

NATIONAL ALCOHOL AND OTHER DRUG WORKFORCE DEVELOPMENT STRATEGY 2015–2018

A Sub-strategy of the National Drug Strategy 2010–15



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Executive Summary

This Strategy has been developed to support the National Drug Strategy at the request of the Intergovernmental Committee on Drugs in recognition of the need for a national focus on workforce development activities for the alcohol and other drug (AOD) workforce. The Strategy development process was guided by a Project Working Group appointed by the Intergovernmental Committee on Drugs. It followed an extensive consultation process involving forums held in each jurisdiction, a written submission process and key informant interviews.

The AOD workforce includes workers whose primary role involves reducing AOD-related harm as well as those whose primary work focus is on other issues but, nevertheless, play an important role in reducing AOD harm. Consequently, this document addresses the needs of workers from the health, welfare, criminal justice and education sectors. These could be workers acting in paid or unpaid capacities.

This document is a national policy framework that is complemented, supported and integrated with a range of other existing national, state/territory, government and non-government strategies, plans and initiatives. The Strategy identifies key strategic action areas to enhance the capacities of Australia's AOD workforce. It is intended to be a strategic, rather than operational, document. The Strategy will link with other work already underway and be used to inform future activity.

The goals of the Strategy are:

- To enhance the capacity of the Australian AOD workforce to prevent and minimise alcohol and other drug-related harm across the domains of supply, demand and harm reduction activities.
- To create a sustainable Australian AOD workforce that is capable of meeting future challenges, innovation and reform.

The Strategy's 12 key Outcome Areas are to:

1. Understand the specialist AOD prevention and treatment workforce
2. Create a sustainable specialist AOD prevention and treatment workforce by addressing recruitment and retention issues
3. Match roles with capabilities
4. Enhance capacity to cater for older AOD clients as well as those with co-and multiple morbidities and other complex needs
5. Improve child and family sensitive practice
6. Improve consumer participation in AOD service provision, policy and planning
7. Increase the capacity of the workforce to respond appropriately to AOD issues among Aboriginal and Torres Strait Islander peoples
8. Increase the capacity of the workforce to respond appropriately to AOD issues among culturally and linguistically diverse (CALD) groups
9. Increase the capacity of the workforce to respond appropriately to AOD issues among lesbian, gay, bisexual, transgender and intersex individuals
10. Enhance the capacity of generalist health, community, welfare and support services workers to prevent and reduce AOD harm
11. Continue to develop the criminal justice workforce to prevent and reduce AOD harm
12. Promote the ability of the education sector to prevent and reduce AOD harm

Responsibility for implementing the actions outlined in the Strategy is shared by all governments, recognising that jurisdictions face different challenges and will undertake actions in line with their own priorities, timing and resources.

PART 1: The Context

Background

Alcohol and other drug (AOD)-related harm represents a significant social and economic burden to the Australian community. Consequently, preventing and minimising this harm is an important national priority which requires commitment from all levels of government and a range of sectors and agencies. The National Alcohol and other Drug Workforce Development Strategy (NADWFDS) was developed at the request of the Intergovernmental Committee on Drugs in recognition of the need to enhance the capacity of the diverse workforce involved in preventing and responding to AOD-related harm.

The multi-level and intersectoral nature of Australia's approaches to preventing and minimising AOD-related harm is reflected in its national framework for action on alcohol and other drugs, the National Drug Strategy 2010-2015 (NDS) (Ministerial Council on Drug Strategy, [MCDS] 2011). The NDS provides an overarching policy context for the NADWFDS. The Mission of the NDS is:

To build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities (MCDS, 2011).

The NDS addresses alcohol, tobacco, illegal drugs, pharmaceuticals and other substances. The approach of harm minimisation has guided the NDS since its inception in 1985. This encompasses the three pillars of:

- Demand reduction:
 - » preventing the uptake and/or delaying the onset of use of alcohol, tobacco and other drugs;
 - » reducing the misuse of alcohol and the use of tobacco and other drugs in the community; and
 - » supporting people to recover from dependence and reintegrate with the community.
- Supply reduction:
 - » preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and
 - » controlling, managing and/or regulating the availability of legal drugs.
- Harm reduction:
 - » reducing the adverse health, social and economic consequences of the use of alcohol and other drugs.

These three pillars are underpinned by strong commitments to supportive approaches which:

- build workforce capacity;
- promote evidence-based and evidence-informed practice, innovation and evaluation;
- encourage performance measurement to enhance quality; and
- build partnerships across sectors.

The impact of alcohol and other drug problems in Australia

Alcohol and other drug-related harm places a high burden on the Australian community. The cost of harmful alcohol, tobacco and other drug use in 2004–05 was estimated at \$56.1 billion, of which:

- Tobacco accounted for 56%;
- Alcohol accounted for 27.3%; and
- Illegal drugs accounted for 14.6% (Collins & Lapsley, 2008).

