewed so far suggests that the community care assessment workforce
in Australia is diverse. For governments, diversity in the educational backgrounds (and
therefore the assumed skill levels) of assessment staff, give rise to a range of potential
policy development and implementation difficulties. For example, when any new
program or service initiative for client care is introduced in the area of community care,
a question that must be addressed is ‘who should be responsible for assessing a client’s
eligibility or suitability to receive the program or service?’ An initiative in Victoria
extended the eligibility and accessibility of personal alarm systems along with the
access points to the service. A key preoccupation of the State government in
developing this new initiative was to decide who in the service system, should hold
responsibility for both assessing for the need for a personal alarm, and deciding relative
priority of need for the service (Department of Human Services, 1998b). These
considerations often stem from a lack of clarity about who comprises the assessment
workforce in this sector and the resultant lack of understanding of the skills and
knowledge of the individuals involved in community care assessment.

2.1.6 Training needs for community care assessment

Identifying assessment skills and preparing staff for the role of assessment have long
been a neglected aspect of community care (Seed & Kaye, 1994), although it has been
recognised recently that, in general terms, the shift away from institutional towards
community care has had implications for the type of workers required in these areas
(Australian Government Productivity Commission, 2005). The need to plan for the
projected needs for trained assessment staff in HACC was publicly recognised as early
as 1990 (Curry, 1990). Within the large body of material that has developed during the
intervening time describing the community care sector and the various approaches to assessment in Australia, some reference is made to the training needs of assessment workers, and some discussion of assessor competencies. However these documents do not comprehensively address the workforce implications for this group of workers in the context of the various approaches to assessment and proposed reforms. In one of these reports (Department of Human Services, 1997) the general lack of clarity about the appropriate qualifications, experience and competency required was noted. In another (Lincoln Gerontology Centre, 1998), the consultants reported that the literature has very little to say on qualifications and specific training needs in aged care assessment. The report also found that there was wide support in the field for specific training over and above the professional training already possessed by assessors. More recently, a report into HACC service provision by local government in Victoria (Auditor General Victoria, 2004, s.4.3.2) found that there were no qualification or competency standards (units of competence) specifically for HACC assessment staff, and recommended that “(g)iven their diversity of occupational backgrounds and specific training needs, competency standards need to be developed”. Others recommend the development of a professional development program, rather than a competency approach, for training HACC assessment staff (Howe & Warren, 2005).

The higher education sector has traditionally provided training for professional workers in the health and community services sector, and the vocational education and training (VET) sector has provided accredited training for ‘lower level’ category workers. Across the health and community services industry generally, neither the VET sector, nor the higher education sector, is producing sufficient graduates for industry needs (Duckett, 2005; National Centre for Vocational Education Research, 1998). The shortage of Registered Nurses throughout in the aged care sector is particularly well recognised (Stein et al., 2000). Other professional categories too such as the allied health professions are constantly in shortage throughout the sector, with rural areas suffering the most (Australian Government Productivity Commission, 2005). These shortages have been recognised in the HACC program for many years (Curry, 1990). However, it should be noted that in the recently released report which extensively examines the workforce requirements of the health sector (Australian Government Productivity Commission, 2005), HACC assessment workers are not specifically mentioned.
Staff shortages experienced in the health and community service sector broadly is felt in specific assessment positions in the HACC program, and there have been reports of difficulties in recruiting high caliber staff to assessment positions (Department of Human Services, 1997, p.54). The growth in the aged and community care sector has seen a number of formal courses developed in the higher education sector to meet the diversifying needs of the industry such as graduate diploma courses offered in gerontology, dementia care, or aged services management. In the UK, a post graduate course for multidisciplinary professionals working in community care for mental health clients proved successful in developing practitioners’ skills in assessment, care management, networking, engagement with clients and carers, and counselling (Shears et al., 1998). However, to my knowledge a specific course on assessment in community care (for aged and disability services) has, so far, not been developed in Australia.

Likewise, in the VET sector a qualification that fits the role of assessment has not yet been developed. Within the Community Services Training Package (Community Services and Health Training Australia, 2002), the qualifications available within the aged and disability care stream range from Certificate II through to Advanced Diploma levels. The introduction of these CBT qualifications was intended to ensure that there is a range of nationally accredited competencies to meet the needs of the aged care industry, but the courses are mostly targeted at direct care staff and coordination staff who have a wide range of duties. From my own experience as a trainer/researcher in HACC assessment, I know that there is demand for accredited modules or a whole course related to assessment, whether this is in the VET or higher education sector. A recently published report suggests that the solution to improving the education and training of HACC assessment workers lies in the higher education sector (Howe & Warren, 2005).

2.1.6.1 In-service training needs

Throughout the assessment/community care literature there are brief references to training needs of assessment workers usually following a discussion of an element of practice or policy direction. New skills and knowledge for all community care assessment staff are particularly implied with changes to service delivery context and clientele. For example, in relation to the shift to a needs-based philosophy of assessment and care provision training was said to be needed for staff (Bland, 1994) in
areas such as “needs assessment, unmet need identification and recording, risk identification and recording, … multidisciplinary practice” and time and stress management (Parry-Jones & Soulsby, 2001, p.423). There is also recognition that the related policy trend towards a more ‘client focused’ approach to assessment and service delivery needs to be directly addressed through professional education and in ongoing supervision (Richards, 2000). There have also been calls for the development of short courses in assessment, to address issues concerned with the variation in standards of assessment practice and inconsistency in the approach between assessors and between organisations (Howe, 2000).

Developing professional competence in case management is another example of an identified training need, to equip staff to deal with a more complex service environment and higher level needs of clients (Haw, 1995). In Canada, a (non-accredited) program for multidisciplinary professionals working in gerontological case management was developed in modular, workshop format to meet the new skill and knowledge requirements of staff. The program covered areas such as theory of case management, specialised knowledge about older adults, understanding the service environment, and techniques of case management such as assessing client’s health and social needs (Joshi & Pedlar, 1992). Specific knowledge of particular target groups (such as older people) is also a widely acknowledged need for quality assessments (Ivry, 1992).

Multidisciplinary (and multi-agency) models of training are often offered as appropriate responses to meeting many of the training needs of assessment and care planning staff (Parry-Jones & Soulsby, 2001; Waddington & Marsh, 1999) and are seen as a means to promote collaboration, one of the cornerstones of effective community care. However, multidisciplinary working in community care itself creates training needs (Kneafsey et al., 2004; Norris et al., 2005). For example, in a study designed to define core skills of professionals in joint working in clinical networks, a strong need for training was found in “interpersonal skills to help staff to work in challenging and dynamic situations: managing change; conflict resolution; negotiation; influencing people” (Norris et al., 2005). Skills in advocacy and facilitating client/family (and broader community) participation in decision-making may also need further development for practitioners working in a (new) community care environment, as, according to Baum, most health professionals have not been trained in participation methods (Baum, 1998).
In Victoria, in-service courses on client assessment are much in demand (National Ageing Research Institute, 2001c). A number of private consultants offer this training, often in the form of one or two day workshops. These training programs are not accredited, and are not developed according to any prescribed curriculum, instead responding to the local training needs of the workforce (Howe & Warren, 2005; Lindeman & Nankervis, 2000).

2.1.6.2 Generic skills and knowledge?

It becomes apparent throughout the literature, where training needs of assessment staff are identified, that many of those identified needs are generic to the community care assessment workforce and do not depend on the professional discipline or specific role of the workers. In relation to gerontological case management, Joshi and Pedlar (1992) recognised that case managers require unique skills and abilities beyond the scope of any single professional discipline. Further, “the breadth and scope of multidimensional client assessment cross several professional boundaries” (Joshi & Pedlar, 1992, p.570). In the HACC comprehensive assessment framework (Lincoln Gerontology Centre, 1998), four key competencies were identified for assessors:

1. “Demonstrates a current understanding of the HACC context and service provider network” (including drawing on supporting knowledge and information such as policy and guidelines, health and welfare systems, specific disability groups, legal issues, client rights, and networks).

2. “Uses a systematic approach to collecting and analysing data” (including negotiating the scope of the assessment, working with the client/carer to assess needs holistically, identifying relevant contributors to the assessment.)

3. “Uses interpretive skills to make decisions” (including referral judgements, integrating data from a variety of sources, prioritises and anticipates problems)

4. “Initiates and coordinates plan of care” (including providing information and options to clients/carers, involving client/carers in decisions and processes, negotiates and advocates, establishes good working relationships with other providers) (Lincoln Gerontology Centre, 1998, pp.62-63).

Similarly, considerable material is available that points to a range of generic skills and knowledge that could ‘belong’ to any profession. For example, Ross and Mackenzie (cited in Vernon, 2000), note that in order to achieve a useful, meaningful assessment of
older people, those performing assessments need good communication skills, knowledge and expertise in caring for older people, and to have a positive view of ageing. Similarly, in a study of initial needs assessment practice in primary care agencies (including HACC) in a region of Victoria, the skills required for all assessment workers most frequently cited were communication, decision-making, public relations (including liaison and networking) and the ability to understand client options (National Ageing Research Institute, 2001b). The importance of intuitive assessment and reflective practice is also highlighted (National Ageing Research Institute, 2001b; Vernon et al., 2000).

Assessment workers also require the skills necessary to assess family dynamics and understand the history of relationships (Holten et al., 1992), and skills and sensitivities are also required for assessment of clients with communication or cognitive difficulties (Hallberg, 1998). Other factors that can contribute to the quality of an assessment, and therefore require particular skills and knowledge, include the various cultural factors that need to be considered in approaching particular client groups (Paniagua, 1998), and the degree of client involvement encouraged by the assessor (Kane & Kane, 2000; Payne, 1995). Skilled assessors ensure that the focus of the assessment interview/s remains with the client and that their views are not overshadowed by any particular view that the referrer wanted to convey (Marshall & Dixon, 1996) or indeed what the assessor themselves regards as important. Kane and Kane (2000) note that too often training neglects basic interviewing and assessment skills and concentrates on the ‘paper flow’ involved in the use of assessment documentation and instruments. Other generic skills include observation, negotiation, analytic and writing (Hughes, 1995; Seed & Kaye, 1994).

In relation to developing good written skills in assessment, learning can occur through reflecting on work collectively and engaging in exercises which make practitioners think about what has been written (Morrison, 2001). Undoubtedly the same could be said for many, if not all, of these generic skills. For example, it has been found that much of the knowledge required in social work practice with older people can be acquired through “talking with others”, including other professionals and older people themselves (Marshall & Dixon, 1996, p.77). The knowledge required included relevant legislation, welfare benefits, available services, and the physical and mental difficulties
experienced by older people, all of which is knowledge required by anyone working in community care assessment.

‘Higher order’ generic skills and knowledge are also apparent in some of the references to training needs in the literature. Although recognised as critical for effective work in community care, they are often regarded as ‘soft skills’. They can include:

“(t)he ability to work with others, negotiate with a range of people who have differing interests, and to be able to frame problems in a way that has meaning for users and carers ... The harnessing of emotions productively and the effective handling of relationships relate to emotional and social competence and the ability to learn” (Gorman, 2000, p.155).

One study of community care nursing staff (Bergen et al., 1996) found there were significant training needs in relation to the exercise of professional judgement. For example, they needed a deeply ethical and practical wisdom (phronesis), the ability to incorporate theoretical perspectives into everyday thinking (praxis) and integrate finely judged decisions into practice: “developing the high level skills required for the full spectrum of needs assessment should be centred around developing the overall capacity of the practitioner to exercise professional judgement in dealing with … the intricate situations” that are the feature of work in community care (Bergen et al., 1996, p.4).

These intricate situations included practical and ethical dilemmas involving different priorities and perceptions within families, between formal agencies and their clients, and in dealing with interdisciplinary working and resource allocation issues. Again, these practices are generic to the community care assessment workforce. For example, similar themes arose in research on social workers in the field of community care (Egan & Kadushin, 1999).

Whilst the diversity of the assessment workforce is potentially a strength that should be preserved, attention also needs to be paid to how these generic skills and knowledge are regarded (acquired and developed) for diverse practitioners.

2.2 Perspectives on adult education and training and professional development

The literature reviewed to this point has focused on community care and assessment. The case is built for greater analysis of the workers by drawing attention to references in
the literature to the skills and knowledge required of assessors and approaches to training these workers.

In this section (section 2), the chapter now turns to reviewing adult education scholarship that will inform such an analysis. I focus on the theoretical perspectives that I feel will help to advance our understanding of home and community care assessment workers. While there are many overlaps and shared assumptions between them, I have loosely grouped these into three areas: those that focus on professional disciplines (including multidisciplinary/interprofessional perspectives), those that focus on communities of practice, and those that focus on the workplace. All have developed from newer understandings of ‘traditional’ education philosophies, in the light of an inability to adequately explain practice and its relationships to epistemology. Taken together these will contribute to understanding the HACC assessment workforce; their practice, learning and identity, and future possibilities for their development and support are all underpinned by such perspectives.

The education systems of Western societies have been dominated by a philosophy of education based on notions of mind-body separation (following Descartes) (Gonczi, 2004). Put simply, learners are ‘taught’ something which they remember through a cognitive process, and which they can draw upon to apply in practice as required. This is sometimes referred to as ‘front-loading’ or a ‘front-end’ model of education (Beckett & Hager, 2002; Foley, 1995; Hager, 2004). Whilst still underpinning much formal education programs, there have been many challenges to this perspective with the result that other educational perspectives have developed. In relation to the field of adult education, the theories of how people create, learn and apply new knowledge in practice, and indeed what constitutes knowledge, have been particularly influential. In short, epistemology has been refurbished.

One of the most significant theorists who challenged the traditional view of professional practice was Schön who proposed that much professional practice occurs in the “swampy lowlands”, the location of indeterminate and real human problems and issues (Schön, 1987, p.3). This, he contends, is overlooked by the hard, high ground, the location of theoretical professional knowledge and of technical rationality. This high/low view essentially reflects the theory/practice divide, in that much of the formal theoretical knowledge does not directly parallel the practice of professionals. Further,
the problem-solving processes used by professionals in practice do not derive wholly from their technical knowledge. When a practitioner “sets a problem”, they are choosing and naming things they will notice. What starts up as an epistemological view becomes an ontological process which is influenced by “disciplinary backgrounds, organisational roles, past histories, interests, and political/economic perspectives” (Schön, 1987, p.4).

Importantly, Schön (1983; 1987) distinguished between knowing-in-action and reflection-in-action. The former refers to observable performances in intelligent action, and which typically cannot be made verbally explicit. Much is tacit and spontaneous. The latter occurs on those occasions that do not go routinely according to expectation, and the professional is required to reshape the action to suit the new problem. This can occur after the fact or it can occur in the present. A professional’s knowing-in-action is embedded in the socially and institutionally structured context shared by a community of practitioners, and reflection-in-action serves to question its assumptional structure (Schön, 1987). Reflection-in-action leads to an alternative epistemology to the traditional technical rationality of professional knowledge, helping to explain the professional artistry required for practice in the zones of indeterminacy (the swampy lowlands) (Schön, 1987).

Technical rationality, part of the traditionally accepted epistemology of professions, rests on an objectivist view of reality (the truth of beliefs is tested by reference to the knowable facts belonging to the profession) (Schön, 1987, p.36). “Knowing that” tends to take priority over “knowing how” and knowledge is regarded as privileged information or expertise (Schön, 1987, p.309). In contrast, underlying the reflection-in-action view of practice, is a constructivist view of reality. This sees the practitioner as formulating perceptions, appreciations and beliefs in worlds of their own making that they come to accept as reality. In this view, a practitioner’s feel for materials, on-the-spot judgements, and improvisations – the forms of his or her reflection-in-action – are essential to professional competence (Schön, 1987, p.222).

Rather than knowledge being first acquired and then subsequently used, knowledge is constantly reinterpreted and developed when used (Eraut, 1994). Cleminson and Bradford point out that this departs from the view that professional knowledge or ‘theory’ is somehow inert or static information which is mechanically applied in various
situations. They also claim that for people to learn information to apply in a professional or workplace context, they must bring to the activity a body of knowledge that can then be challenged and reinterpreted through practice and observation of practice (Cleminson & Bradford, 1996). Eraut offers two parallel definitions of knowledge to explain this process: 1) codified knowledge (public or propositional) which is debated and has status, and which is explicit by definition; and 2) personal knowledge, which is the cognitive resource brought to a situation which enables individuals to think and perform. This can be explicit or tacit. Importantly, knowledge is shaped by the contexts in which it is acquired and used and always involving a location, a set of activities in which the knowledge is embedded or contributes, and a set of social relations from which the activity results (Eraut, 2000).

Because this contextual ‘shaping’, or construction, is central to a new epistemology, the theory of experiential learning scholarship is important to introduce at this point. With its roots in the work of Dewey, Lewin and Piaget, and popularised by Kolb, experiential learning refers to the process whereby knowledge, skills and attitudes are created through the transformation of experience (Andreson et al., 1995). Kolb claims that learning is both an experiential and reflective process which should be closely tied to the real world and the experiences of the learner. His four-stage model of the experiential learning cycle (concrete experience, reflective observation, abstract conceptualisation, and active experimentation) stresses the importance of reflection, as well as experience, in any learning situation or ‘context’ (Kolb, 1984/1993). Miller and Boud, (cited in Jarvis et al., 2003, p.56) define the underlying principles of experiential learning in the following:

- Experience is the foundation of, and stimulus for, learning;
- Learners actively construct their own experience;
- Learning is holistic;
- Learning is socially and culturally constructed;
- Learning is influenced by the socio-economic context within which it occurs.

Thus, experiential learning and constructivist theories of knowledge (and reflection) are closely connected. Under this conception, learning is ongoing and unavoidable as people think and act in the ‘lived’ world (Billett, 2001). Understandings are constructed over time, connecting new information with existing knowledge in ways which have
meaning for the individual (Jarvis et al., 2003, p.163; Moon, 1999). In this way, the learner’s role is central in the construction of knowledge, removing the main focus from the ‘teacher’ (delivery) and content (propositions).

A new epistemology of practice can be articulated. A practice is made up of “chunks of activity, divisible into more or less familiar types, each of which is seen as calling on the exercise of a certain kind of knowledge” (Schön, 1987, p.33). It involves not only a body of knowledge (that is, propositions which can be taught), but also a capacity to make judgements, a sensitivity to intuition, and an awareness of the purposes of the actions (Beckett & Hager, 2002). Reflection is therefore a key concept in understanding practice. Reflection features in experiential education and related perspectives as it provides the mechanism for individuals’ transformations of experience into new knowledge. Mezirow (cited in Garrick, 1998, p.177) distinguishes between reflection, which he defines as an examination of the justification for one’s beliefs to guide action and to reassess approaches to problem-solving, and critical reflection which focuses on the validity underpinning those belief structures. Critical reflection enables people to ‘re-frame’ problems they may be experiencing and to see different perspectives, possibly leading to different solutions and understandings. Moon offers a definition of reflection thus:

“Reflection seems to be seen as a basic mental process with either a purpose or an outcome or both, that is applied in situations where material is ill-structured or uncertain and where there is no obvious solution. Reflection seems to be related to thinking and learning” (Moon, 1999, p.10).

A capacity to reflect, especially critically, raises the ontological here, and questions about the kind of person, or self, that is capable. The role of autonomy and the various approaches that may contribute to promoting individual’s autonomy is also central to notions of experiential learning (Garrick, 1998, p.23). Although these notions of reflection and autonomy in experiential education are not uncontested or unproblematic (Fenwick, 2001; Garrick, 1998), they are pervasive throughout the literature on much contemporary adult education. The ‘self’ is very much ‘under (self) construction’. Such perspectives do not accept the assumption that the individual learner is a static autonomous subject whose reflections are not influenced by their positioning and embodied self. Rather, they are situated in, and affected by, complex social structures and relations: “there is always a form of politics accompanying experience” (Garrick,
This presents a major challenge to constructivist theories of knowledge as individuals’ identities represent the sum of their experiences and are constantly changing. Moreover:

“The identities of human beings are unsteady …, not because we repress our true natures, nor because our true natures are repressed by our parents, or leaders, or our culture, but because we do not have true natures. Each of us is a nexus of relations formed in response to ever-shifting problems. Our identities are formed and reformed in relation to these changing problematizations” (Blake et al., 1998, p.62)

Thus, a new interest in worker identity ties these preceding themes together. Chappell et al. (2003) describe identity as dynamic and involving a co-constructed relationship between ‘reflexive’ and ‘relational’ identifications. A person’s identity may be constructed through a process of self narration (a life history), and in so doing they draw on the narratives available outside of their self. Thus, an identity is social in that it is constructed through the ontological narratives that are available (Chappell et al., 2003). Identity has also been theorised more simply based on construction of personal ‘stories to live by’ which in turn are related to the ‘web of stories’ that make up the landscape of their occupation (and/or workplace), all of which are under constant reformation (Connelly & Clandinnin, 1999). From these, and other accounts (Giddens, 1991), the importance of narrative in identity formation is clear, as is a continual reordering of self-identity “against the backdrop of shifting experiences of day-to-day life and the fragmenting tendencies of modern institutions” (Giddens, 1991, p.186).

Challenges to the traditional view of professional education suggests different epistemological and ontological understandings of worker identity, where ‘knowing how’ is as important as ‘knowing that’. Practice, as I have outlined, is both an epistemological and an ontological process as the embodied practitioner acts in the world. This demands a focus on how individuals learn at and through their practice in modern workplaces, which are, most often, social. Modern labour market conditions demand ‘flexible’ practitioners who are adaptable in local and particular contexts. But, identities are framed and reframed by different workplaces within broader contexts (relations, in nexus, arising from changing problematisations) and identity claims for professions and professionals need to be analysed from multiple perspectives, including those arising from disciplines/disciplinarity, from communities of practice, and from workplaces. It is to these three areas that the literature review now turns.
2.2.1 Professional disciplines

According to Charlton, the term ‘profession’ has been used for centuries to apply to a (high status) group that offered a service through a relationship between a principal and a client. The service required a “particularised form of knowledge and skill with some theoretical basis” generally acquired through a formal education institution (Charlton, 1973). In addition to accepted high social status, characteristics or traits of professions have traditionally been regarded as involving prolonged training and education, to have a distinct body of knowledge, to be altruistic, to be organised, to be autonomous, and to be guided by a set of ethical codes (Millerson, 1973; Waugaman, 1994). However, it is the primary characteristic of the development of a body of theoretical knowledge with a clear relationship to either the natural or the human/social sciences, which has marked out a practice as a profession (Usher et al., 1997, p.122), and traditional notions of professional practice focus on this technological and specialised knowledge that sets the professions apart from other occupations and activities (Harris, 1993). Waugaman (1994, p.25) points out that professionals have social links “not only to their clients and colleagues in the profession, but also to all groups with whose activities their skills must interface”. In this way, their professional status needs to be legitimised by all groups with which they work as well as by other professions (Waugaman, 1994).

The socialisation aspect of professions is strongly emphasised in the literature (Cleminson & Bradford, 1996; Olesen & Whittaker, 1968; Waugaman, 1994), particularly in the formation of professionals’ identity, and in their belief in the uniqueness of their knowledge and worth (Netting & Williams, 1996). Professional socialisation (and therefore identity formation) has been recognised for sometime as a ‘dialogue’ involving a fusion of person, situation and institution, and requiring a high level of self-awareness of the connection between the ‘public’ and private inner world of the professional (Olesen & Whittaker, 1968).

Since the late 1970s, the professional workforce, the numbers of different professional occupations and the number of professional associations to support these new professional occupations have grown rapidly (Watkins, 1999), particularly in the health sector (Duckett, 2005). Definitions of professions may have changed in this time, but they still stress the distinctness of their knowledge (Deverell & Sharma, 2000) learnt in
formal education programs. Alongside the growing number of professional groups, new theoretical perspectives on the education of professionals have developed. One such body of material relates to professional practice and the learning and identity that derive from and are enhanced by practice. Here, professionalism is regarded as an ideology, seeking to identify the features that comprise professional identity including the nature of professional knowledge, competence and expertise. An analysis of the relationship between theory and practice is important from this perspective (Eraut, 1994) and for the ‘traditional’ professions, the application of theory to practice has always been problematic (Usher et al., 1997, p.122). For example, it is common for professions to voice concerns about the theory/practice divide, or to have difficulty finding commonly agreed ways to regard experience within a profession. This theoretical perspective assists with analysis of the different forms of knowledge used by professional workers (for example whether it is proposition or personal, theoretical or practical), how it is acquired, and how it is used and developed (Eraut, 1994).

These newer theories of professional disciplines (following Schön) acknowledge that most practice situations have elements of uniqueness or instability (Eraut, 1994; Harris, 1993; Higgs & Hunt, 1999; Schön, 1983). Professional practice theorists now acknowledge that some of the most important problems in practice are characterised by complexity, uniqueness, uncertainty and conflicting values, and the associated need to be flexible and adapt to changing political and institutional environments (Higgs & Hunt, 1999). This is in contrast to the ‘certainty’ of the technical or specialised knowledge that traditionally defined professional practice. In this newer conception, according to Harris, the goal of practice is “wise action”. Wise action may make use of specialised knowledge, but it is essentially “judgement in specific situations, with conflicting values about which problems need to be solved and how to solve them” (Harris, 1993, p.27). Harris goes on to describe practical knowledge – “knowing how” – which is embedded in practical reasoning, an essential genre of knowledge used in practice. This, she contends, involves knowing-in-action, reflection-in-action, and reflection-about-action, using repertoires of examples, images, and understandings learned through experience. Interpretations of situations are constructed based on “prototypes in memory” from prior experience. The implication of this is that knowledge is best learned through practice and reflection on practice in the “indeterminate zones of practice” (Harris, 1993, p.27).
Other challenges to professions’ epistemology, for example in social work, focus on the ‘self’ as a resource for practice (Parton & Marshall, 1998). For many in these professions, a new regard for personal experiences, values and feelings presents a challenge to the primacy of expert knowledge (Deverell & Sharma, 2000). Fook (2001) points out that there is an implicit assumption in the professions that knowledge must be generalisable to be of use. Personal (self) knowledge, developed through an individual’s experiences and perspectives, is devalued mainly because it cannot be generalised. In the scientific process of legitimation, knowledge can be commodified to be applied in different settings. However, as Fook argues, personal, contextualised, practice experience needs to be revalued as an aspect of knowledge which is needed to make more generalised theoretical knowledge meaningful. This involves focusing on the skills which are used in making pre-existing knowledge relevant in the process of transferring it from one situation to another (Fook, 2001). Similarly, contemporary adult learning scholarship acknowledges that adult learners bring their entire experiential selves to work and learning, requiring workplace learning to be shaped by more than the propositional knowledge required by the workplace (Morris & Beckett, 2004). Formation of identities is implicated here in the process of reaching personal meaning through the practitioner’s experiences, responses and subsequent reflections (that is, the whole person) on practice situations.

The reflective elements of the professional development theoretical perspective are similar to those grounded in the experiential learning tradition (Moon, 1999) referred to earlier. The ideal of the reflective practitioner is of one skilled in drawing on experiences, and is cognisant of the processes involved in doing so (Higgs & Hunt, 1999). As educators of professionals have increasingly recognised that professionals learn through their experience, reflective practicums are used as an important element of learning for student professionals to prepare them for practice (Canfield et al., 2000; Graham & Wealthall, 1999). There is now a distinct movement towards the location of courses of professional education being located substantially in the workplace (Chappell et al., 2003; Cleminson & Bradford, 1996; Erawit, 1994; Gonczi, 2004; Jarvis et al., 2003), which closely ties in with new appreciations of identity formation through and at work - in the ‘doing’ of practice and the exercise of judgements. So, rather than suggesting abandoning codified (propositional) knowledge in the light of new epistemologies, these perspectives instead lead us to rethinking “its connection to the
world of practice and tacit knowledge that develops through acting in and on the world” (Gonczi, 2004, p.28).

Some of the developments in health/social care disciplines are worthy of mention at this point because they highlight some of the tensions between traditional notions of professional disciplines and newer epistemological understandings of diverse practitioners. The emergence of a professional identity was a battle in social work and in nursing which had both been regarded as semi-professions (Netting & Williams, 1996), and the search for a meta-narrative has been a preoccupation of social work in a bid to define its professional distinctiveness (Camilleri, 1999). However, in contemporary times, these professions face increasing pressure to change and adapt as their practice environment and contexts changes, again suggesting a focus on identity issues. As Duckett notes, “roles within the health sector are in transition, and static role and productivity assumptions are thus not reasonable” (Duckett, 2005, p.205).

Theorising has focused on the particular characteristics of health and social welfare professions in a bid to strengthen understanding of epistemology of their practice. For example, Eraut recognised that a feature of health and social care practice implicated in knowledge use and creation arises in opportunities provided by routine communication with clients, for example “when nurses or social workers assess clients’ needs while performing routine caring or form-filling tasks” (Eraut, 1994, p.48). Taking up the same theme, Daley used categories of professionals to investigate the relationship between knowledge presented in continuing professional education (CPE) programs and the ways in which knowledge becomes meaningful at the work site. She found that one way knowledge becomes meaningful in professional practice is by workers changing their own perspectives because of their interactions with clients (Daley, 2001).

As already discussed, epistemology and practice are linked, and various social, economic and political factors help to determine the nature of practice. This makes practice changeable and increasingly context-dependent. Organisational contexts in health and community services, for example, are extremely diverse: they can be government or non-government, locally based or regional/statewide/nationwide, they can employ people from predominantly the same occupation group or employ a diverse mix, they may work with particular target groups or broad target groups, and they can have different organisational philosophies (Jones & May, 1992).
nature of practice is shaped by such organisational contexts. Practitioners’ identities are influenced by perceptions of them by their employing organisation, their clients, and other practitioners within these organisational contexts. As Giddens (1991) argues, an individual’s biography (identity) must continually integrate events which occur in the external world into the ongoing story about the self.

Earlier in this chapter, a brief discussion of the political and economic imperatives impacting on community care was presented. These are manifest in polices concerned with cost containment (targeting and prioritisation), marketisation of services, and importantly, an increasingly diversified workforce. The historical development of social work and welfare work as different professional categories demonstrates what can happen to occupational identity in changing environments (Sturmey, 1992). During the 1970s social welfare workers without formal social work qualifications formed their own body, having been rejected as Associate members by the Australian Association of Social Workers (AASW) (formed in 1946) who at that time were trying to upgrade the education and practice standards of social work. As the sector changed, many jobs undertaken by social workers were relinquished to welfare workers as insufficient graduates were available to fill all the positions. Development of specific welfare courses in the higher education sector (and later in the VET sector) followed as the AASW continued its tightening of membership in a bid to mark out a narrower professional territory. Some opposed this trend to what they saw as ‘elite’ professionalism in social welfare which ignored the similarities in practice between the different groups (Sturmey, 1992). The trend also paralleled professionalisation within the technical rationality paradigm:

“It seems generally to have been taken for granted that professional social work qualifications are commensurate with better training and greater skills development. Such thinking accepts axiomatically that the best knowledge has a research base and that the wider the recognition of professional status … the more reliable and advanced are likely to be the skills of individual members of that profession (Sturmey, 1992, p.17).

In practice, the distinction between social work and welfare work is often not clear cut: “both share a similar body of knowledge, the differences in length of training are narrowing and … employers are tending to view them as overlapping rather than discrete occupations” (Jones & May, 1992, p.13). Many human service organisations advertise for either social work or welfare qualifications, and many even prefer welfare
qualified workers because they are more likely than social workers to immediately address the practice realities of the workplace (Sturmey, 1992). Other organisations have positions designated in other ways (for example ‘project officer’) which are open to people with a variety of qualifications and attributes (Jones & May, 1992). Assessment positions in community care often fall into this latter category.

It is the professional body for social workers (in Australia) that maintain the distinction between the two occupational categories of social work and welfare work despite the many epistemological and ontological arguments that suggest a more critical approach to the distinction is required. Similarly, Bartholomew argues that welfare and social work are in ‘competition’ with psychologists for professional space in the Australian health and welfare sector. The former occupations, which he regards as ‘alternative practitioners’, are generally cheaper to engage than psychologists. For this reason they are likely to take over some of the roles previously occupied by psychologists in the current service system environment (Bartholomew, 1997). Clearly then, these ‘like’ professions can gain or lose professional status and regard depending on the social and economic climate. Their professional skills and knowledge are not regarded as unique or indispensable.

Similar trends have been experienced in the field of nursing, where there are different occupational categories undertaking similar duties and ‘lower’ level groups taking over territory previously held by the ‘higher’ level occupations. The higher education qualified (since the 1980s/1990s) Division 1 nurses have relinquished duties to Division 2 (VET qualified) nurses. This trend extends in the aged and community care sector where many non-nursing categories of worker have taken over many personal care duties previously undertaken by nurses (Lindeman, 2001). In community/district nursing questions have been raised about the knowledge development potential resulting from using less well-qualified staff (McIntosh, 1996) with the implication that knowledge is the exclusive domain of the highly qualified.

The established professions of medicine, allied health (including physiotherapy, occupational therapy, dietetics, speech pathology, and podiatry), nurses, and social workers all contribute to the community care workforce. However, as is evident from the literature reviewed so far, a particular discipline is not prescribed for the role of initial needs assessment. In fact, there are shortages of professionals throughout the
sector, and no one discipline lays exclusive claim to the practice of assessment anyway. In fact, the practice of community care draws from an interdisciplinary knowledge base making it very difficult for one profession to totally distinguish itself from another (Netting & Williams, 1996).

The notion of ‘disciplinarity’ discussed by Usher et al. (1997) is useful here. In technical-rationality models of practice, foundation disciplines provide ‘forms’ of knowledge while more practically oriented professional practice constructs composites of ‘fields’ of knowledge from those forms to assist practitioners to act in the world. Foundation disciplinary knowledge is universal and is the outcome of a particular kind of theoretical practice with its own paradigms, methodologies and rules of work. Further, it is assumed to operate as an authoritative and hierarchical relationship to practices within its field of view (Usher et al., 1997, p.70). Using a Foucaudian analysis, Usher et al. (p.78) demonstrate how disciplinary truth and regulatory disciplining power are co-implicated: “disciplinarity encompasses discipline in the sense of regulatory power and discipline in the sense of a body of knowledge”. The power of disciplinary knowledge is relational rather than hierarchical because professionals are active subjects in practice. They point out that such a critique should lead to an appreciation of knowledge as inseparable from particular practices and that theory is not in a disembodied form (Usher et al., 1997, p.91). This confronts the view of professional disciplines as holding absolute authority of what constitutes knowledge and how knowledge is regarded in practice. It also enables us to see the practitioner as an active agent in applying and reviewing disciplinary knowledge. My interest in this is that the practitioner is co-constituted in knowledge construction.

We can see this at work in the context of work in community care, which brings new knowledge claims to the established professions. This is evident in social work (Egan & Kadushin, 1999), and particularly so in nursing where the knowledge base is inadequate for practice in community care (Keegan & Kent, 1992; McIntosh, 1996). In contrast to hospital settings, in community care settings nurses are engaged in more variable activities, their work is less predictable, there is a less rigid structure, practice tends to be more autonomous (Keegan & Kent, 1992) and greater knowledge of the individual clients/patients is required (Bryans & McIntosh, 1996). McIntosh argues that these settings require application of ‘know-how’ or ‘professional artistry’ which are developed through experiences in practice. She describes professional artistry in district
nursing as “a unique blend of knowledge from a number of disciplines which is selectively interpreted for different circumstances”. She also points out the failure of nursing curriculum to adequately prepare staff for practice in community care (McIntosh, 1996, p.324). In recognition of the ‘new’ knowledge required for these contexts, some educational programs for individual professions now include a specific focus on the knowledge required for practice with older people/community care at undergraduate level (Hughes & Heycox, 2005) and at post-graduate levels (or in-service/CPE) (Oberski et al., 2004).

In 1990, Shepherd (cited in Woods & Baldwin, 1998) recognised that the question of which profession is best placed to function as case manager (including assessment) in community care was complicated because the role combines elements of many different professions. The option of ‘inventing’ a new profession was considered, but at that time was ruled out as it seemed impractical. More recently, the possibility of the emergence and regulation of ‘intermediate professionals’ (Humphris, 2002) or ‘para-professionals’ (Duckett, 2005) and other completely new roles has been predicted resulting from the changing characteristics of the health and welfare sector and users, and the new initiatives in professionals’ education. Case management has now emerged as a specialism in the newly marketised system of health and social care.

As the community care sector and the number of assessment positions continues to grow, the question of who will fill these positions needs to be posed. As was the case with social and welfare work and different categories of nursing and personal care, the potential for a new professional category (or specialism) emerging becomes a possibility. The new critiques of disciplines and disciplinary knowledge as outlined above clears the way for such a possibility.

2.2.1.1 Multidisciplinary/Interprofessional learning

Practitioners are increasingly required to participate in collaborative, multidisciplinary and interprofessional working (Australian Government Productivity Commission, 2005; Beresford & Trevillion, 1995; Bronstein, 2003; Duckett, 2005; Johnson et al., 2003). A growing body of material has developed in response to this that considers multidisciplinary and interprofessional education and training at both pre-service and in-service stages of professionals’ careers as a mechanism for achieving these goals. I
regard this as a sub-strand of the newer professional practice theoretical perspective because it has developed from some of the same concerns about professionals’ practices in new service environments and because it has largely developed in response to the distinctive needs of the health and community services sector. In particular, there is an assumption in the sector that working as a team leads to better client/patient outcomes, and considerable research has recently been undertaken to investigate to what extent this happens in practice and whether professionals are being adequately prepared for this mode of working (Miller et al., 2001).

Initiatives for in-service practitioners include approaches such as shared training programs between different organisations (Larivaara & Taanila, 2004) and broader inter-agency partnership strategies (McWilliam et al., 2003). The learning and change in practice (including barriers and enablers of change) that occurs as a result of models for joint working such as formalised multidisciplinary/interprofessional teamwork has also received attention with many recommending further training for professionals to work effectively in this environment (Johnson et al., 2003; Kneafsey et al., 2004; Nancarrow, 2004; Norris et al., 2005; Schofield & Amodeo, 1999).

Most interprofessional education is at the ‘post-qualifying’ or ‘in-service’ level. However, a growing body of material focusses on the educational strategies that can be introduced at undergraduate or ‘pre-registration’ stage (Torkington et al., 2004). These range from models that incorporate shared practicums between students from different disciplines (Canfield et al., 2000; Reeves, 2000), to models that have common foundation courses prior to either generic practice or further specialisation in particular disciplines (Duckett, 2005; Sheldon et al., 2003a; Sheldon et al., 2003b) through to those that focus on post-graduate students already practising (Fowler et al., 2000). These represent a continuum along which there can be a variety of approaches. However, all aim to improve the ability of health and social care professionals to work collaboratively and flexibly for patient/client-centred outcomes. A further aim of some initiatives is to produce professionals equipped to “deal with uncertainty” in a complex, interconnected system where professional demarcations are no longer relevant (Humphris, 2002). The ‘transfer’ of these effects into professional practice and/or health outcomes at this stage remains unclear (Cooper et al., 2004; Larivaara & Taanila, 2004). However, the growing recognition in these programs that health and social care professionals engaged in joint working are active problem-solvers and constructors of
knowledge (including tacit) (Hubbard & Themessl-Huber, 2005) accords with new epistemologies of practice and suggests that much is yet to be articulated about how these ideals are enacted in practice.

Some concerns with pre-service multidisciplinary/interprofessional education initiatives include the adequacy of personnel involved in placement supervision/facilitation (Graham & Wealthall, 1999; Humphris, 2002) which has led to greater attention on the skills required for this role. Emerson (2004) examined elements of commonality and profession-specific requirements of the placement supervisors in a number of different professions. Having found that very few are profession-specific, the emergence of programs designed to prepare placement facilitators/educators across disciplines becomes a possibility, itself a hopeful contribution to the promotion of interprofessional learning and cooperation (Emerson, 2004). The importance of reflection as a key component in multidisciplinary/interprofessional learning initiatives (at both pre-service and in-service stages) is sometimes emphasised (Bronstein, 2003) with the clear implication that skills and structures to facilitate reflection must be in place.

The notion of collaboration in community care can raise anxieties about loss of (discipline-based) identity (Beresford & Trevillion, 1995), and even though the philosophy of collaboration is espoused by practitioners, “professional apartheid” is still prevalent (Netting & Williams, 1996, p.223). Professionals are socialised into believing in their distinctness from others. This socialisation occurs very early on in their training by which time they have already developed strong stereotypical notions of their professions’ identity (Graham & Wealthall, 1999; Reeves, 2000). Whilst multidisciplinary/interprofessional learning initiatives are designed to limit barriers resulting from stereotypical notions of distinctiveness not all programs report success in this area. In fact, Brown contends that boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working (Brown et al., 2000). Others suggest that professionals need to be secure in their own roles to be able to participate in interdisciplinary and interdependent activities (Bronstein, 2003).

One striking inconsistency with the multidisciplinary/interprofessional programs evident from the literature is that there is little uniformity in the professional categories included in the shared learning experience. At the pre-service stage some programs are limited to, for example, social work and nursing (Fowler et al., 2000; Torkington et al.,
2004), medical, nursing and dental students (Reeves, 2000), and others include a much broader range of health and social care professions (Sheldon et al., 2003b). The same inconsistency is evident amongst programs focused at the in-service stage usually reflecting the work setting, for example family and children’s services (Larivaara & Taanila, 2004), or community based mental health care (Brown et al., 2000). This trend may simply reflect the uncertain world of health and social services and the need to adopt local solutions, and it may be problematic in that there will be little to unify professionals who have trained/worked in different areas from their colleagues.

Apart from factors such as management commitment/style, organisational characteristics, communication mechanisms, degree of common language and work styles, interprofessional practice (and learning) is dependent to some extent on individual practitioners’ attributes and perspectives (Bronstein, 2003). Eraut highlighted the importance of professionals learning to work in teams and in organisations (dependent on the positive qualities of ‘getting on with people’) and the failure, often, of professional education in this respect (Eraut, 1994). Research undertaken by Miller et al. (2001) enabled them to distinguish between three individual philosophies: directive, integrative and elective each of which are more common in certain health professions. Those with directive philosophies value hierarchies and individual leadership based on status and power. Those with elective philosophies prefer to work autonomously and refer to others when they perceive a need, whilst those with integrative philosophies valued both the practice of collaboration and being a team player. They also tended to acknowledge the complexity of communication and valued in-depth communication and negotiation. Further, people with integrative philosophies, unlike the others, ascribed equal value to each practitioner’s contribution, and it was assumed that professionals would develop both as a team and individually by learning skills and knowledge from each other. However, for both directive and elective philosophies, learning, in general, was only valued from those with equal or higher status (Miller et al., 2001). “Feelings of inferiority” can interfere with patterns of communication (and by implication, learning) between (low status) workers, such as those without formal training, and (high status) professionals, such as social workers in the field of community care (Twigg & Atkin, 1994, p.59).

Bronstein (2003) points out that a competent professional role requires reciprocal respect regardless of the profession’s status in the setting. Trust between individual
professionals, as much as between the organisations involved in the collaborative work, is also implicated (Johnson et al., 2003), as is shared understanding and values in relation to the concept of empowerment (McWilliam et al., 2003). Interdisciplinary work is based on relationships between people, so while professionals’ philosophies are shaped to a large extent by the professional background, they are also dependent on their personal attributes.

These models of learning and practice are useful for HACC assessors in the sense that they are practitioners required to work collaboratively and could participate in shared practice/shared learning initiatives. However, multiprofessional/interdisciplinary models of practice and learning are based largely on the premise that the practitioner has a formal ‘discipline’. As this may not be the case for all HACC assessors, although they apply ‘disciplinary knowledge’, the applicability of the model may have limitations. This issue is explored more fully in the discussion (Part III).

### 2.2.2 Communities of practice

Communities of practice as a theory of learning was first applied to the apprenticeship model of learning (Lave & Wenger, 1991). As apprentices learn ‘on-the-job’, they pass through stages of membership of their work group in a process of ‘situated learning’. In this model, the acquisition of knowledge is a social process where people can participate in communal learning at different levels depending on their level of authority or seniority in the group. Lave and Wenger's term ‘legitimate peripheral participation’ particularly refers to the process of novices learning from the group. Legitimation refers to the power and the authority relations in the community and peripherality refers to the individual's social (not necessarily physical) relationship to the community. It explains the process of both the development of knowledgeably skilled identities in practice and to the reproduction and transformation of communities of practice (Lave & Wenger, 1991, p.55). Wenger (1998) further developed the concept of communities of practice for broader applicability based on the premise that learning occurs essentially through social participation.

Communities of practice are “communities of practitioners”, such as those belonging to the same professional group or work at the same worksite. Importantly, their identity and learning are strongly influenced by a shared culture and participation (Eraut, 2004b,
However, communities of practice are also situated outside work settings, they can be locally or more broadly based, they can be formal (structured) or informal (even to the point where members are not aware that they belong to one), and individuals can belong to many communities of practice depending on their work and life. Communities of practice are as diverse as the situations that give rise to them (Wenger & Snyder, 1994/2001). However, three dimensions are generally present: a community of mutual engagement, a negotiated enterprise, and a repertoire of negotiable resources accumulated over time (Wenger, 1998).

Theorising that focuses on ‘communities of practice’ assumes that engagement in social practice is the fundamental process by which we learn and form identities (Collin & Valleala, 2005; Lave & Wenger, 1991; Wenger, 1998). Individuals are active participants in the practices of social communities and construct identities in relation to these communities (Wenger, 1998). Learning takes place when competence and experience are in close tension and either starts pulling the other, or in other words learning results from an interaction between social competence and personal experience (Wenger, 2000). The terms ‘scaffolding’ and ‘modelling’ describe the processes of individuals applying knowledge beyond the immediate context.

For Wenger (1998, p.52), practice is about “meaning as an experience of everyday life”. Meaning, in this conceptualization, is located in a process of “negotiating meaning” involving the interaction of the processes of participation and reification. Participation refers to the social experience of living through membership of social communities and involvement in social enterprises. It is both personal and social, and a source of identity. Reification refers to the process of treating an abstraction as substantially existing, or as a material object. Certain understandings are given form and become a focus for negotiating meaning. In other words, meaning arises out of a process of negotiation that combines both participation and reification (Wenger, 1998).

The theme of identity formation is a major focus. According to Wenger (2000), individuals belong to communities of practice via three modes: engagement (ways and degrees of engagement with others), imagination (image construction of the self in relation to participation in the social world) or alignment (the degree to which local activity is aligned with broader, related areas). Each of these modes contributes a different aspect to the formation of social learning systems and personal identities.
Thus, personal identities are shaped according to the contribution of each mode in the community of practice (Wenger, 2000). Further, “if knowing is an act of belonging, then our identities are a key structuring element of how we know” (Wenger, 2000, p.238). Learning and identity are thus inextricably linked.

Over time, members build up an agreed set of communal resources or a ‘shared repertoire’ of resources. These can include material artefacts such as written files and it can include more intangible aspects such as procedures, policies, rituals and specific idioms (Wenger, 1998). These principles are also recognised by professional practice theorists. For example, as Schön identifies, when someone learns a practice they become:

“initiated into the traditions of a community of practitioners and the practice world they inhabit. He (sic) learns their conventions, constraints, languages and appreciative systems, their repertoire of exemplars, systematic knowledge, and patterns of knowing-in-action” (Schön, 1987, p.36).

Similarly, Jones and May discuss the concept of cultural competence for effective work in organisations. Practitioners interact within their organisations at different levels and in different groups, each of which has its own culture or sub-culture and which requires a high degree of self-knowledge and awareness (Jones & May, 1992). The different groups include those at the practitioner’s immediate workplace, sub-groups according to roles and occupational categories within the immediate workplace, those operating at a broader level within the organisation, and groups that operate outside the organisation such as those related to the professional category of the worker or the specific client group with whom they work. From this perspective, ‘communities of practice’ theory provides a useful model with which to analyse the various communities available to HACC assessors and how they contribute to their learning and identity.

Critics point out major limitations of this theoretical perspective being insufficient attention paid to ways in which the learning of experienced workers differs from that of newcomers (Fuller et al., 2005), that it inadequately addresses power relations and inequalities in communities of practice (Eraut, 2004b; Fuller et al., 2005), and that it provides an inadequate framework for dealing with informal learning at work (Boud & Middleton, 2003). Recent research has addressed these inadequacies by focusing on the importance of individual biographies in communities of practice (Fuller et al., 2005; Hodkinson et al., 2004). Community members, as embodied whole individuals, bring to
work “dispositions formed partly outside that community”. Community membership and other life experiences can modify these dispositions, and they also contribute directly to the form and nature of that community representing a complex interplay between these elements and community members (Fuller et al., 2005, p.63). This theme is also picked up in workplace learning literature; it is the whole, embodied person that inter-relates with the social world, not just the mind (Beckett & Hager, 2002; Hodkinson et al., 2004), and the whole person brings characteristics (such as race, age, gender, sexuality, culture, values) that impact on how (and whether) they participate in communities of practice.

Although communities of practice are often informal and self-organising, they benefit from some external assistance and specific management efforts within organisations or systems. For example, effective learning depends largely on the availability of peers and their willingness to act as mentors or coaches (Wenger & Snyder, 1994/2001). Boud and Middleton found that communities of practice are more likely to be present in larger organisations and more available to more senior staff members. They also found that considerable learning occurs informally at the workplace, and while some informal learning networks share similar features to communities of practice, not all contribute strongly to identity and meaning (Boud & Middleton, 2003). These authors suggest that focusing on communities of practice as the main mechanism for workplace learning does not tap into the rich learning that occurs informally and naturally. Collin and Valleala address this by focusing on how a shared understanding of work contents and professional practices emerges and is sustained during social interactions between employees. They focus on learning as participation in joint team practice and meaning making rather than learning as acquisition of knowledge and meaning giving (Collin & Valleala, 2005).

From this perspective, communities of practice are social situations in the workplace where participation and shared meaning is negotiated and offer a model for understanding the learning and identity derived from these social settings. However, at this stage, communities of practice theories have not been substantially used by educational institutions for formal and professional education. They have been applied more considerably in workplaces by corporations and as a form of in-service support for professionals where they are ontologically more explicit.
2.2.3 Workplace learning

In many ways workplace learning theories extend the arguments of the theoretical positions already presented. They recognise the workplace as a rich site for formal and informal learning, and focus attention on how this learning can be recognised and enhanced (Beckett & Hager, 2002) often drawing on theorists already discussed in the preceding sub-sections. However, because of the high status accorded formal/classroom learning (belonging to technical rationality paradigms), much scepticism remains about the quality of learning acquired in workplaces (Billett, 2001).

The study of workplace learning has arisen out of the focus on workplace change resulting from demographic, technological and global forces occurring in industrialised societies, and the need to re-educate/train the workforce (Velde, 1999). The early pre-occupation on competency-based training (CBT) was due to its promise to tie the acquisition (and recognition) of skills and knowledge directly to industry needs (Mulcahy & James, 1999). Many link the implementation of CBT by governments to its compatibility to economic rationalist agendas, and point out that it was based on a behaviouristic approach to education (Chappell et al., 1995; Schaafsma, 1995; Velde, 1999).

However, there is now an extensive body of scholarship that critiques and broadens this conception of workplace learning. Fenwick has identified at least five major themes for workplace learning scholarship: situated views of learning and knowledge in work; the culture and context of workplaces; texts and discourses mediating working knowledge; identity and difference as a focus of workplace learning; and equity and ethics in workplace learning (Fenwick, 2001). The literature on workplace learning offers insights into the issues important to consider in recommending alternative approaches to educating a group of workers such as how and where competence should be assessed (Hager, 1998b), the learning culture of the organisation and ‘informal’ and incidental learning (Hager, 1998a; Marsick & Watkins, 2001; Matthews, 1999). The most significant development in the workplace learning literature, critiquing the (original) concept of competence, is to explore alternative (broader, holistic, situated, contextualised) conceptions of competence (Hager & Beckett, 1995; Schaafsma, 1995; Velde, 1999) and a focus on the large variety of attributes that underpin performance at work (Chappell et al., 1995). Beckett and Hager, for example, offer an integrated model
of competence as moving beyond tasks lists (what is done in the job) by adding the practitioners attributes (what is brought to the doing of the job) and the characteristics of the context, or ‘situatedness’ (where the job is done) (Beckett & Hager, 2002).

There is a focus in workplace learning on an exploration of the embodied, active experience of work and learning (Beckett & Hager, 2002; Beckett & Morris, 2001). This has led to a model of adult learning which is primarily ontological before it is epistemological. This enables a new epistemology, centred upon: “a community of practice (authentic, embodied work), a dynamic engagement with diversity, power and a variety of discourses, and a context which is well integrated with the wider environment” (Beckett & Morris, 2001, p.44). Fundamental to these themes, and of particular relevance to the current study, is the notion of individual biography (or identity and difference) to learning. Learners bring their whole selves to any situation – the totality of their experience (cognitive, emotive and physical) (Jarvis et al., 2003). As Billet argues, each individual’s learning is influenced by the knowledge and experiences they bring to the situation – these individual influences are the product of personal histories. They are also unlikely to construct knowledge without reflection on their beliefs and procedures. In this way, workplace learning can be interpretivist, reflective and critical, and is therefore unlikely to be uniform between different people (Billett, 2001, p.37-39).

Drawing on cognitive learning theory, Billet presents a model (Diagram 2) to represent the different types of knowledge and their interdependence for performance and learning at work (Billett, 2001, p.55).

**Diagram 2: Interdependence of conceptual, procedural and dispositional knowledge**

<table>
<thead>
<tr>
<th>Propositional knowledge</th>
<th>Procedural knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>(concepts-facts-propositions)</td>
<td>(means of securing goals)</td>
</tr>
<tr>
<td>‘knowledge that’</td>
<td>‘knowledge how’</td>
</tr>
</tbody>
</table>

Dispositions
(values-attitudes-preferences-beliefs)
Individual ‘dispositions’, similarly to the ‘individual philosophies’ in professional practice, are therefore central to workplace learning. All these aspects need to be developed for performance of everyday routine tasks. However, for the achievement of expertise, workplace learning experiences also need to enable the development of attributes to respond to non-routine tasks in the workplace (Billett, 2001). The nature of work in contemporary workplaces is now understood to demand novel responses in non-routine situations (Mulcahy & James, 1999).

As is the case for professionals, all workers need to be able to respond to the changing and flexible demands of workplaces. The notion of ‘innovative skills’ gives greater recognition to the knowledge-creating character of skills, where knowledge is created through interaction between the tacit and the explicit (Mulcahy & James, 1999). This view brings embodied, situated experience to the fore and acknowledges the role of tacit knowledge in the continuous process of re-formulating personal knowledge and performance (Mulcahy & James, 1999). Identity is brought to work, but, like knowledge, is also re-developed and re-formed at the workplace. Fenwick claims that individuals can “understand their identities as hybrids, drawing from multiple images, communities of affiliation, and experiences”. Individuals can be active contributors to their own adaptation to changes at the workplace (Fenwick, 2001, p.11). More broadly, the self is configured as a contingent and constructed concept, one that is subject to continuing social and historical transformation (Chappell et al., 2003).

The workplace learning model also seeks to extend understanding of the relationship between experience and formal knowledge. Beckett and Hager, for example, are interested in how individuals develop ‘know how’ (knowing what to do in practice), and the factors that need to be present for this to be educationally valuable (Beckett & Hager, 2002). There is also an increasing focus on the processes involved in decision-making particularly in the “hot action” situations of practice where the pressure for action is immediate. Beckett and Hager propose “anticipative action”; know how demonstrated in actions “by which we show our knowing how to proceed” (Beckett & Hager, 2002, p.35). This is offered as an extension of professional practice (disciplinary) theories which provide a model for professionals’ learning and converting experience into tacit understanding and even artistry, but may not explain fully how the decisions come into play in all professional practice. The depth of learning may lie in the degree to which workers have the capacity to anticipate action and exercise
judgements. This view becomes important in the analysis of the performance of the work of HACC assessors, and suggests a particular focus on the level and type of judgement-making required in the context of daily practice.

The concept of individual agency is also relevant here, because it is through “what we do – our agency” that provides the ontological significance of learning at work (Beckett, 2005, p.2). A theory of agency places greater significance on the nature of experiences. Agency is seen as distributed, and as a co-construction from the reflexivity of practice involving the materiality (both human and non-human) of work contexts, although obviously only humans make (enact) decisions. In community care assessment, materiality includes peers and colleagues and also clients and carers. Billett and Somerville (2004) explore how individuals engage agentically in and learn through workplace practices, and in ways that transform work. They argue that individuals’ identity and subjectivities shape the agentic action and intentionality that constitutes the self (Billett & Somerville, 2004). Thus, identities, workplaces and learning are linked in ways which both depend on and transform one another.

Mulcahy (2005) adds a new analytical dimension to the relationship between work and learning through her use of ‘relational thinking’. Interconnections and dependencies, (rather than exclusions as in binary thinking), are seen between singular entities such as institutions and students, or work and learning. Using evidence from teacher education, Mulcahy demonstrates how a thinking ‘betweenness’, rather than focusing on boundaries (say, between institutional education and workplace education), acknowledges the interdependence of learning relations and locations. Where knowledge ‘boundaries’ are evident in the epistemology of work practices, relational thinking shifts the focus from their differences to their co-construction and dependency on each other and to the ‘space’ between them. Learning (and by implication, the creation of new knowledge) takes place in this ‘in-between’ space of ‘intra-action’ (Mulcahy, 2005).

2.3 Summary

Community care is a continually growing and diversifying sector as it responds to social, economic and political pressures, and assessment of client need is recognised as central to the whole system of service delivery. However, there is lack of clarity about
who comprises the assessment workforce, and service providers (employers) are provided with minimal policy guidance on the appropriate skills and knowledge required of this workforce. Despite recognition of the importance of this worker in the field of health and social care, they are not highlighted in recent documents focused on the generic workforce needs in this sector. Further, although considerable research, policy and service development reforms have been invested in the area of assessment in community care, very little attention has been focused on the workers themselves, beyond highlighting training needs to enable the assessment function to be undertaken according to desired policy directions.

Assessment is a core role of many discipline-based health and social welfare professions who have a stake in community care. This makes the field of HACC assessment, without mandatory qualification requirements, a highly contested field. The context for assessment work includes increased demand for community care leading to changeable definitions of client need, and practices of targeting and rationing. There is widespread recognition of the need for better preparation and support for assessment workers in HACC (often reflected by poor or uneven practice) but few tangible initiatives that directly focus on this need. Identification of references throughout the literature on the skills and knowledge required for this field of work provides a basis from which to critique current approaches to their preparation and support.

The theoretic tools for such a critique are located in the field of adult education scholarship. A Schönian understanding of the relationship between knowledge and practice underpins much of this scholarship. Practice is now known to be part of the knowledge-making process, and reflection and the making of judgements is strongly implicated in learning and identity formation. But this approach confronts traditional views of worthwhile knowledge, such as those formed in ‘disciplines’.

A practice-based epistemology requires a new understanding of disciplinary knowledge to free up our thinking in relation to discipline-based practice. Far from disciplines maintaining strict boundaries and authority over knowledge, the way has been paved for disciplines to develop, change and adapt to the new world of work, particularly in health and social welfare. This is evidenced from new challenges to traditional epistemologies from disciplines such as social work and nursing, and the emergence of totally new
categories of professions and fields of practice. In each of these challenges, ‘coming to know’ is only partly captured by traditions: experience and reflection on it, and decisional practice is emerging too.

But practices are social. As workplaces are largely social entities, theories of communities of practice provide a means to analyse learning that derives from social interactions with other practitioners. Identify formation is also a major focus occurring through the modes of engagement, imagination or alignment, with each mode contributing a different aspect to the formation of social learning systems and personal identities. The communities of mutual engagement, negotiated enterprises, and repertoires of negotiable resources available to assessment workers will provide insight into the social learning (and formation of identities) that occurs in this sector. A further major theme is highly relevant for these workers, and that is the new regard for individual biographies in communities of practice. Community members, as embodied whole individuals, bring to work aspects of their selfhood formed outside the community but which are co-implicated in their practice, and therefore, formation of identities.

Contemporary scholarship in workplace learning which suggests an integrated understanding of competence provides a more authentic view of the worker and their work context than those that have focused on behaviouristic notions of competence. A focus on agency (in the doing of practice) broadens this view even further by focusing on the nature of experiences. Relational thinking, as has been recently applied in workplace learning scholarship offers a new insight into the interrelationship between professional and ideological boundaries. By focusing on the space between dichotomous relationships existing in work and practice, the emergence of different ways of conceptualising practice (and therefore identities, knowledge and learning) becomes a possibility. These are central themes which the fieldwork will explore.
3. Methodology

This chapter outlines the research methodology and methods used in this study which was initiated to determine how, and to what extent, workers can be better prepared and supported as assessors in community care. Firstly, a rationale for a methodological perspective is provided including an outline of the purpose of a methodology and use of ‘postmodern sensibilities’ in qualitative research. The rationale for selecting a qualitative methodology for this study is provided and a description is given of the interpretivist-constructivist paradigm upon which this study draws substantially.

In the methods section I provide a rationale for the selection of interviews as the empirical method, including a description of how interviews were used and how research rigor (trustworthiness) was established. A detailed description of two distinct stages of the data collection is provided; the first stage was focused on interviews with *key informants*, and the second stage was focused on interviews with *HACC assessors*. I also explain the sampling processes and design of the interview schedules for each group of interviewees. I conclude this chapter with a description of the data analysis phase, and comment on the reactions and feedback I had from research participants.

3.1 Rationale

3.1.1 Why methodology?

A research methodology describes a broad strategy or design that shapes the choice and use of particular methods and links them to the desired outcomes. The theoretical perspectives, or philosophical stance, that provides the backdrop for the chosen methodology “provides a context for the process and grounds its logic and criteria” (Crotty, 1998, p.7). Questions of method are secondary to questions of methodological paradigm, defined as “the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways” (Guba & Lincoln, 1998, p.195). Perhaps because of the centrality of methodology, there is a temptation in conducting social research (and research methodology/methods texts can seem to imply that this is possible and desirable) to

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‘select’ a methodological paradigm to work within and then to follow the methods usually associated with that paradigm.

On closer reading of methodology texts, it becomes apparent that there is no such neat approach. Perhaps it is less important to provide the ‘correct’ name for the qualitative inquiry paradigm for a research study than it is to be aware of the various standpoints, perspectives, and assumptions represented by them that need to be considered whilst engaged in social research. A more productive approach to beginning research is to articulate the ontological and epistemological perspectives driving the research. The main philosophical perspectives contributing to the methodology will then become apparent.

3.1.2 Ontological and epistemological considerations

Ontological concerns are those that question ‘what is the very nature and essence of things in the social world?’ Epistemological concerns are those that question ‘what is the theory of knowledge, and what will be regarded as knowledge or evidence?’ In this study, the ontological and epistemological theories became clear only after considering the issue I wished to investigate from many different perspectives. Rather, I began with an idea, an area that needed to be investigated, and a vision for what such research may contribute. This, my guiding aim, became ‘how, and to what extent, workers can be better prepared as assessors in community care’. The study was planned in terms of the main issue I had identified and the questions that needed to be answered, as is the case with most social research (Crotty, 1998).

HACC assessment workers need to be understood from the standpoint of their local contexts and personal stories rather than from the perspective offered by externally determined categories such as professional groups, policy directions or traditional occupations. Any theorising therefore needs to take account of local contexts, and acknowledge that connections are made by individuals and filtered through their experiences, perspectives and biases (Usher et al., 1997). This is suggestive of an ontological perspective that includes a belief that ‘reality’ is comprised of such things as experiences, accounts, people, understandings, interpretations, ideas, attitudes, values, motivations, actions, identity, essence and being (Mason, 1996, p.11). Further, there are “multiple realities” that are “psycho-social constructions forming an interconnected
whole”, and they can only be understood as such (Maykut & Morehouse, 1994). This essentially means that the focus of inquiry cannot be understood by separating out certain ‘parts’ for analysis without reference to context and situatedness. Meaning will only be made by studying the ‘whole’.

Ontological issues and epistemological issues tend to emerge together (Crotty, 1998). So, with a view of reality as I have described, an epistemology that makes no claim of an objective truth or meaning to be discovered would seem to follow. In a constructivist view of knowledge, meaning is constructed, and different people may construct meaning in different ways about the same phenomenon. Constructivism is the epistemology most commonly invoked in qualitative research (Crotty, 1998; Denzin & Lincoln, 1998).

3.1.3 Postmodern sensibilities

Postmodernism offers a useful perspective that also informs the research methodology. Guba and Lincoln regard postmodernism as a substrand of the “critical theory et al” inquiry paradigm which is related to, but separate from, the constructivist paradigm (Guba & Lincoln, 1998). Crotty links postmodernism with an epistemology where meaning is imposed on the object by the subject, which he calls a subjectivist epistemology (as opposed to either positivist/post-positivist or constructivist epistemology). He does acknowledge that these are “not watertight compartments” (Crotty, 1998, p.9). Others do not regard postmodernism as belonging to any one alternative paradigm for research or a new method for doing research, but as “injunction to be constantly vigilant, to take nothing for granted in doing research” (Usher et al., 1997, p.208).

From this perspective postmodernism need not been seen in contradiction of a methodology that articulates a particular inquiry paradigm or as a separate epistemological paradigm. Rather, it can provide an additional set of questions and reminders to ensure a critical stance towards interpretation, as well as to keep it as research-in-context. The reflexive task of continually asking questions (focused on the origins, purpose, and context of the research, as well those concerned with what it is finding out), help to maintain awareness that “research is not a transcendental activity” but is a “constructed and constructing reality” (Usher et al., 1997, p.208). In other
words, this represents an acceptance of postmodern sensibilities and the approaches to
social research that these sensibilities imply, including a critical questioning of the self
in the research setting (Denzin & Lincoln, 1998; Lincoln & Guba, 2000). This process
of reflexivity – researchers constantly taking stock of their actions and their role in the
research process and subjecting these to the same critical scrutiny as the rest of their
data - has been suggested as one of the features that should be present in all qualitative
research (Mason, 1996). However, this should not imply an approach that necessarily
involved the *participants* beyond the interview phase, as involvement to this extent was
not the case with the present project.

3.1.4 A qualitative approach

Social research methodologies are often presented as either quantitative or qualitative,
and essentially belonging to one of two opposing paradigms. Quantitative
methodologies generally belong to the positivist paradigm (Maykut & Morehouse,
1994) (although qualitative methods are also used by researchers working from
positivist standpoints). Qualitative research encompasses many different methods of
inquiry. The one thing they all have in common is an interpretive, naturalistic approach
to subject matter; in other words that things are studied “in their natural settings,
attempting to make sense of, or interpret, phenomena in terms of the meanings people
bring to them” (Denzin & Lincoln, 1998, p.3).

At early points in the theoretical development of social research methodologies, the
term “phenomenology” was offered as the alternative research paradigm to positivism
(Maykut & Morehouse, 1994; Sellitz et al., 1976). At these earlier stages of the
development of the theories of qualitative methodologies, the “phenomenological
attitude” simply emphasised that individual cases are meaningful in their own right
regardless of whether or not they can be quantified, scaled or grouped in some way
(Sellitz et al., 1976) (other definitions of phenomenology as a distinct methodology are
also present in the scholarship). More recent theorists discuss the major alternative
paradigm to positivism in much greater detail, using the terms constructivist-interpretive
(Denzin & Lincoln, 2000), or naturalistic (holistic-inductive) (Patton, 1990). Usher et
al. refer to the hermeneutic-interpretive epistemology as the alternative to positivism
(Usher et al., 1997, p.181).
Where positivist approaches are concerned with generalisation, prediction and control, the (variously labeled) alternative approaches are concerned with interpretation, meaning and illumination (Usher et al., 1997, p.181). I choose to use the term “interpretive” to refer to the broad philosophical framework that has developed as an alternative to positivism.

Thus, for this study, qualitative research essentially consists of a range of interpretive, material practices that “make the world visible”, and involves “a naturalistic approach to the world” (Denzin & Lincoln, 2000). This essentially means that research is conducted in a natural context and does not involve manipulation of circumstances or environment to produce the research outcome, nor does it involve the researcher being necessarily objective, impartial and detached from the inquiry. Choosing qualitative over quantitative approaches can mean a trade off of breadth for depth (Patton, 1990, p.165). However, in this study, such approaches, when informed by a postmodern sensibility, hold the promise of answering the research questions with both greater depth and in diverse contexts.

Whilst it is possible to identify particular research activities as being qualitative or not, it is less easy to identify the various underpinning philosophies attached to particular qualitative practices and which are broadly ‘interpretive’. There are difficulties in trying to neatly define and label one methodological paradigm to guide a particular research study, as there is so much overlap and merging of the various theoretical perspectives that contribute to qualitative approaches. The tendency to try to ‘name’ one underlying philosophy or paradigm for qualitative research methodology is certainly not without pitfalls:

“Such labeling is dangerous, for it blinds us to enduring issues, shared concerns, and points of tension that cut across the landscape of the movement, issues that each inquirer must come to terms with in developing an identity as a social inquirer” (Schwandt, 2000, p.205).

The positivist/interpretive or quantitative/qualitative distinction can conceal the fact that the qualitative approach itself encompasses many theoretical perspectives, traditions and paradigms. In fact, as Denzin and Lincoln point out, qualitative research has no theory or paradigm that is distinctly its own, nor does it privilege a single methodology over another (Denzin & Lincoln, 1998). However, at a broad level, it is clear that the focus
of this study lends itself more to an interpretive approach as it is concerned with particular contexts and situations rather than broad patterns or causal relationships. What is to be investigated is the meaningfulness of certain interviewees’ experiences interpreted for research purposes, in full and critical recognition of the natural, material world in which the interviewees are contexted.

Philosophically, the methodology for this study just outlined shares many elements with the constructivist inquiry paradigm outlined by Guba and Lincoln. In this, the ontological view is one of relativism in that there are local and specific realities. Further, since the research aim is to develop and reconstruct understanding, there may also be an advocacy/activist aim that extends the ‘critique’ of diverse experiences. Thus, this study is sympathetic to the view that the nature of knowledge is based on “individual reconstructions coalescing around consensus”, although multiple ‘knowledges’ can also coexist (Guba & Lincoln, 1998, p.210).

Taking the interpretivist-constructivist approach to greater detail invites consideration of both ethnography (which is concerned with the culture of groups of people), and phenomenology as a methodology (which is concerned with the essence of experience of people) (Patton, 1990). These approaches also have a bearing on the methodology for this study in that their areas of concern are reflected in the data collection and analysis techniques. The former perspective is relevant because I consider this group of workers (the subject of the study) as possibly sharing elements of a ‘cultural’ group and therefore with explanations to offer about possible cultural milieu in their workplaces and/or other communities of practice. The latter is relevant because I am also concerned about the feelings and emotions invoked by the experience of the work and how these experiences interplay with their work as individuals and as a group.

However, it is the primary orientation towards an interpretivist-constructivist perspective which is central to this study. The focus is on how people in diverse settings construct reality, how they report perceptions, explanations and beliefs, and how those constructions impact on their behaviour and interactions with others (Patton, 1990). In locating the field of inquiry and in formulating methodology, I was also influenced by my own engagement with the area to be investigated (as a former policy worker, and as a current researcher and trainer/educator, in directly related areas). As
such I was not engaging in a value-free endeavor. This is itself is also suggestive of an interpretivist-constructivist approach where the ‘inquirer’ is engaged with the research.

3.2 Methods

According to Lincoln and Guba (cited in Patton, 1990) interpretivist-constructivist inquiry should be judged by the criteria of “trustworthiness” (analogous to rigor), by “dependability” (establishing a systematic process which is systematically followed), and “authenticity” (including reflexive consciousness about my own perspective and appreciation of the perspectives of others). The methods reported in detail here establish that these criteria are embedded in the study. This includes a rationale for selection of the methods, and a detailed account of the research process and how that was followed.

3.2.1 Rationale for using interviews

According to Mason, ontological reasons for selecting interviews include a regard for such things as “people’s knowledge, views, understandings, interpretations, experience, and interactions” to provide meaning for the social reality which the research questions are designed to explore. Epistemological reasons include the belief that “a legitimate way to generate data on such ontological properties is to interact with people, to talk to them, to listen to them, and to gain access to their accounts and articulations” (Mason, 1996, pp.39-40). However, the research itself was also designed to address critical ontological and epistemological issues. These are captured in the research questions and in the empirical methods. To reiterate, the research questions, are:

1. Who are the workers that undertake assessment of client need in HACC and what is the range of contexts in which they are employed?
2. What preparation (including formal education and training) and support do they receive?
3. What relationship does the workplace context have to the skills and knowledge required and acquired, and vice versa?
4. What is the relationship between the professional identity of assessment staff, and their practices, knowledge and expertise?
5. How, and to what extent, workers can be better prepared and supported as assessors in community care?

3.2.1.1 Semi-structured interviews

Where the epistemological standpoint includes a belief "that knowledge and evidence are contextual, situational and interactional”, which was the case for this study, selection of semi-structured interviews as the research method is encouraged (Mason, 1996, pp.39-40). This is to enable the interviews to be flexible and sensitive to the dynamics of each interaction. In the situation of the key informant interviews it was clear that whilst each needed to be asked the same questions for comparison purposes, it would be necessary to engage with each participant flexibly to ensure that their particular areas of expertise, interests and stakeholder perspectives were captured. Likewise, in the HACC assessor interviews, it was important to enable those voices to emerge individually and contextually. There was no compelling reason to take a standardised approach to these interview situations.

A semi-structured interview guide, with open-ended questions, provides a framework within which participants can express their own understandings in their own terms (Fontana & Frey, 2000; Patton, 1990). Other practical reasons are that they ensure best use of the time available and that basically the same information is collected from each participant. So whilst having a series of interview questions to pose to participants, the format also allowed flexibility in probing for greater depth, and in exploring new areas of investigation if the participant’s response moved into new or unexpected territory. In practice, the interviews were often conversational in style, with participants sometimes asking questions which opened up new categories, and I engaged reflexively to seek information on areas I was reminded of or introduced to by participants. This approach is also in keeping with naturalistic/constructivist inquiry because it ensures the interview can be conversational and flowing. In both cases, the interviews were taped to permit me (the interviewer) to be more attentive to the participant and to ensure accurate data collection (Patton, 1990, p.348).
3.2.2 Data triangulation

In interpretivist-constructivist methodologies triangulation is used to capture and report different perspectives to secure an in-depth understanding of a phenomenon in question (Denzin & Lincoln, 2000; Patton, 1990). The research design for this study involved a triangulated approach in that interviews were conducted with two distinct groups of participants and in two distinct stages: key informants and HACC assessors.

Key informants are individuals who possess special knowledge, status, or communicative skills and who are willing to share that knowledge and skill with the researcher (Goetz & LeCompte, 1984). In this case, the key informants were individuals employed in key organisations of relevance (or self-employed) such as those involved in aged care education, industry training board, industry representatives and government/policy representatives, some of whom also had known interest and experience in HACC assessment issues. It was anticipated that key informants could answer questions on worker background, workplace, job roles, available training programs and so on, plus elucidate other areas of interest as well such as key policy trends. Interviewing key informants also enabled me to experience how HACC assessors are perceived by critical stakeholders in the community care sector - those with interests from the perspectives of service delivery, policy and program development, education, research, and advocacy. In short, interviews with key informants provided a window on how HACC assessors are perceived (as ‘other’) by these stakeholders. This, the first group to be interviewed, comprised 12 participants.

Further, only in-depth interviews with HACC assessors themselves would generate the type of data required to answer some of the research questions. This data included personal information, descriptions of work context and practice, and reflections on the personal experiences of being an assessor. This, the second group of participants, again 12 participants, comprised workers employed in HACC organisations in roles that include assessment of client need.

3.2.2.1 Coding

Key informant interviews were coded numerically from 1 – 12 representing the order in which the interviews were undertaken. The HACC assessor interviews were coded
alphabetically from A – L, also representing the order in which the interviews were undertaken.

3.2.2.2 Emergent design

Emergent designs are often a feature of qualitative research allowing “important leads” identified in early phases of the research to be pursued by refining the focus of inquiry, and therefore the sampling strategy, and the questions to be asked (Maykut & Morehouse, 1994, p.44). This design essentially followed a developmental approach in that some decisions about data collection methods occurred following preliminary findings of the earlier stage. Specifically, the key informant interviews were undertaken reasonably early in the project and prior to detailed planning about the second stage of interviews with HACC assessors, as it was expected that these initial interviews might offer insights and other information that would impact on the design of subsequent data collection techniques (Goetz & LeCompte, 1984).

3.2.3 Ethics approval

An “application for approval of a project involving human participants” was submitted to The University of Melbourne Human Research Ethics Committee. The application provided details of the study including a description, aims and justification of the research, proposed methodology, participant details including details about how they would be recruited and any potential risks, details about how data would be stored, and copies of materials that would be provided to participants including plain language statements. Approval was granted by the Arts and Education Human Ethics Sub-Committee on 13 September 2001.

3.2.3.1 Consent

The interview methods I selected required consent from the individual participant only, and did not require me to gain consent from their employers. This was because they were speaking for themselves, not their employing organisations, and they were given choices about time and place of the interview. Each individual was able to obtain their employer’s consent to their participation if they felt it was warranted.
3.3 Data collection - Stage one

Stage one data collection was undertaken during the period October 2001 – March 2002. These key informant interviews were designed to uncover data on some key questions which would then have an impact on how and what subsequent data collection would take place. I developed a series of interview questions in consultation with my supervisors, which was designed to identify certain information that key informants could supply, particularly their knowledge of existing and planned training programs for assessors; and policy trends that may have workforce planning or training implications. I also wanted to gauge their views on who these workers are and who they should be, in terms of their professional/educational backgrounds; whether they felt that current approaches to training were adequate; and how these workers should be supported.

I had also developed a matrix of possible worker (HACC assessor) backgrounds against possible HACC organisational types to use in the interview. I wanted to enter into the second stage of the research being reasonably confident about the profile of workers employed in this role, and the HACC organisational types where they are employed in assessment roles. This was to inform a sampling strategy for the second stage. As it turned out, the worker profile was not used in a subsequent sampling strategy, but was still useful to inform further reading, and the formulation of themes and questions to explore with the assessors (this matrix appears as Table 5, at the beginning of Part II). I also wanted to understand the key informants’ views about how this group of workers learn how to be assessors.

3.3.1 Piloting

The interview schedule was piloted with two key informants. Prior to proceeding with the remainder of the key informant interviews, the transcripts of these initial interviews were reviewed to gauge the effectiveness of the interview questions. Minor changes to the questions were made: one change involved reordering two of the questions, and the other change involved altering the wording of one question (question two) to ensure the focus was on learning, rather than training, the latter emphasis considered unlikely to capture a broad perspective.
The tradition of qualitative inquiry suggests that researchers need to be responsive and flexible, and it is unlikely that these minor changes had a significant impact on the data collected from these two participants, compared with data collected from the remainder of the participants. Even with structured interview schedules, through “skillful interviewing, unexpected topics are still allowed to emerge” (Maykut & Morehouse, 1994, p.87). As the interview schedule was not standardised and not concerned with generating data for proving or disproving a hypothesis, nor for making broad generalisations, inclusion of these interviews in the study is not problematic from a methods point of view. These initial interviews provided very valuable data and were included in the study for analysis (they are coded as interviews one and two).

### 3.3.2 Sampling strategy

I identified potential key informants in consultation with my supervisors. An initial list was developed of individuals or organisations who were considered likely to offer insights into the area being investigated including those involved in relevant aged care education and/or research programs, industry training board, key industry/employer representatives, and government/policy representatives. As I have worked in the aged/community care sector for a number of years, I had a high level of familiarity with the relevant peak bodies, industry groups and individuals with expertise in the area of HACC assessment (as had one of my supervisors). Potential key informants were initially contacted by telephone, and a follow-up letter (Appendix B) was posted to them requesting their participation in the research.

It was initially intended that at least nine individuals employed in key organisations of relevance to the research topic would be interviewed. However it was also expected that this number could increase through ‘snowballing’ whereby these participants may suggest others that should be involved. The final number of key informant participants was 12, at which point saturation had been reached in that new information was no longer being collected. The sampling strategy used for stage one therefore included both purposeful and snowballing methods (Patton, 1990, p.182). Table 2 provides further detail about the key informants including a rationale for their inclusion in the study. In four cases I knew the participants professionally. However, this did not noticeably affect the interviews compared to those conducted with the participants I did not know beforehand.
In general, the key informants were senior people within their employing organisations, and two were self-employed. Approval for their involvement in the study was not required from their employing organisations as by virtue of their seniority they could make this judgement for themselves. The possible need to seek approval for participation was discussed with potential key informants at the initial telephone contact. In one case, a government employee sought clarification from her superior before deciding to agree to be interviewed. However, in this case, official Departmental approval was not required. Neither the key informants nor the organisations they represent are uniquely identifiable in the thesis.

Table 2: Key informants and rationale for inclusion in the study

<table>
<thead>
<tr>
<th>Interview number/ code</th>
<th>Job title</th>
<th>Focus of organisation where employed</th>
<th>Rationale for inclusion</th>
<th>Referred to in thesis as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community Building Adviser</td>
<td>Community based organisation in information technology for community services</td>
<td>Working in aged and disability services networks. Previously worked in ethnic HACC service provision and policy development.</td>
<td>Community worker</td>
</tr>
<tr>
<td>2</td>
<td>Research Fellow</td>
<td>Research Institute</td>
<td>Undertaken research projects in HACC and assessment. Conducts HACC assessment training program in Victoria.</td>
<td>Aged and disability services researcher/trainer</td>
</tr>
<tr>
<td>3</td>
<td>Executive Director</td>
<td>Industry training board (Victoria)</td>
<td>Training board perspective important</td>
<td>Industry training board employee</td>
</tr>
<tr>
<td>4</td>
<td>Manager, Assessment</td>
<td>Victorian State government department</td>
<td>Important to have the perspective of funding bodies. This individual had portfolio responsibility for assessment in HACC and ACAT programs</td>
<td>State government employee</td>
</tr>
<tr>
<td>5</td>
<td>Manager, Aged Care Group</td>
<td>Research institute</td>
<td>Undertaken a number of projects over several years related to HACC assessment and ACAT assessment.</td>
<td>Aged care researcher</td>
</tr>
<tr>
<td>6</td>
<td>Senior Project Officer, HACC</td>
<td>Commonwealth government department</td>
<td>Important to have the perspective of funding bodies. This individual was identified as the key contact</td>
<td>Commonwealth government employee</td>
</tr>
<tr>
<td></td>
<td>Position</td>
<td>Organization</td>
<td>Description</td>
<td>Role in Organization</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Chief Executive Officer</td>
<td>Peak body representing aged and community care service providers in Victoria</td>
<td>Important to have view of service provider representatives.</td>
<td>Service provider peak body employee</td>
</tr>
<tr>
<td>8</td>
<td>Community Services Consultant/Trainer</td>
<td>Self-employed consultant/trainer</td>
<td>Consultant specialising in HACC/community care. Offers long-running training program on assessment in HACC services.</td>
<td>Community services consultant/trainer</td>
</tr>
<tr>
<td>9</td>
<td>Senior Policy Advisor</td>
<td>Peak body representing local government services</td>
<td>Local government is a key player in HACC service provision in Victoria. Area of responsibility includes policy development for HACC in local government.</td>
<td>Local government peak body employee</td>
</tr>
<tr>
<td>10</td>
<td>Policy Officer</td>
<td>Peak body representing consumers/carers (Victoria)</td>
<td>Important to have view of consumer representatives. This individual had worked on projects focusing on assessment.</td>
<td>Consumer peak body employee</td>
</tr>
<tr>
<td>11</td>
<td>Consultant</td>
<td>Self employed consultant</td>
<td>Working in the area of social research on ethnic issues. Had worked on projects related to assessment in these contexts.</td>
<td>Social research consultant</td>
</tr>
<tr>
<td>12</td>
<td>Manager, Community Services</td>
<td>Local government authority</td>
<td>Local government is a key player in HACC service provision in Victoria. This individual had been involved in major projects related to assessment.</td>
<td>Local government senior manager</td>
</tr>
</tbody>
</table>

### 3.4 Data collection - Stage two

Stage Two data collection was undertaken during the period January – June 2004. This second group of participants comprised workers currently employed in HACC assessment roles. As in Stage One, a semi-structured interview schedule/guide was used. I developed this in consultation with my supervisors, firstly by defining key areas to be investigated with participants. These key areas were background/professional...
identity, context, training and learning, and practice. A series of open-ended questions were then developed under each area.

3.4.1 Piloting

The first two interviews conducted with participants A and B were regarded as pilots, in that the transcripts were reviewed to assess the need for further refinement of the interview questions, prior to any further interviews taking place. There was no need to make any adjustments to the interview questions. Interviews A and B are included in the study for analysis.

3.4.2 Sampling strategy

The criteria for inclusion in the sample were that participants had to be currently employed in a role that is comprised of client assessment for at least 50% of their time, and they must have been employed in that role for at least twelve months. These criteria were decided upon because this amount of a person’s job role (at least 50%), and this amount amount of time (at least 12 months) in their current job would ensure sufficient depth of understanding of both the function of assessment, their role, and how they had developed in that role.

A complete list of HACC funded organisations is publicly available from the Victorian Department of Human Services; this list was used to identify organisations for inclusion in the sample: [http://www.health.vic.gov.au/hacc/hacc_victoria/index.htm](http://www.health.vic.gov.au/hacc/hacc_victoria/index.htm). A purposeful random sampling strategy (Patton, 1990, p.183) was used to locate participants. The broad organisational types, refined during stage one, were used to select potential organisations to approach. I had initially made allowance for the possibility that research participants could suggest individuals to be involved, and this was reflected in the plain language statement: “your organisation is one of a small number of HACC organisations randomly selected…… Alternatively, another research participant may have suggested that I contact you”. As it turned out, only the name of the first participant (Interview A) had been suggested to me, by a key informant. The list of HACC organisations available from the Department of Human Services is already divided into regions, which made it easy to identify whether organisations were based in regional/rural or metropolitan/urban areas. The rural/urban separation was
included because it was anticipated that geographical location may provide different contextual experiences, including different communities of practice, for HACC assessors, and so a deliberate selection of some rurally based organisations for inclusion in the sample was made. Organisations were then grouped according to the organisational type they best fitted. A list gradually developed under each ‘organisational type’ heading, which was also split according to whether they were rural/regional or urban/metro. Apart from participant A, who was approached purposefully, organisations were approached randomly (beginning from the top of the lists) to identify possible participants within each category. As potential participants were identified, they were given an interview number/code and placed into the matrix to track the sampling strategy (see Table 3).

While nursing organisations funded by the HACC Program (for example Royal District Nursing Service, Bush Nursing Services) are a major player in the HACC sector, they were not included in the sampling strategy to identify potential participants for Stage Two. This decision was taken for a number of reasons:

- Currently, nursing organisations only employ Registered Nurses (and they are employed as nurses).
- Their role is different to other HACC assessment staff in that they assess clients’ needs but will usually be involved in delivering the on-going care as well (Worth, 1998) (assessment of needs is unlikely to represent more than 50% of their work time).
- Nursing services assessment expertise is more and more being focused on clients with unstable health or complex care needs and not in initial assessments (Department of Human Services, 2003). This means that they are usually called in to conduct assessments following an initial assessment by another HACC agency. It is the assessment staff in this latter group of agencies that is of more interest in this study.

The inclusion of nursing organisations in the sample would therefore have skewed the data on issues such as professional background, professional identity and nature of practice.
It became clear during the sampling process that some organisations would fit under more than one category in the matrix. For example, a church-based organisation, which would fit into the “community or charitable group” category, may run a number of HACC services including an adult day care centre with its own assessment worker. In this case the organisation that would also fit into the “adult day care centre” category if the assessment worker from this location was included in the study. Likewise, an Indigenous agency, which would fit into the “ethno-specific/Indigenous services” category, may be a primary health care agency offering a range HACC services including day care, social support and home care services, that employs an assessment officer/s for the aged and disability target group covering all the HACC services. In this case, the Indigenous organisation would also be categorised as a “community health centre or primary health care agency”.

Other possible dual categorisations would be a day care centre with its own assessment officer/coordinator (categorised as “Adult Day Care Centre”) that is operated by a local government authority (categorised as “Local Government authority”). In this sample, the workers from the local government authorities provided assessment across a broad range of programs and were all physically located in the main community services buildings of their local governments. They were therefore only categorised as “local government authority”. Table 3 (below) shows the sampling strategy, also showing those organisations included in the sample that fit under more than one category (pairs highlighted in bold).

Table 4 (below), provides further detail about the individual participants, including their job titles, and number of years employed in their current positions. The pseudonym used in the thesis is also shown in the table.
Table 3: Sampling matrix – HACC assessors

<table>
<thead>
<tr>
<th>Community Health Centre or Primary Care Agency</th>
<th>Local Government Authority</th>
<th>Adult Day Care Centre</th>
<th>Disability Service (e.g. respite, carer network, Interchange)</th>
<th>Community or Charitable groups (e.g., local welfare agencies)</th>
<th>Ethno-specific/Indigenous services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>G</td>
<td>A</td>
<td>D</td>
<td>F</td>
<td>H</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>E</td>
<td></td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>K</td>
<td>I</td>
<td>L</td>
<td>L</td>
<td>J</td>
</tr>
<tr>
<td>Rural</td>
<td>J</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Research participants – HACC assessors

<table>
<thead>
<tr>
<th>Interview number/code</th>
<th>Position Title</th>
<th>Years in the position</th>
<th>Pseudonym given</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Team Leader</td>
<td>8</td>
<td>Anna</td>
</tr>
<tr>
<td>B</td>
<td>Team Leader</td>
<td>6</td>
<td>Bonnie</td>
</tr>
<tr>
<td>C</td>
<td>Assessment Officer</td>
<td>7</td>
<td>Clare</td>
</tr>
<tr>
<td>D</td>
<td>Social Support Coordinator</td>
<td>8</td>
<td>Delia</td>
</tr>
<tr>
<td>E</td>
<td>Senior Coordinator</td>
<td>4</td>
<td>Ellen</td>
</tr>
<tr>
<td>F</td>
<td>Host Program Coordinator</td>
<td>8</td>
<td>Faye</td>
</tr>
<tr>
<td>G</td>
<td>Case Manager</td>
<td>5</td>
<td>Grace</td>
</tr>
<tr>
<td>H</td>
<td>Program Coordinator</td>
<td>1.5</td>
<td>Heather</td>
</tr>
<tr>
<td>I</td>
<td>Assessment Officer</td>
<td>3</td>
<td>Ivan</td>
</tr>
<tr>
<td>J</td>
<td>Case Manager</td>
<td>1</td>
<td>Jennifer</td>
</tr>
</tbody>
</table>

2 This person’s ethnic background and the name of the ethnic community that she works for is not used in the thesis at any stage as to do so may identify the participant.
This group of participants was contacted by mail (Appendix B) requesting their participation in the research. In some cases, by making an initial phone call to the selected organisation I was able to obtain a name of an assessor and could have a brief conversation with them about the nature and purpose of the research before sending a letter. This proved to be very helpful as in a small number of cases potential participants were able to identify that they did not meet the criteria for inclusion and therefore could not participate. Two others were not available because they were about to go on extended leave. For those who fitted the criteria, it also enabled me to address letters of invitation to a real person who was then anticipating receipt of the letter. I found that there was a very high level of willingness and interest to be involved in this project, and many people, including some who did not fit the criteria, indicated that they felt the topic was important and needed to be investigated. In fact, everyone who was approached, who was available, and who fitted the criteria, agreed to participate.

The introductory letter sent to potential participants explained that the interviews would be conducted at the time and place of their choice. Clarification of the location of the interview was obtained after they confirmed their participation, as soon as they were able to make arrangements. I was required to travel to a number of different locations in Victoria in order to conduct the interviews. With one exception only, all interviews with HACC assessors were conducted at the participants’ places of employment, in a private meeting or interview room. One participant, a part time worker in a rural region, chose to be interviewed, after hours, in her own home.

3.5 Data recording and validation

All participants (Stages One and Two) were advised in the initial letter of invitation that the interviews would be taped and later transcribed. I made verbatim transcriptions which were then subjected to minimal editing only (generally limited to removing most of the ‘ums’ and ‘ahs’). Copies of these transcriptions were provided to individual participants within three weeks of the conduct of the interview.
Participants were advised in a covering letter sent with their transcription that they had three weeks to advise me of any inaccuracies or changes that they wished to make to their transcript. All transcripts were signed and returned to me, most with no modifications, and only some with minor typographical or grammatical corrections. A brief form was developed for the purpose of participants signing off on their transcripts (Appendix B).

3.6 Contingencies

Rarely is social research conducted without something unexpected or untoward occurring. For this reason, some possible problems were anticipated and contingencies developed to prevent these from compromising the research.

The first of these concerned the time and location of the interviews. I had expected that most, if not all, participants would choose to be interviewed at their place of work, and that they would be able to find a room that would be free of interruptions. As a contingency I stated that I would meet participants at their place of choosing, and after hours if necessary. In all but one case, participants chose to be interviewed at their place of work. In this case, the participant was home alone with a young child. We agreed at the outset of the interview that the child could come into the room if she needed to and that the tape would be switched off to allow the participant to interact with her child. This occurred on a number of occasions throughout the interview but did not noticeably disrupt the flow of the interview. In another case, I interviewed a day centre manager in her office. At one point in the interview a client with dementia walked into the room. The tape was immediately switched off to allow the participant to communicate with her client. When the interview was resumed the participant in fact began to relate this client to the discussion we were having in the interview. The point at which this occurred is noted in the transcript.

Secondly, I anticipated that participants may not be able to predict their work pressures on the day of the interview, and that when the day arrived, they may feel pressure to attend to work duties rather than continue with the arranged interview. As a contingency, and to provide reassurance to participants that I could be flexible, all participants had my mobile telephone number and were aware that they could cancel or postpone their interview if they felt they needed to. I also tried not arrange interviews
too far in advance to try to counter participants’ inability to predict future workload. However, in all cases, the interviews went ahead as originally planned.

Thirdly, as all the interviews were being tape-recorded, I had to allow for the possibility that the equipment may fail. Therefore, I also took brief notes as a back-up. However, I kept my notes very brief because I was concerned that the interviews should be conversational in style and I did not want me, nor the participant, to be distracted by detailed note-taking. Fortunately there were no problems experienced with the tape recorder, and I did not need to refer to my notes to prepare the transcripts.

Fourthly, I had to allow for the possibility that participants may disagree with the contents of their transcript and either make major revisions, or would choose to withdraw their consent to participate. As a contingency, I was diligent in making sure that transcripts were returned to participants very soon after the conduct of the interview so that their comments would be fresh in their minds, and I requested that they return their ‘signed off’ transcripts to me as soon as possible (within three weeks). The short timeframes were to reduce the possibility of participants not remembering their intent or their responses to the interview questions. In only one case did the participant take longer than three weeks to return her transcript, and when she did, there were no corrections or alterations made. Participants were also informed that they had the right to withdraw consent up until the time of data analysis.

3.7 Data analysis

The underpinning ontological and epistemological standpoints and the research method selected for this study, fit with inductive methods of analysis. Rather than starting out with categories and units of analysis as in more positivist approaches, a qualitative methodology essentially seeks to allow these to emerge from the data itself. Further, the emphasis is on “illumination, understanding and extrapolation” rather than “causal determination, prediction and generalisation” (Patton, 1990, p.424).

The purpose of descriptive analysis is to answer the basic questions posed by the study and to ‘set up’ the data for interpretive analysis. The descriptive analysis was initially developed using a “cross-case” method (Patton, 1990) meaning that data from all research participants were assembled under common categories, usually those that had
been determined in the interview guides. In other words this involved grouping the data according to the focus of the interview questions.

A second order analysis was undertaken loosely following the “constant comparison method” (Goetz & LeCompte, 1984; Mason, 1996; Maykut & Morehouse, 1994). This analysis involved a fuller reading of the text, searching for other, new, data categories. This is described as “unitizing” or “culling meaning” from the transcripts (Maykut & Morehouse, 1994). This required me to ‘immerse’ myself in the data, and to suspend judgement for a period of time to enable the data categories to emerge. Data categories were then listed and grouped to search for recurring concepts, topics, patterns and themes grounded in the transcripts in a process referred to as “discovery” (Maykut & Morehouse, 1994). Some of these data categories became new ‘headings’ in the findings (descriptive analysis), and some were integrated within existing headings but revealed new themes or patterns within them.

It should be acknowledged that the analysis process, and therefore the data categories that subsequently emerged from it, was based on my personal readings of the transcripts. The actual process involved recording themes and comments on small pieces of paper as I read through the transcripts (citing participants and page number in their transcripts so I could refer back to them) and posting these on large pieces of butcher’s paper which recorded the main data categories. These notes could be moved and grouped (sometimes under multiple headings) as these data categories and themes emerged and patterns of “convergence” and “divergence” could be identified (Patton, 1990). This was a lengthy process but one which enabled sufficient flexibility during analysis. During this stage, I re-read all transcripts in full at least three times so I would not miss any themes. This was also important because the data categories and themes were developing, not fixed. Thus, the analysis process involved both “technical and creative dimensions” (Patton, 1990, p.404). Along with the original transcripts and summary data, I have retained the materials used in this process for validation as an ‘audit trail’ (Maykut & Morehouse, 1994) to ensure trustworthiness.

Some data categories (represented by the headings in the descriptive analysis) were collated drawing equally on both sets of interviews. Other data categories were collated drawing from only (or mainly) one set of interviews, that is, the key informants or the HACC assessors. The data sources (including the particular interview questions where
possible) are clearly identified at the beginning of each section and sub-section in Part II (Chapters Four, Five and Six).

The interpretive analysis was undertaken using various theoretical perspectives (presented in the literature review) to further analyse the descriptive findings. The interpretive analysis (discussion) is presented in Part III (Chapters Seven, Eight and Nine).

3.7.1 Representation of participant quotations and viewpoints

Throughout the thesis, direct quotations and viewpoints of participants are used to illustrate findings and analysis. In relation to the interviews with key informants (Stage One), direct quotations are attributed to individual participants by using a descriptor of their role/stakeholder view, rather than with a pseudonym. These ‘participant-descriptors’ allow each key informant’s interest and expertise to be revealed, but does not identify the individual (shown in Table 2, above).

In relation to the Stage Two interviews with HACC assessors, a pseudonym is used to attribute views and quotations to individual participants. Each pseudonym accurately identifies the gender of the participant (that is, a gender-specific name is given to each participant), and keeps the identity of each participant anonymous (see Table 4).

Where necessary, the numerical key informant codes (1 - 12) representing individual key informant interviews, and the alphabetical HACC assessor codes (A - L) representing individual HACC assessor interviews, are used to present aggregated or summarised data. Use of a numerical code in brackets signifies that data have come from a key informant in Stage One. Use of an alphabetical code in brackets signifies that data to come from a HACC assessors in Stage Two. In some circumstances I have used the assessors’ pseudonym rather than the code to present summarised data to suit the writing style.

3.8 Feedback from participants

One of the issues addressed in the ethics application was the expected benefits (if any) to the research participants. The ethics application stated that “participants may
indirectly benefit from the research as the interview questions will stimulate their thinking on the topic and offer the opportunity of reflection on this aspect of their work”. The feedback I received from participants was positive and many expressed great interest in the topic and commented that they felt it was an important area for investigation. In one case (K) a signed transcript was returned to me with a note from the participant saying that the interview had made her think about her own learning needs and encouraged her to seek out opportunities for networking and training. Another (G) commented at the end of the interview:

“I actually really enjoyed that. That was great, because often you never get the chance to respond, you just listen to other people talk. … It was just so good to have someone ask you what you thought” (Grace).

3.9 Summary

This study set out to explore the question of how, and to what extent, workers can be better prepared as assessors in community care. The ontological and epistemological perspectives informing this study are suggestive of a methodology that engages with participants in their natural setting, and locates me, as inquirer, reflexively throughout the study. Postmodern sensibilities are present helping to ensure a critical and contextual stance towards inquiry, analysis and interpretation. The methodology for this study is qualitative and an interpretivist-constructivist paradigm provides a broad philosophical framework (although other perspectives are present). Such an approach:

“assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and subject create understanding), and a naturalistic (in the natural world) set of methodological procedures” (Denzin & Lincoln, 1998, p.27).

In other words, meaningfulness is reached though an approach that uncovers the views, experiences, descriptions and feelings of individuals involved in the phenomenon in question. Participants are engaged in the study in their natural settings (generally workplaces) and any convergent and divergent patterns are allowed to emerge from the data to describe and interpret the phenomenon.
Part II: Findings (descriptive analysis)

Part II presents the research findings in the form of a descriptive analysis. This essentially represents the outcome of a ‘data reduction’ process, meaning that the data have been summarised from the interview transcripts and emergent commonalities highlighted. In this way, important points are identified and described. Data have been aggregated as much as possible, and quotations are used to demonstrate participant responses. This is the ‘thick description’ that I use to ‘set up’ the discussion (interpretive analysis) presented in Part III.

The findings are reported in three separate chapters. Chapter Four reports on what essentially is a mapping exercise. I describe who the workers employed in assessment in HACC are, and in what organisations and other contexts they work. Chapter Five describes the practice of assessment, and Chapter Six presents the findings relating to education and training issues. At the end of each sub-section within each chapter, a brief summary is presented in dot point form. These dot points are then used to develop the ‘summary and emerging themes’ section included at the end of each chapter.

Where data have clearly been requested of participants, and are drawn from specific questions, these questions are identified by a coding system. I also indicate whether these are from Stage One or Stage Two interviews, or both. For example, *question 3* in a *Stage One* interview would be coded as 1-Q3; *question 4* in a *Stage Two* interview would be coded as 2-Q4; and where data in a particular section or sub-section are drawn from both stages, for example *question five* in *Stage One* and *question 12* from *Stage Two*, then this would be coded as 1-Q5, 2-Q12.

As is often the case with semi-structured interviews, there are instances where participants provided data outside of the framework of the interview schedule and therefore cannot be linked to a question. In many cases, where these were judged to be valuable data, they are included in the descriptive analysis. Whilst I am not able to provide the question that participants were responding to, I can still identify the participant. Where this has occurred the respondents may have been opening up a new data category (one that I had not anticipated or requested), and other participants may not have commented on the same issue, as they were not requested to do so. Other instances where I may not be able to identify particular questions that the data are drawn
from is where new data categories developed resulting from the ‘constant comparison’ method (outlined in previous chapter). An example of this would be the section on “workforce trends and workforce conditions”. Whilst I did not specifically ask participants to note recent trends in the workforce or to comment on work conditions, data emerged that suggested a new category needed to be established, so that these themes could be reported.
4. Organisations and personnel involved in community care assessment

This chapter describes the organisations and personnel involved in assessment based on the findings of the interview data. Specific areas reported include the professional identities of staff, work contexts, and workforce trends. The possible implications of these findings are also introduced.

According to the Victorian HACC Program manual (Department of Human Services, 2003, p.189), an organisation is eligible for funding to provide a HACC service if it is “a legal entity which can comply with the principles and objects of the Program and which has the capability to provide the services under the terms and conditions of service contracts”. The manual goes on to identify the organisations eligible to provide HACC services as including local governments, community organisations, religious and charitable bodies, health agencies and private (for profit) organisations. Some organisations are funded to operate on a statewide or cross-regional basis, but the majority are funded to provide a locally-based service.

Stage One participants (key informants) were asked what they thought would be the typical backgrounds of assessment staff and the types of organisations in which they were likely to be employed (1-Q1). Later in the interviews they were asked to consider a matrix of likely worker backgrounds and organisational types (see Appendix B) and make amendments if necessary (1-Q10). In the Stage Two (HACC assessor) interviews, participants were asked to identify their professional backgrounds (2-Q3). The matrix (Table 5), shown below, was refined using information obtained from this process.