In 2004–05 in Australia, there were:

- 3,494 deaths attributable to alcohol;
- 15,050 deaths attributable to tobacco; and
- 872 deaths attributable to illicit and other drugs (Collins & Lapsley, 2008).

Alcohol and other drug-related harm does not only accrue to those using these substances. In 2005 an estimated:

- 367 people died and almost 14,000 people were hospitalised because of another's alcohol consumption;
- 77 deaths stemmed from alcohol-related violence attributable to another's alcohol consumption
- 277 people aged 15 years and over died as a result of another's drinking and driving; and
- 70,000 Australians were victims of alcohol-related assault, of whom 24,000 were victims of alcohol-related domestic violence (Laslett et al., 2010).

In addition, an estimated 20,000 children across Australia were victims of substantiated alcohol-related child abuse or neglect in 2006/07 (Laslett et al., 2010). Other alcohol-related harms include road and other accidents, domestic and public violence, crime, chronic disease, birth defects and disability, family breakdown and broader social dysfunction.

Tobacco smoking is one of the top risk factors for chronic disease, including many types of cancer, respiratory disease and heart disease. Likewise, illegal drugs can not only have dangerous health impacts, but are a significant contributor to crime. Unsafe injecting drug use is also a major driver of blood-borne virus infections such as hepatitis C and HIV/AIDS.

In light of these substantial costs, it is important that Australia has a workforce with the capability to prevent and reduce this harm.

What is workforce development?

Workforce development (WFD) in the AOD field aims to build the capacity of organisations and individuals to prevent and respond to AOD-related problems and to promote evidence-based practice. It goes beyond the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development and worker wellbeing. As such, WFD can be defined as:

...a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug-related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers (Roche, 2002a).

This broad definition of WFD mandates a focus on a wide range of individual, organisational, structural and systematic factors that impact on the ability of the workforce to effectively prevent and respond to AOD issues. Without addressing these underpinning and contextual factors, the ultimate aim of increasing the workforce's effectiveness is unlikely to be achieved (Roche & Pidd, 2010).

Why have an Alcohol and other Drug Workforce Development Strategy?

Practices aimed at preventing and responding to AOD harm need to continuously evolve in response to changes in societal needs and advances in knowledge. In recent decades, shifts have occurred in patterns of consumption and the types of substances consumed. Advances in knowledge have also led to changes in clinical practice and prevention strategies. These include:

- Shifting patterns of use, particularly poly-drug use;
- New psychoactive substances;
- An expanded range of pharmacotherapies and other treatment options;
- Greater awareness of co-existing mental health disorders and multiple morbidities (especially in the context of an ageing population);
- Greater awareness of foetal alcohol spectrum disorder, child protection and family sensitive practice issues;
- Problematic use across a widened age spectrum;
- Greater emphasis on cost efficiency, professional practice efficacy, improved outcomes and intersectoral collaboration;
- A better understanding of effective preventive measures; and
- Greater recognition of the wide variety of workers involved in reducing AOD-related harm.

Factors such as these increase the demand to prevent and respond to AOD problems. As a result, there is growing recognition of the need for a workforce development approach

that develops the capacity of the workforce to effectively respond to current and emerging AOD issues. A number of jurisdictions in Australia have considered and/or developed AOD Workforce Development Strategies. There is not, however, a nationally consistent approach to addressing the challenges facing the AOD workforce.

A WFD strategy can also help to:

- Identify the workforce implications of the current strategic and operational environment;
- Enhance the professionalisation of the workforce;
- Meet current needs and prepare for the future;
- Raise the profile of strategic workforce planning within organisations and influence change from the top down;
- Integrate workforce planning with future directions for organisations and sectors;
- Assess the current state of the workforce;
- Facilitate the seamless movement of AOD workers within and across jurisdictions as a result of more standardised qualifications;
- Create, drive and implement workforce planning;
- Improve performance;
- Enhance service quality and outcomes;
- Enhance career development options; and
- Optimise implementation of evidenced based practice.

Another aim of the Strategy development process is to achieve general agreement about the future directions of workforce development in the AOD field, which will shape practice in this area and be reflected in service tendering processes and funding agreements.

Key principles underpinning the development of the AOD Workforce Development Strategy

The development of the NADWFDS has been predicated on a number of principles. Specifically:

1. *The Strategy should reflect the National Drug Strategy's overarching approach of harm minimisation and address its three pillars of supply reduction, demand reduction and harm reduction.*

Australia's National Drug Strategy adopts a balanced approach to reducing AOD harm involving the three pillars of supply, demand and harm reduction. It is therefore important that the NADWFDS reflects the National Drug Strategy's balanced approach to reducing AOD-related harm.