All key informants recognised that while there was a large variation in the types of organisations involved in providing community care, and therefore involved in assessment, local government authorities were the predominant players, with district nursing also being highly significant. Despite the proliferation of other programs that offer an assessment function (such as ACAS) and other HACC-funded organisations, the volume of assessments being conducted by local government was also recognised:
“The bulk of people in the community who present for assistance would still be going through the local government gateway, often fairly early on in their contact with the service system” (Local government peak body employee).

Two key informants (3, 10) recognised that ‘for profit’ organisations were beginning to play a larger role in HACC but were unable to provide clarity about the role these organisations played in assessment. Another key informant (12) also acknowledged that ‘for profit’ organisations were part of the HACC service system, but was quite clear that they generally do not get funded to undertake assessment of client needs. Following the compulsory competitive tendering (CCT) process that occurred in Victoria, a number of local governments lost some of their HACC services to private organisations, as reported in the literature review. However, many retained the assessment function in-house. For this reason and the uncertainty about the level of involvement private organisations have in assessment, private/for profit organisations are not included in the matrix (Table 5). Whilst not precise, the table represents a reasonable indication of the type of organisations associated with community care/HACC assessment and some of the typical primary backgrounds of staff employed in those organisations. It should also be noted that some organisations can be categorised as more than one organisational type (see Table 3 in section 3.4.2) and likewise it is possible that some individual workers may claim more than one primary professional background.

This is how one key informant (8) described the profile of the HACC assessment workforce:

“So now, on the whole, you usually get assessment officers that have got social work, welfare officer, nursing, or OT backgrounds. Some have come up, in the past, with a community development framework background but on the whole you are looking at social work or welfare or nursing. In RDNS it is nursing. In community health it is usually social workers or welfare officers. In the social support sector - the ethno-specific, social support sector – it is probably more community development workers or welfare officers, in terms of their qualifications for assessment” (Community services consultant/trainer).
Table 5: Perceptions of typical backgrounds of assessment staff and employing organisations in Victoria

<table>
<thead>
<tr>
<th>District nursing/bush nursing</th>
<th>Community health centre or primary care agency</th>
<th>Local Government Authority</th>
<th>Adult day care centre</th>
<th>Disability service (e.g. respite, carer network, Interchange)</th>
<th>Community or Charitable groups (e.g., local welfare agencies, church-based services)</th>
<th>Ethno-specific/Indigenous services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (Division 1)</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Nursing (Division 2)</td>
<td></td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Nursing (psychiatric)</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Social work</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Other allied health (e.g. OT)</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Welfare work</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Administration</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Direct care experience (e.g. personal care)</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Community development experience</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Other (e.g. evaluation)</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
</tbody>
</table>

**Key:**
- × smaller numbers
- ×× larger numbers
It was the impression of some key informants that people with nursing backgrounds would often be employed in assessment roles and this view is reflected in the matrix. However, it is also clear that not all nurses employed in assessment roles retain their registration as a nurse. For Division 2 nurses (previously known as State Enrolled Nurses), it is unlikely that this qualification is a requirement for their role, as if it were, they would have to be working under the direct supervision of a Division 1 nurse (previously known as State Registered Nurses) as one key informant (3) noted. The same key informant pointed out that many Division 1 nurses would also be in assessment roles but not practising as nurses:

“Well, my perception is that Div 1 nurses would be employed in more settings than you have here\(^3\), particularly local government. There are just so many of them out there – there are 75,000 currently registered, but 40,000 practising, so there are another 30,000 out there and they find themselves in all sorts of roles. So it wouldn’t surprise me to see more of them in those roles. A couple of dealings I have had with (name of Council) – they have had a couple of workers who have both been Div 1s….. Any profession where you are reasonably highly skilled and likely to get burnt out, they could end up in various roles” (Industry training board representative).

With the exception of district nursing/bush nursing services, a nursing qualification for assessors working in other organisational types may be their primary background but not likely to be their current work role. HACC assessment, again with the exception of district nursing/bush nursing services, would not qualify as ‘nursing practice (clinical care) and would therefore not meet the requirements for maintenance of nurse registration (http://www.nbv.org.au/). As one participant commented on letting her registration lapse: “after 5 years if you haven’t had any contact as a nurse you lose that. This job isn’t regarded as like nursing, so I am not still registered” (Clare).

4.1 Professional identities

In order to develop a better understanding of the individuals employed in assessment roles, more detailed information needs to be considered that will help to develop a deeper understanding of their professional identities. Table 6 (below) summarises some information about actual HACC assessors, those participating in this study, including

\(^3\) This comment refers to the version of the matrix shown to all key informants (see Appendix B). The matrix shown above (Table 5) has been refined to reflect this and other comments from research participants.
the type of organisation in which they are employed, and number of years in their current position. Other columns in the table, and for which further detail is provided in separate sections (following), are their position title, their professional background at time of commencement, any qualifications undertaken since commencement in the assessment role, as well as each participant’s professional memberships, if any. A section describing their progression into the assessment role also follows, but this is not represented in the table.
Table 6: Stage Two participants (current positions and backgrounds)

<table>
<thead>
<tr>
<th>Interview code &amp; pseudonym</th>
<th>Employing organisation type</th>
<th>Position Title</th>
<th>Years in current position</th>
<th>Professional background (formal qualifications) at time of commencement</th>
<th>Qualifications since commencement</th>
<th>Professional membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Anna)</td>
<td>Local Government Authority</td>
<td>Team Leader</td>
<td>8</td>
<td>Associate Diploma of Human Services (Welfare studies)</td>
<td>Commenced management &amp;</td>
<td>Australian Association of Gerontology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commenced gerontology</td>
<td></td>
</tr>
<tr>
<td>B (Bonnie)</td>
<td>Local Government Authority</td>
<td>Team Leader</td>
<td>6</td>
<td>Division 2 Nurse</td>
<td>Certificate IV in Community</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>C (Clare)</td>
<td>Local Government Authority</td>
<td>Assessment Officer</td>
<td>7</td>
<td>Division 1 Nurse &amp; Bachelor of Health Sciences</td>
<td>Nil</td>
<td>No</td>
</tr>
<tr>
<td>D (Delia)</td>
<td>Adult day care centre; and Ethno-specific or Indigenous service</td>
<td>Social Support Coordinator</td>
<td>8</td>
<td>Bachelor of Social Work (recognised overseas qualification)</td>
<td>Nil</td>
<td>Australian Association of Social Workers</td>
</tr>
<tr>
<td>E (Ellen)</td>
<td>Adult day care centre; and Community or charitable group</td>
<td>Senior Coordinator</td>
<td>4</td>
<td>Division 1 Nurse &amp; P/Graduate Diploma in Sterilisation and Infection Control</td>
<td>Undertaking MBA</td>
<td>Nurse Registration &amp; Australian Nursing Federation</td>
</tr>
<tr>
<td>F (Faye)</td>
<td>Disability service</td>
<td>Host Program Coordinator</td>
<td>8</td>
<td>Division 1 Nurse (midwife)</td>
<td>Undertaking degree in counselling psychology</td>
<td>Australian Professional Counsellors Association</td>
</tr>
<tr>
<td>G (Grace)</td>
<td>Community health centre or primary care agency</td>
<td>Case Manager</td>
<td>5</td>
<td>P/Graduate Diploma in Program Evaluation &amp; P/Graduate Diploma in Organisational Behaviour</td>
<td>Studying theology</td>
<td>No</td>
</tr>
<tr>
<td>H (Heather)</td>
<td>Community or charitable group</td>
<td>Assessment Coordinator</td>
<td>1.5</td>
<td>Division 1 Nurse &amp; Bachelor of Education</td>
<td>Nil</td>
<td>Nurse Registration &amp; Australian Nursing Federation</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Position</td>
<td>Years</td>
<td>Qualifications</td>
<td>Experience</td>
<td>Certification/Registration</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------</td>
<td>----------------------------------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>I (Ivan)</td>
<td>Local Government Authority</td>
<td>Assessment Officer</td>
<td>3</td>
<td>Division 2 Nurse</td>
<td>Nil</td>
<td>Nurse Registration &amp; Case Management Society of Australia</td>
</tr>
<tr>
<td>J (Jennifer)</td>
<td>Community health centre or primary care agency; and Ethno-specific or Indigenous service</td>
<td>Case Manager</td>
<td>1</td>
<td>Bachelor of Arts in Psychology &amp; Graduate Diploma in Human Services Management</td>
<td>Nil</td>
<td>No</td>
</tr>
<tr>
<td>K (Katherine)</td>
<td>Community health centre or primary care agency</td>
<td>Community Resource Advisor</td>
<td>3</td>
<td>Occupational Therapist</td>
<td>Nil</td>
<td>No</td>
</tr>
<tr>
<td>L (Lionel)</td>
<td>Disability service; and Community or charitable group</td>
<td>Community Connections Team Leader</td>
<td>3</td>
<td>Advanced Diploma in Welfare Studies &amp; Graduate Diploma in Disability Studies</td>
<td>Nil</td>
<td>No</td>
</tr>
</tbody>
</table>
4.1.1 Position titles

Stage Two participants were asked their current job title (2-Q1). The following are each the titles of two participants (also identified in Table 6): Team Leader (A,B), Assessment Officer (C,I) and Case Manager (G,J). The remainder are the titles of individual participants: Assessment Coordinator (H), Senior Coordinator (E), Social Support Coordinator (D), Host Program Coordinator (F), Community Resource Advisor (K), and Community Connections Team Leader (L).

Two participants (H,K) expressed dissatisfaction with their current position title as they felt their titles did not accurately convey the nature of their work nor of their particular expertise. Further, use of the term “assessment” in the title created a mindset of reducing the job to a series of tasks. For example, Heather made the following comments about her title and those of team members:

“…from an industry point of view I am an assessment officer. In actual fact my title within the organisation …is Assessment Coordinator. That’s … what’s printed on my business card. Whereas the other two members of the assessment team are called assessment officers which I think is pretty hideous term and I think they do too, but the alternative that someone came up with was ‘assessment worker’ and I thought that sounded like putting pieces on a circuit board in a production line. So we didn’t like that either and I don’t know what other terms are around. …. assessment officer sounds like you go around with a peaked cap and a clip board and we like to think that we’ve got a better approach than that….“ (Heather).

In Stage One, a key informant noted “in local government … you tend to work to position title rather than discipline” (Local government senior manager). The data presented in this section shows that this is also true of HACC assessment staff in other organisational types.

The variety of job titles gives some indication of the differences between different assessment positions. However, the titles do not always accurately convey the main responsibilities of the job, nor do they describe the professional background of the workers.
Summary

- A variety of position titles is used, although they do not necessarily convey the responsibilities of the job
- Some discomfort about position titles was expressed because titles do not convey the expertise of staff, and can give the impression of a reductionist version of their job

4.1.2 Primary professional backgrounds

The professional backgrounds of the participants at the time they were selected for their current position (2-Q3) are varied (refer to Table 6). Their backgrounds include social work (D), occupational therapy (K), two year qualifications in welfare studies (A,L), and an undergraduate degree in psychology (J). Four participants had been Division 1 nurses (two retain registration), and a further two had been Division 2 nurses (one retains registration). The evident variation in workers’ primary professional/educational backgrounds is supported by the following quote from a key informant (12) who is describing the profile of her assessment team in a local government aged and disability service (1-Q1):

“So in a team of seven, counting the intake worker, we have two social workers, two with welfare qualifications, and three with post-secondary qualifications but not discipline-based - including one physical scientist - and all have experience both here and elsewhere… Three of these people have also worked, maybe when they were students, as attendant carers or personal carers so they have done that very hands on work. One of them has also done the Certificate in Community Services Management and also the personal care certificate some years back” (Local government senior manager).

Summary

- There is diversity of primary professional backgrounds amongst HACC assessment staff, although nursing is the most common, followed by welfare and social work

4.1.3 Further formal education

Participants in Stage Two were asked if they had undertaken any formal study or education since commencing in an assessment role (2-Q4). Seven participants had not, and five have completed or commenced a qualification (shown in Table 6). They
include management (A,E), gerontology (A), and counselling psychology (F) in the higher education sector. For example:

“I’m a third of the way through my MBA. I am doing this for a couple of reasons. Firstly, my Division 1 training was hospital-based and I needed something more on paper. And within the management role I felt I needed some more formalised qualification. The course I chose was work-based, as in work-based projects like developing funding applications. I started it very soon after I started in this role. I used it to analyse my team and to look at a whole range of things that were contributing to the workplace environment. It was great” (Ellen).

One participant (B) had completed a Certificate IV in Community Services from the VET sector:

“…That was a three year course. And that covered everything we do as team leaders. It was office based and covered assessments, even things like teaching. We are a base for a training organisation … so I did that course here [at work]…” (Bonnie).

Another participant (G) is studying theology through interest, and did not feel it directly related to her work. Anna had enrolled in courses since commencing in an assessment role but had not completed them. Her reasons for not completing the courses were mainly due to her dissatisfaction with the external mode of study:

“… With correspondence when I started to do it, I sat there for three nights and read a book, not with anyone else, no one to bounce ideas off with. … I wasn’t getting anything out of it. It is the people, the lecturers and all the others you study with that make the whole experience worthwhile” (Anna).

**Summary**

- Less than half of the Stage Two participants had undertaken further formal study since taking up their assessment role
- Of those who had undertaken further study, their fields of study are varied and there is no obvious common thread amongst them
- Work based education was preferred
4.1.4 Membership of professional associations

HACC assessors were asked if they belonged to a professional body or association (2-Q5). Half of the participants did not belong to any professional association or body. Of the six that did belong to a professional association they were:

- 2 Nurse Registration (Div 1) & Australian Nursing Federation
- 1 Nurse Registration (Div 2) & Case Management Society of Australia
- 1 Australian Association of Gerontology
- 1 Australian Association of Social Workers
- 1 Australian Professional Counsellors Association

For Faye, belonging to a professional association is more about where she sees herself heading in her career rather than to benefit her in her current position:

“I’ve just let my nurses registration go – not sure it was a good idea but I have just let it go. I’m currently a member of the Australian Professional Counsellors Association. … I see that’s the direction I’m going to be heading” (Faye).

Delia, a social worker, maintained membership of the Australian Association of Social Workers and commented that:

“It is just to keep abreast of relevant information and keep my skills up to date. … I don’t really find the AASW that helpful actually. I don’t get much out of it except to receive information and things like that. It is not that much different to the information I get from the other networks I belong to” (Delia).

Of the four participants with current nurse registration, only one (E) stated that registration is a requirement of her assessment position, although she also acknowledged that this requirement was probably due to her manager’s preference for employing nurses rather than an actual requirement of the job. One of the registered nurses (H) commenced working in community care after 20 years in a hospital environment. Although she had left nursing 18 months previously, she still retained her ANF membership and her nursing registration, but had let her Royal College of Nursing membership lapse for financial reasons. Ivan belonged to the Case Management Society of Australia because he felt this group reflected the nature of his work, and because his employer paid the annual membership of the group for himself and his colleagues. He also maintained his Division 2 nursing registration so that he could “still
work the odd hospital shift pretty much when I want to…for a bit of extra cash” (Ivan). Katherine, whose background is occupational therapy, rarely uses her official job title of “community resource advisor”. However, she does not maintain membership of the OT association as “about three years ago” she had decided that she “didn’t really want to be an OT anymore”.

Faye commented at the end of the interview when she was invited to ask me questions or to make further comments, that there was something missing in the sector, such as a professional association that would assist assessment workers and provide professional support. This issue is addressed more fully in section 6.5.2.1. Similarly, another participant (12), responding to a question about the adequacy of training provision for assessment staff (1-Q6), commented that HACC assessment staff experience difficulties in the sector because of a lack of clear professional identity:

“…unless you have a discipline-based profession so you know you are a social worker or an OT, well what are you? You are not a ‘something’. In a very health-oriented field I think people often feel that their experience and expertise is not recognised by others such as Doctors, nurses, OTs from other agencies. Given that a lot of referrals come from health-based agencies, if you are just the intake worker or the team leader/assessment officer, often other professionals aren’t clear who they are talking to in terms of what can be shared based on this person’s knowledge and professionalism. The workers themselves often feel that they don’t get treated well by GP’s receptionists and so on” (Local government senior manager).

**Summary**

- The range of professional associations/groups to which these assessors belong is diverse, as are their reasons for membership
- Half of the participants did not belong to any sort of professional association
- Assessors lack a professional identity recognisable by other professionals in the sector

**4.1.5 Progression to HACC assessment**

Three participants had a long history in aged and/or disability services, and their current role in HACC felt like a natural progression for them to a new and more challenging context (2-Q2). The contexts are: case management for people with complex care needs
(G), Indigenous clients (J), and people with complex care needs due to psychiatric and/or intellectual disability (L).

Two of the nurse-qualified participants (I, H) stated that they moved into the HACC role because they needed a change from the hospital setting (and this change was relatively recent), and another (C) had already made this change by moving into a district nursing role before being offered the job as assessment officer for a local government HACC service. Another (E) felt that coordination of a day care centre was a natural progression for a Division 1 nurse wishing to move into a role that required expertise in both management and assessment. The other two participants with nursing as their primary backgrounds (F, B) had moved into the HACC sector many years previously and had worked for a number of different organisations before commencing in their current job.

For Katherine, whose primary background is occupational therapy, the move into HACC assessment was opportunistic rather than planned because it suited her family situation:

“About seven years ago I joined the … Health Care Group and became employed by the Home Assessment and Rehabilitation Team, and that team had a HACC component – they had recently won the contract to assess for the HACC services - the local Council provided the HACC service itself. That was just being set up and when I came in … So I started there, and mostly I was an Occupational Therapist. I had a child four years ago and worked on and off as an Occupational Therapist but found it too stressful and couldn’t perform the work in a way that I wanted to. Anyway, one day they rang and said ‘look there’s some HACC assessment time if you’d like to do that’. So I’ve been doing that” (Katherine).

Anna’s is a story of someone who began as a carer working at the Council where she is currently employed and moved in to the office setting before beginning in an assessment role. Her training was undertaken whilst she moved into the role:

“A bit of a journey – I have worked in HACC for 17 years. I started off when my son went to high school – I became a member of the home care team. … It was something that really suited me at that particular time of my life. Within two years of working in the home care team, they created an admin position and I had been doing a bit of typing and working with computers so I went for that position. So I went into the office running rosters having been a home care worker for two years. At that time the manager was - there were no known qualified assessment staff - my manager had been in admin at the Council for 27 years and therefore had got to be the home care supervisor and actually assess. The push back then
was to try to get more qualified people into assessment. He saw that I was very interested so the Council paid for me to go back to Uni... I went with welfare studies” (Anna).

Delia followed the progression that is suggested of many of the staff in ethno-specific services (8,11) by undertaking work for her community that then developed into a HACC service. However, in Delia’s case, she came to her current job with a formal qualification in social work and a long history in aged/community care:

“I have been doing this job … about eight years. Before I got this job I was working for the Migrant Resource Centre as a project worker. At the time they were looking at the home and community care needs of [my ethnic community]. So I got to do the research and was lucky enough to be given the job to implement the recommendations. It was really good that I was the one that did the needs study and implemented the recommendations as well. Before I came to the Migrant Resource Centre I was with local government for 16 years as the aged services coordinator. …” (Delia).

Summary

- The reasons individuals become employed in HACC assessment roles are varied and include dissatisfaction with previous work settings (acute), family reasons, or are simply circumstantial
- HACC settings can be a logical progression for those with disability backgrounds seeking challenging or more specialised work contexts
- Primary backgrounds rarely lead workers directly and ‘purposely’ into HACC assessment
- None of the participants had undertaken training specifically to work in community care assessment prior to commencing

4.2 Work contexts

The findings so far show that there is great variation in the types of people employed in assessment roles. Similarly, we may anticipate that there is likely to be significant differences in the types of assessment jobs available and in the work contexts. In this section, evidence is provided of diversity arising from factors such as the number of assessment staff they work with or whether they are a lone worker, the geographical location, organisational characteristics such as organisational ethos or size, the role description of individual assessment positions, and the clientele they work with. Table
7 (below) summarises some of these features for the HACC assessors participating in this study, and further detail on these areas are provided in separate sections (following). Other areas of potential differences, and for which further detail is also provided below, include the proportion of the job devoted to assessment, the model of assessment used by the employing organisation, and service system characteristics.
<table>
<thead>
<tr>
<th>Interview code &amp; pseudonym</th>
<th>Number of assessment staff in organisation</th>
<th>Location</th>
<th>Organisational characteristics</th>
<th>Role description</th>
<th>Clientele</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Anna)</td>
<td>8</td>
<td>Urban</td>
<td>Large Council; multiple HACC services</td>
<td>Assessment, plus management of 30 home care staff</td>
<td>General HACC target group; significant proportion of people with psychiatric illness.</td>
</tr>
<tr>
<td>B (Bonnie)</td>
<td>6</td>
<td>Urban</td>
<td>Large Council; multiple HACC services</td>
<td>Assessment, plus management of 30 home care staff</td>
<td>General HACC target group; high proportion of frail aged people; growing proportion of multicultural clients.</td>
</tr>
<tr>
<td>C (Clare)</td>
<td>4</td>
<td>Urban</td>
<td>Large Council; multiple HACC services</td>
<td>Assessment only</td>
<td>General HACC target group; high proportion of multicultural clients</td>
</tr>
<tr>
<td>D (Delia)</td>
<td>Lone</td>
<td>Urban (Cross-regional)</td>
<td>Small ethno-specific agency; multiple HACC services (day care, friendly visiting, community based transport, senior citizens clubs, and ‘telelink’ program)</td>
<td>Assessment, plus coordination of all HACC services (small scale)</td>
<td>General HACC target group for one specific ethnic community</td>
</tr>
<tr>
<td>E (Ellen)</td>
<td>Lone</td>
<td>Urban</td>
<td>Church-based organisation offering multiple services</td>
<td>Assessment, plus management of 2 full time day care centres</td>
<td>General HACC target group; mainly people with dementia; some with psychiatric histories; younger people with Parkinson’s disease needing respite</td>
</tr>
<tr>
<td>F (Faye)</td>
<td>2</td>
<td>Urban</td>
<td>Small, community based volunteer respite service</td>
<td>Assessment, incl. family case work, plus volunteer training and</td>
<td>Children with disabilities and their families needing respite; 50% from</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>coordination</td>
<td>multicultural background</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>G (Grace)</td>
<td>8</td>
<td>Urban</td>
<td>Non-government agency providing case management</td>
<td>Assessment, and on-going care coordination/case management</td>
<td>General HACC target group with complex needs</td>
</tr>
<tr>
<td>H (Heather)</td>
<td>3</td>
<td>Urban</td>
<td>Local, community-based welfare organisation</td>
<td>Assessment, plus coordination of assessment team (.6); plus coordination of all nursing assessments for personal care (.4)</td>
<td>General HACC target group</td>
</tr>
<tr>
<td>I (Ivan)</td>
<td>5</td>
<td>Rural/Regional</td>
<td>Council; multiple HACC services</td>
<td>Assessment only</td>
<td>General HACC target group; high proportion of multicultural clients</td>
</tr>
<tr>
<td>J (Jennifer)</td>
<td>2</td>
<td>Rural/Regional (Cross-regional)</td>
<td>Large primary care agency, large geographical area</td>
<td>Assessment, and on-going care coordination</td>
<td>General HACC target group for Indigenous community</td>
</tr>
<tr>
<td>K (Katherine)</td>
<td></td>
<td>Rural/Regional</td>
<td>Large generic health service</td>
<td>Assessment only</td>
<td>General HACC target group</td>
</tr>
<tr>
<td>L (Lionel)</td>
<td>4</td>
<td>Rural/Regional</td>
<td>Church-based organisation, specific service within larger welfare arm offering multiple services, outreach model</td>
<td>Assessment, and on-going care coordination/case management, plus coordination of team</td>
<td>People with complex needs due to psychiatric illness and/or intellectual disability</td>
</tr>
</tbody>
</table>
4.2.1 Role descriptions

One of the differences between assessment roles in the sector is the proportion of work time devoted to assessment relating to each worker’s role description (2-Q1). Some jobs are comprised only of assessing individual clients, while others also include responsibilities such as staff management, service coordination and information management in addition to their individual client assessment function. These are indicated in the table for each participant.

The individual’s seniority in the organisation can make a difference to the proportion of their time devoted to assessments. For example, two participants (H, L) are team leaders with responsibility for supervision of other assessment staff. Whilst their teams are focused on assessment, their own supervisory role within the team means that they have other duties associated with managing the other assessment staff in addition to undertaking individual client assessments.

All of the participants in this study worked in roles that had an assessment component of 50% or more. There may be many other people working in HACC services where assessment comprises less than 50% of their overall role but is nevertheless an important part of the individual’s role, and important for their service users.

Summary

- Some assessment jobs are comprised only of assessment, while others carry a wider range of responsibilities

4.2.2 Model of assessment

The model of assessment described here simply refers to the way assessment is structured within each organisation and the organisation’s overall assessment role in the local area and can be either integrated or separated from service delivery (2-Q1, 2-Q7). The model of assessment is a significant point of difference between work contexts, in particular because it can determine whether or not the assessor has an ongoing role with the client. An integrated model refers to assessment and service delivery being connected within the service or through an ongoing case management role.
Of the four local government authorities included in the sample, two operated with a model of assessment which is integrated with service delivery (A,B) and two operated with a model of assessment separated from service delivery (C,I). Of the latter two, one (C) had retained the service delivery function and had kept the assessment team both physically and structurally separate from service delivery teams, and the other (I) had contracted out the service delivery to a private organisation, having lost the tender for service delivery.

Four other organisations in the sample had models of assessment separated from service delivery. In three of these cases (G,K,L), services are provided by other organisations. The other (H) provides services in-house, but maintains a functionally and physically separate service delivery arm. Two of these have an on-going case management role with their clients (G,L) and the other two (H,K) do not maintain any ongoing contact with their clients except when a reassessment is required such as when needs change or for regular reassessments.

For the other (non-Council) organisations that have a model of assessment which is integrated with service delivery, the role of the assessor can include duties associated with the management and coordination of ‘hands-on’ carers (D,E,F), although the degree of involvement with care staff can vary. For example, Faye undertakes recruitment and training of volunteers and coordinates respite placements for her clients in addition to her individual client assessments. However, this is on a relatively small scale compared to the responsibilities of management of 30 staff and the on-going daily care of up to 400 clients which is the case for some Council staff such as Anna and Bonnie. The assessment role can also be free of staff management or coordination duties in integrated models. For example, in Katherine’s organisation, a number HACC services are managed and provided by other staff within the organisation and the model of assessment and service delivery is very flexible to allow for an on-going care coordination role by the assessment staff if required. However, the assessment staff are not directly responsible for staff or care delivery.

The Council assessment staff participating in this study generally preferred the integrated assessment model. However, staff in positions that combine management, as well as assessment, cannot always undertake the assessments for all clients coming in to their care due to high demand or other work pressures. At these times they rely on
assessments being undertaken by others in their service, or they will employ someone on a temporary basis to get the assessment workload under control. For example:

“I find if I have done the assessment it is fabulous because I can really work with the family and work with the carer. If our assessment team have done it I am very dependent on the quality of their information. I don’t enjoy that as much. I prefer to meet the people myself. But there are just not enough hours in the day – I can’t always achieve that” (Anna).

“I think the way we do it here is best, because we can follow an assessment right through to matching up a client with a worker and beyond. ….. (W)hen we get behind in our assessment we get people to come and just do assessments for us and hand them to the team leaders” (Bonnie).

One participant (C) who works for a Council with an assessment service separated from service delivery was clear that an integrated model has more benefits. The Council had decided to separate assessment and service delivery and put service delivery out to tender, and then subsequently won the tender to provide services:

“Having worked in both systems I think I prefer the other way to be honest. Only because if we have contact with the workers – the people that actually have the contact with the clients - the feedback is better. This way the feedback has to come through other people to us and I guess the more people it has to go through, the less well that it works’ (Clare).

The issue of getting to know clients well is particularly important in the day care (planned activity group) context (E). As Ellen pointed out, clients need to be carefully matched when they come in for respite and the assessment and on-going care role on-site enables this to happen very readily. Assessors who have an ongoing case management role because they work with clients with more complex care needs (even if assessment is separated from service delivery) (G) also have the opportunity of getting to know clients over a period of time. The experience of assessors in these types of positions is to work with fewer clients, but potentially to have a much greater depth of understanding of their clients.

Summary

- Both integrated and separated models of assessment are present in HACC
- Integrated models are generally preferred by assessors because they allow for an ongoing relationship with clients
4.2.3 Clientele

The clientele of individual organisations is another potential source of difference between assessment positions (2-Q6). Within the broad HACC target group of “frail older people and younger people with disabilities” (Department of Human Services, 2003) there is a wide range of clientele resulting from characteristics such as language or cultural backgrounds, age and disability type. Some organisations are funded to provide a HACC service to the whole HACC target group (for example, A,B,C,E,G,H,I) and some are funded to provide a service to specific groups within the broader HACC target group, (for example a specific ethnic/cultural group as in D and J, or a specific disability type or age as in L and F). For Grace, although she works for an organisation that provides a service for the whole HACC target group, the service is targeted to people with high or complex support needs and who require case management.

Geographical location of the organisation can have a significant impact on the characteristics of the clientele of individual HACC organisations. For example, one local government-based assessor (A), whose organisation provides a service to the whole HACC target group, works in an area with a large psychiatric hospital nearby which means that many of her clients have a history of psychiatric illness. Psychiatric disability may be less of a feature of the clientele of organisations in areas where there is no major psychiatric hospital. Another (B) works in an area where there is a high proportion of people with acquired brain injury living in public housing flats in an inner-city part of her catchment area, most of whom are clients of her service. For other organisations providing a service to the whole HACC target group, geographical location can also result in a high proportion of the clientele being from multicultural backgrounds (B,I), which in turn has an impact on the nature of the work these assessment staff undertake.

“The service is changing so much because of all the different nationalities we see now. We have the Muslim women who have 5 or 6 children, and if one of them has a disability we have a job just to keep them above board. It is huge for them” (Bonnie).
It is also the experience of assessors in rural areas often to know their clients through other jobs they have done (I, L), or other areas of their lives such as through personal relationships they have via their own family or other community connections (I):

“… I suppose because I have lived in this area all my life, I will go into a lot of clients’ houses and see a photo on the wall of someone I either went to school with or I’ve worked somewhere with or you know them from somewhere, whether it’s sport or whatever from outside, and all of sudden you’ve got this rapport with the client. So you get a lot closer to your clients here. Even though we’ve got a lot, you still have a pretty good relationship with them. And you find that they ring you for anything – like they have a problem so they’ll ring me first because they know me. It’s probably much easier” (Ivan).

Multicultural diversity can be experienced in organisations providing a service to narrow target groups such as families with a child with a disability (F):

“It’s very diverse, it’s a very multicultural area … more than 50% of our clientele are from a non-English background, which is an isolation… for those people. There are language barriers, system barriers all those types of things that these people don’t know. There’s also a different cultural thing in their own countries, there was more of that extended family support, village support for them. Out here they don’t have that, that’s lost. So there’s a higher need for the sort of hand holding type of support initially for them to get into the system, to start to understand the system and how to access it” (Faye).

Diversity of clientele can be experienced by assessors within their organisations, as well as between assessors working in different organisations, as Grace demonstrates:

“(T)he field is so broad, I mean, I can give you an example of a 97 year old client with dementia, but I’ve also got a 5 year old client in palliative care. I’ve got a 48 year old client with MS, so that’s the range of clients, and probably in the last couple of years it’s become more complex” (Grace).

Jennifer, who works for an Indigenous organisation, discussed the need to use different approaches to assessment and service delivery, approaches that she would not think of using if she was working in a mainstream organisation, which she described as “a different cultural way”:

“We went to visit someone not so long ago, and there had been a lot of deaths in the family, they’d been involved in identifying bodies, stolen generation history, all sorts of stuff. Anyway the immediate thought, being from mainstream, was counselling. But because there is a spiritual healing process here then we involved them and they are now accompanying that person back to the cemetery, back to
Jennifer also spoke about the different way of communicating that occurs within the Indigenous community, particularly the different way she receives feedback about her work and whether or not she has been accepted by her clients and their families. This feedback will typically be indirectly conveyed to her and in terms very unlike those she experienced working in mainstream organisations. Likewise, Delia, who works for an ethno-specific organisation, spoke about the need to be aware of the specific cultural beliefs and mores of her community, all of which should play a significant part in her approach to her assessment and care planning practice:

“(O)ne client I had recently who was illiterate and on her own and I had to refer her to mainstream agencies because she had a fall. I referred her for meals and for some home care. And because she is illiterate it took me a month to be able to say that she is safe. The first house keeper was Anglo-Saxon and she got a shock when she saw her. Being [her ethnicity], it is the other way around in [her country] – that is, the maids would be like her. And now she is having an Anglo-Saxon house keeper. So that is a no-no, having a white as a house keeper. And the following week I referred her for physiotherapy because of the fall. And a man came - again it is a no-no for her to be touched by a man. I explained to her that it is to help her physical mobility and that there is no female physiotherapist from the hospital. So you know, explaining that and knowing the cultural and the traditional side of things and telling her that it is okay here, it took me a month. Because she kept ringing me and saying ‘he is here, should I let him in?’, or ‘the housekeeper is here but it is a different one. What happened to Louise?’ So it is me that has to tell her that Louise is sick and they have sent another one” (Delia).

These findings suggest that assessors who are employed to work with specific HACC populations may require different knowledge and skills to assessors working in organisations with a more generic target group. One way of dealing with the different skills and knowledge required for different types of clients is for individual assessors to take on ‘speciality’ roles within their teams. Grace, for example, tends to deal with a higher proportion of younger people with disabilities in her case load because she is acknowledged within her team as having a higher level of knowledge and more extensive networks in the sector than her colleagues.

One of the significant trends evident from the interview data is the fact that the nature of the clientele requiring HACC is changing. In particular, client needs have become more
complex and this results in making the job of assessment more complex (4,8,9,10,A). For example:

“… because of what is happening with our ageing population and with our policies around deinstitutionalisation, people are dealing with more and more complex people” (Community services consultant/trainer).

One participant (2) was clear that elder abuse and depression were becoming more prevalent in the community. In relation to elder abuse, this participant felt that it was essential that assessors were fully aware of the new knowledge about elder abuse and how to respond to it. She also felt it essential for assessors to be aware of how to recognise and respond to depression in older people:

“Depression is a big issue too amongst the older population. Second to young men, the older population has the highest suicide rate. If you want to adopt a holistic and health promotion approach where you are acknowledging the social connectedness and isolation factors that influence a person’s state of health – unless you have got someone who has a knowledge of those psycho-social issues and the ability to talk through these issues with the person, to empathise and actively listen to what the person is saying, then you may not be able to move towards a better outcome” (Aged and disability services researcher/trainer).

Focusing on carer needs in the assessment process also requires particular skill and knowledge. For this reason, carer consumer and advocacy groups have advocated for a greater focus on carers in the assessment process:

“… we would say that carers are the ones that do most of the work and that your interventions need to be focused on what it is that they need to help them cope with what has the potential to become a difficult situation” (Consumer peak body employee).

**Summary**

- There is substantial diversity of clientele within HACC services resulting from variables such as geographical location, disability type, age, and cultural and linguistic background and literacy
- Organisational type (and focus) and geographical location can affect the characteristics of the clientele individual assessors work with
- Diversity and increasing complexity of clients is creating new demands on assessors
- Client diversity and complexity may require new and different knowledge and skills of assessors
4.2.4 Organisational characteristics

Organisational characteristics may be expected to impact on the work contexts for individual assessors (2-Q6). Some of these (such as learning culture and workplace support) are reported in Chapter Six. More basic characteristics that contribute to the nature of different assessment positions include size and organisational ethos including commitment to external relationships.

In smaller organisations, such as ethno-specific agencies, assessment staff may have to take on an even broader range of duties including community development, writing funding submissions, or program evaluation, all of which require additional skills to those required for their assessment and care planning role, a point made strongly by Delia. This observation was also made by key informants (1,11). For example:

“I think it ranges throughout all the organisations involved. If you were looking at the ethno-specific organisations, sometimes there could be one person that does everything – they run the groups, they do the assessment, they provide the services. It just depends on the level of funding they get, and there are many small ethno-specific agencies” (Social research consultant).

Two participants (D,F) worked for small organisations with community-based management committees. In these cases, there is a sense of extra responsibility for staff in assisting to support the management committee. Delia, who works in an ethno-specific organisation, expressed a further sense of responsibility. Because hers was the only organisation focusing specifically on the needs of older people from this ethnic community, she felt a responsibility to plan for the future to ensure their needs are met on a statewide basis:

“… in ten years time [this ethnic] community will be the sixth largest group nationally with 65 years and over population. That is why we are doing a lot of studies and consultation with the community so that we can address the gaps in services and address the issues that could be happening in our community in five to ten years time. I am not interested in just maintaining or enhancing our HACC services. I want to look into the future. We don’t want to wait for that time and say ‘well what are we going to do now’. We need to have some forward plan, some vision, on how we can address those problems, because it is really an ageing community” (Delia).
All the other organisations where Stage Two participants were employed were fairly large including two which are church-based organisations offering multiple services (although the participants worked in specific branches) (E,L). Another is a non-government agency providing case management with “a reputation for being fairly innovative and creative in its work” which is “attractive” to potential employees (Grace). Four participants work in large Councils, which have substantial infrastructure. However even seemingly homogenous organisations such as these can be highly variable in terms of their management/organisational structure as was pointed out by a key informant (referring to Councils) (12). The four assessors (in Stage Two) who work in Councils offered comments that indicated that the commitment to aged and disability services and to assessment can be variable between individual Councils (A,B,C,I).

The organisational values or ethos can also have a direct impact on the work environment for staff (2-Q6). The following quotation illustrates that the values of charitable/church-based organisations can create very supportive work environments, appropriate for the nature of the work:

“It is actually very supportive. Several months ago we lost ten clients in about two weeks and it was very stressful for everybody including the other clients. But given that this is a church-based organisation they’ve got very supportive pastoral care. The Director of Pastoral Care came out and saw us all individually and we got counselling, and I think he was visiting once a week. …. he was supporting us very well. I think that is quite unusual. That made a real difference” (Ellen).

When asked about the context of the organisation she worked for, Faye cited the organisational ethos as being the most critical feature for her:

“I guess the thing that’s kept me here is the ethos of the organisation. It’s what everyone here is working for and that’s about ensuring that the voice of families who have children with disabilities is heard, that we empower them to be able to support themselves and to make decisions, and to advocate for themselves. It’s about the dignity of that family and particularly the young person with the disability” (Faye).

Some organisations were strongly committed to external relationships, indicated by some participant’s descriptions about relationship with other service providers (H,E,G). Heather, for example, recognised that her organisation has always had a strong commitment to fostering cooperative relationships with others service providers and
that this makes a big difference to her work. Likewise, two participants (E,G) were
couraged and supported by their organisations to be involved with external groups.
In both cases, they had had leading roles in developing groups in their local areas. For
Ellen, this was a group of ‘like’ service providers, and for Grace, she had been involved
in establishing support groups of carers and clients (and related service providers),
duties, as she pointed out, that are not generally regarded as core business for case
managers.

Summary

- Organisational size and ethos contributes to the diversity of work contexts for
  HACC assessors
- Different organisational values/ethos contributes to the degree to which workers can
  participate in broader activities

4.2.5 Service system characteristics

The majority of participants in Stage Two reported that they had very good relationships
with other service providers in their local network (2-Q8). These participants
(B,C,D,E,F,G,H,I,K,L) had regular opportunities to connect with the other service
providers in their local area via a variety of formal meetings such as weekly hospital
discharge meetings, or weekly ACAS meetings. They also had regular contact with
other service providers in their local area outside these formal meetings in relation to
individual clients they had in common, and generally reported good cooperative
relationships.

However, participants indicated that considerable time and effort is required by them to
foster and maintain these relationships, and the sheer number of related service
providers means that this comprises a significant proportion of their work. In particular,
assessors have to make choices about the formal networks they will become involved
with, and they tend to prioritise those that relate directly to client coordination issues
(A,B,C,K). Whilst this may be problematic for all assessors, part time staff are
particularly disadvantaged and may choose not to participate in formal network
meetings, as was the case with Katherine. This view was also expressed by key
informants (1,11). For example:
“…if you are employed 15 hours a week and you are there to do a job and you have a certain number of clients that you are looking after - the key issue is how do they fit anything else in to their time? The offshoot is that they need to be fitting in to what is happening. If they don’t they won’t be able to do their job in the way that’s expected of them” (Community worker).

Jennifer, who works in an Indigenous organisation, identified some problems working with mainstream organisations (evidenced by low rates of inquiries and requests from them) related to their lack of knowledge of the role of her own service. However, she felt that this needed a greater effort of her own part to make sure these agencies were familiar with the role of her organisation and the particular needs of Indigenous people. Attendance at relevant networking meetings in her local area is one strategy to achieve this, however, because hers is a cross-regional service, this means that there is extra work to attend network meetings in more than region:

“Our problem is that because we service such a large area, we can’t keep up those contacts. It tends to be on a needs basis and you don’t tend to get a lot of time to do that community development” (Jennifer).

Other local formal networks that have a broader agenda beyond the level of individual clients (and that meet less frequently such as monthly or bimonthly) mentioned by participants included regional networks of disability services and HACC service provider meetings. These meetings focus on funding, planning and policy issues as well as coordination issues within their local service system. Some participants attended formal network meetings associated with their particular service type or clientele, for example, regional ethnic services (D), regional day centre coordinators (E), and regional volunteer agencies (F). One participant (L) attended a biannual statewide network meeting of organisations working with the same clientele.

As I reported in the literature review, the broader service system at present is characterised by a large number and a diverse range of service providers including brokerage programs. These have developed largely in response to the changes associated with the increased complexity of the client population as well as the increasing complexity of the service system. In this context, service system fragmentation is now a major area of concern. The view was expressed that this situation may be placing extra pressure on assessment staff:
“We would say that the system has become incredibly fragmented with the package programs and all the other brokerage arrangements. So for an assessment officer working out what role the Council is going to play, and working out what the total range of services provided by different agencies will be, that adds another layer of complexity. Working out what is fair for different clients in that sort of system must be very difficult. … It was never an easy job to start with, but it is hard now in this complex environment” (Local government peak body employee).

The PCP reforms are designed to address many of the issues associated with service coordination within a complex system. Key informants overwhelmingly identified PCPs as the most significant policy development likely to impact on assessment and related workforce issues, and all participants in Stage Two reported that their organisations were involved in their local PCPs. However, it is also evident from the Stage Two interview data that many of the PCP initiatives do not involve assessment staff directly. Rather, managers and service coordinators are more likely to be involved in the formal meetings associated with the local PCPs (F,I,J,K) raising questions about the benefits of PCPs for individual assessors.

Participants in both stages strongly articulated the need for assessment staff to participate in formal networks and meetings to assist service coordination and cooperation (whether or not they are related to the PCP initiative). However, these opportunities may not eliminate problems with role boundaries completely, although they may provide a forum for dealing with any that arise, as was evident from Anna’s experiences. She identified some problems with role boundaries between her Council and the local nursing agency (mainly in relation to assessments for, and delivery of, personal care) and with her local ACAS. In particular, she mentioned that she had previously regularly attended the local ACAS meeting to discuss clients in common but that that they are now being “challenged” by what she is “allowed to hear” because of the new privacy laws, and so she now no longer attends regularly. She does attend regular Linkages (see glossary) meetings to discuss clients in common. Ivan articulated that formal meetings can actually mitigate against good networking because many people are not comfortable speaking in large groups and the benefits of these opportunities is entirely dependent on the participation of individuals who attend.

Primary Care Partnerships may be designed to solve many coordination problems but there is some evidence to suggest they may raise new coordination and connection issues for staff. As one key informant pointed out, some target groups, such as ethnic
groups, require workers to be networked beyond their local area and this suggests a separate set of skills and knowledge that assessors need to maintain beyond what PCPs will offer:

“there are some common target group interests and some local interests as well as broader policy interests that are happening beyond your own local area. One needs to be aware of the local as well as the bigger picture contexts” (Community worker).

Further, the degree to which assessment staff would be able to devote sufficient time in maintaining a broader knowledge base and networks as well as what is required of them at a local level through the PCP reform was considered impractical for part time assessment staff (reported earlier in this section). Faye also expressed the view that some of the service system reforms have been counterproductive for good networking, possibly because the agenda for many of the meetings became focused on issues other than the coordination of individual client care. Professional and organisational boundaries possibly became magnified in a culture of competition resulting from the CCT process:

“There was for a time, I felt, quite a strong competitiveness, a secretiveness. People were not sharing information. That was at the time that local government was going through their competitive tendering, and even after that. Just as the PCP stuff was coming in, there was a lot of secretiveness and competitiveness. People weren’t wanting to share and were very guarded about how they spoke at meetings and just even informally, you know, people who you had a fairly good link with were saying ‘look I can’t say that anymore because of where the organisation I work for is coming from’. So there wasn’t any sort of strong, or even semi-formal, network for people who were assessing out there for a long time” (Faye).

Another current controversy in the sector reported by key informants centres on the role that each stakeholder group (service provider type) feels they have on the assessment function (7,4). Local councils, nursing services and other groups all claim “they are the best placed to do assessments”, and “there is a lot of politics involved in assessment” (Service provider peak body employee). It was suggested (4) that this debate may result in part from the PCP reforms requiring greater definition about who is responsible for various types of assessment.

The assessment and service provision context in rural areas may be different from those in metropolitan areas, particularly in respect of the relationships they have with other
service providers. The following quotation, from a metropolitan-based worker, indicates her expectation that the service delivery context is more positive in rural areas than in her own geographical area:

“The difference in rural and metro areas is interesting. We are having challenges with [some of the service providers] as I said before. We feel at times that we don’t get the level of support we need from them with clients that might need wound care or catheter care for example. In my experience from talking to other assessment officers, it seems that there are much better connections in rural areas. The rapport between the allied health and nursing services with the Council are greater, probably because they are smaller and they need each other because there aren’t as many other services” (Anna).

Anna’s expectation of better professional relationships in rural areas was supported by one of the rurally-based participants in the study:

“… with the service providers … instead of just faxing them or emailing them a list of what they need to do for a client, you’ll do that but you may also ring them or you may even go do down and say g’day to them because you know them anyway and you have that closer work relationship” (Ivan).

Summary

- HACC assessors mostly reported good relationships with other service providers in their local area
- Although recognised as a critical requirement, attending to networking and communication with other service providers can be very time consuming for assessors
- Part time staff, and those who work with special target groups (and cross-regionally) can find it more difficult to maintain good service system relationships
- Cooperative working can be hampered by a culture of competitiveness in the service system
- Rural service systems may more easily foster good relationships between service providers at the level of client assessment

4.3 Workforce trends and work conditions

Although not specifically requested in the interview questions, the data provides some evidence that the assessment workforce has become more professionalised. Some of the
participants who have a long history of involvement in the aged/community care sector recognised that this had occurred (4,8,9,11,A). The early 1990s was the suggested timeframe for commencement of this trend (8,9,11,A). This was manifest in the increase in both the number of positions dedicated to assessment roles, by the increased accountability and formalisation expected by the funding body, and by the number of people with formal qualifications employed in those roles. The percentage of untrained people, that is those with direct care or administration experience but no professional training, appears to be diminishing over time. Indeed all of the Stage Two participants in this study had some sort of formal qualification when they commenced in the assessment role. As previously reported, one participant (A) did start out as a carer, moved into an administration role, and then into assessment. However she completed formal education in welfare studies when she started in the assessment role eight years previously.

Some differences in work conditions are evident from the interview data. One participant (E) highlighted discrepancies in pay between the three organisations that run similar service models to her own. This is the reason she retains her Australian Nurse’s Federation (ANF) membership:

“…..the care model of weekend respite together with day centre. One of those people is paid less than $20 per hour to do that and one of the others is paid over $60,000 plus a car. I am somewhere in between. So it is just to have some backup- ‘what should we be paid? How should we be managing this?’ – because it is really quite an unusual position” (Ellen).

The low pay for assessment staff was highlighted by a number of participants in this study (1,4,B,E,H) (although this data was not specifically requested of them) and is an observation reported elsewhere (Department of Human Services, 1997). Work conditions can also be variable. For example, Clare pointed out that assessors had to use their own car in her organisation but that this was not the case in many other similar organisations. Similarly, Ellen commented on the wide variations between the pay and conditions of individuals working in jobs in day care centres very similar to her own. Both Grace and Faye reported that they sometimes work longer than the required hours, and at times to suit clients often outside normal office hours. This may account, at least in part, for the difficulties experienced in the sector in recruiting sufficient numbers of high calibre assessment staff as reported by one key informant (4).
In rural areas, there may be a more extreme range of people employed in assessment roles, that is, there may be a higher proportion of people with no (or lesser) formal qualifications, simply because it is harder to recruit in these areas (4,6,9). For example:

“Ideally you wouldn’t want that to happen, but might, say, in a remote area where you can’t find appropriate staff – and we do have issues around workforce development and not being able to attract qualified people in rural areas – but that is not only in rural areas. HACC services are saying generally that they’re finding it hard to find assessment officers and retain them, as much as direct care workers. There are some catchments that seem to have more of a problem with it than others. In the past, it was more of a problem in rural areas, but it appearing more in metro now too” (State government employee).

The other area that may not insist on formal qualifications is the Indigenous/ethno-specific sector (5). However, both the participants in this study who worked for organisations in this category (D,J) had formal qualifications at the time they commenced in the role.

Assessment staff in HACC services are typically women, and typically middle aged, according to the observations one participant (I) had made since he commenced in an assessment role three years previously. Of the 12 participants in Stage Two in the present study, ten are women. Other general trends in the community care assessment workforce that were reported included a growing number of older workers moving into these jobs (12), and an increasing use being made of locum/short term and contract staff (4,12). For example:

“If you look at the newspaper, McArthur’s [a recruiting company] are always looking for assessment officers for locum positions or temporary arrangements to fill in. I think this is a strategy to try and get them as permanent staff – to give them an opportunity and have a go and hopefully retain them” (State government employee).

One research participant (K), although she had been in her current job for three years, much of that time was spent on short term contracts. One impact of this was that she did not access training or networking opportunities: “because I have been on contracts for the last year, just short contracts, I feel like I am just the workhorse to get the assessments done” (Katherine).
Key informants reported that the PCP reforms in Victoria would have some far-reaching implications for workforce conditions. One key informant (12) thought that the changes to assessment definitions could result in services having different pay rates and different training for different competencies and a clear scaling back by service providers of some (higher-level) assessment components as a cost saving exercise. Taking this a step further, this key informant could foresee training less qualified people for specific assessment tasks such as “an ex home care worker to do those simple assessments, particularly for people who are getting a service from somewhere else” (Local government senior manager). Another possible workforce development implication, suggested by another key informant (3), was there could be greater scope for Division 2 nurses in HACC assessment, beyond the district nursing setting, particularly if they could work under the supervision of a Division 1 nurse. It was noted that a lot of policy work had been done in the health sector to extend the practice of Division 2 nurses to be able to administer medications, and “given that medication issues are often the reason for people going into residential care … it would seem to be an important policy consideration” (Industry training board employee). These predicted results of the PCP reforms seem to contradict the observed professionalisation of the assessment workforce also reported here.

Summary

- The assessment workforce has become more professionalised since the early 1990s
- The trend towards professionalisation seems at odds with other observed trends such as discrepancies between rates of pay, generally low rates of pay, and other variable work conditions
- Assessment jobs are primarily occupied by women
- There is an increasing use of short term or contract staff

4.4 Summary of findings and emerging themes

The organisations and personnel involved in assessment of client need for home and community care is typified by both a wide range of organisational types and a wide range of personnel undertaking these roles. Section 4.1 in this chapter specifically reported findings that could relate to the professional identity of the staff, including position titles, primary professional background further education and so on. The
findings reported in Section 4.2 described the work contexts in which assessment staff are employed.

Firstly, I found that there is a range of position titles in use but they do not accurately convey the responsibilities of the job, nor do they relate to the expertise of staff. Further, use of the term “assessment” in the title carries some connotation of a reductionist version of the work. The primary professional backgrounds of assessment staff varied considerably, although nursing was the most common background. However they are not employed as nurses, and assessment jobs do not qualify as clinical practice so cannot be counted towards nursing registration requirements. Possible reasons for the diversity of primary professional background may be that there is a wide range of competencies, skills and knowledge that are appropriate for the role, or it may be due to a lack of clarity in the sector about the appropriate qualifications and experience for the role.

Similarly, there is diversity in the range of formal study that participants have undertaken since commencement in the assessment role. Although the reasons for this are not clear they may include factors such as a lack of suitable courses of study. This finding could also be due to factors such as the time, cost and mode of study that have not suited the individuals. It should be noted, however, that the positive experiences of such study described by two participants were work-based or directly related to their work.

Another possible way of gleaning workers’ professional identity is to examine what professional groups or bodies, if any, they belong to. The professional associations/groups to which these assessors belong is diverse, as are their reasons for membership. Further, half of the participants did not belong to one at all. These findings may suggest that there is no one association that directly fits the nature of the job, and those that relate in part (such as those identified by participants) do not necessarily meet the needs of members working in HACC assessment. Diversity is also present in the workers’ reasons for progression into their current role of HACC assessment, and we also saw that primary background does not lead workers directly and purposely into these jobs.
These findings suggest that obvious (traditional) indicators of professional identity do not draw these workers together collectively.

Differences in role descriptions were found, specifically the proportion of work time devoted to assessment, and the range of responsibilities carried by different assessment staff. There is also variation in the models of assessment employed by different organisations (integrated as opposed to separated models) with assessors generally preferring working in integrated models because it enables them to have on-going contact with clients. Integrated models also carry more variety in the assessment jobs.

Client diversity is a major contextual feature for assessment staff. There is substantial diversity related for factors such as disability type, age, and cultural and linguistic background. Geographical location, as well as the organisational type, also contribute to the characteristics of clients that individual assessors work with. Increasing complexity of HACC service clientele is also evident. The need for new and different knowledge and skill requirements for assessors are implications that may be drawn from these findings.

Similarly, organisational and service system characteristics contribute to the diverse work contexts and experiences of assessors. Features such as organisational size, ethos, and commitment to external relationships, and trends in the service system such as competitiveness, all have a bearing on how assessors experience, and undertake, their role. The ability of assessors to attend to the critical requirement for formal and informal networking depends on some of these contextual factors.
5. The practice of assessment

This chapter briefly describes the practice of assessment focusing on the broad approach and processes utilised by participants, as well as some of the judgements and decision-making that they are required to make. It also introduces the personal attributes, technical skills and knowledge required, and reports the influences on personal approaches to assessment identified by participants. The majority of the data are drawn from Stage Two interviews, although some data from Stage One have been included where linkages were made. The chapter identifies some of the important ontological and epistemological considerations arising from the practice of assessment that will be developed further in Part III.

5.1 Approaches and processes

At the macro level, the PCP reforms are intended to have a significant impact on practice. This includes the requirement to adopt a cooperative intake system and the requirement across a range of program areas (including HACC) to implement particular assessment documents (Department of Human Services, 2000b). All of the Stage Two participants identified that their organisation was participating in the PCP reform process, and all are using the SCTT template in assessment (2-Q6, 2-Q7, 2-Q8).

The majority of participants in Stage Two did not provide critique of the PCP reforms beyond expressions of the inadequacy of the forms or other relatively superficial changes and were not specifically requested to (comments about assessment documents are reported throughout). The one exception is Anna who expressed the view that the PCP reforms are unlikely to improve assessment practice beyond what had been achieved in previous policy initiatives, such as the “CIARR” and “HACC Best Practice”. In fact she felt that the PCP developments signified a loss of control on the part of her organisation in relation to the assessment model. In particular, an intake system was now compulsory which she felt could create more rigid service models and less responsiveness for individual clients. She also identified less flexibility for individual service providers in terms of the assessment documents they were able to use. At the micro level, that is, the level of individual practice, it is less clear from the interview data what the impacts of the PCP reforms have been to date. However,
assessors apply the expected principles of assessment in their practice such as home visits and considering needs holistically, and these areas are now reported (below).

5.1.1 Location and length of assessments

Data on the location and length of assessments were drawn from participant responses to 2-Q7, the focus of which was on the model of assessment. All stated that assessments are undertaken in the client’s home. Two participants identified exceptions to this: one is in day care settings, although a home visit as well as contact on-site is usually preferred (E), or in rare cases where clients are in hospital or respite and a home visit is not possible (H). Although not all participants specifically identified how long initial assessments take, they generally were reported to last approximately an hour, although may last longer (up to two hours) in particular circumstances (K). There is a sense that there are substantial time pressures for assessments to be done in optimal time frames. Councils, in particular, place weekly quotas on their staff (10,B,C). A participant in Stage One was critical of the time pressures on assessment staff in local government:

“The major part of our concern in relation to carers in HACC assessment is around the local government providers and it is not just a question of skill and training, it is a question of time. They have to do assessments fast” (Consumer peak body employee).

Grace, who had worked in an assessment role in a Council previously, and now works in a case management role in Linkages commented on the differences in approaches to assessment between the two work contexts:

“Working in [Council] you honestly have to assess a situation very quickly and you don’t have any luxury about getting to know clients. But in [Linkages] the way I go about it is completing that assessment over a period of time” (Grace).

The time pressures on staff and use of quota systems could appear to work against the ability to be flexible to attend to clients with different or complex circumstances that may take longer than the expected timeframe. However, assessors’ own descriptions of their practice indicate that they can determine when more time needs to be spent with clients. They acknowledge that a second visit may be necessary if additional information needs to be collected or something needs clarification (A,J,I). Further, they
adapt their approach to enable ‘engagement’ with individual clients and their families such as to develop strategies for hearing carers’ views.

“I did one yesterday of a gentleman, 60, who had had a stroke and was wheelchair bound. I took an hour and a half, but I could have stayed longer. … His wife did a lot of debriefing – she felt she had to justify why she needed help, after four years. She felt at the age of 58 she shouldn’t really be asking. Because he was non-verbal I had to ask a lot of questions about how we should communicate. What are his nuances? If he says yes to everything, how do you know the difference? As his wife, she would know him well, but how would a home carer know the difference? So it was quite involved” (Anna).

For the assessors who generally have an ongoing relationship with their clients (D,E,F,G,J) information can be collected at any stage and they report that this can often be an ongoing process for them. While all participants use the SCTT template (INI), there is some acknowledgement that there may be times when they judge it to be inappropriate to complete the form at the time of the assessment interview when they are with the client (E,J).

Summary

- Assessments are undertaken in people’s homes, with some exceptions in day care or other respite settings
- Most assessments average an hour, but assessors are flexible if necessary
- Some work contexts have weekly quota systems for assessments

5.1.2 Holistic approach

Although not specifically requested in the interview questions, study participants recognised the different perspectives brought to assessment by people with a health background as opposed to people with a social welfare background (3,H). Health issues were thought to be the predominant factor in determining peoples’ entry to the service system (3,9), which may explain why employers value workers with knowledge of health-related issues such as medication and health conditions. However, a debate that is pervasive in the service system is the philosophy of care that underpins the approach to assessment, that is, whether approaches to assessment are influenced primarily by a health or a social model of care (3). The need to undertake assessments holistically was emphasised by key informants (8,2,7,9) and the descriptions of the approaches taken by individual assessors suggests that this occurs in practice. For example:
“You have to understand them holistically and look at their challenges in order to support them. What … this program is about, is keeping people at home for as long as possible if that is their choice to do so, or to support their transition into residential care or for additional services. And you have to know what you are doing with all of that otherwise is doesn’t succeed. ‘The wheels fall off the wagon’, as we say here. So that has been about getting the assessment right, and that means not just looking at the physical but also the spiritual, the social and the emotional side of it’ (Ellen).

Assessors consider their clients from a variety of perspectives; they all use the SCTT template as a guide and most feel they can apply it flexibly and do not feel constrained by it (B,C,D,E,I,J,K,L). Ellen, for example, had developed an assessment tool specifically relating to day care needs to be used in conjunction with the SCTT. Ellen also felt that the SCTT was too long and could be intrusive for clients if used ‘prescriptively’, as did Jennifer. Assessors provided examples of flexible practice, adapting their styles to suit individual clients. Jennifer, for example, described how the ‘traditional’ approach to assessment, which involves using a form and posing questions about daily functioning, can feel very ‘white’ to her clients. Because of the negative experiences many Indigenous people have had with governments and with welfare agencies, she is very mindful about the potential impact ‘being assessed’ may have on her clients. She points out that even the language used, such as ‘assessment’ and ‘need’, may have unintended connotations, or even be meaningless, for many Indigenous people. According to a key informant who was involved with the PCP reforms from a policy perspective, the assessment documents have not been designed to encourage a ‘form-driven’ process, but rather, to enable individual assessors and organisations some flexibility while meeting certain minimum standards (1-Q9):

“Obviously there are certain standards and the need for flexibility. That’s why the PCP tools have been developed as templates rather than ‘mandatory forms’ that have to be used in a certain way… It creates a mindset and a framework rather than dictating that this is the one and only way that it can be done” (State government employee).

Summary

- Assessment is undertaken holistically, considering health and social needs
- All assessment use the same basic data tool (SCTT), with some local adaptations to integrate it into individually preferred practices
5.1.3 Clients’ stories

Assessors were asked how they get a picture of individual client need and how they use that information in assessment and care planning (2-Q16). As was evident from responses to this and other questions, clients’ stories feature in their work. Assessors enable clients to tell their stories and to describe their own perceptions of their lives. However, assessment is also a highly embodied, sensory experience. For example:

“You are using your eyes, your ears, maybe there are not many photos around but they have got six kids. Or the photos are really old and that tweaks your interest. If the clothes are hanging off them…. All the senses, the smells, you get a sense of things not being congruent, things not matching with what they say. … As I said, it is using all my senses. As soon as I get there I am looking at the garden. If it’s beautiful, well you know there is someone in there that loves their garden. So you visualize the maintenance of the home. As you walk in, it is the smell, the photos, the demeanour of the person. You use all those senses from the moment you walk in. You still have the set assessment tools. If I smell urine, and I have a good rapport, I might say something like ‘given that you’ve have had five children, it is not unusual to loose urine. Many of our clients have that and it can be embarrassing and even stop them going out’. Some people will warm to that and say ‘well, actually ….’. But you might also see rags hanging up on the clothes line – some of the ladies still use those old cotton cloths - or you might notice modess as you are walking around the home. That is a dead give away. But depending on what the rapport has been, you will still keep that information in the back of your mind even if you can’t ask about it then. It may be something you deal with further down the track’ (Anna).

“Apart from the full assessment [SCTT], in your own head you’re listening to just how they talk about their family, like when you’re asking them ‘who is your next of kin, do you have family locally’, generally just the way they talk about them, you can tell whether they actually help or not and then whether you can then speak to the family to rely on getting a bit of help from them. Also, looking around the house, just to see the conditions - is it safe, what sort of condition is it in? Things like that. Safety aspects like steps, rails and things like that - they may say their walking is fine but they may take a couple of minutes to answer the door and you can hear the frame shuffle up the hallway, but they’ll say ‘oh no I walk really well, I walk to the shop every day’. But then you get in the house and there might be steps into every room, and yeah they may walk fine, but it is an issue because they’ve got to lift the frame up or lower it down. So you look at all that, and it’s just being open to anything, like you just don’t know what to expect when you get into some houses” (Ivan).

Heather (quoted below) describes the process of observing the client and their home environment which gives some sense of the range of considerations that assessors need to be attuned to:
“… how is the family relating to each other? Who’s letting who have a word? What’s the physical environment like? Have these people struggled all their lives and are real battlers? Are these people that perhaps in the past have had very comfortable existences and now are struggling and don’t know how to deal with that circumstance? Is this a household that is absolutely falling down around their ears, that’s perhaps a health risk, dangerous? Are there things like electrical cords everywhere? Are we in a real mess here, are we at the point where we need an industrial clean? You know, all of those things give you alarm bells as to how this person is coping or where they’re at in their life now. Whether it is through health issues, whether it be mental issues, whether it be through just having absolutely no repertoire of the experience to understand, ‘I’m old now and this is what’s happening to me’. You know, all of that, so just listening and observing everything. There are cues everywhere and you’ve got to be on red alert for taking in and looking for information everywhere and then I guess drawing on your experience of all of those things I mentioned before, whether it be professional or personal or whatever and putting it into some sort of context” (Heather).

We can see from these responses that assessors are attentive to the clients’ stories, but they are also clear that their stories need to be matched to what is observed and deduced from the home environment. In other words, they don’t just take things on face value; they verify and interpret what is told to them. In particular, carers are given opportunities to express their own perspectives on the situation. However, because this can sometimes be delicate, assessors develop techniques for ensuring that this takes place. For example:

“If it’s an adult client, and often the carer can be quite dominant in that assessment process and the person may have cognitive deficits and you often find that the carer will talk over them - it’s very difficult to elicit the information from the person. So I often like to visit the client when they stay in respite care or I’ll try and visit them in a day centre or some other setting because often when you get them alone and they have time you actually get a completely different picture of who they are and what they actually think they need. So it’s quite interesting when a client’s needs and a carer’s needs can be even diametrically opposed…” (Grace).

“Working with the carers you do the ‘gate assessment’. That is where as they are walking you to the gate they tell you that the client is telling lies, or it is really like this. We used to joke about this being the ‘gate assessment’. You sit with the client in the assessment, and the carer is sitting there shaking their head or rolling their eyes. So you talk to them as you walk to the gate. But then as an assessor how do you use that information? It might mean another phone call or a second assessment if necessary” (Anna).

**Summary**

- Assessment is highly embodied, sensory experience
Clients’ stories are important, but assessors verify what they are told through observation and talking to family/carers where appropriate, and have developed specific practices to enable this

5.2 Judgements and decision-making

Data reported here are taken from Stage Two (2-Q13) where participants were asked to describe what they draw upon to assist them in decision-making. As a prompt, some participants were invited to describe an example of a decision they may have to make to illustrate their response.

5.2.1 What decisions are made?

Assessment in HACC essentially involves gathering information in order to form a judgement about a person’s situation, and whether services and supports in the service system can assist them. The process of getting to this point, however, involves a series of decisions. From participants’ responses to question 2-Q13, and also some information reported in other parts of their interviews, I have compiled an aggregated list of the types of decisions assessors are faced with, as follows:

- Eligibility and relative priority for access
- Urgency of need for assessment (that is, response time)
- Level and nature of risk (immediate and longer term) to client/carers
- Whether, and how, to involve or consult with family/carers
- Whether to continue with assessment as planned or to return later
- Whether to continue with particular (sensitive) questions/topics (for example, continence)
- How to approach sensitive/personal issues
- Whether a second home visit is required
- Whether or not to conduct a joint assessment (with other service providers)
- The type and level of service to be provided
- Referral action (for example, to ACAS, district nursing, guardianship board)
- Whether or not (and when) to contact other professionals or services for advice or additional information about individual clients
• Whether to consult others to obtain information about a particular disease, condition or social circumstance
• When (or whether) to suggest alternative accommodation (residential care) to client/family
• Setting priorities, goals and review dates for services
• Matching care staff with clients

The following quotations from three participants (E,L,D) help to illustrate the types of situations that assessors are faced with and the types of judgements and decisions they may be required to make:

“Just the initial journey into respite, or it might be a medical reassessment for behavioural management, or it might be for getting assistance with continence or something like that. Or developing plans with carers about where is the cut-off point and what they can do to cope, what can’t they cope with, and trying to get them to explore this before they have been completed; and once that has occurred, assisting them to access additional help. It might be residential care at that point, and that is incredibly traumatic for most of them. These are very difficult decisions to make” (Ellen).

“I suppose the most difficult ones – well, everyone is focused on keeping people in their own living situation. But then you do come across situations where people, in your opinion, just can’t live at home any more, so that’s really difficult, really difficult to say ‘Ok, I don’t think this is working’. In that situation I wouldn’t just rely on my own observations and my own assessment. I’d look at contacting, say if the person is an aged person, ACAS and perhaps District Nursing to come, and quite often we do an assessment together. We quite often do assessments with District Nurses where they’ve looked at the medical side of things and we look at all the other side, and then we put our heads together and say ‘oh look, we think it’s a bit dodgy’. And I’ve done that a number of times, and that’s pretty difficult. We used the Office of the Public Advocate to assist with Guardianship Orders over people who won’t leave home but need to, you know, where it can be quite dangerous for themselves. So that’s always difficult, that’s always the hard bit. …” (Lionel).

“A client who is at risk - the carer is there - and I have mentioned all the options and alternatives, and still they can’t make up their mind what they would take on. I might have prioritised, so I know what the main need to address first. We go to the second [stage] and they may ask me to help them to make a decision for them. I would say that I can’t make that decision for them, that it is up to them. I know that the client is really at risk and so I might say ‘I think you should go for this option’, but then ask them again what they think. So I am not really making a decision for them, just enabling them to look at the options that they have” (Delia).
One of the most significant impacts on the role of assessment in HACC has been the increasing demand for community care. This was recognised by participants in both stages of this study, as previously reported. In particular, this was seen to be creating the need to allocate resources differently, and to potentially lead to the development of policies and tools to assist with assessors’ decision-making. For example (from Stage One):

“The pressure on the system in terms of the population changes and the increases occurring means that you have a lot of pressure on people in terms of being able to prioritise and develop means of being able to identify relative need. That’s a really strong issue that will only increase with importance…. it is a matter of being able to use resources the best way possible. Being able to judge relative need and exercise that professional judgement is going to very important. Tools may be developed to assist with that but tools also require judgement in their use” (Aged and disability services researcher/trainer).

These trends suggest that a major focus of judgement and decision-making is service rationing, as was suggested in the literature review. Participants (in both Stages) spoke about the pressure to do more with less (E), and stretching of resources (9) and the constant supply and demand worries (10) that service providers are faced with. For example:

“…the amount of interaction with the HACC guidelines, eligibility requirements, degree of client dependency, and having to somehow rank people in terms of judgements about who is most in need and of what, and whether it is better to have a small amount of service for everybody so that they are monitored to some extent, or how you work with those programs, these are the sorts of decisions that they have to make” (Local government peak body employee).

Further, funding policy clearly prioritises care, “which is an output”, rather than assessment “which is an input” (7). These factors combined have the effect of creating pressure on assessors to do their part more quickly (10) and without the benefit of unit costing and benchmarking for quality assessments, it is the assessors that have to adapt their practice to the increased demand. It is also their decisions and judgements about their clients’ needs that are potentially affected.

**Summary**

- Assessors are required to make decisions ranging from how to approach individual assessment interviews, through to whether (and when) to raise the possibility of alternative accommodation for clients.
• Prioritisation and service ‘rationing’ also feature in their judgement and decision making

5.2.2 What do workers draw upon in making decisions?

All participants in Stage Two spoke about their cumulative experiences to assist with their decision-making (2-Q13). These experiences included professional training, personal life experience (such as caring for a relative), and their work experience. Interestingly, it did not seem to matter what the participants’ experience had been - all drew upon their past experience to assist them. Participants also described reflective process that they adopt to ensure that their approaches to assessment are informed by their daily experiences (H,J,K,L). Below, I have aggregated some of the other sources that assessors drew upon in decision-making that were identified (the most commonly identified are marked with an asterix*):

- client views - client choices*
- discussion with other people (supervisor, colleagues, peers, other services)*
- past mistakes*
- information from, and views of, the referrer
- personal philosophy and values
- input from clients and family
- cultural knowledge
- knowledge of trends in practice
- duty of care responsibilities (balanced with personal choice)
- formal knowledge available in public domain (e.g. research on a specific disease or a condition)
- polices and procedures

In one of the scenarios above, the participant (Delia) identified that she would be drawing on: “prior experience and skills, my social work values, my cultural knowledge – the values and traditions of the community - all of that - and my role as the ‘enabler’ and my belief in the client’s ability to decide for themselves”. Similarly,

“I guess essentially it would be the information that the client and or the family have given you. And then using a framework of professional knowledge, life experience knowledge, I guess your own personal empathy, and that comes down to your intrinsic personality I guess. All of those things then influence how you process that information, how much you’ve delved into that information, what you’ve known has worked in the past for other people that have given you some more sorts of information. And it’s not just information
that is gleaned from the verbal, it’s what you’ve observed when you’ve walked into that house…” (Heather).

Some participants (G,J) clearly had a preference for taking time to reflect and think through issues before making any decisions (if possible), often discussing cases at length with their colleagues. However both these participants were in positions which meant they had ongoing contact with their clients and they did not face the same time pressures as other assessors most of whom also had greater volumes of assessments to complete. For example:

“I tend not to make decisions on the spot. I am someone who likes to reflect back and think about it. What we often do with our clients is to say ‘this is what we are able to offer. Have you thought about what might assist you? …what are your needs and what are your priorities?’ Then we would give them some options and they can choose. … it is very reflective. It is trying to think on the spot but also not to have all the answers on the spot but certainly we will talk it over with peers afterwards, ‘is there anything else? Have I forgotten anything? Is there anything else I could have offered? Is there more that I need to be doing?’ and also really setting goals. Some of the people we see, there are lots of things we could do but we just try and achieve one thing at a time and then go onto the next thing” (Jennifer).

Along with past experience, almost all participants identified that they would draw upon others, such as colleagues and peers, to assist them to make decisions if necessary. For example:

“Like the other day I had a chap who possibly was stoned and drunk. I went out to do an assessment to organise some hospital-in-the-home personal care, and general home care … So I draw a lot on other service providers. In that case I wasn’t sure if he needed some psychiatric help or social counselling, so I was able to ring up Centrelink and psych services and just work out what waiting lists there were and what was the best way to get the best outcome for him. And in the end it was really important to get the home nursing service involved too because I was quite worried that he was going to get a bad infection in his arm. So, yes, I use other service providers, other team members and the client” (Katherine).

Summary

- Assessors identify that they draw upon their professional training, personal life experience, and their work experience, regardless of what those prior experiences are
5.3 Personal attributes

Stage Two participants were asked to define the personal attributes that they felt were important in community care assessment (2-Q14). The following list was compiled during data reduction from all participants’ responses. Those marked with an asterix* were identified by all or most participants:

- empathy*
- willingness to listen*
- non-judgemental*
- ability to establish rapport*
- patience
- ease in communication and networking
- know own limits
- friendly but professional
- ability to establish connections and engaged with people
- sensitive to different communication needs
- open-minded
- respectful of difference
- supportive
- easy-going, outgoing personality, affable
- democratic
- respectful of difference and individuality
- respectful of privacy and confidentiality
- openness
- approachable
- honest
- caring
- considerate
- ability to establish trust
- compassion
- curiosity
- flexibility
- respectful of individual choices and rights
- ability to see situations holistically
- observant

Throughout the Stage Two interviews, participants spoke in various ways about the critical importance in practice of personal values such as respecting individual choices. All emphasised (in various ways) a non-judgemental approach and a willingness to listen. The list is certainly not exhaustive as participants were asked to think of the
most important attributes and they had no opportunity to review what other had said, and many of the attributes overlap. Another evident theme was a feeling from participants that the personal attributes are part of an assessor’s personality and therefore these vary in prominence. For example:

“I suppose it is about treating everyone as an individual. It is about being very open and not having fixed ideas. Being quite friendly and developing that relationship with people. Some of the people I have done joint assessments with I think, ‘if I don’t feel comfortable, then how is the person going to feel comfortable?’ It is being very honest – not promising things that you can’t do and if you haven’t got the information just say ‘look I’m not sure, I’ll go back and get that information’. …. It is a lot to do with personality” (Jennifer).

Other typical participant responses indicate an awareness of their own personal values and that these should not intrude on the assessment process. For example:

“Leaving your own personal judgement and criteria for a good and productive life, in the office. Like before you’ve even got in that car to go to those people, all your own personal values and judgements need to be very closeted before you go in there. So you go in with a really open mind, you get into their space and work out what’s important to them. …. So probably empathy and non-judgement would be the two words I think that are really crucial. And observation, yeah. Observation, empathy and being non-judgemental” (Heather).

“You’ve got to have a really easy-going, outgoing personality. You can’t dominate, you have to be very democratic. You can’t be going in and telling people what they need or what they should do, you’ve got to go with the flow, because we’re pretty much intruding on their lifestyle….” (Ivan).

One participant (C) spoke about the sensitivities required from being the first point of contact to the ‘service system’. In these (very common) instances, clients are often unfamiliar with the different organisations, and may not even think of their personal situations as constituting ‘need’ for particular services. For Clare, this necessitated a certain ‘mindfulness’ in her approach and a respect for client choices and experiences.

“For a lot of people we might be the first contact they have with these kinds of services. And a lot of people are reluctant and unsure because they have never used anything like this before, and they don’t really want to now, but they have got to a point where perhaps they do need a little bit of help” (Clare).

One participant (L) suggested that not everyone working in assessment shares the same values, and particularly where these values relate to how client needs are understood, there may be inconsistencies in practice in the sector as a result.
“I suppose we come at [assessment] from …. a situation of whatever the person needs. I’m not sure that every other HACC agency looks at it from that point of view. We look at it from a point of view of getting the service to fit the client and I think that is, for us, our work. That is a really important part of our job…but I’m not sure whether that is important to other HACC assessors or not. So there are probably, through the whole HACC system, quite a lot of inconsistencies because of that” (Lionel).

Summary

- Empathy, willingness to listen, being non-judgemental, and having an ability to establish rapport were most commonly identified personal attributes required for assessment
- The required personal attributes were said to be part of each individual’s personality/personal make-up, and not everyone will have them

5.4 Technical skills and knowledge

Participants in Stage Two were asked what they felt were the important technical skills and knowledge required for community care assessment (2-Q15). The following are examples of participants’ responses:

“I think you need to be informed, you have to know all the relevant services. It’s still the rapport. Assessment tools come and go. There are some good ones – although sometimes they can be as simple as a prompt. Depending on how long the person has been working in the area they can look at a word, like nutrition, and go off on a tangent. Whereas a word like nutrition for someone who may not have as much experience, well they would need extra information like ‘is the person presenting gaunt?’” (Anna).

“I’ve seen and used a whole range of different assessment tools – that has been pretty good. I didn’t even think about computers, but yes, you have to come back and put it into some sort of format. I guess another skill is being able to formally write them up and put them into some professional format. From what you’ve actually seen … putting it on paper is a totally different thing. That is quite a skill” (Faye).

The qualities identified collectively by participants are listed below. Some were mentioned by only one or two participants (such as knowledge of the ageing process), and some were mentioned by all or most participants (such as knowledge of relevant community resources). The most frequently mentioned are marked with an asterix*. 
The list is by no means exhaustive. It represents only a broad overview of the most important knowledge and skills required for assessment in HACC. I have separated the responses into two columns (knowledge and skills) which required me to make a judgement about under which heading individual ‘items’ belonged.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>• relevant community resources and services*</td>
<td>• application of assessment tools (non-standardised* and standardised)</td>
</tr>
<tr>
<td>• available assessment tools*</td>
<td>• computer skills*</td>
</tr>
<tr>
<td>• HACC system and policies*</td>
<td>o electronic data management and transfer</td>
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<tr>
<td>• family dynamics</td>
<td>o internet research</td>
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<tr>
<td>• different cultural resources</td>
<td>o typing</td>
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<tr>
<td>• cultural awareness</td>
<td>o email</td>
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<tr>
<td>• relevant policy and legislation</td>
<td>• communication (verbal and non-verbal)</td>
</tr>
<tr>
<td>• occupational health and safety</td>
<td>• writing (communicating professionally and objectively)</td>
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<tr>
<td>• different disabilities</td>
<td>• (client) data collection and data management</td>
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<tr>
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<td>• observation</td>
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<td>• listening</td>
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<td>• duty of care</td>
<td>• negotiation</td>
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<tr>
<td>• the ageing process</td>
<td>• liaison and networking</td>
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<tr>
<td>• clarity about personal and organisational role</td>
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<td></td>
<td>• learning from reflection</td>
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<td></td>
<td>• using interpreters</td>
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<td></td>
<td>• care planning (goal-centred)</td>
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<td>• case management</td>
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<td></td>
<td>• communicating with people with intellectual and/or cognitive difficulties</td>
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Katherine spoke about the skill required in applying assessment tools, including standardised tools that she used regularly working as an occupational therapist. She
described her use of these tools as being second nature to her now because of her experience:

“…then I guess over the years, because I have used quite a lot of the tools before, it becomes a bit second nature. Within an assessment, if I want to do a Mini Mental I might ask them, ‘can you show me this in your phone book’, or just in general questioning rather than have it as an assessment as such. I will just try and nut out a bit and not make it look as though I am checking their memory which people get a bit ‘thingy’ about. Yeah, and I think I take it for granted now in a lot of the assessment. Even like looking at someone’s mobility – knowing about the shoes that they wear or what modifications they have had done. A lot of that is just so second nature” (Katherine).

Similarly, Bonnie and Lionel described how it was difficult to clearly identify what they draw upon because practices had become second nature and they “did them without knowing”. In relation to policies and procedures for example, Bonnie felt they had become “part of her” because she had been working in the field for so long. Similarly, Anna gave the example of viewing individual terms (domains) on an assessment document. For her, an assessment domain like ‘nutrition’ automatically brings to her mind a range of questions, observations and knowledge that she needs to apply in her assessments. For less experienced workers, she felt that these responses would not be automatic but would require them to follow a series of prompts within each domain.

Data from Stage One interviews suggest that the technical skills and knowledge required have changed in recent years and will continue to change (1,4). One example of this trend that I gleaned from the Stage Two participants was that as peoples’ needs become more complex, and the pressure on (costly) nursing services increase, HACC assessors will be expected to do more assessment for personal care. This trend was already evident to Anna and Bonnie and they expected it to become more significant and eventually require a systematic approach to workforce development and training. As Bonnie said, “I think there will be a time when an assessment officer will be trained up enough to be able to do a personal care assessment and not have to refer to nurses”. Other evidence of increasing skill and knowledge required related to working in a more complex service system with more limited resources:

“(Y)ou need to have a care manager who can find services and resources and be a good care manager, because what they have to offer you in funding is quite pitiful really. It really then focuses more on the skills of the care manager whereas probably five years ago you could buy services fairly easily - you had a
big bucket of money so really you could actually be quite slack or be quite uninformed. Now the pressure is on to find other services” (Grace).

Summary

- Participants typically identified community resources/local services, policy and guidelines and assessment tools/documents as the most important knowledge required
- Participants typically identified computer skills, and skill in using assessment documents and forms as the most important skills
- Many important skills and knowledge become tacit over time
- Technical skills and knowledge required by assessors are expected to increase as the sector changes (increasingly complex clients and service system; and increased pressure on community care services)

5.5 Influences on personal approaches to assessment

Data in this section were drawn from Stage Two interviews (2-Q10). Participants were asked to identify the main influences on them in developing their particular approaches to assessment and care planning.

All participants said their current practice is influenced by their prior experiences and professional backgrounds. One participant (B) was very clear that her nursing background was critical for her in developing her approach to assessment, but then acknowledged that her colleagues, who had completely different backgrounds such as community development, also felt the same about their backgrounds. Another participant (I) said his experience working in motor vehicle finance helped his interpersonal communication skills, and another (F) felt her experience working in child protection had been very influential on her current practice. These findings indicate clearly that workers are able to draw meaning from their previous experiences relevant for their current roles.

Surprisingly, only one participant (E) named a particular individual that had influenced her approach to assessment, although it was common for participants to talk about learning from others generally through observation, discussion, joint working and so on. Two (D,I) also discussed now being in the position of mentoring or training others
which they recognised has an influence on their own approach to practice. And Grace identified the trend towards individualised funding (see glossary), which has been introduced in disability services, as challenging her approach to practice and encouraging her to reflect: “…it’s made me look at what I do. What do I do? Is it worthwhile? Can you account for it in some tangible way?” (Grace). These factors cause assessors to reflect on (and modify) their approach as their practice comes under scrutiny from new staff or clients.

In addition to their prior work experience, participants frequently identified personal life experiences particularly their experiences as carers (whether paid or caring for family members) as being highly influential on developing their approaches to assessment (A,B,F,H,J):

“Just my interaction with my grandparents and my parents - I had very close relationships with them and we would talk a lot about life, and living on your own, widowhood. … . and by working in people’s homes over a couple of years in home care, we would get to know people. … When I was working in hostels when I was 19 and 20, you would see young people in their 50s who had had a stroke and shouldn’t be in a hostel, but in those days were forced to go there if they had no-one to look after them. They would talk to me about what that was like for them. That, and being a carer for my grandfather and a support for my grandmother, has probably been the biggest influences. He had manic depression and developed dementia in his 70’s. Other life experience too – my father needed palliative care for cancer, watching my mother yell at him for ‘how dare you die, you’ve got the easy bit’. That was my introduction to grief issues. Life experience – it is the same thing that I hear from others working in the area. … I do find I can have a lot of empathy with people through my life experience. For example, losing my home – what that was like. I try to think of what it is like for an older person leaving their home and all their memories. That is also very vivid for me – not having an option but to shift out” (Anna).

“I suppose it has been working with peers and seeing the ways different people approach a situation and what does and doesn’t work. And also being involved on a personal basis – I care for my parents – I have seen how people have assessed them and I’ve thought ‘I don’t like that, I didn’t like the way that situation was approached’. You just learn. See how you would like to be treated – treated with respect and having those rights respected” (Jennifer).

**Summary**

- Life experience, prior work experiences and professional background all contributed to individual worker’s approaches to assessment and care planning
- Participant’s experiences as carers (paid and unpaid) were very influential
5.6 **The experience of being an assessor**

In the Stage Two interviews, participants were asked if they had any comments on what it is like to be an assessor in HACC (2-Q17). This question followed a series of questions focused on their practice. All participants indicated in one way or another that the work they did was valued and made a difference to people who require assistance to live at home. For example:

“Sometimes it is devastating because you see some of the things that people have to deal with. But I honestly believe that we make an enormous difference. I have that sense absolutely. Because once you know somebody you know how to help them, and we can make a difference to their carers. I wouldn’t do it otherwise. That’s the backbone of what we do” (Ellen).

“It’s a good job. I feel that it is very rewarding. I enjoy it. The people you go to, you meet so many people and each one of them is different. And if one of them is not so good well it doesn’t matter because you are only going to be there a short time, and you are moving on and you are going to meet somebody who is lovely. They have such interesting stories to tell and it is really rewarding - I guess that is the main word. It is pleasure to meet them, and if we can help them to stay at home, play some small part in that, well sometimes even small things can make a big difference to them” (Clare).

Lionel spoke about the satisfaction he gets when he sees the benefits for his clients who have been extremely disadvantaged and isolated because of their disability and are now linked in with the service system and receiving additional support from his service:

“… to see someone who just didn’t have a clue about what was available and to see them have a chance of a better quality of life and be able to get the services they need to be able to stay at home, you know, they’re better off at home if that is where they can be, and just to see people become, well a lot of the people we work with they might be housebound because they are scared of going outside, and to see them actually start to do more things than just sit inside” (Lionel).

Heather highlighted similar rewards but also identified other positive aspects of the job such as variety. The quotation from Heather (below) and also others included in this sub-section, point to the essential feature of the experience of being an assessor, which is to listen and engage with people’s stories:
“Fantastic. I love it. I love the job. It is the perfect mix of dealing with people, ... and I just love the aged. I think they’re fantastic. And it’s a very privileged position going into somebody’s home, and being told about what I guess is very intimate stuff about how their lives run and their family and their relationships within that family and all that. That’s very personal stuff and it’s a very privileged position to be privy to that information about a person. The elderly being the elderly they don’t just tell you what you need to know, they’ll tell you about their life and they’ve lived through great times the people that are old now, you know, from World War I on. They’ve had extraordinary lives, whatever their involvement in the world has been and just, I don’t know, being told those stories and being able to have an opportunity to listen and not be thinking, ‘oh hang on I’ve gotta go and answer that buzzer or flush that pan’. That is the background that I’ve come from where you didn’t have time to sit down and listen. It’s just wonderful. However, because you then come back to the office and process that information and liaise with people and set up the services, you’ve got the perfect mix where you’re not like, ‘yeah right, the 50 millionth world war two story for the year’, you don’t get sick of it. You’ve got that wonderful mix. You’re not stuck in front of the computer, you’re out in your car driving out to … wherever it might be that the next person is. …” (Heather).

The essence of an assessor’s job is essentially to engage with clients’ stories (as evidenced from the quotations included in this sub-section). However, it is also about re-framing those individual stories into a format which indicates need, or otherwise, for services. A number of participants (A,B,C,E,I) highlighted the frustration they feel due to the high demand on their service and their inability to meet that demand. Another highlighted the fact that it can be emotionally demanding and sometimes stressful because it can involve complex decision-making (K). One participant in Stage One identified that the increasing demand on services can have significant impacts on assessment staff often resulting in staff “getting to burn out stage and getting very frustrated” (State government employee). For most in this study, however, these challenges are outweighed by the rewards and other positive aspects of the role. For example:

“I love it. For me it satisfies my need to be helpful. It also challenges me because I know that some of the needs and wishes – well it’s been getting more challenging over the years - not enough staff, extremely vulnerable clients being kept at home. … You go out there to achieve a positive outcome for that person, but we all know that within HACC now, you only get an hour and a half of housework a fortnight. So a lot of your professional judgements about what you think they should have and what they are going to get, well that is challenged. Yes, I probably feel compromised by that. … I actually ended up going to counselling when it first started to happen because I was angry. In the days when I first started, well you gave everything to everybody. Then we went into
a thing where we, as a Council, had to go out and review every client, and cut
them back from weekly to fortnightly. And sometimes, the ones that were
playing bowls or going to Queensland for their holidays, they lost service. Yes it
was really challenging, and people were angry about their rights and
expectations not being met” (Anna).

“(S)ometimes I find it hard if you have assessed someone as needing a service
but it might have a waiting list….you might assess for someone’s need but
inevitably there are not enough services to meet that need so you are putting in a
bare bones approach or you are stressing other family members more because
they might need to contribute more. Generally waiting lists are quite problematic
so you just sort of scrape from other services” (Katherine).

This issue was noted by participants in the key informant interviews and highlighted by
one (12) as a potential risk to assessors. For example:

“The risk is that people can’t combine advocacy on behalf of an individual with
the realistic requirements of the organisation. So you either see people
becoming a bit de-sensitised to the fact that they’re telling people who are in fact
very needy that they can’t help them, and then going home and sleeping at night
with that because how else would you survive. I’ve just been through this
yesterday because I was on intake, and yes I found I could hardly sleep because I
had spoken to five people with high level needs, who basically I knew we could
not provide a service to, or we could not respond appropriately - we have these
particular problems – and if people are very good at caring about the outcomes
for people, I’m not sure that they could keep working for us and that is a
tragedy” (Local government senior manager).

In general, assessors have strategies for dealing with the frustrations of not being able to
meet people’s needs to the level they would like. For example, in one of the quotations
above Anna spoke about going to a counsellor to help her deal with the changes in
service delivery levels because she knew the impact service reductions would have on
the lives of clients. Clare (below) recognises the challenges to her professional
judgement by the inability of the service system to respond at the level and at the time
she judges to be needed, however she also acknowledges the risk involved in taking that
too much “to heart”:

“I have to say that you move on. Like you do all you can for one person, but
because you have got another ten people to see that week, they probably don’t
stay with you too long. I don’t worry about it too much after I have done what I
can for that person. If they have to be on the waiting list, well so be it. I explain
that and that’s all that I can do at the time. It is not nice, especially as some
people really do need some service and it is not available. That is really hard. It
is hard explaining that to a person who is very needy” (Clare).
Similarly, Faye spoke about the need to maintain a balanced life and described a range of personal activities outside work in which she is involved which keeps her busy and provides an outlet from the stresses and emotional demands of her daily work. However, these issues bring into focus the tension that exists between individual assessors’ personal values and motivations to be working in community care (frequently about empowering, advocating and assisting people to achieve better quality of life), and the realities of the job which is becoming more and more about prioritising and rationing, a tension also highlighted by key informants in Stage One (4,9,12).

The increasing complexity of clients living in the community (reported in previous chapter) and the resulting increased demands placed on services brings increasing pressure and new experiences for assessors. Grace, for example, spoke at length about the impact on families of lower levels of service being available to them, often leading to relinquishments (see glossary), and how this impacts on her as an assessor/care manager:

“(S)adly, it’s more about helping people come to terms with the fact that they are not going to get a placement and providing sufficient supports to keep them at home. Right across Melbourne there is a major issue with relinquishment of children with disabilities. …. That’s another matter that we’ve had to deal with - most relinquishments we’ve had have been sudden and they haven’t been handed back to DHS so we’ve continued to case manage the child even though they’ve been given up. … I’ve had two relinquishments and two other team members have had one relinquishment, and as respite care houses become full of children who are relinquished there’s a backwash effect on the 200 families that use that house because when those six beds are full of relinquished children then there is no respite, which therefore causes more people to relinquish which has this effect. I’ve had one family say to me, ‘the major reason we relinquished is because our three weekends a term are now cancelled and we have no respite in residential care, and that is one of the factors that drove us to relinquish’. So relinquishment is an issue in the back of your mind all the time in Disability’ (Grace).

The possible move to residential care is also present for the older target group. Supporting clients through the distress of this decision can be a common experience for assessment staff, and is one of the features of working in this sector:

“But then there are the people that you think they’re going alright but they’ve got no family, they’ve got no friends and you’ve got to suggest that ‘look maybe it’s getting a bit hard now and you need to look at some alternate accommodation’. That can be a bit upsetting to them and for us. They get upset, and you know, we’re not sort of proud of putting them in a home, hostel
or nursing home but it’s maybe going to save them, prolong their life a bit. …” (Ivan).

The following quotation is from Faye who works in an organisation which provides a respite service for families of children with a disability. I have included this quotation because it provides a snapshot of the daily experiences as an assessor. It also reveals some of the personal and emotional filters clients’ stories pass through as they are re-framed to form a professional judgement for a service response.

“I saw this woman – a new family - this morning who had heard about our agency. She has never used any type of support all the way along, and her child is now 9½. She’s got other kids and suddenly she is feeling like the other kids are missing out because of the time she has to spend with her child. And what is available? And she really wasn’t able to express what her needs were – it took me ages to get down to it: ‘so you are concerned about your other kids but you don’t want to leave this kid out?’ – ‘yes, we do want to do things as a family still but I feel my girls are being held back because of this other child. What can we do to balance that?’ But it took me an hour before she could start to talk about some of those things that were really bothering her which she wasn’t able to articulate very well. She hasn’t accessed services in all those years. She just thought that this is my child, and it is partly the attitude that she encountered at the beginning that coloured her– they offered to take her child away and put her in the nursery and not even let her see her! … Nobody was offering much help then so that’s what they did, they shut themselves down and ‘just managed’. They had support from a couple of members of the family but others’ attitudes were the same that they’d had in the hospital. And she says now that she can see that they need to open their doors and their minds because this child needs more than what they are providing, but the other two girls need more as well. She saw one of our volunteer ads and just rang up and I had a talk to her. They need some other services too as well as what we can provide, so there is quite a bit we can do for them. Coming to the support group will be great for her because she will learn so much from the other parents. That’s far more than I can do, although I can empathise and say that I have got a child with a disability and ‘I understand’, but mine’s grown up and she needs to hear from people who are living it now” (Faye).

The essence of being an assessor is about listening to people’s stories, and it is this aspect of the job that seems to bring the most satisfaction for individual workers. Other rewarding aspects of the job include meeting and learning about interesting people, the feeling that their work is making a difference in some people’s lives, and that it can be a job with great variety. Participants also spoke about the feeling of privilege to be invited into people’s homes and to be trusted with intimate details about their lives. Changes in the service system and clientele bring new demands, often emotional, to the work of assessment.
Summary

- The rewarding aspects of the job include meeting and learning about interesting people (listening to their stories), the feeling that their work is making a difference in some people’s lives, and that it can be a job with great variety.
- There are frustrations and stresses associated with not being able to meet people’s needs to the level they judge to be appropriate, and a sometimes mismatch between worker’s values and work realities.
- Workers generally have strategies for dealing with the demands of their work.
- Clients’ stories pass through assessors personal and emotional filters as they are re-framed to form a professional judgement for a service response.

5.7 Summary of findings and emerging issues

This chapter began with a description of the approaches to assessment in HACC. Approaches to assessment are influenced by the policy framework and service system requirements for the program, as well as by the characteristics and philosophy of individual organisations and individual assessors.

Firstly, assessment in HACC is undertaken holistically, meaning that assessors describe their approach as considering needs from a broad perspective, and not from the point of view of what their service is able to offer, and that they consider needs across all health and social welfare domains. Assessment is also a highly embodied, sensory experience. Assessment staff use the assessment documents (SCTT) but also bring to their judgements comprehensive sensory experiences. Clients’ stories are important, and they verify what they are told through observation and talking to family/carers where appropriate.

Judgements are made all the time during the interaction with the client, for example, when to probe for further information or when to talk to the carer privately; and information is collected from multiple sources (other service providers, carers, family) and using a variety of techniques, including observation. Workers are required to make decisions ranging from how to approach individual assessment interviews, through to whether (and when) to raise the possibility of alternative accommodation for clients. To
assist them in their judgements and decisions, they report that they draw upon their professional training, personal life experience, and their work experience, regardless of what those prior experiences have been. Peers and colleagues are also important for discussion, reflection and information.

The personal attributes found to be important for assessment are what might be expected for any human services occupation (for example, empathy, listening and openness, being non-judgemental, being respectful of difference and choices). The technical skills and knowledge important for assessment include IT and computer skills, the ability to use and understand the application of assessment tools and client data forms, and knowledge of program policies and guidelines. All Stage Two participants felt that knowledge of resources or local services was crucial. However, there was also another element to their responses to these questions which was less easily articulated. Participants suggested that what is really needed is a “way of thinking” that formal education and training provides, and there is a sense that at some point the important processes of assessment become tacit.

Individual assessor’s approaches to the work are influenced by their life experience, prior work experiences and professional background. Workers’ personal experiences as carers (whether paid or unpaid) were also very influential on their individual approaches. Being in a position of trainer or mentor for new staff was identified by two Stage Two participants as influencing their approaches to assessment by encouraging them to reflect on their approach and consider how it may be viewed by others learning from them.

The chapter concluded with an account of what it is like to be an assessor, including a number of participant quotations that vividly depict some common experiences encountered in their daily work. The experience of being an assessor includes many rewarding aspects including meeting and learning about interesting people (listening to their stories), the feeling that their work is making a difference in some people’s lives, and that it can be a job with great variety. However, there are also frustrations and stresses associated with not being able to meet people’s needs to the level they judge to be appropriate. Some of the new demands on being an assessor (associated in particular with increasing client complexity and increased pressure on services) may indicate that new knowledge or supports need to be available to assessment staff.
6. Current approaches to preparing and developing assessment staff

This chapter presents findings in relation to the professional backgrounds of assessment staff, the types of education and training currently available, and the process of learning about the assessment role.

6.1 Pre-employment/basic training

In Stage One, key informants were provided with a list of possible educational backgrounds for community care assessment staff from both the higher education and VET sectors (see Appendix B), and were asked to identify what professional/educational backgrounds are appropriate to undertake the role of assessor (1-Q2). This was designed to determine the common views in the sector about what qualifications would be regarded as appropriate for the role of assessment in HACC. This process elicited an interesting and varied range of responses.

Some felt strongly that certain backgrounds were well suited to community care assessment, such as Division 1 nursing and social work (1,2,4,6,8,9,10,11). However, even when backgrounds such as those were identified as suitable, qualifying comments were offered. For example:

“So most of these I think, depending on the person’s level of experience and skill, such as in social work – if their experience has been predominantly in policy, then I think there are skills that need to be enhanced in more appropriate areas before they could do HACC assessment” (Community worker).

“I think with some of those, you would need something else as well as that degree. If we pick a Division 1 nurse, well yes, obviously the clinical assessment would be very well done, but the social side may not be, or the other family members and their needs may not be. So whilst all of these people I have ticked, I feel have a background that could enable them to do assessment, I think they would need not just that background. They would either need experience with dealing with the whole of the person – the holistic approach – or they would need experience in delivering care. But not just that degree on its own” (Service provider peak body employee).

These quotations suggest a reticence to state outright that certain professional backgrounds will qualify someone to work in community care assessment. Concerns about the personal qualities such as ability to build trust, and the level of understanding
about the aged/community care sector and philosophies of care are regarded as *additional* to formal qualifications and not guaranteed by them.

Further, at times when key informants identified some backgrounds as inappropriate, they could come up with exceptions that contradicted their belief. For example:

“I’d say psychology, no, except that I know of one person who is a psychologist who does this job really well. Now whether that is because of her personality/personal qualities or whether it is because of her training, I don’t know” (Consumer peak body employee).

Indeed, one of the participants in Stage Two of this study (J) had psychology as her primary professional background when she commenced in an assessment role. Another key informant (12) was very clear that her “preference is for people to have a discipline-based degree such as OT, nursing, social work, and maybe welfare because a lot of people do welfare as a mature aged student so they bring other experience as well” (Local government senior manager). However, this same key informant currently had a physical science graduate performing well in an assessment role and was supporting him to undertake regular in-service courses to build up his knowledge of human services, and basic skills such as counselling. Her identification of his personal attributes, and her actions to support this worker, indicates her high regard for these attributes: “he is a very gentle soul and treats people very well and he actually has a lot of human service values and skills”.

Comments were also focused on the level of the knowledge acquired in these qualifications. Counselling and interviewing skills were identified as critical by two key informants (2,9). For example:

“…counselling skills are essential. You can be confident that those skills are covered in degrees in social work or welfare studies. Also allied health professions, and certainly Division 1 nursing, if they were covering counselling techniques and interviewing skills then that would complement the other sorts of knowledge that they have. Not only interviewing techniques, but advanced counselling skills are important” (Aged and disability services researcher/trainer).

One participant (3) felt that knowledge of health and medical issues was the most critical:
“…given that health is probably the biggest driver, then it is knowledge of the underlying medical conditions, physiology, and medications that is what is needed most” (Industry training board representative).

Another (5) felt that understanding of “disability and functional dependencies” was most important and identified nursing, the allied health qualifications, and welfare and social work as the most appropriate to provide this knowledge. This key informant then went on to say that much of the important knowledge and skills needed for assessment in community care are not necessarily guaranteed by professional education:

“These professional backgrounds probably don’t offer a lot in terms of assessment … When it all boils down, it is quite remarkable how little there is in these [higher education] courses relevant for frail older people … So I think coming through these courses, sure you have got the basic framework to work with, but an enormous amount of learning would happen on site” (Aged care researcher).

However, there was also the view expressed that the important element provided by the primary qualification is a framework for thinking, rather than the specific content:

“I think the qualifications they have help them to think in a particular way and to create some sort of framework or terms of reference for them. But application on the job is really important” (State government employee).

This view was supported by participants in Stage Two. Heather (a nurse) in particular, recognised that “in the main it’s a way of thinking that your training and your experience gives you”, although she also recognised that “there are some nurses that’d be hopeless in a community setting … because … they’ve never had to do that person to person contact stuff”. This suggests that practical experience and its context also contributes strongly to developing the range of attributes required in assessment.

In general, key informants were less confident about selecting qualifications from the VET list than from the higher education list. Almost half (5,6,9,10,11) stated that they did not know very much about VET qualifications and courses and were unwilling to make specific selections. Others felt they did not know what is covered in some of these courses for example whether or not counselling skills were covered in sufficient depth (2,8) and therefore could not make an informed judgement. One of these (8), whilst she was not familiar with the content of the VET level qualifications, commented that:
“I have come across people through my training that have said they have a Certificate III or Certificate IV and it is not necessarily related to the assessment function. It is much broader, so they have required something additional to that. But all of these vocational qualifications are very good grounding. So it’s like taking that to another level and specialising in the assessment function” (Community services consultant/trainer).