2. *The Strategy should have a systems focus which addresses the range of factors impacting on the ability of the workforce to prevent and reduce alcohol and other drug-related problems.*

Using a systems approach will enable the Strategy to move beyond a simple focus on education and training to include the wide range of factors which impact on workforce effectiveness.

3. *The Strategy should be developed following an extensive consultation process.*

The Strategy was developed following consultation involving:

- Forums held in each state and territory;
- A written submission process; and
- Key informant interviews.

4. *While recognising that a broad range of workers have a role in reducing AOD harm the primary focal point of the Strategy is on the workforce development needs of specialist AOD workers.*

The scope of the Strategy includes a wide range of workers with a role in reducing AOD-related harm. Nevertheless, having a highly skilled specialist prevention and treatment workforce is fundamental to positively influencing the activities of generalist workers (i.e. those whose primary role is not reducing AOD related harm). From this perspective, the role of the specialist workforce is not only to provide specialist services, but also to support non-specialists.

5. *The reduction of AOD harm in Australia will be optimised by having a workforce engaged in evidence-based practice.*

The evidence base concerning effective practice in preventing and responding to AOD harm continues to grow. The Strategy should therefore promote strategies to enhance the uptake of these evidence-based practices.

6. *Workforce planning and development in the AOD field should be built on a comprehensive understanding of the national workforce including demographics, roles and qualifications as well as modelling of future demand.*

Considerable work has been undertaken in workforce development as well as workforce planning activities and it is important to build on this and increase our knowledge and understanding of the specialist AOD workforce.

7. *The key driver of the AOD Workforce Development Strategy is enhancing the quality of AOD service provision.*

Having a skilled, professional and adaptable AOD workforce is essential to enhancing the quality of AOD services in Australia.

8. *The Strategy should recognise the diversity, and acknowledge the contribution of the totality of the workforce with a role in reducing AOD harm regardless of roles, professional qualifications, or whether paid or unpaid.*

A broad range of workers have a role in reducing AOD harm in Australia. These include workers from the health, welfare and criminal justice sectors. The AOD sector itself is also diverse, with workers from many different backgrounds. For example, those with professional training in a range of disciplines, those with vocational or on-the-job training, and those with lived experience of recovery from AOD dependence. Each group has unique needs that warrant attention in the Strategy.

9. *The Strategy should provide a framework for national AOD workforce development while recognising jurisdictional differences and facilitating innovation.*

Alcohol and other drug workforce development efforts in Australia cannot be undertaken without cognisance of the sector's history. There are already many effective jurisdictionally-based initiatives in place, upon which the Strategy can build. In addition there are historical variations between jurisdictions and complex differences in funding arrangements which can impact the provision of AOD services in different jurisdictions (Chalmers, Ritter, & Berends, 2013). All these factors were taken into consideration in the Strategy's development. The Strategy should also not be so restrictive as to stifle innovation in approaches to preventing and reducing AOD harm.

10. *The Strategy should reflect a range of future trends and challenges likely to impact on the AOD workforce into the future.*

It is evident that a range of issues will impact on the AOD workforce into the future. These include: an ageing population; an ageing AOD workforce in the context of increasing

demand for workers; the emergence of new substances of concern; the need to link with other agencies and sectors to meet the needs of clients with complex needs; and changes in funding arrangements. In addition, future prevention and intervention efforts are likely to involve greater attention directed towards the social determinants of AOD problems. The Strategy should aim to provide a foundation for the AOD workforce to meet these challenges.

11. *In recognition of the often complex needs of individuals experiencing AOD-related harm and their families, the Strategy should foster enhanced cooperation between sectors and agencies.*

Alcohol and other drug treatment services cannot effectively meet all the needs of clients with multiple morbidities. For this reason, agencies will require new ways of working that cater for these complex needs.

12. *The Strategy should focus on building capacity in specific areas of need.*

Alcohol and other drug related harm differentially impacts groups of Australians. Some groups, such as Aboriginal and Torres Strait Islander peoples, lower socio-economic groups and children living in families in which AOD-related harm is occurring, experience greater levels of harm. The Strategy should therefore focus on these areas of need.

13. *Reducing AOD harm among Aboriginal and Torres Strait Islander peoples is dependent on recognising that Aboriginal and Torres Strait Islander culture is a source of strength, resilience, happiness, identity and confidence.*

The promotion and protection of culture is critical to progressing improvements in Aboriginal and Torres Strait Islander health and is inextricably linked to health and wellbeing. In order to reduce AOD harm among Aboriginal and Torres Strait Islander peoples, the Australian AOD workforce must be responsive

to cultural differences and the impacts of racism (conscious and unconscious) and a lack of cultural safety¹ on Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islanders are also more likely to access, and will experience better outcomes from, services that are respectful and culturally safe (Australian Indigenous Doctor's Association, 2013).

Who is the AOD workforce?