Similarly, two other participants (4,7) recognised that VET level qualifications can be appropriate for people in assessment roles if sufficient additional training is provided. They also recognised that relevant higher education qualifications are no guarantee of suitability to undertake assessments. For example:

“But I think with all those people, even if they don’t have the same degree as these people [with higher education qualifications], with the appropriate training and the appropriate opportunity they could probably develop the assessment skills. It is not like you can get a degree and then you are able to do assessments - you can have a degree but you might not have the people skills, or the observation skills” (Service provider peak body employee).

Two key informants were clear that VET level qualifications were inadequate, because they do not prepare people for complex management tasks and responsibilities (12), and because they did not prepare people for understanding and delivering specialist care (3). Another key informant (5) felt that VET qualifications may be sufficient for assessing someone with “straightforward needs”, but are inadequate preparation for assessment beyond that level because assessors would be unable to apply “standardised assessment instruments”. However, use of standardised assessment instruments is very uncommon in HACC but very common in ACATs (Lincoln Centre for Ageing and Community Care Research, 2004) and this key informant had been heavily involved in ACAT research.

The clear message from this exercise is that not “any one of these is necessarily it” as one key informant (8) put it. Whilst higher education qualifications were more likely to be identified as appropriate educational backgrounds for the role of assessor, there was little agreement between the key informants about which backgrounds these were and under what circumstances. Most felt that some sort of relevant tertiary qualification was helpful but that they should always have other relevant experience, or undergo additional training on the job to really develop the knowledge and skills needed. Even
for workers with qualifications, “it is those life skills” (Social research consultant) and the person’s personality that make the difference. As a participant in Stage Two put it:

“So me people have the personality to do it and some people don’t. I have seen some good assessors and I have seen some bad ones! … I think you need to have the training and the theoretical basis but I also think that some people are much better at relating to others…” (Jennifer).

Summary

- There is little agreement between key informants about what professional/educational backgrounds are appropriate to undertake the role of assessor, although social work and nursing were commonly identified
- Higher education level qualifications are preferred but there is still an element of having ‘the right personality’
- A framework for thinking (or higher order thinking) is valued, as are generic interpersonal attributes

6.1.1 Formal qualifications: essential or not?

The previous section reported on views about the appropriate professional/educational backgrounds for HACC assessment. This section considers whether formal qualifications should be regarded as essential. Data are based mainly on key informant responses asking is it acceptable for assessment workers to have no formal qualification, and if so, in what circumstances (1-Q4). Five felt that a formal qualification was essential (1,3,6,7,8). For example:

“It is not acceptable. It is such a pivotal role. With the carers, they can probably get away with it to a point because they are doing very specific things with specific people, but in terms of assessment, you couldn’t risk missing out on something that could be really critical. There are too many duty of care implications” (Industry training board employee).

“It’s unacceptable. I think if you see assessment as I do, which is that it’s the gateway to service provision, … … The assessment officers that I have trained that have come up through the ranks … lets just say it makes them a better assessment officer if they have got formal qualifications. I think if they don’t they are way behind and need a lot of on-the-job training and training to get up to speed. It is not that they can’t establish rapport with people, they often have fabulous rapport with consumers they are working with. But in terms of really looking at the assessment function holistically there are gaps in their knowledge.
I don’t know that you get that holistic understanding in the absence of formal qualifications” (Community services consultant/trainer).

For participants that felt formal qualifications were essential, they provide at least some assurance that assessors are not working beyond their skill level, and/or they can provide the basic required skills (such as counselling) upon which workers can build knowledge about the HACC/community care sector.

Another (5) felt that formal qualifications are not absolutely essential if there are others working in a team environment that can provide more specialist assessment if required. In this view, team based approaches can augment the need for formal qualifications, because the team can provide the mix of skills needed. This can be particularly useful for larger organisations to assist them to work with specific target groups such as Indigenous or ethnic communities:

“It is far preferable to have a Koori person on your team and to be able to use that person for assessment than not include them because they haven’t got a formal qualification. But again, it focuses on the whole communication, the whole interaction in an assessment, that’s what they are about – clients need to be able to communicate what their needs are. So if that communication doesn’t happen because of language or cultural difficulties then you might as well not have any physiotherapy qualification, you wouldn’t be able to walk in the door! So I would certainly say that yes, there would be instances where it is acceptable” (Aged care researcher).

A participant in Stage Two (D) noted that there is no qualified worker in many of the smaller ethno-specific services, but also felt that their lack of formal qualifications contributed to many of them not being able to “do the job properly” (Delia), particularly the aspects of the job that require high level writing, planning, or evaluation skills.

The remainder of the key informants (2,4,9,10,11,12) were non-committal, generally expressing preferences for qualifications but offering examples of exceptions and situations that would not make this an essential requirement such as working with specific cultural groups or in rural areas. For example:

“My preference would be for people with no qualifications not to be regarded as ineligible. I think that is asking a lot of someone. There are always exceptions where people like that, for other reasons, do have the level of skill that is required, and who I assume have grown and developed through the system. …I am feeling ambivalent about having absolute rules. One of the best HACC
assessors that I have come across, and this was a few years ago, was totally untrained, but really good at it, and well respected. So that is the reason for my ambivalence, and I imagine there would be a few of them…” (Consumer peak body employee).

The perspective of the HACC assessors themselves is that some form of formal education is better than none at all because it can provide a framework or way of thinking for their work. However, in general, they are no more willing than key informants to state what the qualifications should be. In the words of a Stage Two participant:

“I believe that you need some professional background, whether it is nursing or social work, as a technical training background. In my experience I feel you can tell when people who are doing assessments don’t have that. … But I think what it is, it’s the thought process that your training and experience in those fields has given you that impacts the most, not the technique or the questions that you ask, because in the main we’re all asking exactly the same questions, … and look there’s differences between nurses and social workers too but your skill in observation is very different and what you observe is very different. Therefore, how you engage with the client or the family is very different to somebody that doesn’t have that observation thought process and yeah, interpreting the subtleties, I think, is done better by social workers and nurses than people that don’t have that background. Within that obviously there are personality differences” (Heather).

A number of key informants noted that some policy work had occurred in the sector to try to define competencies required for assessment through the development of the comprehensive assessment framework (Lincoln Gerontology Centre, 1998). Some participants (5,8,9,10) felt that the direction the comprehensive assessment framework was taking was promising at the time (including consideration of competencies), but noted that it was unclear whether that would still be progressed given the PCP initiatives in Victoria. It remains to be seen how the issue of competencies will be dealt with given the multidisciplinary nature of PCP assessment and the model being promoted in this policy framework which brings together a range of different Program areas administered by the State Government (Department of Human Services, 2000b). As one key informant commented,

“…agreed competencies that are related to professional disciplines. We haven’t got them in the HACC area. We have done some of that work through the comprehensive assessment framework a few years ago, but that never went anywhere. It may be picked up now through PCPs, but that is a real challenge,
because you have got a very broad range of sectors. That is a good challenge to have to bring them all together to look at the competencies of the assessment function within the framework of the different disciplines” (Community services consultant/trainer).

Whether community care assessors in HACC should be required to have a formal qualification in order to qualify for employment is an issue that relates closely to the local contexts where individuals are employed, and to the policy and service environment of community care. The range of views presented by key informants, when they were asked if it was acceptable for assessors to have no formal qualifications, gives some clues to the types of knowledge and skills regarded as the most critical for this role.

Summary

- There is little clear agreement on whether assessors in HACC must possess a formal qualification
- Qualifications can provide at least some assurance that assessors are not working beyond their skill level, and/or they can provide the basic required skills (such as counselling) upon which workers can build knowledge about the HACC/community care sector
- Formal qualifications cannot guarantee suitability for the work itself
- It may not be in the best interests of ethno-specific or Indigenous organisations to set absolute rules about formal qualifications
- To date no definitive policy work has been completed to clarify competencies/formal qualifications required for the assessment function in HACC

6.2 Post-employment/In-service training

In Stage One, participants were asked if they were aware of any training programs focused on HACC assessment (1-Q5). In Stage Two, participants were asked if they had attended any courses (2-Q9), and they also had other opportunities throughout the interview to identify training programs (in the series of questions focusing on training and learning). This process identified three generic short courses (2-4 days) specifically on assessment for community care offered in Victoria and were mentioned by participants in both stages of the study. These courses are offered by (1) a private
consultant, (2) TAFE institutes, and (3) a research institute, and were developed by the respective individual and institutions offering them. Some of the HACC assessors had attended one or more of the courses, or knew of other staff who had attended them. A fourth course, possibly generic, run by a large nursing service in metropolitan Melbourne was also mentioned by two assessors (B,H). However, apart from saying the course was too basic and unhelpful, and was offered sometime ago (B), participants had no other information.

Two participants in Stage One (2,8), both of whom have involvement in the provision of training for assessment workers, noted difficulties associated with the generic ‘short course’ approach to providing training to this group of workers that has such a wide range of skills of knowledge. Both felt that two levels of training are required to deal with the diversity of the assessment workforce:

“Any training or any learning needs to be pitched at two different levels. You need induction programs for these workers when they first come into the role. One doesn’t exist at the moment. They are at a different level to those assessment officers that have been around a while. And because of what is happening with our ageing population and with our policies around deinstitutionalisation, people are dealing with more and more complex people. The whole area of complex care coordination is an area that people are struggling with, and partnership building with everyone that is involved. So that sort of training is needed.” (Community services consultant/trainer).

A range of specific short courses (mostly one to two days) available on certain areas of practice related to assessment were also identified. Most of these were mentioned by participants in Stage Two who cited examples of short courses/workshops they had attended, or knew had been offered in the sector. Those mentioned were focused on:

- carer needs
- responding to ethnic clients
- occupational health and safety in home care
- nutrition and older people
- dementia and Alzheimer’s awareness
- dealing with bullying and
- family crisis and grief
- report writing
- fitness and the elderly
- using interpreters
- validation therapy
- first aid
- disability and sexuality
- drug and alcohol issues
aggression
- managing aggressive clients/clients with behaviour problems
- conflict resolution
- negotiation skills

- suicide risk assessment
- elder abuse
- communicating with difficult families

Many of these courses are developed and run by organisations with particular interests in these areas such as peak bodies and most charge a small fee to attend. Two key informants expressed concern that particular knowledge and skills required for working with carers (10) or with ethnic clients (11) were not properly addressed through short courses because they were perceived as ‘added on’ rather than integrated with basic training offered to assessment staff. In other words, most staff only attended such short courses if they had an interest in that particular client group or issue and many assessors had not accessed such training. It was also suggested (11) that there may be an over-reliance on workshops for skill development and information dissemination, which is particularly problematic for smaller organisations, since:

“there is a lot of movement out there – if someone leaves an organisation and they were the only ones to attend a workshop, then the information leaves with them. That is another area that needs looking at” (Social research consultant).

Summary

- Three generic short courses on HACC assessment are available in Victoria offered by (1) a private consultant, (2) TAFE institutes, and (3) a research institute
- The short course/workshop model of training can be problematic for workforce with diverse training/learning needs
- Variety of workshops/short courses available on topics related to assessment (for example, carer needs) and most are developed and run by relevant peak body/industry groups
- There may be an over-reliance on short courses/workshops
6.3 Adequacy of training programs currently available

All participants were asked if they felt the current provision of training for HACC assessment is adequate (1-Q6, 2-Q12). Half made comments that indicated that they felt it was not adequate (1,3,8,9,10,12,A,E,F,G,K,L). Four said they were not aware of any specific training or were unsure what is available (5,7,C,D). Only one participant felt that there was adequate provision of training (H). However her comments were focused on training concerning the technical aspects of HACC policy or data management which was provided by the funding body and by the company that developed the software system used in the agency. None of the other seven participants directly expressed a view about the adequacy or otherwise of current training in the area of HACC assessment.

Reasons for participants regarding training provision for HACC assessors to be inadequate included that the short courses or programs that are offered are not sufficiently practical for assessors’ needs. For example:

“So you get all the correct procedures and the correct strategies and all of that’s written down but it isn’t about what the task is really, about how you communicate with people. So I don’t think there is enough support and enough professional education. I think they are missing the point a bit. There’s one or two that have been really good where you actually have learnt something. … I believe that you should be constantly trying to take in new information - I think it keeps you open and flexible and you do a better job for that. But there’s very few - The courses are probably not practically enough based, you know, for giving people the practical skills. They give you the educational skills but they don’t perhaps give you all the practical skills that you need” (Faye).

One key informant (8), who regularly offered assessment workshops for HACC staff, said that the issue of accreditation was important to participants in her training programs and that there were few accredited programs available in the sector.

“Our training is not based on accredited competencies. Even though people might enjoy our training and feel that they get a lot from it – they are the comments I get – from their perspective, in terms of their professional enhancement, they are not getting a piece of paper. Do you know what I’m saying? They want accreditation, they really do, they are crying out for it. So firstly, there is only [myself and the research Institute] that have been doing it. And secondly, the accredited courses that have been out there, as I have said, the reports are that the facilitators that teach the courses don’t have the backgrounds,
say, that we’ve got, so that they are not relevant to them …” (Community services consultant/trainer).

This participant’s comment that she had received negative feedback about the accredited modules for assessment staff offered in the TAFE system was a view echoed by a Stage Two participant (A):

“We have just had two of our admin staff go through a course … and they felt that they knew more than the trainer. The woman didn’t even talk about the ‘SCoTT’ tool or know any of the history of that. There are a few running out of TAFEs … but the staff who fed back to the assessment officers group a few years ago said ‘look, a lot of it we know’ (Anna).

Katherine based her opinion of the inadequacy of assessment training on her judgement of individuals who had previously been employed in HACC assessment.

“Sometimes I try and see what it would be like if this job was advertised again and if they had a new employee coming in, what sort of training that person would have relating to HACC assessments. In the past it may not have been, well just looking at what past assessors have done on people, they just don’t seem to be as comprehensive as they could be. ... I just didn’t find the assessments holistic enough probably. Even things like a personal alarm system for a person that had been falling hadn’t been considered, or a physio program for a person that had mobility problems. For a new person going into the job, I don’t know how they get trained to holistically look at things. I don’t know what happens in other areas, but here if you are a HACC assessor it is presumed, and this is just my opinion, that you know. I personally don’t think it would be adequately addressed in our group” (Katherine).

Another view expressed was that even if staff were well prepared for assessment due to relevant professional training, the reality of assessment in the current service system context does not value or utilise many of those professional skills. The training that is available does not prepare staff for work in this complex and resource-dependent environment:

“I would have thought going back to the basics, that if people are well trained in the original case work skills, then they should be able to go out and do a comprehensive assessment, and understand about referral, and understand about follow through and so on. At the moment they are not funded adequately to do a lot of follow on referral or case management. I don’t know that means they haven’t got the skills to do it, it is the environment that they are put in and that they are more and more being gatekeepers for resources” (Local government peak body employee).
Of the seven participants who did not directly express a view about the adequacy or otherwise of current training in the area of HACC assessment, one (2) felt that postgraduate or CPE programs would meet most training needs as long as assessors came to the job with appropriate counselling and case work skills:

“I feel that if you have got some strong competency and experience in being able to counsel and to provide that type of case work/counselling service, then it is the content knowledge that is required that deals with some of the more specialised aspects of the role …. This can be gained through postgraduate courses or advanced studies, or through continuing professional education – those sorts of opportunities. …” (Aged and disability services researcher/trainer).

Two assessors who did not directly comment on the adequacy or otherwise of available training, instead commented specifically – in both cases reiterating – that gaining experience on the job is the best way for assessors to learn:

“…Someone might come up with a fantastic thing - something like a social work blah blah - that will slot you in perfectly, but with everything you do, whether it is assessing for personal alarms, or whether it is assessing for personal care, a lot of it is learnt by doing it over and over. We have our initial training but I don’t know whether someone can put together a program that combines everything an assessment officer needs – it would be huge…” (Bonnie).

“I think because we are from a nursing or social work background you’ve got that sort of health and community thing behind you already. I think it’s a job that you need to learn actually on the job. Because you are dealing with different people all the time you can’t learn it all out of a book, because a book is only one scenario and that seems to be a problem for a lot of the health field, like with the nursing courses now they do so much work in a classroom and it’s just not right, because people react differently to different situations and they are not all the same. People don’t work to a timetable, because they can’t, because things just happen. So I think it’s really important that it is mostly ‘on the job’. Have a basic understanding or background of medical or social work type thing, but really, it is all on the job stuff” (Ivan).

Four key informants (3,8,9,12) felt that training for assessors is most appropriately addressed in the higher education sector at the level of a graduate certificate, graduate diploma or specific modules within more generic courses. This would assist in providing (12):

“… for a much more productive team dialogue if people have a similar knowledge base, similar competencies and share similar concepts and understandings of why you do things this way. There are lots of good reasons why we should have
accredited training, in fact it is a bit amazing it hasn’t happened to date” (Local government senior manager).

One Stage Two participant (H) articulated that she would not be interested in completing a qualification at VET level because she already has higher education qualifications in nursing and education. However, as previously identified, few key informants (Stage One) had direct knowledge of VET sector qualifications, including the Australian Qualifications Framework (AQF) levels.

Summary

- Current provision of training for assessment in HACC is generally thought to be inadequate
- Reasons for this view included that there are insufficient accredited options; the TAFE trainers (offering accredited modules) have not demonstrated sufficient content knowledge; and that the courses available are generally not sufficiently practical and/or are wrongly targeted
- The higher education sector was suggested to be the most appropriate level for assessment workers (for example a graduate certificate and/or graduate diploma)

6.3.1 Policy trends with potential training/learning implications

In Stage One, participants were invited to comment on any policy trends in community care/HACC that may have workforce planning and/or education and training implications (1-Q9). The PCP reforms, initiated by the Victorian State government, was the single most significant policy trend identified. The Department of Human Services, through the PCP process, is actively seeking to define the different types of assessments which, as one key informant (4) believed, will enable closer attention to be paid to the different competencies required for each type of assessment:

“we would then look at what competencies are required to deliver on those standards. And then you would hope there would be training opportunities and possible developments around courses” (State government employee).

However, it was noted that, to date, there have been inadequate resources available for assessment staff to participate in training and skill development activities:
“One of the biggest issues is that training is generally not funded – that’s another thing that needs to be brought up in your work. There needs to be proper recognition of the time that needs to be put in to training for these people to do their jobs properly” (Community worker).

There was recognition that HACC agencies undertake a range of assessments and that the PCP initiative “is all about defining out those different types of assessments and how they work, what they are about and what they mean” with significant implications for workforce planning/training: “I think there is an enormous gap in terms of providing the field with greater specifications as well, but also training” (Aged care researcher). There appeared to be little doubt that the PCP reforms, whilst aimed at making improvements to the practice of assessment and care coordination, will require significant workforce development in order to make those aims reality, evidenced by the following quotations:

“…there will be a need for training around those specific streams of assessment. [including] intake, .. the assessment function, …. care planning, care coordination, case management and just about everything else – referrals, interagency referrals – so there will be a need for training on that. … Everyone will need to have an understanding of the total process, but you will need to target particular staff that are doing particular things within agencies…” (Community services consultant/trainer).

“There has always been ongoing work about establishing protocols, that is, whose role is to do what? PCPs has really got them to think about who in the primary care partnership catchments - which bring together between 30 and 60 agencies - is actually going to be involved in initial contact information? Who is going to gather that information? How is it going to be gathered electronically and passed on within the system? What sort of skills and requirements might be appropriate? I think that is probably the single thing that stands out” (State government employee).

Again, defining the different types of assessment and the skills and knowledge required for each type was regarded as a critical step which had yet to be taken. No specific training on assessment arising as a result of the PCP initiatives to date was identified in the research interviews.

Summary

- PCPs are expected to have significant education and training implications particularly following tighter role definitions with training being required for specific functions
To date, no specific training on assessment has been developed as a result of the PCP reforms.

6.4 The process of learning

In Stage One, key informants were asked to comment on how assessors learn best (1-Q3) and in Stage Two participants were asked a series of questions related to how they learnt their jobs including identifying what has been the most significant for them in learning about their role (2-Q11).

Some key informants were unequivocal about the best learning occurring from experience ‘on the job’ (4,6,7,10). For example, “[m]y guess is that learning from doing, learning from practice experience, is best. I think more could be made of that sometimes” (Consumer peak body employee). Specific types of ‘on-the-job’ learning opportunities were suggested by key informants including (aggregated from the interviews):

- supervision
- teaming up less with more experienced staff
- peer support, peer discussion and debate
- peer supervision and assessment
- team discussion
- mentorship
- guided reflection (with peers)
- clinical debriefing
- case conferencing
- secondments to other programs for short periods
- network meetings and information sharing

The provision of good supervision and mentoring is a key mechanism for assessors learning about their work and is also critical for supporting workers. Importantly, “you need really good supervisors … to pick up on people’s strengths and weaknesses or areas where they need further development or to be challenged” (State government employee).
However, the degree to which the supervisor is closely connected to the actual ‘doing’ of assessing is going to impact significantly on what and how assessment workers learn from them. One key informant noted that “on the job training works if you have really good mentors” but that this requires a properly resourced environment where those mentors are actually identified as such, nurtured and encouraged in mentoring roles (Community services consultant/trainer). This implies a necessity to be ‘close’ to the work, to the exercise of judgements (amidst hot action) in order for professional ‘know how’ to be nurtured by supervisory or mentor relationships. This is not always the case for supervisors who may be more closely aligned with senior management responsibilities and/or come from an unrelated professional background. Where supervisors do come from a related background, participants (B,L,I) indicated that they provided good supervision and support and could undertake assessment of individual clients if necessary. For example:

“[my] manager is really supportive, you know, assists with all that sort of stuff. He used to work in Linkages so he’s got that sort of background as well. So that makes it, you know, we can discuss things - everything’s really open and that really helps” (Lionel).

Another form of embodied learning, cited by a key informant as potentially useful for assessors, was to actually experience being a direct carer, or to directly experience the environments of direct care:

“Well I think if they have the right background to start with, as in the right education as a basic degree or certificate – then probably delivering care is one way, because you can be told how to go in and help with showering or prepare meals for people, or take them on a social outing, or be on a bus with them. So maybe just being part of the care to start with might give you a good exposure to what giving the care is about. And I think being in the environment of community care or day care centre, or a nursing home, where you are actually part of people’s lives, and you can see the different components of care, is useful. I think you need to get some experience, then you could go on to assessment after that as long as you understood the holistic part of what the person required…” (Service provider peak body employee).

This links with assessors’ own accounts of the value of their caring experience for their work as assessors reported earlier (section 5.5).

As we have seen, the view of some key informants was that ‘on-the-job’ learning is critical for preparing assessors for their role. HACC assessors themselves express
decisively that most of their learning happens on the job, in social situations, mainly through working with others via discussion with colleagues and peer support. For example:

“I guess sort of anecdotal stuff - you know, what worked, what didn’t work. Where things might have gone wrong. And reflection. Again, that cross-pollination within the team and networking, you know, going along to the network meetings and so forth and just listening to how other people are doing it … You need to be involved in doing the professional development, doing the networking, making sure that your lines of communication with your own team are healthy and open and also constant reflection on your own experience with the assessments that you are doing. Always being reflective and so forth” (Heather).

One (G) felt that the opportunity to conduct joint visits with a peer and then discussing their different perspectives on the same client was the most valuable learning experience. One participant (D) was a ‘lone assessor’ in that she was the only person in her organisation that had a role in assessing clients’ needs. In this case, she relied on an external network (ethnic HACC services network) for her learning and support needs.

Another participant (H) felt that gaining (and being open to) feedback from clients provided significant (and constant) learning opportunities. Client feedback was also important to the assessor working in an Indigenous organisation (J). However, a particular flexibility and openness is required that may not be an expectation on workers in other, more mainstream, workplace contexts: “You’ll hear through the community how people will relate to you or if you’re accepted or if you’re not” (Jennifer). Reflective practice processes occurring through ‘trial and error’ or ‘learning from mistakes’ was also mentioned by four participants (A,E,F,H) as very significant in learning about their job. For example:

“I guess that’s trial and error. It’s stuff that you find out, that you do learn. It’s not something that people can teach you. You actually have to learn that yourself. People can give you formally a whole range of strategies, but the book might say one thing and in the real situation it’s quite different. You may take some of those things but you really have to be prepared to mull them around or to say, yes, that’s what they actually say but I can see that it’s slightly different here or quite a lot different here. But still be aware that there are boundaries that definitely need to be in place and set up quite clearly and I believe being very honest and very open with people and stating up front exactly what it is, that this is my role, this is what I’m here to do and this is what I hope to achieve. I think that’s really, seriously, important” (Faye).
Learning was also said to be an “attitude” that required open communication and a willingness to “admit when maybe we’ve stuffed up” (Ellen). A number of assessors commented that many important things about the job cannot be learnt ‘from a book’ (A,B,F,I). From this perspective, learning derives from the embodied experiences of assessing, for example, from their reactions to particular situations, such as reading a written referral and still being unprepared for what they actually ‘see’ when they get to the person’s home.

Three participants in Stage One (4,9,12), in their response to the question about learning (1-Q3) spoke about the supply and demand tension experienced by assessors. For these key informants, what assessors needed to learn was critical, and that included how to deal with that tension. Other Stage One participants also commented on what assessors needed to learn, including working in a (newly) needs-led environment (5), the role of other (broader) service providers (7), and interpersonal skills (2,5).

To work effectively on ‘needs-based’ assessments (which was described by one key informant (5) as a paradigm shift), it was suggested that HACC staff need to learn about this concept “possibly through peer assessment”, or to work across other program areas, as has been done by ACAT staff: “I know that in the past some ACATs have done six month swaps with HACC people so each can see they how they do their business and the approach that they take” (Aged care researcher). In relation to how HACC workers need to learn about the broader service system, it was suggested (7) that the process of being “exposed” to these broader programs in their work might be sufficient for some depending on their employing organisation or work setting, but most would need to access this knowledge through a formal education program, such as a short course or seminar: “I think that to be an assessor, you do need to have some education about the different programs and about how to access them and to refer on” (Service provider peak body employee). Further, for assessors to learn about issues that relate to CALD client groups, formal opportunities for discussion and information sharing were said to be beneficial (11).

Other essential skills of assessment such as interpersonal communication and observational skills, it was suggested (5), are ideally learnt “in an apprenticeship type of arrangement” in a team environment, where workers get lots of opportunity for observing other staff:
“I think a team-based approach is good for this – if I could draw on the ACAT experience again – that team based approach where you are case-conferencing, not every client but the complex cases … and you bring back information about the clients to a case conference - this is another learning environment” (Aged care researcher).

Diversity of worker backgrounds can be problematic for developing approaches to the education and training of this group of workers, as we saw earlier in relation to having workers “at different levels” and therefore needing different training responses (2,8). However, worker diversity associated with different professional backgrounds and/or different organisational types can provide a rich learning environment in workshops and networks. One key informant (8) (a trainer) found this type of diversity (multidisciplinary/interdisciplinary) useful to break down “professional territorialism” and also gives workers an understanding of the value that each profession brings to the task (Community services consultant/trainer).

Summary

- Learning ‘on-the-job’ is thought to be the best for learning the job of assessment, including supervision, peer support/discussion, observation, and reflection on trial and error
- Learning derives substantially from the embodied experiences of assessment workers
- Multidisciplinary relationships, such as found in workshops and networks, are helpful in breaking down professional territorialism

6.4.1 Structural considerations

Many of the learning opportunities described above will depend on the conduciveness of the workplace and service system environment. Attention to the structural considerations that provide for a constructive learning environment was highlighted by one key informant (12). In particular, the management structure was said to be crucial in creating a good learning environment:

“I think it is that congruence of factors that make for a good environment – good management, good commitment, well resourced, good policy and good interagency relationships, and people having a job that is manageable. In a way it doesn’t take much for any one of those things to get out of kilter, and I think
people learn less well, because what they do is adapt to what is possible, what is survivable, and things like standards and good practice get compromised without people being very open about it……. You need good HR practices, good recruitment, good training, good supervision, good job descriptions, reasonable work load – it’s that congruence of all the things that make for a well managed service, and staff do learn well as long it is a very open and supportive environment where staff are game to tell people the things that you are doing wrong. If you don’t tell anyone about the things you worry about, or the things you don’t think you did very well, you don’t actually learn. There are a lot of factors that come into play for that to be right” (Local government senior manager).

Structural support such as “people working together in networks, with either like workers or within a network in their local area” (Community worker) provides a learning environment as well as support structure. Assessors themselves recognised the valuable learning that occurs through networking and service system meetings. For example:

“So you learn every day. Different clients, different issues. Every day I feel as though I am learning something new. Going to the meetings, I learn from listening to the doctors or how the social workers do their assessments. Well, what they look for is something you might look for next time you come across that issue. So it is a job that you learn on the job and the longer you do it the more you look at” (Bonnie).

Summary

- Internal (within organisation) and external (within service system) structural support are both critical for creating learning opportunities for assessment staff

6.5 Supporting assessors in their role

Data in this section were drawn mainly from Stage One in a question requesting participants’ views on how they felt assessors should be supported in their role (1-Q8). Some data from Stage Two are also included (2-Q9, and from elsewhere in the interviews where relevant patterns and themes were evident). During data reduction it became clear that the types of support available to assessment workers could be separated into three types (workplace, service system, and programmatic). I have maintained this separation to report the aggregated findings of the types of support that may be available. These are listed below and a more detailed description of each follows:
### Table 8: Types of support available to HACC assessment workers

<table>
<thead>
<tr>
<th>Workplace support</th>
<th>Service system support</th>
<th>Programmatic support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supervision</td>
<td>• Intranet</td>
<td>• Policy development for greater recognition of value of assessment</td>
</tr>
<tr>
<td>• Mentors</td>
<td>• Formalised mentoring and peer support in local areas</td>
<td>• Increased funding for assessment</td>
</tr>
<tr>
<td>• Peer review and debriefing</td>
<td>• Local networks with mandate for professional development and provision of orientation training</td>
<td>• Resource files/manuals (e.g. for CALD groups)</td>
</tr>
<tr>
<td>• Facilitated peer discussion</td>
<td>• Networks for information sharing and communication between agencies</td>
<td>• Self-instructed resource manuals to assist decision-making</td>
</tr>
<tr>
<td>• Effective human resource practices</td>
<td></td>
<td>• Laptops</td>
</tr>
<tr>
<td>• Ongoing professional development</td>
<td></td>
<td>• IT infrastructure</td>
</tr>
<tr>
<td>• Service development processes (policies, service review and evaluation)</td>
<td></td>
<td>• Funding for training and CPE/PD</td>
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<td></td>
<td></td>
<td>• Conferences</td>
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<td></td>
<td></td>
<td>• Policy development on client classification, prioritisation, service level benchmarking</td>
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<td></td>
<td></td>
<td>• Professional association or body</td>
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</table>

#### 6.5.1 Workplace Support

Supervision was a theme in most interviews (Stages One and Two), and can be further broken down into a range of critical *functions*, as follows (aggregated from the interview data):

- • Modelling good practice
- • Offering debriefing and discussion
- Facilitating peer support and discussion
- Supporting critical reflection
- Showing empathy with difficult decisions
- Keeping abreast of local issues and trends (the context for many of the decisions made by assessors)

The emerging trends associated with prioritisation (reported earlier) were thought to require a new, more intensive level of support from a supervisor (2,4,8,9,12). For example;

“Priority of access is a real challenge for people in this service industry – many people get into this area because they want to support individuals and promote independence and give them opportunities and advocate for them, and now they have to try and determine out of everyone who has these needs, who has to drop off the list, whereas probably all of them should still be on it. It takes a different level of support from a supervisor, whether it is clinical or just generally the person they report to, or even their organisation in supporting their workers to cope with the impact of that” (State government employee).

In larger organisations it is possible to create a role for someone to provide support to assessors as well as deal with the more complex issues, such as “a clinical coordinator”, as this key informant had done in her previous role as a manager of a large HACC service. This can help assessors when options are not clear, providing them with “some objectivity and some support” (State government employee). Bonnie and Lionel (Stage Two participants) reported that having a manager who was qualified and experienced in community care assessment was extremely helpful for personal and practical support with difficult decisions.

Some participants (3,10,D,E,K) regarded assessment as largely an isolated role, often without good access to professional support and supervision in their workplaces. For Ellen, this was mainly due to her role in supervising and supporting all the personal care staff as well as being the only person responsible for assessment. She described this as a “big educational gulf” which was both difficult and isolating: “at times I find I am propping up my staff as well as assessing upwards of 200 clients” (Ellen). Isolation is also the experience of Katherine even though she is based in a large team of other professional assessment staff. She attributed this to the lack of professional recognition as a HACC worker within the larger team, and noted that when she was working in a different role, as an Occupational Therapist, in the same team she did not feel that sense
of isolation. Delia’s isolation was due to her status as a lone assessment worker in her organisation.

A paid (external) mentor or professional supervisor is one solution to improving workplace support. One key informant (12) reported that this occasionally occurs in the HACC sector if the employing organisation is unable to provide it themselves, and if the cost can be built into their training budget. Another Stage One participant (2) recognised this as a useful strategy for smaller organisations and was aware of it being used successfully in other sectors such as child protection.

In organisations where the assessment function is undervalued, good supervision may be a secondary consideration, as one key informant noted:

“They also need to have a very skilled supervisor or manager, someone who has either done assessment themselves, so understands the complexity of the role, or who has really taken the time out to really learn that role and to supervise people in the role. I think the assessment function is undervalued within organisations. And many of the managers don’t actually understand what it is that their staff are doing out there and the sorts of decisions that are being made; particularly the whole area of duty of care and ‘at risk’ and the staff members’ constant dilemma around the values of dignity of choice versus the duty of care requirements of an organisation and of a profession” (Community services consultant/trainer).

The adequacy of workplace support (including supervision) relies to some extent on management having a high level understanding of, and commitment to, assessment and community care. For example:

“…when I came here I was horrified at the state that assessment was in, and it spoke to me of poor management. Basically the people managing it had not understood its critical role, why it was important and how to make it work. And the people who had come to it had not stayed in that environment” (Local government senior manager).

Other types of workplace support such as peer review and debriefing, and facilitated peer discussion also depend on the understanding and commitment of management to the issues. In effective team environments, such as those experienced by two participants in particular (H,G), they highlighted the value of ‘cross-pollination’ that occurs within their work teams between colleagues with diverse backgrounds and expertise. They found this social feature of their workplaces very supportive and
helpful for the quality of their practice. Some assessors (A,J) relied to a large extent on their own external informal networks for peer support.

Workplace support is diminished without effective human resource practices such as commitment to ongoing professional development of assessment staff. Some participants in Stage Two (A,B,I) indicated that their employing organisations are very encouraging of them undertaking further study. Anna had taken up this opportunity some years previously and had completed welfare studies, Bonnie had completed a work-based certificate course, and Ivan has not yet taken up the opportunity of further study but is aware that he would have his employer’s support.

Summary

- Supervision should offer a range of functions including modelling good practice, facilitating debriefing, peer support and critical reflection.
- Supporting staff with difficult decisions associated with prioritisation is also important for supervision in the current service system environment
- Professional isolation experienced by some assessment workers in their workplaces can be alleviated by accessing external mentors or supervisors
- Supervision and other types of workplace support (such as peer discussion, CPE), depends largely on commitment and understanding of assessment by management and the existence of good HR practices

6.5.2 Service system support

Other types of support available to assessors can occur outside their employing organisations in the service system, which I have termed “service system” support. Basically I define these as support mechanisms arising within, and maintained by, the service system itself.

In Chapter Four (section 4.2.5) I reported how assessment workers related to others in the service system, with many participating in formal network meetings concerned with individual clients and with broader issues concerning aged and disability services generally. Whilst some of these network meetings may be statewide and designed to support staff working with particular target groups (as was the case for Lionel), the majority are locally based bringing together the range of relevant aged and disability
service providers. They may also be more narrowly defined, to bring together ‘like-services’ in local areas (E,F). This type of networking is recognised as critical for the effective provision of services for clients, but is also critical for provision of support to the individual workers. For example:

“The … meeting of day centre coordinators is now more about support. Setting that group up originally was also about asking things like “who are we” as a group of workers? We sat down and looked at what we thought our attributes were. We looked at the different qualifications that people had within that group. We also talked about how we could be ‘movers and shakers’ and how we would could be heard and get some support. We got a bit distracted from that at the time because of the standards assessment and we decided we needed to be supporting each other on the ground a bit more. Within that group I think we are very generous in sharing our material. There has been some real collaboration particularly with the assessments and the National Standards assessments” (Ellen).

No professional association relevant for HACC assessment staff currently exists (reported in section 4.1.4). However, there is one statewide organisation in Victoria that operates for the benefit of local government assessment officers in Victoria. This group is a special interest group under the umbrella of LGPro (a local government peak body), although is essentially run by its membership, and meets on a bi-monthly basis (A,I). Of the four local government-based assessors participating in this study (A,B,C,I):

- Ivan, based in a rural area, attends most meetings and is appreciative of the opportunity to travel to Melbourne. He also pointed out that all the assessment officers working in the same Council usually attend.
- Anna used to be very active in the group but no longer attends because another person in her team now does, and her organisation will only allow one person to attend.
- Bonnie had attended the group only once or twice and (similarly to Anna) attendance is now designated to another member of staff who reports back to the other assessment officers.
- Clare and her immediate colleagues had never attended (although they receive the minutes) because the meetings are generally held at the other side of the city and the travel time is preclusive for them.

Whilst this is a very small sample of local government assessment officers, it indicates disparity amongst participation rates in a group essentially established to support them
in their work. Further, the group is only open to local government employees so has no
relevance for HACC assessment workers in other organisational types.

Establishment of a broader network was discussed by Stage One participants to enable
assessors to share ideas and approaches that are working well (6,9), and which could
provide access to others who may have specialist knowledge, such as in ethnic issues
(11). For example:

“…there is an obvious need for people to get together and thresh through the
issues that they are facing. The decisions that are being made about the
level of care we are expecting home carers to undertake, all those issues that
come up about medication and more complex procedures, they are all the
sorts of things that people would want to talk about” (Local government
peak body employee).

A network could also assist with more professional development issues, in particular,
for nurses that are no longer registered, to help them keep abreast of developments in
the sector (3). An Intranet for relevant assessment staff may be effective for providing
connection and information between individuals and organisations, as was one key
informant’s (1) view, as an alternative to, or in conjunction with, face-to-face network
meetings.

Summary

• Workers participate, in varying degrees, in a diverse range of communities of
  practice
• There is a need for assessors to be able get together to discuss practice issues,
  beyond those opportunities currently available

6.5.2.1 A professional association?

A professional association as a means of support may be defined as both service system
and programmatic depending on who should/would take responsibility for establishing
and maintaining such as group. There is no evidence of such a group existing at present
(beyond the local government assessment officers’ network), although evidence of the
need for such a group was provided. One key informant (5) described assessment in
community care as “an emerging field”, and for this reason is in need of finding a
collective voice for their experiences and professional development issues. This
suggests a need beyond what service system ‘networks’ are able to meet. Faye took up this theme and suggested a network or organisation along the lines of a professional association:

“(T)hat’s the idea you get when you talk to people informally, that there is something that people would want that would give them that professional ‘something’ that is missing. I don’t know whether it would be an association or supportive - I don’t know - but I know that there is something that people are looking for that is not there… People join things if they get value out of it. If it was something that provided good material, opportunities to have their voices heard, and to link to others who could provide you with knowledge and support, yeah, it would be good” (Faye).

The Industry training board employee (3) felt that if the area of client assessment in community care is “recognised as a specialisation then you can start to build up some networks and professional development that flows from those”. A body operating along the lines of a professional association may fill this gap within the service system.

Summary

- A body similar to a professional association may help to develop a collective identity and provide professional development

6.5.3 Programmatic support

I have given the term “programmatic support” to the type of support that is the responsibility of the HACC Program broadly (funding bodies) including policy development, information technology infrastructure and support including equipment and skills development. Programmatic funding and support for training also fits here although was reported earlier (section 6.3) and is not covered again in this section.

Assessment is not separately funded in the HACC program. Rather, any organisation receiving HACC funding for service delivery is expected to provide client assessment. This funding policy for assessment in the HACC Program was regarded as problematic and a policy which does not properly reflect the importance of the function of assessment in the program (4,6,7,10,D). There is a general view of an “undervaluing of the assessment” function in policy and funding terms (Service provider peak body employee). For example:
“(T)here is a need for more funding so [assessment staff] don’t have to do it in such a rushed way. Assessment, as I understand it, has never been funded well other than in the case management programs” (Consumer peak body employee).

Other participants too (10,12) were clear that resource levels and funding models do not adequately reflect the requirements of quality service delivery, and that service providers sometimes adapt to policy changes at the detriment of the service. For example:

“It is funny how economic issues or fashions like CCT drive you to some different solutions and it is often hard to keep the principles about quality service provision. I still have a lot of clarity about the quality of service I would like to provide, but I am sitting on a service that is dysfunctional because it is not well resourced enough to meet the demands and we can’t keep going like this” (Local government senior manager).

Policy development more generally was said to be needed to assist assessment workers to perform their job more effectively (9):

“The program-level support, sorting out some of these issues about client classification, and possibly even some sort of benchmarking around the level of service provided to different clients, those are things I would have thought would help support them. There needs to be some program development work that recognises what they are already doing and taking that a step further” (Local government peak body employee).

A Stage Two participant (H) felt that the program guidelines were very “didactic” and needed considerable interpretation in order to make meaningful practice decisions. Another (E) was adamant that programmatic support in general was inadequate. She felt that the funding body placed too many demands on the sector for “paperwork”, reporting, accountability, and minimum service standards without providing adequate funding and other supports to assist services with these tasks nor to meet the growing demand for their services in the community. Another also felt that the paperwork requirements at assessment were burdensome (K).

One key informant (4) recognised the policy support already provided by the funding body such as providing “a common tool template” to record basic client data, and assistance with establishing protocols between organisations and other players in the field, most recently through the PCP reforms (State government employee).
Other types of programmatic support were highlighted by key informants including provision of IT support (particularly for smaller organisations) (1,11), the provision of laptops for assessment staff (6), and further development of resources to support the assessment function (11):

“People often ask me for details of how to work with specific communities – they need information quickly. They don’t want to spend two hours trying to find the Somali community … They need something brief and quick that they can refer to, to assist them to understand the background of that person that they are working with. … People don’t know what’s around and what is available – they work in their own little vacuum. So some sort of communication/coordination process between services would be of great benefit” (Social research consultant).

Many of these findings are supported by recommendations of a report on strategic directions for assessment in HACC (in Victoria) released in December 2005 (Howe & Warren, 2005), particularly those focused on policy development.

Summary

- Policy development to improve the status of assessment function was said to be needed especially in funding (amount and model of funding) for assessment, and development of guidelines and resources to support assessment workers
- Provision of funding for training opportunities and IT support was also highlighted

6.6 Summary of findings and emerging themes

This focus of this chapter has been on preparing and developing assessment workers in community care. It began with an account of the views of participants on the appropriate pre-employment education/training which found little agreement on, nor even strong views concerning, the appropriate professional/educational backgrounds for the role of assessor, although social work and nursing were commonly identified. Higher education level qualifications were preferred but there was still an element of having ‘the right personality’. Significantly, closer analysis showed support for the ‘higher order’ capacity to think rigorously (in a framework) and to do so with sensitivity (interpersonal attributes).
I then considered participant views on whether formal qualifications are essential, and if not, in what circumstances. For those participants that felt formal qualifications were essential, they provide at least some assurance that assessors are not working beyond their skill level, and/or they can provide the basic required skills (such as counselling) upon which workers can build knowledge about the HACC/community care sector. However, as participants pointed out, formal qualifications do not guarantee suitability. The particular instances where to set rules about requiring formal qualifications may not be in the best interests of clients may be in the case of ethno-specific or Indigenous organisations where language, cultural or community knowledge can be regarded as the most essential attributes. The other significant local contextual issue that had a bearing on whether or not formal qualifications were essential was rurality. It may be acceptable in rural areas to employ people that show some aptitude and interest in the work and to consider the types of education and training that those people could do through workplace training, part-time study in higher education or in-service short courses. However there are divergent views about the requirement for assessors in HACC to possess a formal qualification and, to date, no definitive policy work has been completed to clarify competencies/formal qualifications required for the assessment function in HACC.

Next, a description of the post-employment (in-service) education and training opportunities currently available was provided. Participants generally felt that this was inadequate in the sector for reasons such as insufficient accredited options, TAFE trainers not demonstrating sufficient content knowledge, and that the courses available are not sufficiently practical and/or are wrongly targeted. The higher education sector was suggested to be the most appropriate level for assessment workers (for example a graduate certificate and/or graduate diploma).

The processes of learning were then described. Learning ‘on-the-job’ was said to be best, including supervision, peer support/discussion, observation, and reflection on trial and error. Learning derives substantially from the embodied experiences of assessment workers and the quality of learning depends largely on the structural support provided within organisation (such as supervision) and within the service system (such as networks and peer support).
The chapter concluded with an account of the types of support that may be available to assessment workers. Three broad approaches to supporting staff were identified:

- **Workplace**: including supervision (internal or external) to, amongst other things, model good practice, facilitate debriefing and critical reflection, showing empathy with difficult decisions; peer support and discussion.
- **Service system**: such as networks/forums. A need for assessors to be able get together to discuss practice issues, beyond those opportunities currently available was reported.
- **Programmatic**: including provision of ongoing training, IT infrastructure, and resource manuals; policy development (giving proper recognition of the assessment function, including increased funding).

The degree to which workplace and service system support is operating is variable and influenced by factors such as the level of understanding of assessment by management (including the degree to which managers grasp the complexity of the role). A body similar to a professional association may help to develop a collective identity and provide professional development, and to acknowledge assessment in community care as an emerging field of work.

### 6.7 Conclusion to Part II

In Part II, I have reported and analysed the findings in descriptive form. I have described who these workers are, and the contexts in which they work. A descriptive account of their practice was given, including the decisions and judgements they make and the bases they have for these. The current approaches to preparing and developing these staff were described and evident tensions and inadequacies were reported.

In Part III, these emerging themes are extrapolated. In particular, the ontological and epistemological implications of these findings are considered more deeply. This includes a discussion of the knowledge claims and identity issues that arise from assessors’ diverse contexts and practices. For example, what presents as the real filters through which they experience their work? How does the experience of being an assessor construct the nature of practice, and what are the elements of professionalism
evident from the practice of assessment? By probing deeper into the identity and knowledge claims of these workers, a ‘reframing’ of the (problematically professional) identities of assessment staff will become possible. This will allow for the emergence of a new direction for preparing and developing these workers for the complex role for assessment.
Part III: Discussion

Part II presented the research findings in the form of a descriptive analysis (the ‘thick’ description). In Part III, I present the interpretive analysis of these data in the form of a discussion, using concepts and theoretical perspectives presented in the literature review. Chapter Seven focusses on the professional identities of workers and the nature of their practices. Chapter Eight discusses current approaches to preparing and supporting workers and proposes an alternative model based on a consideration of their identities. Chapter Nine concludes the discussion and returns to the research questions to answer these more precisely.

Throughout Part III, when I refer to specific findings, I note the relevant section for ease of reference. For example, if I refer to a quote, or a theme addressed in a particular section, then that section is noted in brackets. This cross-referencing allows the reader to refer back to the findings if required.
7. Professional identities and the nature of practice

In Chapter Four, I reported that the organisations and personnel involved in assessment of client need for home and community care is typified by both a wide range of organisational types and a wide range of personnel undertaking these roles. There is diversity in workers’ position titles, primary professional background, further education and membership of professional groups or associations. Diversity is also present in the workers’ reasons for progression into their current role of HACC assessment. I also reported that primary background does not lead workers directly and purposely into these jobs. These findings suggest that obvious (traditional) indicators of professional identity do not draw these workers together collectively. However, the findings also reveal that the function of assessment has become more professionalised since the early 1990s evidenced through such indicators as increasing numbers of positions dedicated to assessment roles, the increased accountability and formalisation expected by the funding body, and by the increasing number of people with formal qualifications employed in those roles (section 4.3). A new way of analysing and explaining the professionalism of these workers is, therefore, required.

This chapter is devoted to considering the role of practice in formulating the professional identities of community care assessment staff. The chapter begins by focusing on this emerging professionalisation and locates this professionalism firmly in the ontology and epistemology intrinsic in their practice. I conclude with a discussion on the (theoretical) location of HACC assessment work as this is where practice (the doing of the work) occurs. Inherent tensions between, on the one hand, ‘traditional’ accounts of professionalism, identity and practice, and, on the other hand, those of community care and HACC assessment in contemporary workplaces and systems of health and community care are discussed. The implications of these tensions are pointed out and an argument for the need for new perspectives on how this occupational group should be regarded emerges.

7.1 Emergent practitioners

In much contemporary adult education scholarship, theorising needs to start with the reality of the local, particular, personal; that is, ‘truth’ must be discovered in local
contexts, and connections made by individuals and filtered through their experiences, perspectives and biases (Usher et al., 1997). This leads to consideration of identity issues for the workers arising from their practice, how they experience their work, and how the experience of being an assessor may, in turn, construct the nature of practice. To this end, I discuss workplace situatedness and contexts, workers’ embodied practice, and their personal attributes and biographies. I also consider levels of autonomy and agency evidenced through their judgements and decisions, including consideration of the experience of service rationing from this perspective. These are the major themes arising, and are the mediators (filters) through which assessors experience their work.

7.1.1 Workplace situatedness and contexts

As discussed earlier in the thesis, it has been the development of a body of theoretical knowledge with a clear relationship to either the natural or the human/social sciences, which has, historically, marked out a practice as a profession (Usher et al., 1997, p.122). For community care assessors the relevant theoretical terrain belongs to a range of different professions. Moreover, the role has evolved from within a rapidly changing system, arising out of the socio-political environment, rather than according to a professional discipline-defined function. This makes assessment in community care highly contested. Several professional disciplines, including nursing and social work, claim assessment as a primary function of their role. HACC assessors took over some of the ‘core business’ of these professions when these disciplines were unable to adapt to the needs of the changing and expanding service system and were insufficient in number. However, the context of community care, as delivered by HACC services, challenges the definitions of those professional categories, and is congruent with theoretical approaches that emphasise diversity, different forms of knowledge and the significance of contextualised knowledge (Usher et al., 1997, p.128). HACC is an emergent space, and is, therefore, a site of practice for an emerging specialism. This brings into sharp focus the situatedness, or contexts, of workplaces.

For nurses, the transition from the controlled hospital environment to the home requires an appreciation of the totally different context in which the nursing care is carried out (McIntosh, 1996) with many finding their professional skills inadequate to deal with many of the situations they are faced with in community care (Keegan & Kent, 1992). This corresponds with the findings of the current study. In the cases of Heather, Ivan
and Clare, they commented specifically on the totally different context of community care practice as opposed to hospital-based practice. Working in different contexts demands that previously-held assumptions and perspectives are viewed differently and questioned, as Clare points out here:

“...when I was in the hospital you just used to concentrate on getting people well and getting them home. You didn’t give an awful lot of thought to how people managed when they were home. They just went home and you assumed they managed – it was not our concern. But once you get into the community and you see how people have to manage their lives at home, you get a completely different perspective” (Clare).

Similarly, in ACATs, where professionals are employed because of their high level of clinical expertise, many tasks they undertake “tend to be learned on the job”. They may have high level disciplinary knowledge and have multidisciplinary skills, but if they have been employed primarily in hospital settings, then they need to “acquire knowledge about the range of community services” and the types of support that individuals may require (Clark, 1998, p.24).

A closer reading of the technical skills and knowledge in assessment reveals the same applies for HACC assessment (section 5.4). Knowledge of relevant community resources and services, available assessment tools, and HACC system and policies were the most frequently identified by participants in the current study, regardless of the professional/educational background of the assessment worker. The skills most often identified were application of assessment tools (non-standardised), and computer skills including electronic data management and transfer. All are highly procedural and relate to processes used in daily practice. Some are program-specific, meaning that they relate to the particular processes required of the HACC program in Victoria (such as HACC policy). Some may even be specific to individual workplaces or organisations (such as electronic data management). Attending to these knowledge and skill requirements in a front-loaded model of learning (as discussed in section 2.2) would be neither efficient nor accurate for all workplace requirements. While it is true for traditional professions to value the learning derived at the workplace when they commence practising (and enshrine this in internships, for example), it is also true that they require universalised, propositional knowledge prior to practise.
Other required knowledge identified by participants in the current study included family dynamics, cultural awareness, different disabilities including psychiatric illness, elder abuse, the ageing process and so on. Such knowledge requirements (‘knowing that x’) could be covered in preparatory programs. However, once again, some may be more important in different workplace contexts than others. Psychiatric illness, for example, may have more relevance or importance in areas where there is a psychiatric hospital (as was the case for Anna) or where the client target group includes those with psychiatric issues (as was the case for both Ellen and Lionel). For other identified skill requirements (for example, communication, writing, observation, listening, negotiation, liaison and networking, advocacy, or learning from reflection), this is ‘know how’ best developed in authentic contexts. For example, there is propositional knowledge underpinning counselling, but this requires practical application before it becomes ‘skill’ or ‘expertise’. This issue is addressed more fully in the next chapter.

According to Clark, assessment decisions in ACATs “seldom involve purely ‘clinical’ judgement” (Clark, 1998, p.24). Decision-making is influenced by the external service environment, the client’s wishes, as well as information obtained from other sources such as GPs, hospital staff and community services, as well as the carer/family. ACATs exist for the purpose of providing comprehensive, clinical assessment, yet clinical judgement alone is insufficient. A discipline-trained professional needs to learn and deploy a much broader range of skills than their professional backgrounds guarantee. The context, or ‘situatedness’, of practice (including the client’s situation) plays a big part.

There is substantial diversity of clientele within HACC services resulting from variables such as geographical location, disability type, age, and cultural and linguistic background and literacy. This diversity can be experienced between assessors and organisations, as well as within individual organisations and by individual assessors. In the case of Grace, at the time I interviewed her she was working with a 97 year old client with dementia, a 48 year old client with Multiple Sclerosis, and a 5 year old client in palliative care (section 4.2.3). Such diversity presents major challenges to individual assessors in terms of their knowledge of particular diseases or conditions, life stages or expectations, and of the community resources available for different client groups. Clearly, it would be an impossible task to develop, retain and continually update sufficiently detailed relevant knowledge for the whole range of clients. HACC
assessors therefore develop innovative ways of mediating these varied knowledge requirements in their practice.

One way is to develop expertise through practice in working with particular client groups (and become recognised for this expertise, and thus a resource for others). Grace, for example, was regarded as having specialised knowledge of younger people with disabilities within her organisation, even though she still maintained a diverse case load. However, without exception, assessment workers develop expertise in locating the knowledge they need; all draw upon peers, other services and community organisations, and other relevant knowledge sources (section 5.2.2). This is clearly evident in assessors’ accounts of their own practice.

As discussed in the literature review, client interactions are critical for knowledge formation. Daley (2001) reported that differences in meaning-making processes are framed by the nature of professional work and also by the client-based experiences within an individual (traditional) profession. For example, social workers combined new information gained in CPE with their experience in professional practice; attendance at CPE programs reaffirmed their commitment to their profession, and they tended to frame meaning-making through their advocacy role. Nurses identified their work as providing care, and as such, knowledge to them became meaningful when they took caring action with it; new knowledge functioned like a web of information to be drawn upon when presented with new clients (Daley, 2001). This leads us to consider the relative impact of the discipline base, or the type of ‘self’ (individual disposition), on the meaning, or personal knowledge, constructed from such experiences. This is of particular interest when the same work (role) is undertaken by diverse disciplines/professionals, as is the case for HACC assessment.

HACC assessors’ practice is not dependent on their having (or even developing) the ‘know that x’ relevant for all types of clients conditions, problems or circumstances, although they may develop ‘know how’ over time, based on past experiences. Rather, it is in negotiating all the diverse knowledge sources and bringing those to their judgements and decision-making when required, that is central to their practice. Their epistemology is dependent on the nature of the clients and the service system in which they operate; it is preceded by the ontological. Put simply, this means that their experiences, rather than any prior-held propositional knowledge, largely determines
both the nature of their practice and the knowledge and expertise derived from it. This is evident from examining the nature of the ‘gaze’ of observation that individual assessors apply in people’s homes. From a (traditional) disciplinary perspective, it might be expected that different professional backgrounds would affect the nature of this assessment technique in practice, as implied by Daley (above). Indeed, much of the literature highlights that this is the case for discipline-based practitioners. However, HACC assessments do not focus on reasons for frailty or underlying conditions of clients, or any role specificities related to the assessor’s discipline, as a clinical assessment might. Rather, they focus on how the client copes with their life circumstances, and considering the supports they may need to enable them to maintain a reasonable quality of life.

This shifts the focus directly to the client’s life and their perspectives. Assessors’ identities are thus linked, not to clinical assessment or clinical care, but to an ability to interpret need from their client’s diverse stories and life circumstances. Quotes from Anna (with a background in welfare) and Ivan (with a nursing background), included in section 5.1.3, demonstrate this at work. Rather than bringing an apparent disciplinary perspective, they describe how they would approach seeing the client’s home life, their interactions and relationship with the family and listening to the client’s own stories to help them see the client’s perspective on their current circumstance. Their observations are broadly-based (holistic) and are determined by each individual situation they face. Their disciplinary backgrounds are just that - in the background. This removes some of the power of the (old) assertion of nurses (or health-qualified professionals) that they can undertake holistic assessments, and social welfare professionals cannot (Parry-Jones & Soulsby, 2001), because the latter can only focus on social care, whereas the former have the knowledge to focus on the full spectrum of needs.

Professional boundaries become problematic in contemporary workplaces, particularly in the health and community services sector. Much effort is put into re-negotiating how discipline-based professionals work within and beyond their boundaries as workplaces change, creating a constant tension between professional identity and the demands of current practice. One of the markers of this emerging specialism (in HACC assessment) then, must be a ‘trans-professionalism’; an ability to work beyond traditional professional boundaries, and other structural features of the service system, for the benefit of clients, in deploying specialist knowledge and expertise in timely and
appropriate ways. HACC assessors’ agentive selves (knowing what they can and must do) in fact, lie in transgressing boundaries, and their professionalism is grounded in the unique contexts and situatedness of their work (the ontological).

7.1.2 Embodied practice

“As soon as I get there I am looking at the garden. If it’s beautiful, well you know there is someone in there that loves their garden…. As you walk in, it is the smell, the photos, the demeanour of the person. You use all those senses from the moment you walk in” (Anna).

“There are things like electrical cords everywhere? Are we in a real mess here, are we at the point where we need an industrial clean? You know, all of those things give you alarm bells as to how this person is coping or where they’re at in their life now” (Heather).

Provision of care in the home for people requiring support is essentially about the body. And maintenance of the body is intrinsically related to a sense of “identity, personhood and control” (Tanner, 2003, p.503). Practice should involve clients in identification of their own need, utilise their own problem-solving ability and help them to maintain control over their own lives. In this way, practice in community care is critical in maintaining a positive sense of self and hence in “identity management” (Tanner, 2003). The implication is that practice that is underpinned by these values and approaches is more likely to be effective in keeping people independent and living in their own homes for longer compared with practice that is less concerned with these values.

Concerns about the body are integral to the practice of assessment in community care. Indeed, it is the lived bodily experiences that result in people ‘becoming’ clients of community care, such as through ageing and increased frailty, or through theirs or others’ perceptions of the impacts of bodily (including social and emotional) changes. These issues are so central to this work that potentially there is a danger of reduction of the person’s whole lived and past experiences to the immediacy of their body’s changing degree of functioning. To avoid this reductionism, practitioners (in assessment) are encouraged to focus on the whole person, to “recognise the interconnectedness of mind, body, emotions, behaviour, and belief systems” (Tangenberg & Kemp, 2002, p.15). Particularly where a person’s communication or cognitive ability has declined, their life story, referring to both physical and psychosocial aspects, as a means of understanding their present situation and coping is
critical (Hallberg, 1998). This requires a particular engagement with the client (and carer) that would need to be attentive to that client’s circumstances. Anna recounted a story from her practice the previous day where she had assessed the needs of a man without speech and wheelchair bound following a stroke. Her approach was adapted to suit the needs of both the client and his carer, and she was mindful to ensure that she had captured nuances for this couple in relation to communication and coping patterns (section 5.1.1). In this way, ‘particularity’ is practised for every client, and the concern with the “local, particular, personal” (Usher et al., 1997) is seen at work.

The epigraphs from Anna and Heather draw attention to the highly sensory experience of practice in people’s homes. The meanings of these experiences are contingent on how these embodied experiences are re-formed to enable a judgement for need. Judgement is reached through filtering information through the client’s own views and choices, knowledge/views acquired through discussion with other people (supervisor, colleagues, peers, other services), and through reflection on past mistakes and past experiences. Other filters may include information from, and views of, the referrer, personal philosophy and values, input from clients and family, cultural knowledge, knowledge and interpretations of trends in practice, duty of care responsibilities (balanced with a respect for client choice), formal knowledge available in the public domain (such as research on a specific disease or a condition), and polices and procedures (section 5.2.2). These are the elements of a framework for a ‘higher order’ capacity to think rigorously and to do so with sensitivity, and many ontological features permeate it: the realities of family life, the home itself, the existence of ‘data’ from carers and referrers, and so on.

However, emotion and feelings also play a part. Clients’ stories also pass through personal and emotional filters as they are re-framed to form a professional judgement (section 5.6). Emotional reactions play a significant part in how assessment workers build a picture of their clients. However, much remains undocumented or unspoken because it arises from ‘gut’ feelings, for example, when something is different or uncertain about the client. The following quote is from a participant who coordinated a day care centre, so got to know her clients very well:

“…when he’s upset you know that something is happening probably … where he lives – he gets very distressed, but it is very hard to document that and the reason behind his behaviour management problems” (Ellen).
This participant was speaking about a particular client with dementia who had no informal carers. Emotional reactions (or feelings) of the assessor thus played a big part in this client’s ‘management’. Similarly, assessors relate their own experiences to those of their clients, as we saw vividly in quotes included in sections 5.5 and 5.6. Many interactions with clients invoke an emotional response for workers because they relate an event from their own life to their client’s situation, or because for many clients their situations are, quite simply, distressing from any point of view. Emotions and feelings thus comprise some of the other filters which mediate assessors’ experience of their work, and there is a lot of tacit understanding and wisdom implied here.

Hodkinson et al. remind us that there are wider aspects of worker identity which cut across many arenas of work including gender, sexual orientation, ethnicity, social class, nationality and age (Hodkinson et al., 2004). Although most assessors are women (and many are middle aged) other aspects of diversity are likely to be represented in the assessment workforce, as in any work context. These factors, the make-up of individuals, are important in the complex inter-play of work and learning, and are characteristics which should be central in considerations of learning and identity. The assessment worker’s body is present in all aspects of their work, including their assessment interaction with clients. Therefore, what is ‘written on’ the assessor’s body also contributes to the client’s experience of assessment and vice versa.

The embodied client and worker are inextricably linked in the interactions involved in assessment in the home. And yet there is a tension between the embodied function of assessment (sensory, emotional, ‘gut’ feeling, tacit wisdom) and the pull towards the disembodied elements (tools, prioritisation, waiting lists). The current, and evidently preferred, practice of workers in HACC assessment is for a highly embodied process (section 5.1), and there is some suspicion in relation to the introduction of forms and tools that may detract from the nature of their practice. One interesting issue to arise in the interviews was the Department of Veterans’ Affairs initiative in home care (a program with the same goals as HACC, but for frail older veterans only) 4 which was to have a “telephone assessment” process (7,9). This was regarded by these participants as undervaluing assessment because it removed those aspects of assessment that relied on

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4 Reference to DVA’s home care program and the use of telephone assessments can be found at http://www.dva.gov.au/health/homecare/guidelines/section5.htm#s51.
observation of the client in their home environment. It also removes assessment from local contexts and removes any possibility for it (the assessment process) to engage with clients’ diverse stories and lived experiences. For this reason it will be an interesting program to watch in the future; the telephone assessment component is clearly regarded as a process that can be standardised and formalised and completely disembodied. It certainly removes any possibility for practice as highlighted in the epigraphs.

7.1.3 Personal attributes and biographies

“…you go in with a really open mind, you get into their space and work out what’s important to them” (Heather).

To create an environment for client participation in the assessment and care planning process an assessor requires the skills and personal attributes that will create a climate which is “open and safe and within which differences of opinion, painful emotions, deep-seated fears, anxieties or aspirations can be explored” (Hughes, 1995, p.91).

Interpersonal skills are, therefore, crucial. The findings of the present study also indicate the primacy of interpersonal skills (such as the ability to establish rapport, communication and listening) in the assessment process (section 5.3).

I reported (in Chapter Six) that the findings showed support for the ‘higher order’ capacity to think rigorously (in a framework) and to do so with sensitivity, again reflecting the importance of interpersonal attributes. The literature review also drew attention to the necessity of interpersonal or ‘people skills’ in these work settings; key skills for practice in community care (Gorman, 2000). However, these people skills are often regarded as ‘soft skills’, as opposed to hard skills that display technical or clinical substantive expertise (Beckett & Hager, 2002, p.28). Attributes of creativity, sensitivity and emotional intelligence often go unrecognised or are taken for granted by employers and trainers (Hodkinson et al., 2004, p.12) yet, as the findings highlight, these are often the most relevant in working in community care assessment. Assessors themselves tended to identify empathy, willingness to listen, an ability to establish rapport, and being non-judgemental (not imposing their own values) as the most important personal attributes (section 5.3).

The finding that counselling skills are important in community care assessment (sections 5.4, 6.1) links with an assertion in the literature that the process of assessment
itself can be beneficial even if the provision of on-going services is not an outcome of the assessment (Byles, 2000; Richards, 2000; Worth, 1998). An assessor with good interpersonal and counselling skills can empower the client to identify their own strengths and areas of need, assist with some level of problem solving and goal setting, and can provide appropriate information. Similarly, Tanner asserts that approaches that enable client narratives to be heard and for their strengths and own problem-solving abilities to come to the fore are critical for effective community care assessment (Tanner, 2003).

The value of life experience is also a pervasive theme throughout the findings. This is particularly clear in relation to the question of whether formal qualifications should be regarded as essential. Just over half of the key informants felt that this was not a good policy to adopt (section 6.1.1). Life experience, coupled with the right interpersonal skills, were often seen to count as attributes that may ‘qualify’ someone to work as an assessor, such as in the case of Indigenous or NESB/CALD groups. The remainder felt that formal qualifications provided at least some surety that individuals had a framework for thinking, but again life experience counted. Deverell and Sharma point out that many professionals (those with formal qualifications) find that personal life experience is as important as formalised knowledge in their everyday work with clients. However, by its very nature, this cannot be conveyed through professional training (Deverell & Sharma, 2000). The values and dispositions of individual workers contribute to the co-production and re-production of the communities of practice and/or organisational cultures and/or activity systems where they work (Hodkinson et al., 2004, p.10). Thus, assessors working in workplaces with strong value bases, where interpersonal attributes (caring, empathy, sensitivity, listening, advocacy and so on) are considered important, and where there is a culture of discussion, such attributes developed through ‘life experience’ are more likely to be valued and cultivated as a (personal) resource for practice. Of course, this can also work in the reverse if the workplace culture is one dominated by antithetical values.

But what is it about life experience that makes it so valuable for practice? An examination of how judgements and decisions are made in practice helps to answer this question. Life experience (such as caring for a relative) was drawn upon in exercising judgements, as were other sources such as the views and perspectives of others, past mistakes, personal philosophy and values. As I noted in the findings, it did not seem to
matter what the participants’ experience had been - all drew upon their past (life) experiences (section 5.5). Prior work experience as diverse as nursing, child protection, administration, community development, and even motor vehicle finance were useful to assessors’ current practice. Participants also described reflective processes to ensure that their approaches to assessment are informed by their past and daily experiences. Reflection thus provides the link between the necessary personal attributes for practice, and broader life experience that assessors bring to work. Without the ability to reflect critically, action (practice) may be separated from the worker’s whole ‘self’.

HACC assessors’ identities are connected to the caring nature of the work. However, they also recognise the need to negotiate professional boundaries in the emotional aspects of the work. That is, not to take too much “to heart” (section 5.6). This ability to maintain emotional ‘boundaries’ is also one of the hallmarks of discipline-based professionals in health and social welfare. Given the degree to which assessors draw on their personal life experiences, such as caring for a relative, it is also another area for considerable levels of self-reflexivity and self-awareness in practice. Put simply, assessors demonstrate the ability to use their personal (emotional) experiences to inform their practice, but can recognise the risk to their identities (and emotional wellbeing) if they allowed these emotions to drive their assessment interactions. They are deployed usefully as filters for their assessment experiences, but not beyond this.

7.1.4 Autonomy, agency and the exercise of judgement

The degree of autonomy exercised by community care assessors is a useful point of reference as this is a characteristic of professions, yet the degree of autonomy that can be exercised is often highly contextualised to particular work sites. According to Usher et al., autonomy is the “government of self, a freedom from dependence, a situation where one is influenced and controlled only by a source from within oneself”. Challenges to autonomy occur from sources external to the individual, that which is “other to the self” (Usher et al., 1997, p.93). Kouzes and Mico (1979) propose that human service organisations are comprised of three domains (which they define as a sphere of influence or control claimed by a social entity): the policy domain, the management domain and the service domain. They claim each has its own identity, structure, modes of working and principles. The principles of autonomy and self regulation permeate the service domain, which is often in conflict with principles held
by the other domains. These principles of autonomy and self-regulation, stem from the
belief of those who provide services to clients, that, “after years of schooling, 
professionals consider themselves capable of self-governance and believe they have the 
expertise to respond to the needs and demands of their clients” (Kouzes & Mico, 1979, 
p.457). As agents within human service organisations, assessors comprise part of the 
service domain, although their levels of autonomy may be influenced by a range of 
factors, including their educational and professional backgrounds.

Part of the rhetoric of the new order in post-compulsory vocational education and 
training in Australia is that learners have more autonomy and control over their own 
learning through flexible delivery, self-paced and modularised courses, a focus on 
outcomes rather than training inputs, and recognition of prior learning (National Centre 
for Vocational Education Research, 1999). Competency based approaches in VET 
shifts attention to the assessment and transfer of learning, where the acquisition of new 
knowledge and skills is demonstrated by the learners being able to ‘do’ or apply what 
they have learnt, as well as simply having new knowledge.

Whilst the claim to learner ‘autonomy’ is not in question here, new order vocational 
education encourages learner-centred, self-directed, and empowering models of 
education and training. Professional categories outside the VET system, on the other 
hand, have traditionally held a high degree of autonomy because of their professional 
knowledge. Paradoxically, autonomy did not feature in their training, which, in 
traditional approaches, was focused on acquiring formal (propositional) knowledge 
(Eraut, 1994), and the approach often didactic. This body of knowledge, coupled with a 
subsequent, and largely un-critiqued, acquisition of ‘experience’ (Usher et al., 1997) 
was thought to be sufficient justification of this degree of autonomy. And while VET 
category workers, in theory, now have a high degree of autonomy about how and when 
they are trained and credentialed, typically they have lower degrees of autonomy in the 
workplace, being employed in ‘lower order’ roles. Whilst this is a generalisation it 
helps to point out some points of tension between the different worker categories, and is 
represented in the table below.
### Table 9: Levels of autonomy in the workplace compared to worker educational backgrounds

<table>
<thead>
<tr>
<th></th>
<th>Degree of autonomy in training</th>
<th>Degree of autonomy in the workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VET category workers</strong> (for example Division 2 nurse, Certificate-qualified aged care worker)</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td><strong>Higher Ed (professional) category workers</strong> (for example Division 1 nurse, social worker)</td>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

The changing nature of organisations, however, is presenting challenges to professional autonomy and the impacts of this need to be explored more fully. Daley suggests that with dwindling professional autonomy within modern organisations the linkages between context and practice need to be defined and analysed so that learning and professional practice can continue to grow in these new settings (Daley, 2001). Making these linkages is also important from the point of view of groups of workers attempting to construct professional identities across diverse work contexts.

So, what is the level of autonomy of community care assessors? Is the degree of autonomy they experience shaped primarily by their organisational context or their professional background? The types of decisions that assessors have to make are an important consideration here (section 5.2.1). These range from those that have immediate impact on the client such as determining eligibility and relative priority for access, and those that have an impact for the client and their carers in the longer term such as setting priorities, goals and review dates for services. These are instrumental (technical) decisions that are supported by codified knowledge in the form of policies and guidelines, but still require judgement and discretion in their application. There are also judgements that need to be made in the ‘hot action’ such as how to approach sensitive/personal issues during an assessment interview, or whether to continue with particular (sensitive) questions/topics, such as continence. In the hot action of these situations, assessors have a great deal of autonomy and agency (responsible action).
Responsible, but also wise, action is evident in their practice. For example, Katherine described her anticipation of a client’s health deteriorating because of his co-related drug and alcohol and mental health issues (section 5.2.2). Her reflection-in-action led to a series of decisions concerning consulting and involving others, and accessing services creatively (to circumvent waiting list problems). Similarly, Jennifer relayed a story from her recent practice where she had attended the home of a potential client following a referral from an ACAT. When she arrived she noticed beer cans and a person lying drunk on the floor. She had no prior warning that the house had “drinkers”, but in the hot action, she decided it best to return later rather than risk putting the client in a potentially volatile or conflictual family situation. She had to balance the urgency of need considerations (duty of care) with confidentiality and safety considerations (her own and the client’s). Many of these judgements, over time, become tacit. This is inarticular wisdom acquired from reflection-in-action, when things do not go routinely. In both these examples, both Katherine and Jennifer reshaped the action to suit the new problem. This is part of an epistemology which helps to explain the professional artistry required for practice in the zones of indeterminacy (the ‘swampy lowlands’) (Schön, 1987).

A high degree of agency is present in other common judgements and decisions, such as whether, and how, to involve or consult with family/carers, whether or not to conduct a joint assessment (with other service providers), and any referral action (for example to ACAS, district nursing, or the guardianship board). The nature of experience (leading to these types of judgements) warrants further analysis. Although the work is poorly remunerated, many decisions made by assessment workers have direct and highly significant impact on client’s lives. The nature of these experiences for assessors is shaped by a great deal of responsibility (power) over others’ lives, but underpinned by the caring nature of the work.

Identities are important here. Clearly, assessors see the value of their work and of the HACC program (section 5.6), and can see their place in the whole system of care as highly significant. However, the degree to which they see how much power they have over others’ lives is not clear, because they can feel limited by the increasing demand on services and their inability, often, to meet a client’s assessed needs.
7.1.4.1 The experience of service rationing

In these cases (where service rationing has to be undertaken), ‘power’ is shifted to external entities such as waiting lists, targeting policies, priority of access guidelines, or sometimes scored-based normative assessment tools. That is, their agency is also distributed materially (Beckett, 2005), and shortfalls in the service system can be ‘blamed’ on the inadequacies of the system and/or levels of funding for the program.

Assessors have less autonomy (and therefore less agency) for other types of decisions too. These include the type and level of service to be provided, or matching care staff with clients. The former is related to the experience of service rationing, and the latter is related to the nature of the organisation and the person’s role in it (some assessors have no control over matching staff with clients). These workers, as we have seen, have extensive knowledge of community resources, and over time build up knowledge to inform their judgements about decisions such as services and levels of service that will assist their clients. However, this is often coupled with frustration in not being able to use this knowledge to maximum effect. They have the knowledge of the community resources, but they are not always able to arrange timely access to those services. The experience of service rationing, itself leads to new knowledge (practice wisdom) for the assessors from observing the impact of these delays on their client and their families and the inherent frustrations for their own powerlessness over other services and their policies.

The rewarding aspects of the job include meeting and learning about interesting people (listening to their stories), the feeling that their work is making a difference in peoples lives, and appreciating that it can be a job with great variety (section 5.6). The experience of service rationing is not, at this stage, the dominating influence on assessors’ identities. Rather, from the evidence in the current study, assessors do not see themselves as being involved in simply technical work which is driven by economic considerations. They can critique this trend, but can still draw meaning from their work related to their caring role, and being able to engage with people as individuals.

Some of the terms used by assessors in the interviews to describe the nature of their experiences included ‘caring’ and ‘being helpful’ or ‘making a difference’. Their identities are closely tied to these human service values. However, the trend of service
rationing in the service system has also led to new forms of ‘codification’ and formal knowledge in the form of guidelines for prioritisation (see for example, Black & Buckley, 2003). In the current study, Anna spoke about her involvement in a trial of a “priority of access” document which was developed by one region of DHS and which is now being trialled more broadly. The impact of initiatives such as these, designed to assist assessors’ decision-making, may, over time, remove some of the embodied aspects of the job. This has the potential to devalue their practice knowledge, and to remove some of the ‘caring’ aspects of the work, in turn affecting identity formation and re-formation.

7.2 Community care: an emergent space

The preceding discussion highlights certain ontological aspects of HACC assessment practice. The chapter now turns to highlighting some contradictions within the context of assessment in community care, as this is the site (and scope) of practice for HACC assessors. These contradictions are present in the philosophy of care underpinning discipline-based perspectives on assessment, the professional status of assessment workers, the use of assessment tools in practice, and assessors’ personal values as opposed to their workplace realities. These tensions create an ‘emergent space’ for the emerging identities of HACC assessors.

7.2.1 Philosophies of care

“HACC can be limited because people see it as medical model service rather than social. But it sits between those, so that is part of the challenge for it” (Industry training board representative).

The different perspectives in needs assessments are often presented dichotomously. Some of the terms appearing in the literature are:

- health vs. social (Parry-Jones & Soulsby, 2001)
- medical model vs. social work model (Johnson et al., 2003; Worth, 1998)
- clinical vs. clerical (Mykyta & English, 2002)
- professional vs. non-professional (or lay) (Dill, 1993)
- professional/medical vs. empowerment/social welfare (English & Mykyta, 2002)
- cure vs. care (Tanner, 2003).
In these dichotomies, the former term is generally accorded higher status and privileged over the latter term, which is essentially representing personal or social accounts of individuals’ circumstances. Such dichotomies are characteristic of modernist discourse which relies on the notion of a ‘grand narrative’ (or ‘universal story’) explanation of phenomena (Camilleri, 1999). The dominance of medical perspectives in aged and community care is well documented (Hughes & Heycox, 2005). In fact, even in arguments proposed to advance the status and role of social workers in community care assessments, alternative (that is, non-medical/health) staff are described as ‘lower level’ (Payne, 1995).

Such value judgements on assessment workers also serve to devalue the clients in community care. Dill’s description of ‘lay’ perspectives in assessment also refers to clients’ own views on their situation. In this way their views are relegated to the lower status end of assessment knowledge. Professional constructions and lay models essentially represent ‘competing epistemologies’, with lay models reflecting broad cultural categorisations and folk knowledge, and each individual’s lived experiences. Further, “(p)erceptions of need are grounded in biographical reconstructions and as such are intimately related to issues of personal identity” (Dill, 1993, p.458). As social needs tend to be dismissed as low level, they may, therefore, even be screened out at initial assessment (Tanner, 2003).

Mykyta and English conceptualise the directions of assessment in aged care programs in Australia as becoming too skewed towards the client population need for “welfare support” rather than “health care”, and with this direction, assessment can be done by “clerical rather than clinical workers” (Mykyta & English, 2002, p.84). They further contend that “removal of clinical expertise from the front line of assessment or removing assessment from its clinical connections would do a disservice to aged people” (Mykyta & English, 2002, p.90). In contrast to this assumed superiority of a medical practitioner’s approach, some clinicians admit to being deficient in exposing and understanding a patient’s social background and how that may interact with other aspects of their needs and/or care regime (Netting & Williams, 1996).

Critical approaches invite practitioners to “eschew the traditional approach of authoritative voice in favour of a dialogic and collaborative orientation” which requires
engagement with clients and negotiation of possible realities (Iversen et al., 2005, p.698). In this way the client is not assessed in an essentialist fashion but is assisted dynamically and collaboratively (Iversen et al., 2005). Nevertheless, even in these critical approaches, there is still an element of accepting these competing perspectives as single entities and that in order to practise effectively, workers must somehow negotiate how to ignore them, whilst accepting that they exist. However, these debates occur within modernist discourse. What is required is a way of shifting the debate from such discursive (binary) representations to see community care as a new theoretical space in which HACC assessors practise. In short, this field of practice needs to be recognised as an “emerging field”, as one key informant in this study put it (section 6.5.2.1).

Some of the assumptions that underpin the view that there are competing epistemologies in community care include the notion that medical/health issues require high level of skills and knowledge and require more intensive and longer interactions from practitioners than other issues. A study of assessment/case management practice in Canada (Bay Consulting Group & Workflow Integrity Network, 2004) found that the predictors of assessment/case management time are not necessarily related to acuity of illness, but rather more to psychosocial needs and supports (personal email communication with Karen Parent, 29 March, 2005). This is contrary to the accepted view in community care that the severity of the client’s illness or disability equates to complexity of care and therefore to assessment time. Rather, what this Canadian research is pointing to is that client’s psycho-social needs are the most pressing to them, and require the most input from assessment and case management staff.

The scenario described by Delia (section 4.2.3), where she describes her interactions with a client she was assisting to access home care and physiotherapy, vividly highlights the time required in situations where social and cultural issues feature. Considerable time was spent in reassurance and what effectively amounted to cultural brokerage. For example:

“…explaining that and knowing the cultural and the traditional side of things and telling her that it is okay here, it took me a month. Because she kept ringing me…” (Delia).
This scenario also clearly demonstrates the *particular* knowledge and understandings required for working effectively with this client who also had language and literacy challenges. This situation (getting services into the person’s home following a fall) could take on many different forms for an assessment worker depending on an individual client’s situation, such as whether social, cultural or literacy issues are present for them. Degree of difficulty/complexity, length of assessment time, and depth of assessment knowledge and expertise did not equate with any assumption of a ‘health vs. social welfare’ dichotomy, which would have the former holding the position of higher status/higher knowledge/higher degree of difficulty.

In relation to HACC assessment, traditional professions have failed to meet the demands of the sector. There is little agreement on the professional/educational backgrounds appropriate to undertake the role of assessor, although social work and nursing are commonly identified (section 6.1). Nurses’ knowledge base is regarded highly, but the job itself is not regarded as nursing practice so does not count towards maintenance of professional skills for registration purposes. Assessment in HACC is therefore unlikely to be attractive to nurse-educated individuals who wish to practise as nurses. Social workers too are regarded as having highly relevant knowledge but HACC assessment is not a position that *requires* eligibility for membership of the AASW, and for this reason may not be a first choice for a social worker wishing to have a strong professional identity in the field of social work. Other professional categories, such as occupational therapy, may be in the same position. Indeed the participant in this study who was OT trained (Katherine) did not regard her HACC assessment job as an OT position (section 4.5). Other research has found that assessment workers in HACC services are generally not employed under the terms and conditions of professional groups (Prideaux et al., 2004).

Therefore, community care assessment remains a highly contested field and disciplines vie for recognition of their distinctive contributions. Payne, for example, argues that social work skills offer “more flexibility and breadth and a more appropriate approach for community care work than will generally be offered by any other professional groups and by lower-level (sic) staff trained in particular skills” (Payne, 1995, p.30). The dilemma for assessment in HACC is that is does not *require* a particular background (section 6.1). Nurses are assumed to bring useful propositional knowledge and skills, as do social workers, occupational therapists and others. However, applying
for a job as a HACC assessor will most usually mean taking on a title such as “assessment officer” regardless of the person’s professional background (section 4.1). These jobs are thus categorised according to their function in community care; the titles in use tend to present a reductionist view of the work and no assumptions can be made about the professional/educational backgrounds of the individuals employed in these positions.

English and Mykyta, who see competing ideologies in community care assessment as the professional/medical approach as opposed to empowerment/social welfare models, argue that the boundaries between these paradigms have become blurred through the increasing utilisation of non-professional staff in human services, but that it is “a fiscal and economic paradigm that is currently the most influential determinant of aged care assessment and service delivery practice” (English & Mykyta, 2002, p.134). The findings of the current study support their view that economics drive many assessment decisions evidenced by targeting polices and service rationing practices (section 5.2). However, I would argue that the blurred boundaries of the competing perspectives, rather than being a direct result of using non-professional staff as these authors claim, is a characteristic of contemporary workplaces and systems of health and community care and the increased involvement of clients and carers in the assessment process.

That is, discipline-based professionals have been unable to respond to the increasingly uncertain and changing system of health and community care. There have been insufficient graduates to fill the increasing numbers of community care assessment positions, and existing professional categories have not always shown a ‘good fit’ for the role. Coupled with increasing demand and increasing financial pressures on the sector which has often meant that ‘cheaper’ occupations begin to fill new work roles, the HACC assessor has moved in and a new occupational category has begun to emerge in the space between the (variously described) health - social dichotomy. The dichotomy is discursively bridged by referring to ‘holistic’ practice which means that the whole person is considered; their needs are considered broadly, and not from the perspective of either, or mainly, their health needs or their social or emotional needs (section 5.1.2). There is, however, as yet, no other term that effectively captures the practice in these contexts. It is emergent, and new discourse (and therefore possibilities for agency) may also emerge along with a new specialism.
The quote from a key informant that I used to open this section encapsulates what can be seen from the above discussion, and that is, that HACC/community care lies between the knowledge bases of health and social care disciplines, rather than representing the philosophies or knowledge claims of one in particular. Further, the value-laden assumptions that fit with these dichotomies do not hold up in the practice of assessment in HACC. At this level, there is insufficient evidence to suggest that HACC assessors have difficulty negotiating this dichotomy. HACC assessment workers appear to operate in the ‘in-between’ space of the competing epistemologies (or ideologies), and are not constrained by disciplinary knowledge boundaries. However, there are problems for assessment workers practising in this emerging space, particularly related to their legitimisation as professionals.

7.2.2 Legitimation of professional status

“… unless you have a discipline-based profession so you know you are a social worker or an OT, well what are you? You are not a ‘something’” (Local government senior manager).

This quotation seems to encapsulate the problem of legitimisation of professional status for many HACC assessors. In the health sector, professional identity is inextricably linked to the professional training received, which is usually required in order to qualify for a professional position. For example, a vacancy for a physiotherapist in an ACAT, can only be filled by a physiotherapist. It cannot be filled by someone who has a high level of related experience, ‘transferable’ skills, and/or a preparedness to undergo on-the-job training. This differs from the jobs in assessment in the HACC/community care sector where mandatory qualifications are rarely specified. Without a recognised professional background, such as physiotherapy, occupational therapy and so on, and being employed as one of those professionals, then there is no obvious ‘claim’ that a HACC assessor has to be making assessment judgements. As a mark of professional status of an occupation, the legitimacy of their professional contribution must be acknowledged by all groups with which they work as well as by other professions (Waugaman, 1994).

These professional identity issues may contribute to some of the difficulties of service delivery experienced in the aged and community care sector, as outlined in the literature review, particularly the problems associated with the reluctance on the part of
individuals and organisations to accept another organisation’s assessment. The assessment document promoted through the Victorian State Government’s PCP reforms (SCTT) is intended to addresses the issue of duplication of assessment and service coordination difficulties in the same way that the Commonwealth Government’s HACC Client Information and Referral Record (CIARR) intended a few years ago. Both aimed to streamline the collection of client data and initial needs identification, to reduce duplication of assessment and improve client access and service coordination. However, requiring service providers to use a common form for recording client assessment data has been difficult to implement:

“Years ago I remember all the debates in HACC about multiple assessments and I don’t think it has ever been resolved, and I’m not sure that it every will be, because every organisation wants to do its own assessment” (Service provider peak body employee).

This could be due to a variety of factors such as a belief in obtaining information first hand from clients is the best way, or because they feel that face-to-face contact, and the observation opportunities that provides, is more important than written data collected by someone else. Wenger’s concept of reification is also useful here (Wenger, 1998). Assessment workers in community care, including HACC, come from a variety of professional backgrounds. HACC assessors are encouraged to use forms, such as the SCTT, or earlier CIARR, but there are potential conflicts (tensions) between some members of this community of practice (HACC providers) and those who are members of other communities of practice (such as district nursing, or ACAT) as well. For example, a nurse may strongly object to the use of the recommended assessment document because it reifies too small a component of their work and/or because they are unsure about what has actually been reified in the production of the form. This may be a source of professional territoriality which is often played out in this debate, that is, one profession may have little or no trust in another’s form, or assessment tool, preferring to trust one that is a reification of their own professional territory. This distrust is likely to be further exacerbated if the form does not originate from a professional category, but rather, is, or is perceived to be, an abstraction of bureaucratic and managerialist values.

In short, professional identity issues may be at the heart of why there is so much reluctance to accept an assessment undertaken by another individual or organisation.
Professional expertise is not reflected in position titles for these workers, which also contributes to the problem, since:

“…often other professionals aren’t clear who they are talking to in terms of what can be shared based on this person’s knowledge and professionalism” (Local government senior manager).

The findings presented in chapter 4 (specifically 4.3), indicate that assessors in local government generally feel that they are not accorded the same status as other professionals working in the area in organisations such as ACATs or other key referring agencies. Claims to professional standing are negotiated in organisational settings, and further, the nature of direct practice is shaped by the organisational context (Jones & May, 1992). In the current study, Katherine, who had practised as an OT in the same organisation before accepting the job of HACC assessor, found that her professional standing diminished in the latter role. The job of HACC assessor had not existed in the organisation until it won the tender to provide assessment services for the local government HACC service in the area. So, having a professional background does not automatically provide the professional status for HACC assessors, as this suggests. Katherine herself did not feel she was still an OT, even though she described aspects of practice that clearly used expertise developed as an OT (section 5.4). For example she still uses some of the tools (such as the MMSE) in her practice because they are ‘second nature’ to her. However, the role itself needs to be legitimated as ‘professional’.

The sector currently does not provide a (traditional) mechanism for recognition of the professional status of HACC assessors. There is no course of study that directly leads people into these jobs; no existing discipline or professional category provides a direct fit for the work requirements. Rather, the progression to HACC assessment for the participants in this study took a variety of forms (section 4.1.5) and there is considerable diversity in the professional backgrounds of workers. Also, the evidence is that the range of professional associations/groups to which these assessors belong is diverse, as are their reasons for membership, and half of the participants in the current study did not belong to any sort of professional association (section 4.1.4). This indicates that there is no single professional association or group that has yet developed relevant for the work of assessment, and it indicates that the associations that do exist provide minimal benefit to HACC assessors.
As primary backgrounds rarely led workers purposely into HACC assessment roles their professional identities are not predetermined, but are tied to practice and diverse work contexts. Similarly, Billett and Somerville (2004) demonstrate how identities both shape, and are shaped by, the conscious process of engaging in activities and interactions that secures knowledge. They provide the example of aged care workers who generally enter that field for pragmatic reasons, but over time, the process of doing the work becomes part of their sense of self. And the more care workers are engaged in and committed to their work because it is part of who they take themselves to be, the greater the level of learning that will take place through their participation in work. Rather than the abstract concept of occupation, it was the reality of their role that forged their identity with their practice (Billett & Somerville, 2004). Thus, professional identities so closely linked to the ontological require a new understanding of the theoretical space for practice, as this is where many of the external ‘stories’ will be that HACC assessors will draw upon in constituting their own biography (self-identity) and where they will exercise agency. And in turn, this requires understanding by other stakeholders of the complex interplay between work, learning and identity.

An identity is social in that it is constructed through the ontological narratives that are available. However, this also implies that the categories a person chooses to identify themselves must pre-exist before they can be used, even if the associations of the category change over time (Chappell et al., 2003). The variable recognition of HACC assessors as professionals in the sector is a problem for them at this stage in their professional emergence. An appropriate organisation (or formalised ‘community of practice’) is currently missing in the sector. The possibility of establishing an association that would provide professional support to assessment workers (raised in section 6.5.2.1), may contribute to legitimising their professionalism and status. It would also provide a new social space for workers to engage in developing (professional) identities including through shared and personal narratives.

7.2.3 Apparent tensions is use of assessment tools

As I pointed out in the literature review, medical/health professions tend to favour standardised assessment as a mark of their professionalism, and social welfare professionals tend to favour non-standardised (judgement approaches) as a mark of their professionalism. I also discussed an evident tension emerging between the need for
service providers to manage the volume of clients presenting for services (often managed by the use of more and more formalised or codified documentation) and to be responsive to the diversity of clients and contexts (which becomes more difficult as the degree of formalisation increases). The trend in HACC (and community care more broadly) is to adopt approaches that are shifting towards the more formal end of the assessment tool continuum (see 2.1.4). The SCTT, although not standardised, is a more highly codified assessment document than the CIARR and other tools used by the majority of HACC assessors. Although standardised tools are not yet the norm in HACC, this may be anticipated for the future if current trends continue. This section discusses the issues that arise with more formalised assessment documentation.

The experience of the body in assessment, both the client’s and the assessor’s, can be marginalised by highly formal, prescriptive instruments which determine both what is to be investigated, and the range of responses. Client’s stories, the narrative that should provide the context for assessment judgements, can be secondary. As Tanner says, “it is difficult, if not impossible, to capture peoples ‘stories’ if assessment is confined to predetermined frameworks” (Tanner, 2001, p.128). It is also claimed that a focus on health and medical concerns may even obscure the significance of clients’ social situations as the medical model serves to objectify or depersonalise clients’ stories (Tanner, 2003). Jennifer, who worked with Indigenous clients, made a similar observation when she described existing assessment documentation as too skewed towards health and medical information. She felt such questions were often not necessary as Indigenous people found them intrusive and they served to obstruct the assessment process. For Jennifer, it was the relationship between the client and the assessor that was the most crucial tool, rather than the documentation:

“…I don’t think assessment is one form, one visit. It needs to be an ongoing process where you are learning more about the person and developing a relationship as you go along” (Jennifer).

However, there tends to be higher value placed on clinical expertise over other areas of expertise. Mykyta and English criticise the trend of “de-medicalisation” of assessment on the basis that assessment, particularly basic assessment for home and community care, has been “de-professionalised by the introduction of protocols and screening instruments that can be administered by clerical rather than clinical workers” (Mykyta & English, 2002: 84). However, the evidence from the current study refutes this
conceptualisation; such a polarisation is not evident from the professional identities of assessment workers. They are, in fact, a highly diverse group with health and social care backgrounds represented. Further, the number of people with administrative backgrounds or no formal qualifications working in these roles has diminished (section 4.3) and not the reverse as these authors suggest. The prediction of participants is for the trend of professionalisation to continue (section 4.3), and all assessment workers in the current study had some form of formal qualification.

However, HACC assessors are faced with the program requirements for more formalised documentation and standard approaches to assessment (section 6.5.3) which can present challenges to holistic practice. Client-centred assessment necessarily requires the assessor to obtain “biographical information” in order to arrive at an understanding of the client’s world view (Worth, 1998). Without allowing the client to tell their own story, their account could become objectified and depersonalised through the assessment process so that their goals and values are hidden (Richards, 2000). Attention to narrative is therefore crucial. In addition to eliciting information about the client that will help needs identification and care planning, it will tend to reduce the power imbalance between clients and practitioners as the assessor engages with the client instead of “expecting them to fit into bureaucratic and professional agendas and ways of thinking” (Richards, 2000, p.47). Some commentators view the language of ‘assessment’ itself as unhelpful as it is a “social construction that privileges the professional and disempowers the client” (Iversen et al., 2005, p.695). In the current study, Jennifer made a similar observation, pointing out that terms such as ‘assessment’ and ‘need’ are very “white”, and may have unintended connotations, or even be meaningless, for many Indigenous people with whom she works (section 5.1.2).

Dill (1993) provides a vivid account of how clients’ stories are not easily interpretable within the frame of many formal assessment instruments used by highly trained professionals. She recounts an assessment interview (which she observed) where the professionals, a nurse and a social worker, were unable to ‘fit’ the client’s story into the standardised assessment instrument. As a result, the client’s perspective was open to misinterpretation, assumptions were made based on normative data, and there were missed opportunities to allow the client to tell her own story which would have held valuable information to enable a more accurate judgement about the person’s situation, with tragic consequences (Dill, 1993). Similarly, Chevannes found that diverse voices
of older people are little considered in defining needs, and professionals exercise control over how clients are categorised (Chevannes, 2002).

The findings of the present study indicate less constraint felt by assessment workers in implementation of assessment tools in current use. Participants were very aware that clients’ stories were critical to establishing the nature of client need and, although the SCTT is not a standardised assessment instrument, assessors were aware of the consequences of using the assessment document too prescriptively (section 5.1). They were aware of the primacy of client stories and dialogues and described instances of negotiation and collaboration with clients (section 5.1). From participants’ own accounts of their practice, the diverse stories and experiences of clients are at the heart of the assessment interaction.

In social work, and arguably in other community care professions, the modernist values that underpinned practice are increasingly contested. Contingent and local decision-making are replacing the moral certainty of practice (Camilleri, 1999). Paradoxically, more formalised and standard documentation is encouraged by funding bodies for ease of data collection and analysis, and to enable comparison between organisations for quality assurance purposes. The policy direction of common client assessment documentation eliminates the potential for local areas to develop their own documentation, thereby removing their ability to respond to diversity within their local areas (Stewart et al., 1999). Anna noted this in relation to the PCP reforms which signified, for her, “a loss of control on the part of her organisation” and “less flexibility for individual service providers in terms of the assessment documents” they could use (section 5.1).

However, the trends towards more formalised documentation may have other consequences for practice. In a study of implementation of a standardised assessment tool in community care in Canada (Bay Consulting Group & Workflow Integrity Network, 2004), assessment/case management staff were found to be experiencing “pathology of drift”, meaning that increasing administrative functions (a bi-product of the current environment of community care and associated trend towards more formalised, standard documentation) were reducing the ‘flow’ of their work. This was found to create a less than ideal environment for the “critical thinking” required in dealing with complex clients and “messy situations” which tend to be common in
community care (personal email communication with Karen Parent, 29 March, 2005). Indeed, in the current study the potential burden created by excessive paperwork was identified with similar implications for practice (section 6.5.3).

Standardised tools, based on rationalist, normative assumptions can have difficulty capturing diversity. They can also represent a somewhat disembodied approach to assessment. At this stage, HACC assessors report flexible approaches in their use of common documentation, and clients’ stories are of primary importance in assessment interactions. Further, local adaptations of common documentation (SCTT) were reported to integrate centralised program requirements into individually preferred practices (section 5.1.2). The current policy framework is for common documentation to create “a mindset and a framework” rather than prescribing a rigid approach to assessment (section 5.1.2). However, current practice may be challenged as assessment documentation becomes even more formalised, along with the (perceived) associated trend towards professionalisation of the workforce, and the need to manage ever increasing demand for services. Deeper understanding of the practice and professionalism of these workers is therefore required.

7.2.4 Personal values and workplace realities

Gorman points out various contested realities in care management roles in community care such as collaboration vs. competition or quantity vs. quality (Gorman, 2000). These can operate as dichotomies which essentially represent clashes of personal and workplace ideologies. Garrick notes that the (mis)alignment of work contexts with the individual’s values is a critical ingredient in the tensions and ethical dilemmas experienced at work (Garrick, 1998). Some obvious misalignments can be interpreted from the findings of the current study, which I have represented as paradoxes between ideal values and realities in the workplace.

<table>
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<th>Values</th>
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<td>Attracts individuals who value universality of services, and advocacy, to promote independence</td>
<td>The role is often about determining priority of access</td>
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<tr>
<td>Assessment is highly complex process</td>
<td>Relatively low pay/low status; ill defined</td>
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Individuals attracted to the role (mostly women) tend to hold human service values such as equity, universality of care, and advocacy to promote independence. These values, however, are at odds with the reality that many clients’ needs cannot be met, and much of the work is driven by processes to ensure cost containment, such as prioritisation (section 5.2). Anna, for example, said that the job satisfies her need to be helpful, but she is challenged because her professional judgements about need cannot be met with sufficient levels of service (section 5.6).

The assessment role has evolved to be extremely complex in terms of both the nature of the target group and the service environment. Assessment is now a highly complex process requiring high level skills and knowledge. The reality of the job, however, is that it is relatively poorly remunerated and often not accorded the same status as other professional staff working in community/aged care (section 4.3). The professionalisation of HACC, manifest by the reforms designed to improve the standard of assessment practice introduced in recent years, were thought to hold the promise of leading to “decent pay” (Helling, 2002, p.91). However, the findings indicate generally low rates of pay and other variable work conditions. There is also an increasing use of short term or contract staff. The low rates of pay contrast sharply with the increasing complexity of the assessment function and of its critical importance in the whole system of community care. This may be a contributing factor in the difficulty experienced in recruiting high calibre assessment staff to community care assessment roles, reported in the literature review. The acknowledged complexity (and ideal high knowledge and skill requirements) also contrasts with the realities of ill-defined qualification requirements (section 6.1) and ad hoc professional development opportunities available in the sector (section 6.3).

Assessment and care planning in HACC, at its most effective, demands a high degree of collaboration with other agencies in the service system. This contrasts with the
isolation of the assessment role, both professionally and structurally. While clearly not true of all assessment workers, it is significant that some are lone workers, some are not networked with ‘like’ workers, and some feel isolated from other organisations because they do not have a health or allied health background (sections 4.2, 4.2.4 and 4.2.5).

The ideal of the ‘needs led’ assessment is promoted in policy documents. This essentially represents the philosophy of responding to individually-assessed needs, rather than according to what services individual providers have available. The reality, however, is that the service system (and individual service providers) are increasingly involved in cost containment. The community care system now embraces an individualistic, marketised approach to welfare based on a manageralist (economic rationalist) philosophy (section 2.1). The priority for management of public funds replaces universalist welfare provision. Ife (1997) notes that, “for social workers and welfare workers, who have defined themselves and their work within the structures of the caring welfare state, this has been a hard lesson to learn” (Ife, 1997, p.5). He goes so far as to say that this threatens the very foundation of those professions.

Thus, personal values and identities are challenged by many workplace realities. As others have noted, human service professionals commonly experience discrepancies between the professional requirements they are ‘taught’ (and what they believe they should do), and the realities of practice (what they are required to do) which challenge their ‘stories to live by’ (and identities) (Connelly & Clandinin, 1999). For those experiencing these contradictions, a way is required of thinking about themselves and their place in those contexts. Critical reflection has been proposed to assist to resolve the binaries representing opposing ideologies/values (Garrick, 1998, p.30) although in reality critical reflection is rarely “allowed to penetrate organisational boundaries” (Fenwick, 2001, p.5). Following critical reflection, the worker may exercise intentionality and agency, choosing not to take up particular workplace practices that challenge their values and to learn differently (Billett & Somerville, 2004). In the current service environment, critical reflection can lead to greater personal awareness of ideological divergence, and to personal strategies for ‘coping’. Such strategies ranged from acceptance and moving on (Clare), seeking support through counselling (Anna), or ensuring emotional outlets via recreational or community activities (Faye) (section 5.6). The frustrations felt through practice, and the personal coping strategies adopted, may lead to a re-formulated identity, and it may or may not lead to improved practice. At the
extreme, the individual may adopt a position of inert indifference to their work and learning, or may even decide to leave the role. This possibility was evident from some of the interviews, particularly for one key informant (12) who pointed out the risk in assessment workers being unable to combine advocacy on behalf of an individual, with the realistic requirements of the organisation (section 5.6).