The NDS recognises that an appropriately skilled and qualified workforce is critical to preventing and responding to AOD-related harm. The NDS also highlights that a broad range of workers are involved in preventing and minimising AOD harm. However, there is currently limited information concerning the characteristics of the AOD workforce in Australia. A primary goal of the Strategy is to gain a better understanding of the extent and nature of the AOD workforce.

The AOD workforce is commonly considered in terms of two main components, specialists and generalists.

Specialist AOD workers are those whose core role involves preventing and responding to AOD harm. They include AOD workers, nurses, social workers, doctors, peer workers, needle and syringe program workers, prevention workers, addiction medicine specialists and specialist psychologists and psychiatrists. These workers may be employed in AOD specialist organisations or in AOD programs within non-specialist organisations (Roche & Pidd, 2010). They may have specialised degrees or little or no formal training (Libretto, Weil, Nemes, Copeland Linder, & Johansson, 2004), and can be employed in the

government, not-for-profit (non-government) and private sectors. Specialist AOD workers are the primary focus of the NADWFDS.

Generalist workers are employed in the mainstream workforce and have non-AOD-related core roles, but nonetheless can prevent and minimise AOD harm. Examples include:

- The criminal justice workforce, including the court system, police², Aboriginal and Torres Strait Islander law enforcement and community liaison officers and correctional officers;
- Emergency medical services, paramedics and emergency department personnel;
- The mental health workforce;
- The broader health and medical workforce including general practitioners, other primary healthcare workers and hospital workers;
- Community, welfare and support services including those working with culturally and linguistically diverse communities, in child protection, in disability support services, and in the homelessness, unemployment, income support and youth sectors;
- Pharmacists and the pharmacy workforce;
- The aged care sector; and
- The education sector.

As is evident, there is a diverse range of workers involved in preventing and responding to AOD harm in Australia across the supply, demand and harm reduction domains. It is important that the Strategy addresses this diversity and focusses attention on the developmental needs of each group. The levels of prevention and response activities can be categorised into four tiers. Generalist and specialist workers have roles across these tiers (see Figure 1.).

¹ Cultural safety refers to the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms. Aboriginal and Torres Strait Islander AOD workers are more likely to stay and thrive in learning and working environments that consistently demonstrate cultural safety. Aboriginal and Torres Strait Islander AOD professionals' experiences of a lack of cultural safety, racism and discrimination significantly detract from their mental health and wellbeing and negatively impact on their job satisfaction (Australian Indigenous Doctor's Association, 2013).

² It is important to note that some police have highly specialised AOD functions. This includes those involved in drug investigations, the policing of licensed premises and in AOD-related aspects of road safety (such as random AOD screening and testing).

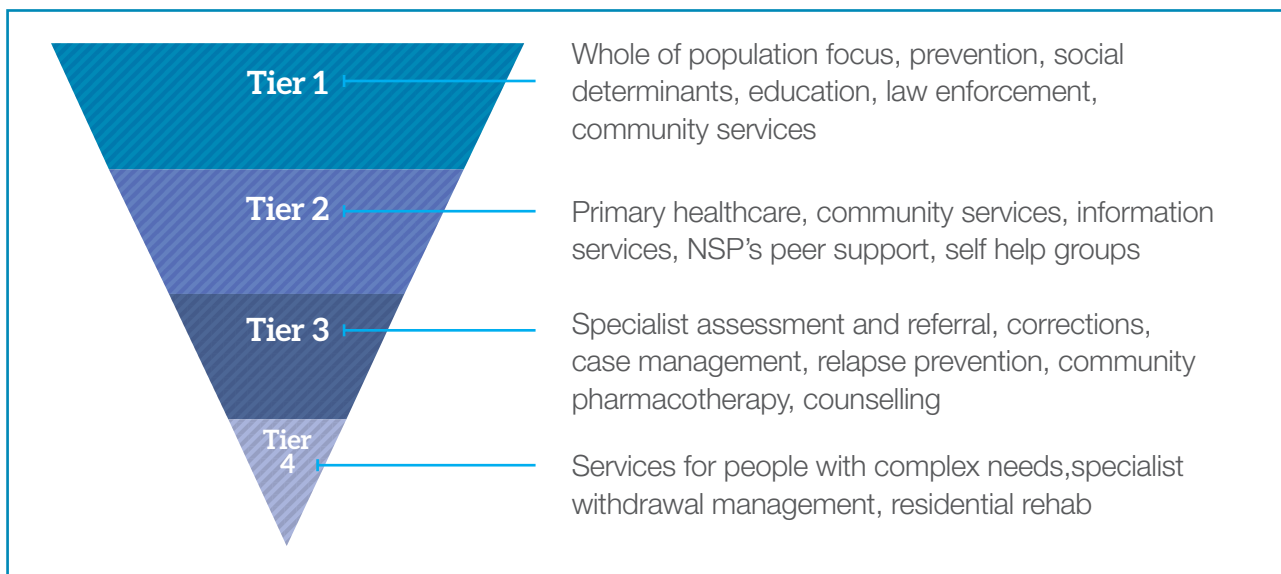


Figure 1: Tiers of activity involving different services/workers.

Based on these tiers it is possible to identify the ways in which different occupational groups make their contributions to preventing and reducing AOD-related harm (see Figure 2).³

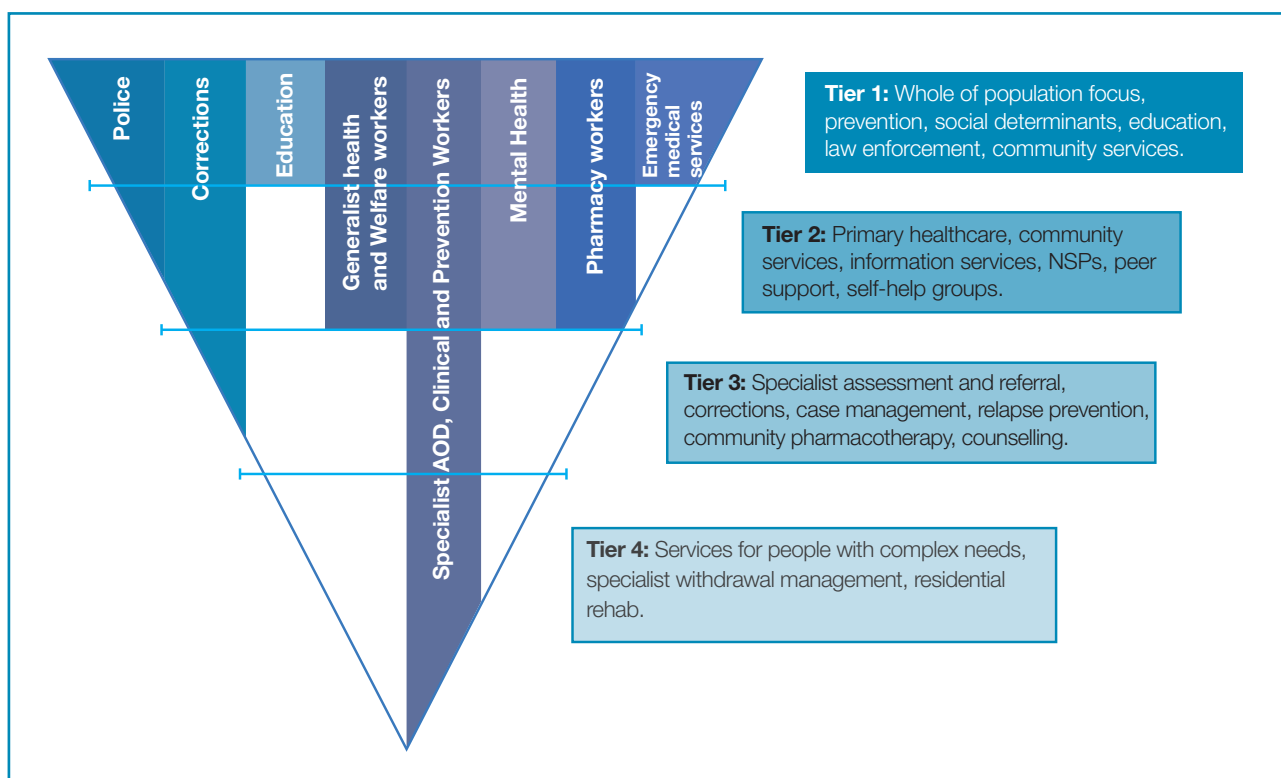


Figure 2: Tiers of activity in which different occupational groups make their contribution to reducing AOD-related harm.

³ Figures 1 and 2 are intended to be indicative, rather than definitive, as services may have different roles in different tiers at different times.