7.3 Summary: towards the emergence of new identities

As much contemporary adult education scholarship understands, ontology contests epistemology; often there is no epistemological meta-narrative that guides practice. Instead, knowledge claims arise from the experiences of individuals, and identities are tied to local and particular contexts. HACC assessors need to be understood in these contexts, and as products of contemporary workplaces and systems of health and community care. Discipline-based professions have been unable to meet the needs of the changing sector. There are shortages of professionals throughout the sector, and, in assessment in particular, there is a lack of clarity about the appropriate professional background for the role. As a result, or perhaps because of this, assessment positions in HACC tend to be valued less than the discipline-based professional roles in the rest of the health and community service sector. This diverse group of workers has stepped into a void that has been unable to be defined, nor filled, by traditional professions. They lack a collective identity deriving from a (traditional) professional base.

These workers, then, have identities as practitioners, whose epistemology is derived from their practices in diverse contexts with diverse clients. Their identities are not ‘given’ but are constructed and contestable. HACC assessment workers appear to operate in the ‘in-between’ space of the competing epistemologies (or ideologies), present in community care and are not constrained by disciplinary knowledge boundaries. In Schön’s swampy lowlands lies the indeterminate, the location of real and individual human problems. This is the site of practice for many different health and social welfare professionals. However, there is no single disciplinary narrative for this field of practice, a narrative occupying the high, hard ground, which is the location of professional knowledge based on technical rationality, overlooking the swamp (Schön, 1987). Despite this, they are able to practise in the swampy lowlands like other professionals also working in the field of community care. The high/low view, essentially reflecting the theory/practice divide of professionals, does not exist as a
hierarchy because there is no discipline-based narrative that drives their practice. Rather, the nature of their practice derives substantially from the local contexts in which they work, and they draw from a diverse range of knowledge sources including their embodied practice. This, in my view, creates a space for the emergence of a new practitioner. There is, as yet, insufficient discourse that adequately captures this professionalism in these contexts beyond ‘holistic’ practice. This is, then, an emergent specialism in an emergent space.

Community care (HACC) assessment workers then are emergent practitioners; the ontological is central, and their practice, identity, and epistemology share many elements with traditional professionals in comparable work contexts (similar levels of autonomy, reflective practices, and development and application of ‘know how’ and tacit wisdom). Their embodied practice is the site of a potentially robust professionalism which can provide the foundation for new approaches to the education, training and development of this increasingly important and growing specialism. As others have noted, the messy, swamp-like conditions of daily work life provide good prospects for education in the very activities of work itself (Beckett & Hager, 2002). This is a major focus of the next chapter.
8. Towards a model for professional learning

In the previous chapter I argued that assessment workers are emergent practitioners with a new specialism, an outcome of contemporary workplaces and the trend to community care. In this chapter, I consider the implications of the findings for current approaches to the education and training of assessment workers. With a new specialism, and emerging identities as assessment workers, the focus logically shifts to the development of a model for preparing and developing the professional community care assessor. Such a model of learning should help to address both the equity issues evident for community care assessment workers, as well as offer a rigorous approach to preparing and developing this group of workers to maintain quality practice in a growing and increasingly important field of work.

I firstly discuss elements of ‘authentic learning’ gleaned from the findings. These include aspects of learning from daily work (in the ‘swamp’), significant features of social learning (including from the broader service system), the applicability of multidisciplinary/interprofessional approaches, and importantly, acknowledging the self as a resource for practice. A more detailed critique of the current (education and training) approaches to the preparation of assessment workers follows, with suggestions for a structure for both a new preparatory program and on-going support and development for practitioners.

8.1 Authentic learning

“…you learn every day. Different clients, different issues. Every day I feel as though I am learning something new. … it is a job that you learn on the job and the longer you do it the more you look at” (Bonnie).

This quote gives an insight into assessors’ own view of the relationship between their work and their learning, and is underscored by the view expressed by a number of assessors that many important things about the job cannot be ‘learnt from a book’ (section 6.4). Essentially this is suggestive of a need to focus on what they may regard as ‘authentic’ learning experiences, which will provide the basis for a lifelong learning model.
8.1.1 Learning in the swamp

What can be derived from assessors’ views of how they learn is that much learning results from the embodied experiences of assessing, such as those unexpected situations where there are elements of risk to themselves or others; seeing something written in a referral and still being unprepared for what they actually ‘see’ when they get to the person’s home; experiencing the disparity between the carer’s own accounts of their coping compared to what they actually observe in the home; and witnessing the divergence between client’s and carer’s perspectives on their living situation. This is the type of learning that occurs in the swampy lowlands, where indeterminate and real human problems and issues are located (Schön, 1987), and the ability to reflect (in and on action) is essential to make this happen. The tacit wisdom developed from these experiences provides much personal knowledge upon which assessors draw to enact judgements.

Other forms of encounters with clients, such as where the professional’s knowledge, beliefs or assumptions were challenged through the experience, have been found to change practice (Daley, 2001). The whole person has to learn from the experience of doing the job, engaging both heart and mind with the process (Gorman, 2000, p.157). The importance of emotion as a reality in the workplace of community care is therefore stressed. CPE that recognises the significance of personal development and the social world of the learner is recognised as one way of bridging the gulf between emotion and the technical aspects of community care (Gorman, 2000), although critical reflection (using a variety of approaches) on these kinds of client interactions is seen as key for professionals’ learning (Hallberg, 1998; Harris, 1993; Moon, 1999). Formal discussion groups to promote reflection at the workplace are also recognised as important learning tools (Geeves, 2000).

The political nature of workplaces (including the often divergent values of organisations and broader ethical and social concerns), has sometimes served to keep critical reflection out of workplaces (Fenwick, 2001). However, models of workplace learning need to work with the political nature of work(places), and to encourage learners to acknowledge any mismatch of values that may occur. In the case of HACC assessors, where individuals had adopted personal strategies for dealing with the inability to meet clients’ assessed needs to the level they felt was required, they also showed a high level
of awareness that this was happening (section 5.6). That is, they knew that their actions to ration services (exercised either through their own judgements or through other measures such as waiting lists or prioritisation tools) would have an impact on the client.

Such ethical considerations demonstrate ‘mindful’ practice and contribute to the type of learning available to the HACC assessor. Mindfulness in this way encourages greater creativity and innovation on the part of the assessor (for example, consider Katherine’s actions described in section 5.2.2 where she worked with other services to try to get the best outcome for her client despite the existence of waiting lists), but it also provides a continued ‘conscious engagement’ (not necessarily material) with clients who do not receive a service. If a client presents for assessment again, having been earlier assessed as low priority, or unable to access a service immediately because of waiting lists, the assessor will be able to link the client’s increased needs to their lack of receipt of appropriate services earlier, or other circumstances that have emerged for the client. This builds the assessor’s repertoire of knowledge relating to risk identification and the pace of decline of function in clients who are assessed as low priority and/or who are provided with inappropriate types or levels of service.

Similarly, Faye’s account of her assessment of a client (mother of a child with a disability) on the morning of her interview with me (included at the end of section 5.6), indicates the wisdom acquired over many such encounters with clients (as well as from her own experience as a carer). In this situation, she was quickly able to judge the woman’s situation and extrapolate her coping ability without the need for the client to articulate this clearly or at length. Faye demonstrated empathy, and related prevailing social and cultural attitudes to a personal ethical position which was non-judgemental and supportive of the woman’s life situation. From a purely instrumental (task focused) perspective, Faye only needed to collect sufficient client data to link this woman into an appropriate service. Rather, she demonstrates deeply ethical and practical wisdom (phronesis) in her judgement. As others have found, community service workers apply skills but they are also “social actors who take moral, ethical and cultural contexts into account” (Mulcahy & James, 1999, p.98).

McIntosh (1996) applies Schön’s concept of professional artistry as an interpretive framework to expose the knowledge (and therefore learning) in community/district
nursing. How to behave as a ‘guest’ in someone’s home, although generally regarded as ‘common sense’, was found to represent a complex range of knowledge and skills for good nursing practice. Essential knowledge included knowing that a dependent relative can cause family tension, knowing which of the client’s needs had to be met, which could be left for another time (prioritising) and which could be ignored completely (judging long term risk), and knowing how to interact with the family in an empowering way. McIntosh found that more experienced nurses developed a “repertoire of responses to use in the changing contexts of different homes”. Such ‘know-how’ (professional artistry) develops through experience:

“As the nurse tries to make sense of a particular situation, she reflects on the understandings which have been implicit in her actions, brings those understandings to the surface, analyses them and then embodies them in further actions … [Such ‘know how’] resides within each practitioner, in the individual or private domain, rather than the public domain…” (McIntosh, 1996, p.320).

As such, community/district nursing practice is largely founded on experiential knowledge (McIntosh, 1996) developed in the ‘swampy lowlands’. However, despite claiming that much of the knowledge required for district nursing practice is developed experientially, McIntosh then goes on to argue that for less qualified support staff undertaking similar duties in similar settings, their “knowledge base … is less likely to be founded upon such a broad range of disciplines such as sociology and psychology which are supportive of and complimentary to nursing” (McIntosh, 1996, p.324). McIntosh seems unable to extend her own argument for the quality and comprehensiveness of experientially-derived knowledge to an end point which relies on something other that the highly valued formal discipline-based education. In fact, she sees the failure to articulate the ‘know how’ and professional artistry in district nursing in academic and professional terms, as potentially leading to greater use being made of less qualified staff, and therefore lower quality care. In other research on community nurses, the development of the capacity to exercise professional judgements was found to require the opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations (Bergen et al., 1996), thus building personal knowledge developed in a range of situations.

The review of the workplace learning literature (section 2.2.3) drew attention to a new focus on the processes involved in decision-making particularly in the “hot action” situations of practice where the pressure for action is immediate. The term “anticipative
action” was offered as an explanation for how the decisions come into play in professional practice (Beckett & Hager, 2002, p.35). Workers’ capacity to anticipate action and exercise judgements, and the level and type of judgement-making required in the context of the daily practice of HACC assessors, may hold the key to deep learning opportunities. In fact, the ability to anticipate and use interpretive skills to formulate judgements was highlighted as a particular skill required for practice in community care assessment (section 2.1.6.2). From the accounts of assessors’ use of assessment tools (discussed in section 7.2.3) we can see that assessors’ judgements are made in response to more than the cues set up in assessment tools. Often, they are responses to feelings and emotions (gut reactions), and their own personal knowledge which, in turn, leads them to anticipate a client’s immediate needs, as well as those that can be regarded as less urgent.

The ‘swamp’ of daily working life is a key site of learning for assessors, but how can facilitators of learning ensure that this happens to the greatest extent, given all the elements that interplay in the workplace? Team environments, where there are opportunity for observing other staff, modelling, discussion and debate was thought to provide solid learning, as was simply matching less with more experienced staff (section 6.4). Some of the essential skills of assessment such as interpersonal communication and observational skills may be fostered, in the words of one participant, “in an apprenticeship type of arrangement” (Aged care researcher). The robustness of learning evidenced through ‘scaffolding’ (Lave & Wenger, 1991, p.48) or modelling can be enhanced by focusing on the level of demonstrable understanding of the worker. Beckett and Hager’s focus on the inferences the learner can articulate is useful here (Beckett & Hager, 2002, p.192). This focuses at the level of understanding as well more instrumental evidence of change such as through work performance.

Marsick and Watkins emphasise three conditions to enhance informal and incidental workplace learning: critical reflection to surface tacit knowledge and beliefs, stimulation of proactivity on the part of the learner to actively identify options and to learn new skills to implement those options, and creativity to encourage a wider range of options (Marsick & Watkins, 2001, p.30). However, planning and implementing workplace learning activities should be responsive to the micro-conditions of specific working groups and contexts including power differentials, the cultural realities of workplaces, as well as individual aspirations and dispositions (Hodkinson et al., 2004).
Because learning is highly influenced by social and cultural norms, power dynamics may distort the way in which people understand events (Marsick & Watkins, 2001).

8.1.2 Social learning

“...staff do learn well as long it is a very open and supportive environment where staff are game to tell people the things that you are doing wrong. If you don’t tell anyone about the things you worry about, or the things you don’t think you did very well, you don’t actually learn. There are a lot of factors that come into play for that to be right” (Local government senior manager).

In workplace learning models, rather than focusing on mastering individual skills defined beforehand, attention needs to be focused on the operations and activities of the work community and the learner’s own participation in it (Collin & Valleala, 2005; Gorman, 2000). In this way, attention to the social learning and the formation of identities provided by workplaces is given prominence. This will require dialogue between the learner and the workplace learning supervisor/facilitator about the social aspects of the workplace. These should be regarded as critical features in the learning process that will affect performance. Further, the organisation’s ethos, and broader social, cultural and political environments are important contextual factors for workers within which the ‘doing of practice’ occurs. Therefore, critical reflection on these, and the type of practice (and identities) that they shape, must be present to bring learning to the fore.

Interpersonal attributes are critical for client interactions (sections 5.3 and 7.1.3), but they are also critical for other aspects of assessment work. Miller et al. (2001), for example, argue that the influence of individual beliefs on teamworking is highly significant. These individual philosophies in turn help to shape styles of communication and learning. In interprofessional or multidisciplinary teams the opportunities for communication that promotes learning include those at the level of discussing clients, as well as more “risky” forms of communication where practitioners feel able to discuss their “feelings of inadequacy, dislike and despair” knowing that their team members will be receptive and supportive (Miller et al., 2001, 89). These opportunities require a high level of personal and professional trust in members of the team to listen, provide support and to reciprocate, and those with ‘integrative’ philosophies are more open to participation in these situations. This notion of ‘risky communication’ accords with the view that learning is maximized when competence
and experience are in close tension in communities of practice (Wenger, 2000). Challenges to the shared understating of competence within a community ensure a dynamism within that community that can promote learning and improve practice.

It is likely that deeper learning will result in environments that foster ‘risky’ communication but it is also likely that considerable maintenance is required to ensure that the environment remains supportive and based on principles of communication equality between practitioners, as the findings of the current study indicate (section 6.4.1). It is also clear that “feelings of inferiority” can interfere with patterns of communication between workers without formal training and professionals such as social workers in the field of community care (Twigg & Atkin, 1994, p.59) thereby limiting (and shaping) the nature of learning from social interactions with discipline-based professionals. The personal philosophies of individuals play a large part on their own and others’ learning opportunities. In relation to teacher education, it was found that more ‘individualistic dispositions’ limited possible collaborative learning opportunities (Hodkinson et al., 2004, p.14). Personal attributes/individual dispositions are thus implicated in learning at, and from, the social environments of work.

Recent research has demonstrated that prior abilities are important in moving to new work contexts, but that these are not decontextualised transferable skills. Rather, they are abilities which have structural and referential features. Their structural features may be carried (tacitly) between environments but they have to be situated, underpinned by domain-specific knowledge and developed through social interaction within the culture and context of the work environment (Hodkinson et al., 2004, p.11). The workplace climate and nature of working relationships can contribute to the degree and depth of learning. A culture based on mutual learning and mutual respect, and a specific focus on the development of coaching skills is suggested to enhance learning from work (Eraut, 2004a).

Research on social learning in the workplace has found that categorisation is a central activity operating in workplace cultures (Collin & Valleala, 2005, p.408). Workers engage in the production of categories to both develop and gain access to the workplace culture. This can involve categorisation of work tasks and the development of “shared talk” by which they can participate in the common team culture. Ellen referred to the phrase ‘the wheels fall off the wagon’ (section 5.1.2). This phrase was used in her
immediate workplace to describe situations where clients can no longer cope with their increasing frailty or disability and require alternative accommodation and support options. Anna talked about the ‘gate assessment’ (section 5.1.3) which was shared talk in the community of practitioners of HACC assessors in her local area (the ‘gate assessment’ was a strategy for eliciting information privately from carers as they walked the assessor to the gate of the property, following an initial interaction with the client inside the home). Over time the categories become embedded into the discourse of that community and become one of the cultural features for newcomers to grasp and apply. Categorisation also operates at the level of how individual workers are regarded (categorised), how they are talked about by others, and how their tasks are regarded in relation to other workers. Categorisation, therefore, “is an activity where each worker’s identity and status within the work community is constructed and defined” (Collin & Valleala, 2005, p.411).

8.1.2.1 Service system dynamics

There is little doubt that the service system characteristics have a substantial impact on the nature of the client assessment function in aged and community care. The quality of service delivery depends largely on the degree of cooperation and communication (or ‘sociality’) that occurs between the different service providers. The structure of the service system has become increasingly complex in recent years due to a range of factors including a proliferation of new programs to cater for greater numbers of clients and the increase in the complexity of many clients. Government has put considerable effort into improving the service system ranging from the introduction of the CIARR and ‘best practice’ projects in HACC in the early – mid 1990s, and more recently though the PCP reforms. However, we have also seen that the quality of the relationships between different service providers depends to some extent on the skills and values of the individuals working in the system, as well as the values (ethos) of the organisation, thus co-implicating practitioners, at least to a certain extent, in the development of the service system.

Practitioners operate in service systems, and the dynamics of the system affect the nature of practice. Any discussion about social learning at work needs to consider the dynamics of the service system in which the worker is situated. Service systems are social structures, but, because they are concerned with the distribution and maintenance
of resources in the community, they can also be highly political (McDonald & Zetlin, 2004). In particular, there can be considerable distrust between organisations such as between large and small organisations (McDonald & Zetlin, 2004, p.273) or between organisations with differing ideologies or competing interests. I reported in section 4.2.5, for example, that cooperative working can be hampered by a culture of competitiveness in the service system. Factors operating within service delivery organisations can also disrupt the service system functioning. These include the high turnover of staff which results in having to continually rebuild formal and informal relationships, and the tendency of agencies to be inward looking due to work pressures (McDonald & Zetlin, 2004, p.274). The latter reason means that service delivery agencies tend to focus on their own work with little attention to partnership approaches. So, service systems are variable in how they function, yet these provide many of the learning opportunities for workers.

Networking opportunities in service systems can be formal or informal. Formal networks identified in the findings included:

- local service provider meetings of key referring agencies (to discuss client issues);
- networks that have a broader agenda beyond the level of individual clients including regional networks of disability services and HACC service provider meetings;
- networks associated with a particular service type or clientele (for example, regional ethnic services, regional day centre coordinators, and regional volunteer agencies); and
- statewide (or national) networks associated with particular job function or organisational type (for example local government assessment officers).

These are the organised communities of practice that assessment workers may participate in beyond those within their organisations. Within organisations, formal communities of practice may comprise a group of assessment and care planning staff (such as in large local governments), a work team (such as a day care centre), or a whole office staff in the case of small organisations (such as the case for Faye). Other assessment workers may be employed in large offices with a very broad agenda (as was the case for Delia), where their HACC work is a very small component of the overall focus of the office.
These formal social structures all have (in varying degrees) a community of mutual engagement, a negotiated enterprise, and a repertoire of negotiable resources accumulated over time; the dimensions present in communities of practice (Wenger, 1998). The simple model below helps to explain this using one formal network type as an example.

Table 11: Local service provider meetings as communities of practice

<table>
<thead>
<tr>
<th>Dimensions of communities of practice</th>
<th>Local service provider meetings</th>
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<tbody>
<tr>
<td>Community of mutual engagement</td>
<td>Practitioners come together to ensure coordinated care for clients, and to ensure good working relationships between assessment and care staff</td>
</tr>
<tr>
<td>Negotiated enterprise</td>
<td>Decide how clients will be discussed, how referral recommendations will be actioned, and how and when specialist assessment expertise will be accessed and used</td>
</tr>
<tr>
<td>Repertoire of negotiable resources accumulated over time</td>
<td>Familiarity between regular attendees leading to an accepted culture in the group, and in their practice Meeting agendas and minutes Communication and referral protocols</td>
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</table>

Such networks, viewed as communities of practice, provide social learning opportunities. However, the level and degree of participation in formal networks was highly variable in the current study (section 4.2.5), and further, the organisational context, and local service system dynamics affects how and to what extent workers can participate as members of these communities of practice. A practitioner may be involved in many communities of practice all focused on different aspects of their work, or they may be involved in very few. In addition, the benefits of formal meetings are largely dependent on the participation, and often, therefore, the personal attributes of individuals who attend (section 4.2.5).

Some assessors maintained membership of professional bodies, which also comprise communities of practice. These were (section 4.1.4) Nurse Registration, Australian Nursing Federation, Case Management Society of Australia, Australian Association of Gerontology, Australian Association of Social Workers (AASW), and the Australian Professional Counsellors Association. These seem to be more strongly related to
development (or maintenance) of professional identities rather than to contribute to workers’ current practice or learning needs. Delia, for example, belonged to the AASW. She felt this was not very helpful to her work, but maintained a link with the profession of social work. Faye belonged to the Professional Counsellors Association, not because of what it offers her current practice, but because she sees herself developing a professional identity as a counsellor in the future.

However, communities of practice may also be informal, and practitioners may have a variety of informal networks in which they participate. Their general workings with other agencies in the day-to-day work of making referrals, arranging care or joint visits, or seeking updated information or advice about a client, may also, over time, comprise a community of practice for these workers. In the current study, participants mostly reported good relationships and good communication with other service providers in their local area (section 4.2.5), suggesting that these informal networks may also offer powerful social learning opportunities. In fact, because of the political processes that influence how some service delivery systems operate, informal networks may have greater significance for individuals. The political process occurring at the time of CCT had the effect of changing the culture of some of these groups (sections 2.1.2.1 and 4.2.5) which led to re-negotiation of their operations.

Active community development support is suggested for the maintenance of service delivery systems (McDonald & Zetlin, 2004). In Victoria, the PCP program has aimed to meet this need, albeit in a highly formal, high level way. However, the fact that the interviews of HACC assessors indicate that the PCP model of networks does not operate at their level (the senior managers in their respective organisations tended to participate in PCP ‘business’) suggests that a less formal community development approach may be more effective; or at least something at the level of discussing shared clients, resource sharing and professional knowledge sharing. Network effectiveness is most likely in a resource rich environment (McDonald & Zetlin, 2004), and for those organisations that struggle to meet client needs and find funding levels insufficient to meet demand, then the workers at this level are less likely to be able to participate effectively in service system networks. Although recognised as a critical requirement, attending to networking and communication with other service providers can be very time consuming for assessors and is often not a priority for them when they have other competing demands (section 5.2.5).
According to Helling (2002) organisations and individual HACC workers need to progress through what she terms “a roadmap (or continuous improvement matrix)” to successfully implement the reforms in HACC policy designed to encourage greater collaboration between services and improved assessment standards, including implementation of the CIARR, and the Comprehensive Assessment Framework (see section 1.3.1). She conceptualises the ‘roadmap’ as a learning process consisting of a series of levels commencing with the realisation within organisations that change to practice needs to occur and ending with a team approach to service delivery where “there will be structures to share and support whatever learning people are doing”, and “training to continue reforms” with structures to support ideas for service improvement (Helling, 2002, pp.97-98). The phases of learning that need to be passed through to reach this end stage include, at the lower levels, recognition that workers need new skills such as teamwork with people who “might not really think they are part of the same team”, and attention to external relationships to clarify the tasks and roles required in a service system approach to assessment and service delivery. At the middle and higher levels, the learning processes include larger scale group meetings to share problem-solving and joint training sessions, action learning processes where strategies are generated by participants, and real attention to sustainable structural changes within participating organisations and within the service system (Helling, 2002). The findings of the current study indicate that the provision of structural support such as “people working together in networks, with either like workers or within a network in their local area” (Community worker) provides a learning environment as well as support structure. This is an area that could be strengthened with more considered, and possibly more formalised, support.

8.1.3 Supervision and workplace culture

“…many of the managers don’t actually understand what it is that their staff are doing out there and the sorts of decisions that are being made …” (Community services consultant/trainer).

Over twenty years ago effective staff training programs in home care (broadly) was regarded as drawing liberally on the personal experiences of workers and the educational potential of supervisor-supervisee relationship (Kaye, 1985). Thus the critical elements of ‘self’ (discussed in more detail below) and supervision are not new
for the field of community care. There is no doubt that there is considerable ‘artistry’ involved in supervision, particularly in the complex environment of community care. For workers who are charged with making decisions that have the potential to alter a person’s life situation and choices, as is the case for assessment workers, the supervisory relationship and the responsibilities of the supervisors are brought into sharp focus.

The importance of supervision is a theme in a number of key references in community care practice. The need for regular peer discussion and debriefing and regular individual supervision to encourage open and critical reflection is particularly highlighted (Cluning, 2001; Hallberg, 1998; McVicar & Reynolds, 1995; Pierce & Nankervis, 1998). Arranging access to professional support is the responsibility of management (Lincoln Gerontology Centre, 1998), and if this is not available within the organisation, then access to external supervision may be necessary (Cluning, 2001), a practice which was found to occur in some instances for HACC assessors (section 6.5.1). The provision of good supervision and mentoring is obviously a key mechanism for assessors learning about, and being supported in, their work. However, supervision needs to be unpacked so that the elements of a model of learning can be exposed.

One view is that it is not so much the practice expertise of the supervisor, rather, it is their supervisory skills that are crucial for creating and sustaining a climate for learning (Horwath & Morrison, 1999, p.158). Skills in promoting reflection and in openly acknowledging the obvious power differences between supervisor and supervisee are identified. However, the degree to which the supervisor is closely connected to the actual ‘doing’ of assessing was found to impact significantly on what and how assessment workers learn from them. In the current study, one participant noted that “on the job training works if you have really good mentors” but that this requires a properly resourced environment where those mentors are actually identified as such, nurtured and encouraged in mentoring roles (Community services consultant/trainer). This implies a necessity to be ‘close’ to the work, to the exercise of judgements (amidst hot action) in order for professional ‘know how’ to be nurtured by supervisory or mentor relationships. The epigraph in this section draws attention to the need for this. The key informant (8) was particularly referring to situations where the client’s ‘dignity of risk’ and choice could be divergent from the organisation’s duty of care requirements.
This level of understanding is not always the case for supervisors who may be more closely aligned with senior management responsibilities and/or come from an unrelated professional background. For supervisors who progress from practitioner providing a service to clients to a management/supervisory role, this can cause an “identity crisis” (for themselves and for those they supervise) because they have moved from one domain, with its own sets of values and principles, into another (the management domain), with different, and often conflicting values and principles (Kouzes & Mico, 1979, p.459). Other research has found that workplace supervisors are part of networks of learning but workers do not necessarily go to them first as a source for learning (Boud & Middleton, 2003), possibly because of the power differences between supervisors and their staff, or because they are removed from the ‘hot action’. Where assessors described good supervisory relationships their supervisors had come from a similar background (section 6.4). As the supervisors had first-hand experience of the challenges and dilemmas the assessors were experiencing, they could provide a more supportive supervisory relationship.

Attention to the structural considerations that provide for a constructive learning environment was a theme in the findings (6.4.1). In particular, the management structure was said to be crucial in creating a good learning environment. The development of personal and professional knowledge in community care can be promoted by innovative staff programs and participative management approaches that create a supportive work environment (Keegan & Kent, 1992). Whilst this will be important for all workplaces, greater effort may need to be employed in non-metropolitan areas. In rural and remote areas there is likely to be less supervision, less support and monitoring by experienced colleagues, less help managing tasks, making critical decisions and learning and developing practice skills and professional judgement (Lehmann, 2005; Sturmey, 1992).

In rural areas, the worlds of public work and private life cannot always be kept as separate as in cities (Sturmey, 1992). Whilst this may be a disadvantage for much practice in public welfare or health and medical areas, in the field of community care assessment, it was described as often advantageous to practice because it enables rapport to be established more quickly (section 4.2.5). Once again, the situatedness of the workplace context is brought to the fore. Supervisors without first-hand awareness
of the often personalised nature of assessment in rural areas could be detrimental to the supervisory relationship, and hence to the quality of the assessments.

Maintenance of professional boundaries from clients, once thought to be the hallmark of professionalism, is challenged in the particular locations and situations of community care, but also by the very nature of community care. Ignoring the human (emotional) impact of maintaining strict professional boundaries in worker-client relationships would be contrary to good practice in assessment where attention to inter-personal relationships and communication is valued, and drawn upon, in practice. In fact, as Beresford and Trevillion point out, in the new environment of community care, professional training has sometimes served to distance workers from the people they work with and to desensitise them to their own and other people’s feelings. Identities aligned with human understanding, empathy and support, rather than to a constructed ideology of ‘care’ in the (traditional) professional sense, are more highly valued by clients of community care services (Beresford & Trevillion, 1995, p.91). Attention to developing supervisors who acknowledge and foster these understandings in their supervisory relationships with assessment staff is, therefore, required.

8.1.4 Developing the self as a resource for practice

Assessors draw upon their professional training and work experience to make decisions and judgements (section 5.2.2). They also use resources at the workplace including peers, colleagues, supervisors, professionals in other services, policies, procedures, and clients and carers involved in the assessment process. But they also draw on their own personal values and cultural knowledge, and general life experiences, regardless of what those prior experiences have been. Throughout the findings there is a strong sense that assessors take their role seriously, that they believe in the value of what they doing, and whilst they recognise the shortfalls of the service system, they will ensure that they can get the most they possibly can for their clients (section 5.6). The narratives that the assessors themselves provide about their experiences do not give the impression that they tire of their client’s stories. Rather, they suggest that assessors are engaged in ‘mindful practice’ often relating their clients’ stories back to their own lives or to how they would wish themselves or family members to be treated. Drawing on personal values and experiences thus appears to be very important for practice.
A study in the UK found that, in relation to assessing for carer needs, and in the absence of formal professional training, home care organisers drew on their own assumptive worlds regarding kinship and family life (Twigg & Atkin, 1994, p.57). In this situation, this was regarded as inappropriate compared with professionally-trained staff who were able to demonstrate more objectivity and who were more non-judgemental in their approach. However, as I outlined in the literature review, new epistemologies for discipline-based professions such as social work are focusing more and more on the self as a resource for practice. This new understanding of professionalism, where the personal is seen to be a potential resource, ensures that personal qualities such as interpersonal skills and intuition are integrated in the professional identities constructed (Deverell & Sharma, 2000). Aspects of the ‘self’ which were found to be an important source of (personal) knowledge for assessment practice, such as racial and cultural background, and often overriding the necessity to possess formal qualifications (section 6.1.1), also need to become accepted as contributing to this new area of practice and understanding of professionalism.

An epistemology of practice (including broader life experiences) relies on critical reflection on past experiences, and this was discussed in the previous chapter. This is assumed to be reflection on recent experiences. However, in my view, the time lapse between an experience and reflection has not been adequately addressed, but may hold the promise of unlocking other powerful learning opportunities. In the case of Clare, reflecting on her acute nursing experiences in relation to hospital discharge practices, she realised that she had not viewed the client’s (patient’s) situation holistically (section 7.1.1). Quite simply, their life at home was not her concern. Her frame of reference at that time restricted her to reflecting on her care in the hospital and not beyond. Her reflection was, inevitably, context-dependent. But contexts vary, particularly over time. Reflecting on the same experience in the different context of community care led to different reflection and new learning. Individuals can therefore learn anew from ‘old’ experiences because their current context (and identity) has changed. In this way, an experience can be transformed into many different learning opportunities over time as the individual’s frame of reference is expanded and developed.

Assessors draw meaning from a diverse range of prior experience, some of which would not immediately be recognised as related to assessment practice, such as working in motor vehicle finance (section 5.5). This clearly brings critical reflection to centre stage
as a key skill for assessors, and has profound implications for the development of learning programs to prepare workers as assessors. It strongly suggests that learners should be encouraged to identify and articulate past experiences and personal values so that they can be cognitively and emotively re-framed as their identities and practices change and develop in authentic workplace contexts. Learning from reflection-on-practice, as well as reflection on personal experiences in earlier contexts, should be a primary focus of any preparatory or support programs for these workers.

There are clear links between prior (whole person) experience and current working practice (Hodkinson et al., 2004). For example, from the current study, caring for a relative clearly impacted at the workplace: assessors identified that these personal caring experiences contributed to their approach to practice (section 5.5). However, prior experience alone is not usually a sufficient determinant for practice. Skills and knowledge have to be developed and possibly changed, as they are operationalised in the culture of the new workplace. Furthermore, it is the whole person that needs to adjust to the workplace (Hodkinson et al., 2004) implying that identity needs to be re-formulated and skills and knowledge need to be re-contextualised.

The value of ‘liberal’ learning for the development of a range of skills such as critical thinking, planning, negotiating, and communication is promoted in some of the literature on professional development (Armour & Fuhrmann, 1993; Zwerling, 1992). Although it has been critiqued in relation to its relevance in contemporary workplaces (Usher et al., 1997), liberal learning in professionals’ education is a strategy to get professionals to venture outside the traditional knowledge paradigms of their discipline. Despite not being regarded as directly ‘vocational’, a general (liberal) education is said to provide (in addition to those already mentioned) “an intellectual and social context for thought” and will potentially assist students to develop and question their values (Armour & Fuhrmann, 1993, p.127). Grace’s theological study (section 4.3) is surely in this category. Although she did not feel it related to her work, these higher order skills would be further developed through her studies despite her prime motivation for studying theology being purely for interest. It has helped shape her ‘self’ with a “certain kind of subjectively, with certain qualities and attitudes” rather than with directly vocational skills (Usher et al., 1997, p.11). This experience of formal study then becomes part of her biography and adds to the epistemology of her own practice.
In several areas in the findings, a ‘framework for thinking’ was identified as a critical requirement for assessment work. The person’s educational/professional background was commonly thought to provide this (sections 6.1, 6.1.1 and 7.1.3), although there was also strong recognition that personal attributes, past experiences and the ability to reflect were implicated in the type of ‘ideal self’ for assessment practice (sections 5.3 and 6.1). Thus, personal biographies which reflect diverse experiences, and other intrinsic aspects of ‘self’, contribute to such a framework. Clearly, such a framework for thinking (and practice) can be constructed by the individual from any, or all, of these sources discussed above. Acknowledging that the self is drawn upon to inform decision-making, shifts the focus of potential models of learning programs towards those that actually foreground the self in the learning process. Personal knowledge should be given centre stage rather than devalued because it cannot be generalised. The use of “individual learning portfolios” in higher education where there is a work-based component includes learners constructing narratives of themselves as “worker-learners”. This both personalises and abstracts their work and learning experiences and contributes to their identity construction (Chappell et al., 2003). Other practical measures such as keeping a learning journal (Moon, 1999) to record critical events in specified time frames (Shears et al., 1998) enables learners to self assess attitudinal changes and to record ‘useful’ knowledge acquired. Similar techniques are now often used in the education of professionals such as social workers.

8.1.5 Applicability of multidisciplinary and multiprofessional models

As discussed in the literature review (section 2.2.1.1), the relatively new move towards interdisciplinary education of health and social care professionals is recognition of the value of shared learning experiences to improve communication and multidisciplinary practice in real work settings. However, whilst the aims of such programs are to support better communication for the benefit of clients, the underpinning principles of interdisciplinary education exclude community care assessors from the outset. One of the main underlying principles is that it is important for students to have a professional identity so that they can gain maximum value from their shared learning experiences: a trainee physiotherapist learns how to communicate with a trainee social worker in a simulated work scenario and in the process learns more about the discipline of social work and vice versa. However, this experience is not challenging the exclusions that professional disciplines perpetuate. Rather, it reinforces the premise that a professional
identity – narrowly defined – is necessary to engage in multidisciplinary practice. Graduates from programs such as these may enter their profession with the skills and willingness to engage with other professionals, but will not value the input of staff without such a claim to a (discipline) professional knowledge base. Assessment workers in HACC are at a distinct disadvantage here because they do not carry a title that conveys their professional expertise (section 4.1.1), and their backgrounds vary considerably anyway (section 4.1.2).

There is an acknowledgement in the professional development literature that professionals are socialised into their roles in order to acquire the skills, knowledge and professional behaviour expected of their chosen profession (Millerson, 1973; Waugaman, 1994). Humphris (2002) notes that “employment and education practices are rooted in tradition. While some of these practices may be sound, many remain unquestioned and enshrined in the structures of professions and organisations”. As a consequence, the environment in which staff work and students learn can perpetuate and socialise the same values and practices (Humphris, 2002, p.7). In the new service environment, the socialisation process for professionals needs to include an ability to work collaboratively with other professional disciplines. This tended to be inadequately addressed in professionals’ training (Waugaman, 1994).

Much of the work of the multidisciplinary/interprofessional practice approaches is, therefore, effectively trying to undo some of the socialisation that professionals have been subjected to which has often reinforced narrow and explicit role boundaries. In a project which implemented a shared learning experience for social work and nursing students in a community care assessment work setting in England, one of the initial concerns of participants was the possible threat to their distinctive professional roles and identities (Torkington et al., 2004). The project actually found that interprofessional working would not necessarily imply the loss of a professional identity, but that practice changes to encourage joint working would lead to an adaptation of professional identity so that new, cooperative and complementary ways of working could emerge. However, these authors also note that whilst there is literature that supports the success of interprofessional working, there is also extensive literature that casts doubt about the potential to establish meaningful interprofessional relationships due to issues such as “professional identity and territory, the relative status
and power of professions and their different patterns of discretion and accountability” (Torkington et al., 2004, p.28).

In the case of HACC assessment workers their professionalism is preceded by the desirable elements of multidisciplinary/interprofessional practice (collaboration and interprofessional/interagency communication). This is thus an ontological feature of their practice. HACC assessors must work in these ways, regardless of their own professional/education backgrounds. Their practice is based on the ability and the need to use a diversity of community resources, services and other professionals. This is implicit in their roles and is ‘know how’ that is derived from their authentic practice. That is the nature of their practice, and one of the premises upon which the HACC system relies for effectiveness. Assessment workers in many cases do not have to unlearn their narrow role boundaries and relearn how to work collaboratively because they are not practising as a discipline-based professional.

For other discipline-based workers already practising, the environment of community care (and the requirement for interprofessional working) has created the need for training, but, as one study found, paradoxically, there is low demand for such training amongst professional staff possibly due to “time constraints and the nature of training, location and environment” (Norris et al., 2005, p.162). In the current study, the diversity of personnel employed in assessment roles was seen to be a complicating factor in providing formal learning opportunities, as workers come to the role with great variations in professional backgrounds and levels of formal training (section 6.2). However, this was also seen to be a source of learning if tapped into appropriately in educational opportunities such as workshops. A skilled facilitator can utilise this diversity in the same way as multidisciplinary learning is intended to encourage a greater understanding of others’ roles and perspectives. Thus, these models can be applied in in-service contexts, as long as disciplinary role boundaries (and the associated hierarchical assumptions about disciplines) do not construct unhelpful power relations and communication between participants.

In one paper which examines the impact of intermediate care service delivery on the role boundaries of service providers (Nancarrow, 2004), it was found that practitioners were not threatened by overlapping roles. Confidence in their own roles and an understanding of the roles of other workers was necessary to avoid feeling threatened.
The key was found to be greater interprofessional (including ‘lower level’ support staff) awareness, which, the author argues, can be promoted in the workplace through joint working across disciplines. In the professional development literature, as part of the need to understand and learn about others’ roles (important for effective teamworking), communication was seen to encompass learning from and teaching one another, both in terms of “formal teaching, and in ad hoc exploration of issues” as situations arose in practice (Miller et al., 2001, p.89). Helpful scenarios included activities such as jointly preparing and delivering an education program, attending conferences together, and discussing recent research together. Others also identify the benefits of working together on committees and projects to strengthen interdisciplinary links (Keegan & Kent, 1992). Such shared professional development opportunities serve to increase confidence in the expertise of others and reinforcing ‘teamness’ (Miller et al., 2001). Where HACC assessors can participate with others in the broader community care ‘team’ in this way, will it help to build others’ confidence in them? This inference cannot be conclusively drawn from the findings of the current study. If the other professionals did not value the professional knowledge of HACC assessors highly (as the findings seem to indicate) it could work in reverse. The hierarchical nature and often value-laden assumptions of the worth of discipline-based (health/medical) knowledge cannot be overlooked in interprofessional learning programs. Therefore, legitimation of the professional nature of HACC assessment must be a motivating factor in the development of new options for preparing and developing this workforce.

8.2 Beyond current options for ‘education and training’

“…learning from doing, learning from practice experience, is best. I think more could be made of that sometimes” (Consumer peak body employee).

So far in the thesis, I have argued that assessment workers in community care are emergent practitioners, whose work is the site of a robust professionalism. In other words, an ontology and epistemology of practice emerges from wherever the nascent role of (HACC) assessor in community care is situated. I have also presented findings indicating that existing models of education and training are inadequate and discussed the elements of an alternative approach based on assessors’ authentic learning experiences. This is essentially an argument for education to capitalise on the learning opportunities provided by work itself as well as the individual’s prior experiences. In
order to propose a model of learning that can take the preceding elements into account, the task now is to consider the location of such learning programs.

The current approach to preparing the assessor workforce in HACC is reliant on traditional knowledge-based approaches (education) and competency-based training (vocational education and training). Although these dichotomies are contested, they remain at the foundation for (formal) preparation of community care sector workers (and the health-welfare sector more broadly). The lack of an existing ‘tight fit’ formal preparatory program for HACC assessment, from either educational sector, was highlighted in the literature review (section 2.1.6) and confirmed in the findings (section 6.1).

The emergent environment of community care is creating both new knowledge, and new knowledge requirements. These requirements can be met formally through preparatory programs leading to a formal qualification or via in-service programs such as workshops and seminars. Along with the recognition of the need for new roles in health and community services industries (such as HACC assessors) is an acknowledged need to support these new roles with appropriate training (Lawson, 2006). However, what would comprise appropriate training? To date no appropriate preparatory program has been developed. Instead, the sector has relied on existing qualifications that provide a ‘loose fit’ (such as nursing or social/welfare work) to provide this workforce, with many diverse professional and educational backgrounds represented amongst HACC assessors. Instead, short generic (and specific) courses and workshops have been developed in response to the learning needs of these workers, once they are in-service.

The location of formal education programs is determined to a large extent by education polices of the day. In Australia, the vocational education versus general education, or competency-based versus knowledge-based dichotomy, underpins educational policy. Where preparatory education programs for this workforce have received attention (as outlined in the literature review) the location of the program is often considered from an either/or basis, that is, competency-based or (professional) knowledge-based. The model I propose for this workforce takes its lead from recent theorising in workplace learning which removes this binary, instead focusing on a mutually inclusive model. This requires a thinking ‘betweenness’, rather than focusing on boundaries which
acknowledges the interdependence of learning relations and locations (Mulcahy, 2005). In this way, we can see assessors’ workplaces and educational institutions as co-constituting a model of learning. The relationship between the two needs to be interdependent.

In relation to developing educational standards for staff involved in home care provision, it was predicted in 1985 that the most effective staff training programs would need to draw liberally on the personal experiences of workers, the educational potential of the supervisor-supervisee relationship, and the resources and expertise to be found at local tertiary educational institutions in adult human development and gerontology. It was suggested that the effectiveness of staff training programs may be conditional on service providers and educational institutions being able to strengthen ties between traditional modes of education and worksite training (Kaye, 1985, p.98). Although this was referring to the whole home care workforce, including direct carers, it was also inclusive of staff in other roles such as organiser, or care manager. Assessment roles, at that time, were not explicitly defined. Nevertheless, it is a useful reminder over two decades later that the sector has recognised for a long time that, given the nature of home and community care, work settings and formal learning need to have close links.

8.2.1 Preparatory approaches

As Gonczi suggests, contemporary approaches to professional learning need not abandon propositional knowledge taught in formal programs. Rather, we need to rethink its connection to the world of practice and the tacit knowledge and wisdom that develops through practice (Gonczi, 2004). However, what is clear from the lack of clarity and agreement about what should constitute a suitable preparatory program (section 6.1), and the debates in the sector about the place of health/medical knowledge as opposed to social/welfare knowledge, is that the propositional content of any preparatory course that may be developed in the future needs to reflect the realities of the new environment of community care. As this is a newly emerging specialism, no such ‘tight fit’ program exists at present. Therefore, the skills and knowledge used by practitioners currently working in these contexts need to be carefully considered, and, I claim, represent a good start if designing such a program.
Duckett proposes a common foundation learning program to produce graduates with a common knowledge and skill set as a platform for either generic practice (such as in assessment and case management) or for further discipline specialisation. He proposes this to be focused on science and health care knowledge which he sees as the central requirement for primary care practice enabling graduates to exit with registration at Enrolled Nurse (Division 2) level (Duckett, 2005). Rather than providing a framework for thinking, as was the ideal for formal education programs relevant for HACC assessment articulated by participants in the current study, such a preparatory program provides a framework for tasking. This is an instrumental perspective, rather than one that values ‘higher order’ capacity for thinking and formulating judgements required in assessment and care planning. This perspective is also situated firmly in the health/medical paradigm. Different conceptualisation is required that acknowledges community care as situated in the emergent space between the health and social care paradigm divide, and acknowledges the need for higher order skills. My study shows what this conceptualisation should contain.

As one participant (2) in the current study raised, issues such as elder abuse, depression and suicide requires assessors to be sophisticated enough “to adopt a holistic and health promotion approach where you are acknowledging the social connectedness and isolation factors that influence a person’s state of health” (Aged and disability services researcher/trainer) and to be fully aware of the legal and ethical implications of these issues. Thus, adaptation to a ‘primary health care’ framework is required for effective practice (Keegan & Kent, 1992). This is in line with the ‘ideal’ philosophies of community care which focus on functionality rather than diagnosis of disease or illness, and, further, with clients’ desire to continue to exercise maximum choice and control over their lives (Tanner, 2003, p.512). Some of the evidence indicates that assessors do adopt this approach in their practice (consider Delia’s efforts to ensure her clients’ exercise maximum control in section 5.1.2), although none of the in-service courses cited (section 6.2) appears to have focused specifically on the implications of primary health care approach to community care assessment.

Despite the lack of a ‘tight fit’ educational program, assessors do engage in formal courses of study whilst employed (section 4.1.3). For example, Anna commenced higher education study in gerontology expecting a stimulating program of learning that would assist her practice. However, the program did not live up to expectation as there
was no face-to-face (social) component. Another participant (Ellen) undertook an MBA which enabled her to use work-based projects for study purposes, which she found both useful and practical for her role as coordinator.

The acknowledgement that professionals need to be educated for uncertainty (Humphris, 2002; Keegan & Kent, 1992) needs to be kept in mind during the development of a learning program/s. Duckett proposes a ‘just-in-time’ model of learning, rather than a ‘just-in-case’ model as the most appropriate in the context of rapidly changing service environments (Duckett, 2005). This fits with new epistemological understandings that emphasise the ontological (in the sense of ‘human-ness’ of experience) in developing practical wisdom. Such a shift from emphasising ‘front-loading’ is strongly suggestive of experiential approaches which equip learners with skills to access and apply new knowledge and develop context-dependent expertise. This removes the exclusive focus on propositional knowledge (‘knowing that \( x \)’) to include ‘know-how’ which is developed daily through practice, such as in making judgements and subsequent reflection-on-action.

8.2.1.1 Reflective practicums

Propositional knowledge requires practical application before it becomes skill or expertise. Schön contends that the traditional education of professionals views learning as receiving, storing and digesting information, and ‘knowing that’ tends to take priority over ‘knowing how’. He suggests that a reflective practicum can counter the traditional view of knowledge as privileged information or expertise by offering a way of learning that more accurately reflects how knowledge is ‘acquired’ and ‘used’ in practice (Schön, 1987, pp.305-326). Reflective practicums have the features of “learning by doing, coaching rather than teaching, and a dialogue of reciprocal reflection-in-action between coach and student” (Schön, 1987, p.303). This idea has been adopted and developed by a number of professions such as social work, which now requires extended practicums involving reflective journals and intensive supervision. A distinct movement towards the location of courses of professional education being located substantially in the workplace was noted earlier in the thesis (section 2.2.1).

Social work practicums were initially regarded as relocation of the student from the classroom to a workplace, with structured supervision from both the workplace and the
educational institution. Students could generally not receive payment for their work because they were, by definition, still learning their profession. More recently, mature age students have challenged this assumption and insisted that the jobs they are often already employed in should count as a practicum (personal communications with Denise Taylor and Sue Fielding, 2005). The notion of a paid practicum is now a possibility in social work education in Australia and is a trend which acknowledges that there is often not a clear line between ‘inexperienced student’, with little to offer a professional workplace, and ‘competent professional’. Many social work students are experienced professionals who are upgrading their formal qualifications, and engaging in ‘lifelong learning’. Similarly, HACC assessors who have experience in their workplace should not be required to undertake a practicum as an ‘inexperienced student’. Their current work could be the site of their practicum.

Of course, this is not a new idea. Many higher education courses (such as MBAs or Professional Doctorates) place most of their curricula firmly in the workplace and require work-based projects, research or other indicators of professional application on the job (Chappell et al., 2003; Jarvis et al., 2003). However, the differences between competency-based ‘training’ at work as opposed to the education of professionals through practicums need to be debated within the sector (how great are those differences?). This is required to overcome any conceptual misunderstandings that may be present about the intent of these approaches and the level of knowledge and skill developed by learners.

Cleminson and Bradford (1996) caution the restriction of a workplace experience to a single workplace because it can produce a narrow or even biased view of practice which will not prepare the learner for practice in different contexts. This makes the broader community of practice critical for this broader contextualised learning, and points to the importance of formal mentor programs to counter this potential narrow learning. The importance of peers available to act as mentors and coaches has been highlighted (Boud & Middleton, 2003; Wenger & Snyder, 1994/2001).

Another form of embodied learning potentially useful for assessors is to actually experience being a direct carer, or to directly experience the environments of direct care. Involvement in a particular home care function has been shown to bring about an increased appreciation for the complexity and difficulty of that function (Kaye, 1985).
which supports the finding of the present study that direct experience of ‘hands on’ care assists with assessment and care planning decisions (section 6.4). The important elements are twofold; firstly they provide a basis upon which to understand the world of the direct care workers who will be involved in delivering the care the assessors may find is needed. Secondly, in the words of one key informant, it is about “… being in the environment of community care … where you are actually part of people’s lives…” (Service provider peak body employee). Such experiences serve to make connections between the identities (and personal knowledge) of assessors, with both the care staff, and importantly, the clients. These kinds of experiences could be built into learning programs, but for those who have these experiences from prior work or family responsibilities, focusing on their personal knowledge (‘know how’) derived from these experiences should be drawn upon in preparatory learning programs.

8.2.2 Support and development programs

Currently, the response to in-service training needs in HACC assessment is market-driven rather than coordinated or monitored by the funding bodies, and costs are met by employing organisations. The high demand for short generic assessment courses (National Ageing Research Institute, 2001c) is indicative of the need for ‘training’ to be available to this group of workers. However, there is a lack of clarity in the sector about the type of training that needs to be developed and who should be responsible for driving such development.

The findings indicate that different skills and knowledge may be required for different client groups (section 4.2.3), and a number of projects undertaken in community care assessment in Australia have focused on this need. A conclusion of one HACC program report examining the care options for children with a disability was that assessment staff needed specialist skills to work with this target group and that this was an expectation of parents (clients) (Department of Human Services, 1997). Other projects have focused on the particular skills required for working with NESB/CALD groups (Action on Disability within Ethnic Communities, 1997; Butcher, 1996; Centre for Applied Gerontology, 1996), carers (Pierce & Nankervis, 1998) and people with particular disabilities (Centre for Social Health, 1995). There has also been a focus on training for dementia assessment, including the use of interpreters, and availability of community resources (Centre for Applied Gerontology, 1996). Projects such as these
will often be developed into short courses or in-service workshops, often offered by the relevant peak bodies (such as the Carer’s Association) to improve the skills of assessment staff working with particular client groups.

The assumed model of training in these cases, where an interest group or funding body identifies particular training needs, is for traditional workshop-style initiatives. However, the findings of the present study point to the inadequacy of this model of training (section 6.2). Given high staff turnover in the sector, workshop-style learning opportunities do not contribute substantially to building the capacity of the workforce as a whole. Further, they tend to be accessed by workers with a particular interest in the topic, and only if the individual has the time to attend given other competing priorities of the job.