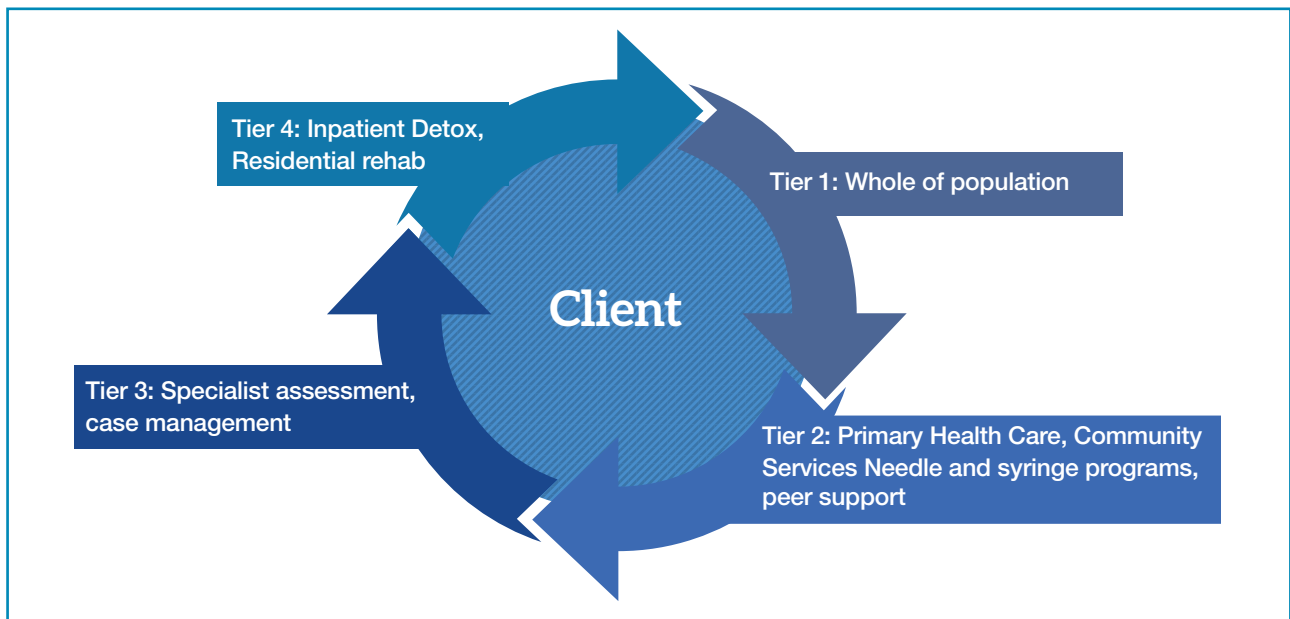


Figure 3: Wrap-around services, particularly for clients with complex needs.

It is important to note that individuals may receive services from multiple providers working within or across multiple tiers at the one time (see Figure 3). Indeed this ‘wrap around’ approach can be an important part of service provision for individuals with complex needs.

Future challenges

The development of the Strategy occurred in the context of a range of challenges which will be facing the AOD workforce into the future. These challenges and their implications are explored in more detail below.

The ageing population

Australia’s population, like that of most developed countries, is ageing as a result of sustained low fertility and increasing life expectancy (Australian Bureau of Statistics, 2011). This has major implications for the NADWFDS.

Health and welfare professionals and workforces (including those focussing on reducing AOD harm) need to be better equipped to deal with a dramatic increase in the incidence of

non-communicable diseases (World Health Organization, 2011), along with ageing, fertility and mortality trends. If, as predicted, baby boomers have greater rates of lifetime alcohol and drug use than previous generations, this will lead to more older people experiencing AOD harm in the future (Hunter, Lubman, & Barratt, 2011). This trend will require a better understanding of the physiological and psychological impact of drug use in ageing populations (Colliver, Compton, Gfroerer, & Condon, 2006). The ageing population also means that programs will be required to prevent harmful AOD use among older Australians.

The ageing of the population has particular significance for Aboriginal and Torres Strait Islander Australians who have a shorter than average life expectancy. Many chronic illnesses (including those stemming from harmful AOD use) that are often evident among older Australians are common in middle age among Aboriginal and Torres Strait Islander peoples. Therefore, services focussed on meeting the needs of older Australians experiencing AOD harm also need to target middle aged Aboriginal and Torres Strait Islander people.

Different substances and patterns of use

The landscape of available psychoactive substances is rapidly changing. In Europe new psychoactive substances are reported to authorities at a rate of approximately one per week (European Monitoring Centre for Drugs and Drug Addiction, 2012). These trends are highly likely to impact Australia because the Internet has increased the flow of information about these drugs, and provides a means through which they can be purchased (European Monitoring Centre for Drugs and Drug Addiction, 2012). This is likely to present particular difficulties for treating individuals who experience acute and chronic harms stemming from the use of these drugs, because the nature of the substance they have taken can be unclear to both the client and the treating clinician (Arnold, 2013).

Furthermore, over the past decade there have been significant changes in the profile of substances for which Australians are seeking treatment. Since 2001-02, among publically funded AOD treatment episodes in which the client was seeking help for their own problems:

- Alcohol problems increased from 37 to 47%; and
- Heroin problems halved from 18% to 9% (Australian Institute of Health and Welfare, 2012).

Prescription drugs such as smart drugs, opioids, antipsychotic medicines and sedative hypnotics as well as performance and image enhancing drugs have the potential to displace the demand for illicit drugs. This will require quite different responses from AOD treatment and prevention services, and has important implications for the development of the AOD workforce (Roche, 2013). In the past twenty years, for example, there has been a dramatic increase in the prescribing of pharmaceutical opioids in Australia and correspondingly increasing harms (Royal Australasian College of Physicians, 2009).

Smart drugs are a further issue on the horizon. These are prescription drugs used to treat conditions such as attention deficit hyperactivity disorder, narcolepsy and Alzheimer's disease. When used by healthy people they may improve cognitive functions (Partridge, Bell, Lucke, Yeates, & Hall, 2011). The harmful use of these powerful medicines could significantly impact on AOD treatment services in the future.

New paradigms and treatments

In the future, approaches to preventing and responding to AOD problems are likely to arise from a much broader foundation. Dealing with the end results of problematic substance use will always be important, and there will always be a role for specialist treatment services. However, future responses will be shaped by drivers that extend this orientation, including increased emphasis on the prevention and treatment implications of:

- Social determinants of health (e.g. early life experiences, work, unemployment, social exclusion) which will feature more prominently in our understanding of causal factors as well as response strategies to ameliorate problems;
- Integrated models of care (mental health, aged care, child and family, Aboriginal and Torres Strait Islanders, prisoners, non-English speaking) will become more prominent as pressure and expectations grow for more coordinated and holistic care;
- Complex health and comprehensive community services models; no longer will narrow and simplistic models be adequate (Roche, 2013); and
- Technology-based approaches to treatment (Cunningham, Kypri, & McCambridge, 2011).

The development of a Quality Framework for Australian Government funded drug and alcohol treatment services, funded by the Australian Government Department of Health, is also likely to

influence future directions and standards in AOD service provision in Australia. The project aims to develop a quality framework for alcohol and other drugs treatment services that:

- Complements other models/frameworks that services currently comply with;
- Is adaptable, flexible and suitable for a range of service types and settings, including Indigenous-specific services;
- Considers clients with comorbidity and the need to build and/or maintain capacity of services to appropriately manage these clients;
- Considers all funding sources for services including client/patient contributions;
- Clearly describes the expected quality standards for each service type;
- Has clear guidelines, policies and procedures to support the achievement and maintenance of these quality standards;
- Allows incorporation of accreditation models that services currently have in place or may have in place in the future; and
- Considers related aspects such as accreditation and minimum qualifications.

Additionally, the project will aim to provide a detailed draft implementation plan for the framework, with recommendations drawn from the project and other information that informs use and future development needs.

The needs of Aboriginal and Torres Strait Islander Australians

Aboriginal and Torres Strait Islander Australians have higher rates of tobacco and other drug use compared to the non-Indigenous population. Alcohol and other drug use by Aboriginal and Torres Strait Islander Australians contributes to compromised physical and psychosocial health status and ongoing socio-economic

disadvantage, and needs to be understood in the context of a history of dispossession, denial of culture, and conflict (Gleadle et al., 2010).

Aboriginal and Torres Strait Islander AOD workers play an important role in preventing and responding to AOD-related harm among this population, and are critically important in the context of the NADWFDS. Nevertheless they cannot bear total responsibility for addressing AOD-related harm among Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islanders seeking treatment for their AOD problems may not have the option of accessing an AOD service established to cater for their needs. Even in Aboriginal and Torres Strait Islander-specific services, not all AOD workers are Indigenous. Consequently, these clients are highly likely to have contact with non-Aboriginal and Torres Strait Islander service providers. From this perspective, it is critically important that all AOD workers, regardless of their own Indigenous status, are capable of preventing and responding to AOD harm among Aboriginal and Torres Strait Islander Australians in a culturally safe and sensitive manner.

Aboriginal and Torres Strait Islander AOD workers are usually employed in comparatively low status, lower paid positions such as Health Workers or community workers (Gleadle et al., 2010). Against a background of disadvantage and complex AOD use, these AOD workers face unique stressors including:

- Heavy work demands and a lack of clearly defined roles and boundaries reflecting high community need and a shortfall of Aboriginal and Torres Strait Islander AOD workers;
- Dual forms of stigmatisation stemming from attitudes to AOD work and racism;
- Difficulties translating mainstream work practices to meet the specific needs of Aboriginal and Torres Strait Islander clients;
- Challenges of isolation when working in remote areas;

- Dealing with clients with complex comorbidities and health and social issues; and
- Lack of cultural understanding and support from non-Indigenous health workers (Roche, Nicholas, Trifonoff, & Steenson, 2013).

These challenges mean that Aboriginal and Torres Strait Islander AOD workers have distinct workforce development needs, and that WFD strategies are required that can be implemented in a culturally safe manner.

Responding to multiple morbidities

Individuals experiencing AOD harm are at risk of a range of comorbid conditions including infectious and non-communicable diseases (Australian Government Preventative Task Force, 2009). Mental illnesses are a particularly prevalent comorbidity among AOD clients.

The appropriate management of long-term multi-morbid disorders is a key challenge for health systems internationally. It is increasingly apparent that multi-morbidities are the norm for people with chronic health problems, particularly the most socio-economically disadvantaged. Co-and multiple morbidities have important implications for the training and structure of the AOD workforce. Strategies such as co-location, multi-disciplinary health professionals and teams, inter-professional education and cross sectoral workforce development will increasingly be required.