Other training occurs as a strategy to support new Departmental policy or service development initiatives such as to introduce data collection and management systems (Lindeman, 2000), or for new service initiatives (Department of Human Services, 1998b). However, this type of training addresses process issues (procedures), it does not address underpinning knowledge or skills in depth, and generally does not continue beyond the life of the strategy. It also is not linked with actual practice of new knowledge or skills back in the workplace. The variable practice and implementation of common assessment tools in Victoria is a case in point. Whist all participants in the current study were using the SCTT, they were used differently and adapted to suit local and personal preferences (section 5.1.1 and 5.1.3). As Eraut reminds us, new practices cannot just be learnt, they also have to be recreated for new contexts. So even when a practice has been codified by a series of protocols (as in the PCP reforms), and presented to the workforce for implementation through training (workshops), it still needs to be adapted to local contexts and clients (Eraut, 2004a).

For some authors, formal education is said to hold the key for developing knowledge, skills and attitudes for community care practice (McIntosh, 1996), including CPE (in the form of workshops and seminars) (Keegan & Kent, 1992). However, research has shown that traditional models of in-service training have an inconclusive correlation to changed (improved) performance back in the workplace (Clarke, 2001), with the recognition that success is often dependent on the informal learning that follows it in the workplace (Eraut, 2004a). Without the existence of other ‘enablers’, such as
participation in all stages of reform management and attention to adult learning principles at both individual and organisational levels, such workshops are unlikely to result in significant and sustained change in practice (Helling, 2002). Workshops may be an efficient way to impart certain types of formal or codified knowledge, such as new policy information, knowledge about certain client groups such as CALD, or knowledge of local resources, but these cannot substitute for the ‘know-how’ developed through the ‘doing’ of work. It should also be acknowledged that even codified knowledge can be gained through practice, such as from participation in communities of practice, or through the structural, supervisory or peer support available to workers.

The focus and role of in-service training is an area that I feel requires policy action. Moving towards a ‘lifelong learning’ model, as I am suggesting in this thesis, requires a different approach in the deployment of training resources. For example, a legitimate role for HACC staff is to contribute to training other workers and professionals within the service system (Department of Human Services, 2003). This seemingly minor policy statement has the potential to specifically channel worker time, and focus, onto peer support/mentoring roles. This would need to be properly supported, possibly through the structures already in place to support HACC training.

Currently, part of the Department of Human Service’s role is to provide funding for coordination of training activities in Victoria. This is in addition to contributing to a national and statewide analysis and response to training needs in the HACC program. Funding is made available to a specific agency or training network in each Departmental Region to carry out this role:

“This enables region wide identification and discussion of training issues, the development and coordination of in-service training from a variety of sources, and to some extent, the coordination of the provision of registered vocational training” (Department of Human Services, 2003, p.51)

Funding may also be made available for in-service training in response to specific identified needs (Department of Human Services, 2003). The policy development needed is to allow for flexible local responses to the learning needs of HACC assessors, and a move away from a reliance on traditional models of in-service training. One advance would be to tie local training provision more closely to formal education programs offered by universities and/or other education providers. This would require a
stronger connection between funding bodies, employers and education providers than has existed in this sector previously, hence the suggestion to develop policy to this end. A trial or pilot program may assist to demonstrate the effectiveness of such a new approach.

8.2.3 Vocational education and training versus higher education

“(P)eople feel that they have accumulated a lot of knowledge that is never properly accredited ..... this is the feedback from the assessment officers themselves” (Local government senior manager).

The findings indicate a distinct lack of clarity about pre-service and in-service training/learning needs, and to be able offer training at different levels to suit the diverse profile of assessment workers. However, they also indicate a relatively low understanding of CBT/VET particularly by service provider managers and program policy staff about the types of qualifications offered, possibly reflecting the general scepticism surrounding the quality of workplace learning (section 2.2.3) and the view that VET can only prepare ‘low level’, non-professional workers. There was some expectation from participants that further work on identifying appropriate competencies for assessors in primary care would occur in Victoria as part of the PCP initiative (section 6.5.3). This would be focused on the broad range of services and personnel involved in primary care not just those associated with providing community care to the aged and disability client group. Yet, while the focus on competencies was expected within the HACC program, the preferred location of any education program was in the higher education sector (section 6.1).

The question of how experience should be regarded is an important one, in particular, how to acknowledge (and nurture) workplace learning, as indicated by this section’s epigraph. On the one hand, participants, in general, had a preference for assessment staff to have some formal qualification (although there is no clear agreement on what this qualification should be) (section 6.1), but on the other hand, they felt that the most important learning happens on the job (section 6.4). A scepticism remains about the quality of (informal) workplace learning, and its apparent poor fit with formal education courses (Hager, 1998c). However, in the VET sector at least, there is growing recognition that “smarter” learning methodologies are required, including courses with flexible lengths, well integrated on and off the job work, better recognition of
competence, and different approaches to designing qualifications (Lawson, 2006, p.8). There is currently no way of linking valuable work experience to a qualification type or level acceptable for the role of HACC assessor. This suggests that a new course or program needs to be developed. And this, in turn, demands that the community care sector have a position on how (and where) assessors will be credentialed.

Binaries can be problematic because they conceal more than they reveal. The emerging paradigm of learning overcomes this by its emphasis on holism and the integration of dichotomies such as education – training, knowing that – knowing how, or mind – body (Beckett & Hager, 2002, p.165). However, it does not overcome the fact that the CBT/vocational – higher education/general education dualism is perpetuated in educational policy. At this stage, qualifications (credentials) are one or the other. They are either ‘competency-based’ and issued in the VET sector, or they are ‘knowledge-based’ and issued in the higher education sector (although some discipline-based professionals may also have to meet competency requirements after completing their initial education). As Thompson’s ‘truth strategies’ (Thompson, 1976) suggest, mechanisms have been available for universities to offer education for professionals that acknowledges multiple knowledge sources without reliance on scientific validation. His conceptualisation of four types of reasoning (scientific, analytic, direct and inspirational), with different levels of both codification of reasoning and reliance on experience, allows for categorisation of different approaches to the education of professionals. The ‘inspirational strategy’ with its low reliance on both codification and experience is adopted by universities who wish to offer courses to a broad cross-section of society and to legitimate ‘insights’ that come from outside established disciplines and without reliance on scientifically collected and analysed data.

In Australia, each sector (that is, VET and higher education) has its own quality assurance framework and assessment process and they have different funding bodies. Educational institutions may be in the business of both VET and higher education, but there is still no way around the distinction at the level of qualifications. The aged services industry (not specifically community care) has been urged to include professional level workers within the relevant National Industry Training Package/s (Wheeler, 2002). A recent policy initiative within the Australian Qualifications Framework (AQF) provides the potential for vocational graduate certificates or graduate diplomas (http://www.aqf.edu.au/vgc_vgd.htm, AQF Advisory Board website accessed
The Community Services and Health Industry Skills Council is encouraging take-up of these qualifications within the health and community services sector to support skills development and service delivery where they are being seen as:

“an attractive alternative to traditional higher education qualifications (i.e. more academically-orientated qualifications). The increased requirement for hybrid roles, especially for workers with an existing qualification, lends itself to these qualifications as workers are increasingly attempting to develop skill sets at a level commensurate with their existing qualification. Preliminary discussions have identified interest in developing qualifications at these AQF levels to reflect a range of functions undertaken by occupations from both the VET and university sectors…” (http://www.cshisc.com.au/load_page.asp?ID=111, Community Services and Health Industry Skills Council website accessed 23 March 2006).

These qualifications would be of similar duration to qualifications at the same level in the higher education sector but will be competency-based. However, once again, it requires a choice to be made about the sector in which the qualifications should be available.

Parallel with the expected trend in VET to include professional-level qualifications, there is a distinct movement towards courses of professional education being located substantially in the workplace. This trend, perhaps following the ‘inspirational truth strategy’ (Thompson, 1976), can now been seen emerging in the health/welfare sector in the UK to support staff already working in roles not directly (or adequately) covered by discipline-based professionals. For example, the University of Chichester has developed a foundation degree in social care for unqualified staff who work with older people and in other social care settings. The course has been designed to support “non-traditional students with consolidated previous experience”, providing recognition for their work-based learning and assessment and combining academic and practical learning (http://chiuni.ac.uk/socc/TheCourse.cfm, University of Chichester website accessed 16 May 2006). However, to date, work-based learning has more commonly been associated with CBT (VET sector) than in higher education.

Whilst the model I propose for the emerging specialism of community care assessment is for practice (work) to be the site of professional learning, a choice still needs to be made about how and in which educational sector the (new) qualification/s would be developed and issued. If the sector moves toward a competency-based approach in the
VET sector, then this must be based on a broad conception of competence; one which acknowledges the embodied, situated, holistic, and interrelated nature of practice, learning and identity, and which is recognised as such by other stakeholders in community care including discipline-based professionals. If the sector moves towards a higher education approach, then this must not be to educate a ‘problematically professional’ practitioner with the associated territoriality and boundary issues and the theory/practice divide developed in the wake of ‘disciplines’. Rather, practitioners need to be seen as co-constituted in professional knowledge construction as I have outlined. In the case of HACC assessors, this is first and foremost an ontological endeavor, as I have shown in this thesis.

8.3 A model for professional learning

From the preceding discussion, it is now possible to articulate the essential elements of a professional learning program, as well as some possible learning outcomes that could be expected of such a program. Although not exhaustive this provides the foundation for a model for professional learning.

Essential elements of a professional learning program

- Discussion and reflection on (daily) client interactions
- Experience of a workplace as ‘learning environment’ including opportunities for team discussions, strategic pairing of workers, modelling, mentoring, appropriate supervisory relationships
- Experience of community care assessment in more than one workplace (that is, reflective practicums in different workplace contexts)
- Experience of direct care (either drawing on past experience as a direct carer or through a short placement in a direct care role)

Possible learning outcomes of a professional learning program

- Well developed emotional (personal) awareness, and strategies for dealing with challenges to personal beliefs arising from practice
- Ability to identify (surface) tacit knowledge and beliefs arising from practice
- Ability to engage in mindful practice (including awareness of impacts of decisions on clients, ethical and practical wisdom)
- Well developed skills in, for example, advocacy, repertoire of responses for working in people’s homes, anticipative action, ‘trans-professionalism’, mediating conflicts
• Opportunities for interdisciplinary/multidisciplinary working, including in maintenance of service delivery systems (networking and communication)
• Linking of past experiences (obtained in work and life) and personal values to current practice
• Regular participation in formal communities of practice (could include locally-based as well as more broadly-based)
• Opportunities for joint work with other practitioners on projects, committees and so on
• Access to propositional (codified) knowledge relevant to community care assessment (based on skills and knowledge used by practitioners in authentic work contexts)
• Well developed empathy for clients/informal carers and direct carers
• Recognition of culture (and discourses) of workplaces and communities of practice in the service system environment
• Well developed understanding of own organisation’s ethos and it’s place within the broader service system
• Identification of formal and informal communities of practice and potential modes of engagement
• Articulation of personal biography, and framework for thinking
• Development of personal strategies (goals) for lifelong learning
• Understanding of power differentials existing in work with clients, in the workplace, and in the service system, and strategies for mediating these differentials
• Ability to locate and negotiate with a range of community resources for diverse client groups

The elements are derived from assessors’ authentic learning experiences including from daily work (such as through client interactions), aspects of social learning (including at the workplace and from the broader service system), multidisciplinary/interprofessional working, and, importantly, the self as a resource for practice. The model is dependent on the development of a new qualification such as a Graduate Certificate/Diploma (that enables enrolment based on extensive prior experience), taking the points raised in section 8.2 into account. Other qualification options include a Certificate IV that articulates into a degree program, or an undergraduate degree program.
The proposed professional learning program requires learners to develop skills in critical reflection, and the learning outcomes require learners building both personal knowledge, as well developing propositional (codified) knowledge to support good assessment practice. Thus, the role of the educational institution is to facilitate access to a support structure through a formal course of study, which will require work experiences either through the learner’s current employment and/or through organised placements (reflective practicums). In essence, this amounts to a ‘hybrid’ approach to professional learning; one that has elements of formal and informal learning, including those based at the workplace and in educational institutions. However, a range of strategies to support the advancement of such a professional learning program also needs to be initiated. These strategies, along with the responsible sector, are set out in Table 12, below.

Table 12: Strategies to support a new approach to professional learning

<table>
<thead>
<tr>
<th>Responsible sector</th>
<th>Strategies</th>
</tr>
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| Funding bodies (State and Commonwealth governments) | • Investment in developing formalised communities of practice for assessors  
• Channeling current training resources into peer support/mentoring roles |
| Employer/Industry groups                  | • Investment in developing the skills of workplace supervisors                
• Support for development and maintenance of local communities of practice, and for a professional association for assessors  
• Enable release of workers to participate in formal learning (weekly, monthly, or as dictated by the location of both the learner and the educational institution) |
| Educational institutions                  | • Curriculum development to include explicit strategies for developing self awareness and skills in critical reflection (including requirements for learning journals to record reflections and development of personal knowledge)  
• Negotiate agreements with industry/employer groups to develop the expectation that formal learning will be tied to workplace activities  
• Negotiate agreements with local service systems to ensure |
assessors participate in regular communities of practice meetings (e.g. monthly) which also count towards the requirements of a formal learning program

The proposed model of learning is thus comprised of essential elements and learning outcomes to be incorporated into a new ‘tight fit’ formal qualification. Additional dimensions to the model include a range of strategies to be initiated by the various sectors involved in HACC assessment and with an interest in the professional development of assessment practitioners.

8.4 Summary: from education and training to learning

Traditional models of education and training have failed to adequately prepare and support the HACC assessor workforce. These approaches to education and training only partly explain ‘coming to know’. Rather, experience and reflection on it, and decisional practice is also involved, as are other aspects of personal knowledge developed throughout a person’s life. New understandings of ‘lifelong learning’ or simply ‘learning’ represent a more inclusive view of the different forms of education/training/development that can occur both formally and informally in a person’s life and work, offering an integrated view of knowledge.

However, educational policy dictates that a choice needs to be made about which education sector needs to take the lead in developing a new formal learning program. Competency based approaches, with their legacy of behaviourism and narrow conceptions of learning and performance (and their poor regard in the professional community), are not favoured in the sector currently. New developments in education that enable the development of vocational graduate certificates or graduate diplomas may be the answer, as long as this provides HACC assessors’ professionalism with legitimate status within the community care sector.

The model of learning proposed is based on elements derived from assessors’ authentic learning experiences. This includes learning from client interactions in daily practice, social learning at the immediate workplace and in the broader social system where communities of practice may exist, and cultivating the ‘self’ as a resource for practice. Thus, learning at work provides the basis for professional learning programs for HACC
assessors if tapped into appropriately and strategically. This will also require a range of initiatives to be taken by the sectors with a stakeholder interest in HACC assessment, and in the professional development of assessment practitioners, to support such a program. These sectors include funding bodies, employer/industry groups and educational institutions.
9. Conclusion

9.1 The research approach

Services such as home care (cleaning, shopping, and laundry), home maintenance, personal care, social support, day activities/day care, other forms of respite, delivered meals and community transport are becoming increasingly important for countries with ageing populations and policies which encourage care in the community. Gaining access to basic community care services such as these is via an assessment process undertaken by workers in roles that may be comprised partially or solely of assessment and care planning tasks. However, little information has been available to date about who comprises this workforce, making initiatives to improve practice difficult to plan and implement. Reaching this understanding provided me the initial impetus for this study, along with the realisation that existing education and training programs were falling short of meeting the needs of these workers, and therefore of the home and community care sector. The research questions were designed to contribute to the knowledge base available to the sector to enable better preparation and support for these workers.

A qualitative methodology was used drawing from an interpretivist-constructivist research paradigm. I conducted 12 in-depth interviews with key informants in the sector. These key informants were purposefully selected for their perspectives and stakeholder views on assessment in HACC. Data from this set of interviews (Stage One) were used to design the approach for the second set of in-depth interviews (Stage Two) with HACC assessors themselves. A stratified random sampling technique was used to ensure representation from all services types as well as from urban and rural areas, and 12 HACC assessors participated. Data were analysed using the constant comparison method, which provided the ‘thick description’ reported in Part II.

In keeping with ‘postmodern sensibilities’ in qualitative research methodologies (sections 3.1.3, 3.9), during my engagement in this study, I have continued to critically question the origin, purpose, context, and aim of the research. I have maintained sensitivity to the ‘local, personal and particular’ sensibilities of assessors in constructing a new approach to their learning. And I have acknowledged my own location, or context. In the introduction (Chapter One) I stated that I was not a dispassionate
observer in relation to this topic. Rather, I have been involved in this area for a number of years from a number of different perspectives (policy and service development as a government employee, researcher and educator/trainer) and these standpoints have provided me with direction, and confidence that the study has legitimate purpose. However, I have not practised as an assessment worker, so I cannot consider the thesis from that particular standpoint.

The voices of practitioners provide much of the narrative for the thesis, and it is their accounts and stories that comprise much of the primary data. However, further engagement with both HACC clients and assessment workers by stakeholders (policy makers, employers/service providers, research bodies and educational institutions) will be required for any further development along the lines suggested in this thesis. Policy development, or development of preparatory or support programs, that may occur in the future will be for and about them, so such programs should involve them whilst still inchoate.

I have not argued that all HACC assessment practice is exemplary. Indeed, I pointed out in the introduction that I intended to remain focused on the workers themselves and to avoid a critique of the function of assessment. The methodology was not designed to capture the level of detail to enable such an evaluation of the quality of practice or how it is structured in the service system. Instead, I have searched for the realities of practice by considering the reflexivity of the epistemological and the ontological. This analysis provides the foundation for a better approach to preparing and supporting these workers because it takes their experiences as a whole, very seriously.

9.1.1 Limitations and recommendations

There are limitations related to the sample population of HACC assessment workers I used. Firstly, participants had to satisfy certain criteria in order to qualify as research participants. One of the criteria was that they must be employed in a role where assessment comprises at least 50% of their work time. The methodology deliberately targeted these people as they would be more likely to articulate sufficient detail about their assessment work. The exclusion of these other staff prevented the potential to compare their experiences with those whose primary work is client assessment. Additional research is recommended to consider the group of individuals whose
assessment of clients comprises only a small proportion of their overall work, but who, nevertheless, contribute to the provision of community care. This level of investigation would enable other questions to be answered such as ‘does the proportion of work comprised of assessment affect work satisfaction?’, and ‘does it affect the rate and style of learning about the practice of assessment and the development of expertise?’ Answers to questions such as these would assist policy-makers to develop appropriate assessment models for a diversity of settings.

Secondly, the sample size was small. This was in keeping with the interpretivist-constructivist research methodology which seeks to uncover the views, experiences, descriptions and feelings of individuals. This approach, however, does not provide statistical data which are often drawn upon to assist the formulation of policy, and which is an acknowledged gap in the existing literature. A larger sample population, with a survey approach to data collection, would reveal a breadth which was beyond the scope of the current study. Further research using an approach such as this is recommended. This is to enable governments and educational providers to establish the statistical significance of this workforce, and to estimate the participation of individual assessors and workplaces in alternative models of preparation for practice and professional development such as that proposed in this thesis.

Lastly, this thesis has focused on HACC assessment workers in Victoria, with the implication that the findings are applicable for other locations where there are HACC (or similar) services. However, in remote areas this may not be the case. By definition, there are no truly remote locations in Victoria, although HACC services are established in small towns that are often a significant distance from larger centres. However, another population of HACC assessment workers deserves attention, and these are workers based in remote/Indigenous communities of Australia. The theoretical framework used to analyse the research participants in the current study would have limitations for those in remote areas, although a similar analysis of this group may highlight differences (in identity, practice and learning) from their ‘mainstream’ counterparts. For example, these workers often have no related work background or related formal education (HK Training and Consultancy, 2002). Further, they work in cross-cultural contexts, often in professional isolation and without a (public) knowledge base to draw upon to assist with assessment and care planning decisions (as is the case for assessment workers in more mainstream settings) because their work contexts are so
different (Lindeman & Pedler, 2004). They have few, if any, opportunities to identify as a member of a community of practice related to their HACC/assessment work, and their opportunities for learning from their assessment practice are restricted by the extremely small number of clients with whom they work, compared to other HACC contexts. This is an area that, I feel, requires a dedicated research focus.

9.2 ‘Their being is their doing’ and ‘their work is their learning’

In this section I conclude the thesis by returning to the research questions, providing a summary of the relevant findings for each one.

9.2.1 Workers and contexts

Research question one was “Who are the workers that undertake assessment of client need in HACC and what is the range of contexts in which they are employed?”

I found that there is diversity of primary professional backgrounds amongst HACC assessment staff, although nursing (Divisions 1 and 2) is the most common, followed by welfare and social work. Less than half of the participants had undertaken further formal study since taking up their assessment role. Of those who had undertaken further study, their fields of study were varied and there was no obvious common thread amongst them, possibly indicating a lack of relevant educational opportunities. The range of professional associations/groups to which these assessors belong is diverse, as are their reasons for membership, although it should be noted that half of the participants did not belong to any sort of professional association, again indicating that nobody currently exists that is directly relevant for all who work in HACC assessment.

The reasons individuals become employed in HACC assessment roles were varied and included dissatisfaction with previous work settings, particularly hospitals, family reasons, or simply circumstance. However, educational backgrounds rarely lead workers directly and ‘purposely’ into HACC assessment. Significantly, none of the participants had undertaken training specifically to work in community care assessment prior to commencing.
A variety of position titles are used, although these titles do not necessarily convey accurately worker responsibilities or expertise, giving a reductionist version of their role. Further, some assessment positions are comprised only of assessment, while others carry a wider range of responsibilities. Both integrated and separated models of assessment are present in HACC, although integrated models are generally preferred by assessors because they allow for a continuing relationship with clients. These factors contribute to considerable variance amongst assessors’ roles, and therefore their practice, identities, and learning opportunities.

Organisational size and ethos also contributes to the diversity of work contexts for HACC assessors. For example, different organisational values (ethos) contribute to the degree to which workers can participate in broader activities in their local communities. Local government is the biggest stakeholder (in HACC) in Victoria, although this is not the case in other states.

Trends gleaned from the findings relating to the personnel employed as assessors included that the workforce has become more professionalised since the early 1990s. However, this trend seems at odds with other observed trends such as generally low rates of pay, discrepancies between rates of pay of individuals employed by different organisations, and other variable work conditions. As might be expected, assessment jobs are primarily occupied by women, and there is an increasing use of short-term or contract staff.

Considerable diversity of clientele is also present within HACC services resulting from variables such as geographical location, disability type, age, and cultural and linguistic background and literacy. Organisational type (and focus) and geographical location can affect the characteristics of the clientele individual assessors work with. Client diversity, coupled with the increasing complexity of clients is creating new demands on assessors, with the strong implication that new and different knowledge and skills for assessors are required (and acquired in different settings).

9.2.2 Current preparation and support

Research question two asked “What preparation (including formal education and training) and support do HACC assessors receive?”
I have already reported that there is diversity of primary professional backgrounds amongst HACC assessment staff, although nursing is the most common, followed by welfare and social work. These professional disciplines provide a ‘loose fit’ rather than a ‘tight fit’ for the role of assessor. Further, less than half of the participants had undertaken further formal study since taking up their assessment role. However, there is also little agreement in the sector about what professional/educational backgrounds are appropriate to undertake the role of assessor. Higher education level qualifications are preferred but there is also still an element of having ‘the right personality’ (interpersonal attributes) in hiring practices.

Formal qualifications were thought to provide a framework for (higher order) thinking, and can provide at least some assurance that assessors are not working beyond their skill level, and/or they can provide the basic required skills (such as counselling) upon which workers can build knowledge about the HACC/community care sector. The higher education sector was suggested to be the most appropriate level for assessment workers (for example a graduate certificate and/or graduate diploma) if a specific course were to be developed.

However, it is clear that formal qualifications cannot guarantee suitability for the work itself. In fact, there is little clear agreement as to whether assessors in HACC must possess a formal qualification, as in some instances, personal attributes were more highly valued. This is particularly so for ethno-specific or Indigenous client populations. It should be noted that to date no definitive policy work has been completed to clarify competencies/formal qualification required for the assessment function in HACC.

I found three generic short courses on HACC assessment available in Victoria. There is also a variety of workshops/short courses available on specific topics related to assessment (for example, carer needs) and most are developed and run by relevant peak body/industry groups. However, the short course/workshop model of training can be problematic for this workforce with diverse training/learning needs. Current provision of training for assessment in HACC overall was generally regarded as inadequate, supporting evidence from the relevant literature which suggests serious problems with these kinds of traditional approaches.
The types of support available to assessment workers could be separated into workplace, service system and programmatic support. Workplace support included supervision (internal or external) to, amongst other things, model good practice, facilitate debriefing and critical reflection, showing empathy with difficult decisions, peer support and discussion. The importance of supervision was amplified in the current service environment where service rationing and prioritisation is more prominent. Service system support included structures arising from within, and maintained by, the service system such as networks/forums. A need for assessors to be able to convene to discuss practice issues, beyond those opportunities currently available is apparent. Programmatic support is the responsibility of funding bodies, and included provision of ongoing training, IT infrastructure, and resource manuals. The degree to which workplace and service system support is operating is variable and influenced by factors such as the level of understanding of assessment by management (including the degree to which managers grasp the complexity of the role and their closeness to the ‘hot action’) and existence of good human resource practices.

In short, current approaches to preparing and developing assessment workers, based on traditional ‘education and training’ models, fail to address the realities of practice, and therefore to adequately prepare workers as assessors. Better approaches are required that acknowledges how these workers learn and practise as assessment workers. A framework for such better approaches emerged in Chapter Eight, underpinned by the responses to research questions three and four, as follows.

9.2.3 The relationship between skills, knowledge and workplace context

Research question three asked, “What relationship does the workplace context have to the skills and knowledge required and acquired, and vice versa?”

The commonality of embodiment for client and worker is crucial in the interactions involved in assessment in community care. There is a materiality, or ontological significance, in any explanation of the relationship between on the one hand contexts, and, on the other, skills and knowledge. And yet, there is a tension between the embodied function of assessment (sensory, emotional, ‘gut’ feeling, tacit wisdom) and the pull towards the disembodied elements (tools, prioritisation, waiting lists). The
professional identities of assessors are linked to an ability to interpret need from clients’
diverse stories and life circumstances. Judgement is reached through filtering
information gained through the sensory and emotional experiences of assessment as
well as drawing upon a diverse range of knowledge sources. These comprise the
elements of a framework for a ‘higher order’ capacity to think rigorously and to do so
with sensitivity. But many material features mediate including the client’s family life,
cultural background, the physical home environment, and other sources of information
such as carers and referrers. HACC assessors work in diverse workplace contexts and
with a diversity of clients and target groups. However, assessors’ practices, in all their
materiality, are not dependent on their having (or even developing) the propositional
knowledge relevant for all types of clients’ conditions, problems or circumstances.
Rather, it is in negotiating all the diverse knowledge sources and bringing these to their
judgements and decision-making when required, that is central to their practice. Their
epistemology is dependent on the nature of the clients and the service system in which
they operate; it is preceded by the ontological. This is highly significant for the better
preparation of assessors, as the responses to research questions four and five, below,
made plain.

Assessment in home and community care contexts is underpinned by common values
and ethical concerns, but these are often in conflict with workplace realities. Common
values and ethics include a commitment to universality of services, and advocacy, to
promote independence, which is often juxtaposed with the reality of the role being more
and more about determining priority of access. The ideal of needs-led assessment
espoused in policy is pitted against the reality of the pressure on services for cost
containment. Assessment is highly complex process requiring high levels of skill and
knowledge, but paradoxically is often poorly remunerated and has relatively low
professional status. Effective assessment and care planning is reliant on collaborative
relationships in the service system, but in reality these workers are often professionally
isolated. Thus, the ‘ideal’ (and personal) values of community care and identities are
challenged by many workplace realities. These values and conflicting workplace
realities are unifying features for this workforce, and can be a starting point for better
approaches to its learning, and are thus included in the framework for professional
learning proposed in Chapter Eight.
9.2.4 Practice and the formation of professional identities

Research question four was “What is the relationship between the professional identity of assessment staff, and their practices, knowledge and expertise?”

The most significant finding relating to this research question is that most learning happens ‘on-the-job’. In fact, this was thought to be the best location for learning assessment work in community care, where there are opportunities for supervision, peer support/discussion, observation, and reflection on trial and error. This is where worker identities are formed and re-formed. Significantly, learning was found to derive substantially from the embodied experiences of assessment workers where feelings, emotions, personal knowledge and biographies work in a complex interplay. This fits with the new epistemology of professional practice which underpins contemporary understandings of professionals’ development, and is fleshed out by the examples of learning opportunities with which Chapter Eight concluded.

I have argued that these workers have identities as practitioners whose epistemology is derived from their material practices in diverse contexts with diverse clients. Their identities are not ‘given’ but are constructed and contestable. HACC assessment workers appear to operate in the ‘in-between’ space of the competing epistemologies (or ideologies), present in community care and are not constrained by disciplinary knowledge boundaries. There is no single disciplinary narrative for this field of practice yet they are able to practise alongside other professionals also working in the field of community care exercising similar levels of autonomy and developing tacit and practice wisdom. The nature of their practice derives substantially from the local contexts in which they work, and they draw from a diverse range of knowledge sources including their embodied practice. This creates a space for the emergence of a new specialism (and professionalism) based on ‘holistic’ practice and what I have called a ‘trans-professionalism’, an ability to work beyond the constraints of particular professional boundaries.

9.2.5 Better approaches to preparing and supporting assessment workers

Research question five asked “How, and to what extent, can workers be better prepared as assessors in community care?”
From the preceding discussion it is clear that new approaches to preparing, supporting and developing HACC assessment staff are required, and that these new approaches should be inextricably linked to new ontological and epistemological understandings of practice and the formation of worker identities, including in the direction of ‘trans-professionalism’.

A new preparatory program should be based on the elements of ‘authentic learning’ including those derived from daily work (in the ‘swamp’), features of social learning (including from the broader service system), and importantly, the place of the ‘self’ and personal knowledge in assessment practice. A structure for both a new preparatory program for practitioners could take the form of a qualification that is based largely in the workplace and which acknowledges the preceding elements (incorporated in the model for professional learning proposed in section 8.3). On-going support and development can be enhanced by more strategic and considered use of existing training resources, again based on an understanding of assessors’ authentic learning.

There are two other areas where initiatives could be focused to enhance the preparation, development and support of HACC assessors. Firstly, the findings indicate that assessment in HACC has gradually become more professionalised, although there are some contradictions to this trend such as relatively low rates of pay, and variable work conditions between different organisations. Recommendations for policy development can be made here that would significantly contribute to better preparation and support for HACC assessment workers. The most obvious relates to policy development to improve the status of the assessment function especially in funding (amount and model of funding) for assessment, and the development of guidelines and resources to support assessment workers (section 6.5.3). These variable work conditions between organisations are most notable in the local government sector where there appears to be significant discrepancies between individual councils in their level of commitment to the assessment function (expressed in rates of pay, conditions, models of service and so on). These differences may also be present amongst the other types of organisations involved in HACC/community care. Smaller organisations, in particular, may not be in a position to pay higher salaries. As this workforce does not have a collective identity, it is not surprising that they experience inconsistencies. Discrepancies between
organisations of the same type are not likely to exist for designated nursing positions, where there are basic mandatory qualifications and highly regulated working conditions.

Secondly, client assessment is often the focus for political debate and action because of the central role that it plays in service delivery and in enacting policy directions for community care. Carer advocacy groups, for example, recognise that assessment workers are the link between policy and practice and have advocated for a greater focus on carers in the assessment process. The implication that can be drawn from this type of political action is that assessment workers themselves need to be recognised as key contributors to such policy formulation. Once again, they are disadvantaged through a lack of a collective identity. However, a new regard for their professionalism, and legitimation with the broader community care sector as professionals (with a new specialism), may assist this situation. Development of a professional association recommended earlier (section 6.5.2.1) would enable this group of workers to participate in policy development from the perspective of their role and place (and identities) in the sector, rather than from the perspective of their employing organisations. It would also help to acknowledge HACC assessment as an emerging field of practice in the emergent space of community care. Employers (service providers) have other interests and perspectives which are represented by service provider peak bodies. The perspectives of assessors working within the community care sector, as well as within organisations, need to find a voice.

9.2.6 Conclusion

This study set out to determine how, and to what extent, workers can be better prepared and supported as assessors in community care. This has required a new understanding of these practitioners; their identities are emergent, and their professionalism is based in the ontology and epistemology of their practice. As with new theorising for professional disciplines due to the failure of traditional explanations of professional practice, we know that their ‘knowing’ is directly tied to the ‘doing’ of the work. The former cannot exist without the latter. Further, identities are formed and re-formed through their practice. A phrase that may sum up the interrelationship between these workers’ practice, knowledge and identities is ‘their being is their doing’. This demands a new regard for their agency, the very nature of their experiences at work.
With such an understanding of the complex relationship between assessment workers’ epistemology and ontology, we can now formulate better approaches to their preparation for, and support in, professional practice. Workers bring their whole selves to their work, the sum of their lived experiences. Their agency, and what they bring to the doing of assessment, is foregrounded. However, meaning-making occurs through the exercise of judgements, and identities formed and re-formed through their social relations (communities of practice) as well as through their autonomous selves. In essence, ‘their work is their learning’, and this is where better preparation and support for these workers should be centred.

However, I do not propose a workplace learning model separated from formal education institutions. I am not proposing a model of learning that swings so far in that direction that it becomes either a solely CBT approach and/or is removed from educational institutions. This would take us down a path of debating how to connect or improve the relationship between the two. Removing the focus from an either/or approach, or an approach which privileges one site of learning over another, enables us to see that for a successful learning program to be established, both must exist, not in a dichotomous relationship, but ‘co-related’. Thus, a hybrid model is proposed which builds on the learning strengths of both educational institutions and the workplace.

The temptation is to develop a new professional category (or para-profession or intermediate professional) as has been done in this and other sectors previously as new demands on workplaces and workers have emerged. However, the danger in doing this is to fall back into a traditional ‘discipline’ framework potentially leading to a ‘problematically professional’ worker and therefore an uncertain relationship between the new formal (propositional) knowledge required and practice (the situated, contextualised doing of the work). Rather, I am proposing these are emergent practitioners with a new specialism and professionalism. This locates the worker firmly in the newly emerging space between health and social care that is community care, and does not privilege one form of epistemology, or knowledge claim, over others. We are witnessing emerging identities in this space; where diversity, discourse, power and uncertainty shape their engagement in work. Creative regard for their practice, learning and professional development, where the ontological is central, is therefore required.
A return to traditional education paradigms to provide these workers with professional status and legitimation through education would only serve to place them ‘problematically’ along with other discipline-based professionals in this sector. By accepting that ‘their being is their doing’ and ‘their work is their learning’, the way is paved for better preparation and support for these professionals. The challenge is for funding bodies, employing organisations, educational institutions, community care clients and the workers themselves to negotiate this understanding. Approaches can then be developed for their preparation and development that will enhance their positioning and professionalism in modern workplaces in the provision of community care.
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Appendix A: List of abbreviations and key terms

Acronyms
AASW    Australian Association of Social Workers
AIWCW   Australian Institute of Welfare and Community Workers
ADL     Activities of Daily Living
ACAT/ACAS  Aged Care Assessment Team / Aged Care Assessment Service
ACN     Australian College of Nursing
ANF     Australian Nurses Federation
AQF     Australian Qualifications Framework
CACP    Community Aged Care Package (Package of care available for people
        with high support needs to remain living at home, but who would
        normally be admitted to low level care in a residential setting).
CCT     Compulsory Competitive Tendering
CIARR   Client Information and Referral Record
CPE     Continuing Professional Education
CSTP    Community Services Training Package
CALD    Culturally and Linguistically Diverse
DHAC    Department of Health and Aged Care (Commonwealth)
DHS     Department of Human Services (Victoria)
DVA     Department of Veterans’ Affairs
EACH    Extended Aged Care at Home (Package of care available for people with
        very high support needs to remain living at home, but who would
        normally be admitted to high level care in a residential setting).
GP      General Practitioner
HACC    Home and Community Care Program
INI     Initial Needs Identification
InterRAI International Resident Assessment Instrument (Refers to a suite of
        standardised assessment tools applicable in a range of settings;
        developed and promoted by an international organisation of
        professionals working in health and social care research of older people).
LGPro   Local Government Professionals (a local government peak body
        organisation in Victoria)
MAV     Municipal Association of Victoria (a local government peak body
        organisation in Victoria)
MMSE  Mini Mental State Examination (standardised memory assessment tool)
MS  Multiple Sclerosis
NESB  Non English Speaking Background
OT  Occupational Therapist
PCP  Primary Care Partnership
SCTT  Services Coordination Tool Template
TAFE  Training and Further Education
VET  Vocational Education and Training

Other terms appearing in the thesis

Centrelink  Australian Commonwealth government department responsible for income support and welfare benefits

Division 1 Nurse  Formerly known as State Registered Nurse
Division 2 Nurse  Formerly known as State Enrolled Nurses (SEN)

Grey literature  Term used by researchers to describe non-refereed research and policy documents available in the public domain produced by governments and research organisations.

Individualised funding  Individualised funding is an approach to service delivery (in disability services), where clients who are able to manage their own services are provided with funds to purchase services, rather than with a case manager to undertake this function for them which is the traditional approach to service delivery.

Koori  Refers to Indigenous Australians from South-Eastern regions.

Linkages  Linkages is the name of a HACC-funded brokerage and case management service for clients with high and complex support needs. There is a Linkages service in each region (with a variety of auspice agencies). Participant G works for an organisation that provides a Linkages service.

Mini Mental  An alternative shorthand term for the MMSE (see above)

Personal alarms  Personal alarms, or personal alert systems, are a new innovation in community care. Clients wear an alarm around their neck or on their wrist which has a wireless connection to their (specially modified) telephone. If the client has an urgent need for assistance, such as following a fall or in a
medical emergency, they can summon assistance by pressing the alarm. The alarm registers at a call centre and an individualised response protocol is followed, such as telephoning a neighbour or family member, or calling for an ambulance.

Relinquishment

The term ‘relinquishment’ refers to the decision of family/carers to place their child in long-term residential care because they can no longer meet the demands of care at home.

Telelink

Telelink is the name of a HACC funded volunteer social support service.
Appendix B: Interview tools
Dear 

I am contacting you to invite you to participate in a research project. This statement has been prepared to provide you with information about the project and to assist you to decide whether or not to participate. This project constitutes the requirements of a Doctor of Philosophy degree.

Who are the researchers?:
The principal investigators are:
Dr David Beckett, Department of Education Policy and Management, Faculty of Education (Tel. 83448516)
Dr Elizabeth Ozanne, Department of Social Work, Faculty of Arts (Tel. 83449403)
Ms Melissa Lindeman, Department of Education Policy and Management, Faculty of Education (contact details below)

What is the topic of the thesis?
Community care is an approach to meeting the care needs of frail older people and younger people with disabilities in their own homes, and the Home and Community Care (HACC) program is responsible for the vast majority of such services. Prior to receiving services, a person will normally be assessed by one or more organisations that may be involved in the person’s care. Staff employed in HACC organisations, in roles that include assessment of clients’ needs, determine what services clients will receive and how the services will be delivered.

This research will examine the approaches to client assessment in community care for the purpose of establishing whether there are particular skills and knowledge required for this role that would be generic to all undertaking it. To this end the thesis will identify the range of staff performing this role, seek to establish appropriate skills and knowledge across a variety of locations, identify the current educational and training opportunities currently available for these staff, and explore alternative approaches to preparing staff for client assessment roles.

Who are the research participants (subjects) and what are they required to do?
Two groups of voluntary participants will be involved in this research project. The first group comprises individuals employed in key organisations of relevance such as those involved in aged care education, industry training boards, industry representatives and government/policy representatives (key informants). The second group of participants will be a small sample of staff employed in HACC organisations in Victoria in roles that include assessment of clients’ needs (HACC assessment staff).

As a potential key informant for this research project, you have been contacted because of your position in an organisation considered by the researchers to be of major relevance to the topic. Should you agree to be interviewed, you will be asked about the
workforce involved in HACC assessment including education and training issues, and policy trends that may have an impact upon HACC assessment.

The interview will take up to 30 minutes, and will be audio-taped and later transcribed. You will be provided with a transcript of the interview to correct/sign off as a true and accurate record.

**How will the research data be processed and stored?**
The privacy of the information you provide will be safeguarded subject to any legal limitations. Your anonymity will be assured, however the sample size is small. To introduce quotes and viewpoints in the thesis it may be necessary to refer to you in relation to your current position. For example, terms such as “an industry training board representative”, “an aged care peak body spokesperson”, “an aged care educator” may be used to refer to key informants. You can discuss this with the researcher to ensure that the most appropriate term is used.

Interview transcripts will be stored in a locked filing cabinet, accessible only to the principal researchers, for up to six years, after which time they will be destroyed. No names will be stored with transcripts.

**What will happen to the research findings?**
It is anticipated that the research findings will contribute to gaining a greater understanding of the educational and training needs of this group of workers which is growing in size and significance in Australia. The researchers may seek to publish the findings of the research through conference presentations, discussion paper and journal articles.

**Who should be contacted to obtain more information?**
If you would like further information about this project, please contact Melissa Lindeman, PhD Student, Department of Education Policy and Management, Faculty of Education via email: <m.lindeman@pgrad.unimelb.edu.au>, or phone: 03 83872148 (bh).

**What is the next step?**
If you would like to be involved, please complete the consent form attached and return it to me in the envelope provided. I will then contact you to arrange a time and place for the interview to be conducted.

Please note that participation in this project is voluntary and you are free to withdraw consent at any time up to the point of processing data arising from the interview.

If you have any concerns about the conduct of this research project, you can contact the Executive Officer, Human Research Ethics, The University of Melbourne, Ph: 83447507; Fax: 93476939.

Thankyou for taking the time to consider this request.

Yours sincerely

Melissa Lindeman
Interview schedule (key informants)

KEY INFORMANT INTERVIEWS
Interview schedule

1. In your view, who comprises the community care/HACC assessment workforce and what organisations undertake this role?

2. In your view, what professional/educational backgrounds are appropriate to undertake the role of assessor as indicated in this list? (Attachment A - mark all that apply)

3. In your view, how do these HACC/community care assessors learn best?
   - Prompts (if necessary): is this a new field where the workers have particular learning needs? How does the diversity of the field impact on how they learn about their role?

4. To what extent is it acceptable for assessment workers to have no formal qualifications? If so, in what circumstances?

5. Are you aware of any accredited or non-accredited training programs focusing on HACC assessment?

6. Do you think the provision of training for this role is currently adequate? Why? Why not?

7. Are you aware of any planned developments for training HACC assessment staff?

8. How should these workers be supported in their role?
   - Prompts (if necessary): a professional network or association; technology (such as mobile phones); access to continuing education (if so, in what form?).

9. What policy trends in community care/HACC assessment are you aware of that may have workforce planning and/or education and training implications?

10. How does this matrix, showing work context and the range of personnel, fit with your understanding of this group of workers – who they are and where they are from (Attachment B)?

I have no other questions. Is there anything you would like to discuss further, or anything you would like to ask me about the research? Thank you very much for your time.
Suitable educational/professional backgrounds for community care assessment staff from the *higher education* sector (mark all that apply)

- Division 1 Nursing (Degree level qualification)
- Occupational therapy
- Physiotherapy
- Welfare Studies (Degree)
- Social work (Bachelor of Social Work)
- Teaching
- Psychology
- Sociology/policy studies
- Recreation
- Health promotion
- Management/Business
- Disability studies (Degree)
- Community development (Degree)
- Gerontology (Graduate Diploma)
- Other (please state)

Suitable educational/professional backgrounds for community care assessment staff from the *Vocational Education and Training (VET)* sector (mark all that apply)

- Division 2 Nursing (1 year Certificate level qualification)
- Welfare Studies (Diploma)
- Disability studies (Certificate III or IV)
- Disability studies (Diploma or Advanced Diploma)
- Community development (Diploma)
- Aged care (Certificate III or IV)
- Aged care (Diploma or Advanced Diploma)
- Administrative/office skills (Certificate or Diploma)
- Other (please state)
### Attachment B

#### Typical staff backgrounds and employing organisations

<table>
<thead>
<tr>
<th></th>
<th>District nursing/bush nursing</th>
<th>Community health centre</th>
<th>Local Government Authority</th>
<th>Adult day care centre</th>
<th>Disability service (eg respite, carer network, MS society)</th>
<th>Ethno-specific services</th>
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<tr>
<td>Division 1 nurse</td>
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<td>Division 2 nurse</td>
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<td>Social worker</td>
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<tr>
<td>Other allied health (eg OT)</td>
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<tr>
<td>Welfare worker</td>
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<tr>
<td>Admin. Background</td>
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<td>Direct care experience (eg personal care)</td>
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</tbody>
</table>
Dear assessor,

I am contacting you to invite you to participate in a research project. This statement has been prepared to provide you with information about the project and to assist you to decide whether or not to participate. This project constitutes the requirements of a Doctor of Philosophy degree.

Who are the researchers?:
The principal investigators are:
Associate Professor David Beckett, Department of Education Policy and Management, Faculty of Education (Tel. 83448516)
Associate Professor Elizabeth Ozanne, Department of Social Work, Faculty of Arts (Tel. 83449403)
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This research will examine the approaches to client assessment in community care for the purpose of establishing whether there are particular skills and knowledge required for this role that would be generic to all undertaking it. To this end the thesis will identify the range of staff performing this role, seek to establish appropriate skills and knowledge across a variety of locations, identify the current educational and training opportunities currently available for these staff, and explore alternative approaches to preparing staff for client assessment roles.

Who are the research participants and what are they required to do?
Two groups of voluntary participants will be involved in this research project. The first group comprises individuals employed in key organisations of relevance such as those involved in aged care education, industry training boards, industry representatives and government/policy representatives (key informants). The second group of participants will be a small sample of staff employed in HACC organisations in Victoria in roles that includes assessment of client need (HACC assessment staff).
Your organisation is one of a small number of HACC organisations in Victoria which was randomly selected to provide an assessment worker to participate in the research. Alternatively, another research participant may have suggested that I contact you. To be eligible to participate in this research you need to satisfy both of the following criteria:

- you must be employed in a role that includes assessment of clients for at least 50% of your work time
- you must have been employed in the role for at least 12 months

If you satisfy both of those criteria, and you agree to be interviewed, you will be asked questions about your work, the context of your work, your background, and your views about the important skills and attributes of HACC assessment staff.

The interview will take up to one hour, and will be audiotaped and later transcribed. You will be provided with a transcript of the interview to correct/sign off as a true and accurate record.

**How will the research data be processed and stored?**
The privacy of the information you provide will be safeguarded subject to any legal limitations. Your anonymity will be assured. As the sample size is small, a pseudonym will be used to refer to you in the thesis.

Interview transcripts will be stored in a locked filing cabinet, accessible only to the principal researchers, for up to six years, after which time they will be destroyed. No names will be stored with transcripts.

**What will happen to the research findings?**
It is anticipated that the research findings will contribute to gaining a greater understanding of the educational and training needs of this group of workers which is growing in size and significance in Australia. The researchers may seek to publish the findings of the research through conference presentations, discussion paper and journal articles.

**Who should be contacted to obtain more information?**
If you would like further information about this project, please contact Melissa Lindeman, PhD Student, Department of Education Policy and Management, Faculty of Education via email: <m.lindeman@pgrad.unimelb.edu.au>, or phone: 0417 537 485, or 08 89518348 (BH).

**What is the next step?**
If you would like to be involved, please complete the consent form attached and return it to me in the envelope provided. I will then contact you to arrange a time and place for the interview to be conducted.

Please note that participation in this project is voluntary and you are free to withdraw consent at any time up to the point of processing data arising from the interview.

If you have any concerns about the conduct of this research project, you can contact the Executive Officer, Human Research Ethics, The University of Melbourne, Ph: 83442073; Fax: 93476939.
Thankyou for taking the time to consider this request.

Yours sincerely

Melissa Lindeman
**Interview schedule (HACC assessors)**

1. Could you tell me your job title, and briefly describe your role in the organisation?

**Background – professional identity**

2. How long have you been in the role, and how did you come to be in that position?

3. At the time you were selected for the job, what was your professional background?
   - Prompts: tertiary qualifications, work experience

4. Have you acquired any formal qualifications since you have been employed in the position? Why did you undertake the qualification?

5. Are you a member of a professional body? (eg AASW, AIWCW, Registered nurse)
    If so, why?

**Context**

6. Thinking about the context in which you work, could you tell me a little about the organisation you work for?
   - Prompts: HACC or other related services provided, size of organisation, core business of the organisation, clientele

7. In relation to the HACC service/s provided, how would you describe the model of assessment in use in your organisation, and why was that model adopted?
   - Prompts: how referrals are processed, particular staff performing particular functions, assessment tools used etc

8. Could you tell me about the relationships you have with other relevant professionals and service providers in the local area? More broadly?
   - Prompts: peers, links or networks (are they formal or informal?)

**Training and learning**

9. If you think about what has prepared you for the role as assessor, what courses have you undertaken, and to what extent have you been supported?
   - Prompts: short courses; “in-service”, professional development programs accredited or non-accredited); informal or formal peer support, networking, mentoring, supervision etc

10. If you think about your particular approach to assessment and care planning, can you identify what have been the main influences on you in developing your approach?
• Prompts: prior professional training (e.g. nursing or social work), learning on the job, HACC policy, organisational policy, watching peers, feedback from clients

11. Given what you’ve just said, what has been most significant for you in how you learnt (and how you still learn) about your role as an assessor?

12. You’ve talked about how you actually learnt your job. Could you reflect on whether you feel the provision of training for HACC assessment is currently adequate? Why? Why not?

Practice

13. If you think about the decisions you have to make as an assessor, what do you find yourself drawing upon to assist you in that decision-making?

• Prompt: use one decision as an example and describe the decision-making process

14. What do you regard as the most important personal attributes for community care assessment?

15. What do you regard as the most important technical skills or knowledge for community care assessment?

• Prompts: use of particular assessment tools; knowledge of resources/services; IT

16. How do you get a picture of your individual clients, and how do you use that information in your assessment and care planning?

17. Do you have any other comments on what it is like to be an assessor in HACC?

I have no other questions. Is there anything you would like to discuss further, or anything you would like to ask me about the research?

Thank you very much for your time.
Consent form for persons participating in research projects

PROJECT TITLE: Approaches for the Education and Training of Staff Involved in Client Assessment for Community Care

Name of participant:

Name of investigators: Associate Professor David Beckett, Associate Professor Elizabeth Ozanne, Ms Melissa Lindeman

1. I consent to participate in the project named above, the particulars of which - including details of the interview - has been explained to me. A written copy of the information has been given to me to keep.

2. I authorise the researcher or his or her assistant to use the interviews referred to under (1) above.

3. I acknowledge that:
   (a) The possible effects of the interview have been explained to me to my satisfaction;
   (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data previously supplied;
   (c) The project is for the purpose of research;
   (d) I have been informed that the interview will be audio-taped and copies of transcripts will be returned to me to correct/sign off as a true and accurate record;
   (e) As the sample size is small, a pseudonym, or other term I agree to referring to my current position, will be used to refer to me in the thesis or any publication arising from the research;
   (f) Confidentiality of the information I provide will be safeguarded subject to any legal requirements.

Signature ___________________________ Date ___________________________

(Participant)
Transcript sign-off form

Interview Transcript

Name of Interviewer  Melissa Lindeman

Name of Interviewee  _____________________________________________

The attached transcript is a true and accurate record of the interview conducted with Melissa Lindeman on (date inserted).

Name:  ____________________________

Signature:  ____________________________

Date:  ____________________________

(NB: A covering letter was sent with the transcript and the sign-off form which invited participants to make corrections/amendments on the hard copy).
Author/s: Lindeman, Melissa Ann

Title: Emerging identities: practice, learning and professional development of home and community care assessment staff

Date: 2006-12


Publication Status: Unpublished

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File Description: Emerging identities: practice, learning and professional development of home and community care assessment staff

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