This issue will become a growing challenge for AOD service provision in the future. AOD services will need to develop ways of meeting the multi-morbidity needs of their clients through a combination of enhanced generalist in-house service provision and enhanced linkages with other service providers. This 'no wrong door' approach means that regardless of where clients with complex needs present they can obtain the services they require.

Increased emphasis on service outcomes

Future service funding is likely to be increasingly linked to agencies' ability to deliver demonstrable outcomes for clients and the broader community. Outcomes in relation to prevention and treatment and recovery are as yet undefined. The implications of a movement towards outcomes-based funding extend beyond changes in service provision. Such a movement will also mean that the AOD sector will need to be more familiar with the collection, interpretation and presentation of data in order to ensure continued funding. It will also be important to ensure that outcomes focus on the characteristics and clients of individual services, so as not to disadvantage programs which cater for clients with more entrenched problems.

Increasing consumer input into their own treatment and care

Consumer input into service provision is an important part of providing person-centred care. The challenge for the AOD sector is to turn widespread acceptance of the principle of service user participation into processes and resourcing that make it both feasible and effective. As well as involvement in service planning, clients should have:

- Improved knowledge and confidence to make choices about their treatment and awareness of how to self-manage after formal treatment;
- High levels of active involvement in their treatment including planning, setting goals and decision making; and
- A comprehensive assessment and care plan that is oriented towards their goals and designed with them according to their choices, preferences and changing needs (Department of Health Victoria, 2012).

Child and family sensitive policy and practice

The AOD, family and child welfare sectors have increasingly recognised the relationship between AOD problems, child and adolescent development, and child wellbeing and protection. Child and family sensitive policy and practice involves raising awareness of the impact of substance use problems upon families, addressing the needs of families (Addaction, 2009), and seeing the family-rather than an individual adult or child-as the unit of intervention. It includes identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of prevention, treatment and intervention processes, in order to ensure that as parents they are supported and child wellbeing and safety is maintained (Battams & Roche, 2010).

Workforce-related challenges

The AOD workforce faces a number of future challenges which impact on the development of NADWFDS.

Ageing workforce

As a result of an ageing population, demand for workers in health care and social assistance in Australia will outstrip all other sectors over the next few years (Community Services & Health Industry Skills Council, 2013) which will increase pressure on AOD services to attract and retain suitable staff. This will be particularly relevant for medical practitioners and nurses (Australian Bureau of Statistics, 2003). As older workers retire, the human services workforce is likely to be negatively impacted by a loss of highly skilled workers. This means that the AOD sector will continue to age and will have to compete with other sectors for staff in an increasingly difficult human resource environment. Furthermore, the demand for workers will not be confined to Australia. As the human services workforce becomes increasingly globalised, AOD agencies will be required to compete with other countries for staff.

Differences between government and non-government sectors

In some jurisdictions there are significant differences in workforce profiles between government and non-government organisations (NGOs) (Roche & Pidd, 2010). Some of these differences are due to alternative service delivery models, different funding levels and different client groups. As a result, workforce development issues may be different for NGO and government workforces. This, in turn, has workforce development implications (Duraisingam, Pidd, Roche, & O'Connor, 2006). In several jurisdictions there are also significant disparities between salaries and conditions offered by NGO agencies and public sector agencies. Staff employed by NGO agencies are generally paid considerably less due to funding arrangements and differences in awards (Roche & Pidd, 2010). This can lead to a workforce drain from the NGO to the public sector, with the NGO sector bearing a significant burden for recruiting and training new entrants to the AOD workforce.

Part 2: The Strategy

The Strategy addresses a broad range of factors designed to improve the quality and functioning of the AOD sector and systems responses. It contains a series of suggested actions which jurisdictions may take to implement the goals of the Strategy. Jurisdictions already have a range of measures in place and face different challenges. It is therefore anticipated that jurisdictions will undertake actions in line with their own priorities, timing and resources.

Goals:

To enhance the capacity of the Australian AOD workforce to prevent and minimise alcohol and other drug-related harm across the domains of supply, demand and harm reduction activities.

To create a sustainable Australian AOD workforce that is capable of meeting future challenges, of innovation and reform.

Outcome areas

Outcome area 1: Understand the specialist AOD prevention and treatment workforce

Considerable work has already been undertaken in workforce development and planning, and it is important to build on this and increase our knowledge and understanding of the specialist AOD workforce. To be able to conduct effective workforce development and planning, information on three issues is required:

- The existing workforce and their characteristics;
- The demand for the workforce; and
- Entries to and exits from the workforce (Health Workforce Australia, 2013).

Some jurisdictions have undertaken surveys of their AOD workforces, but these are often confined to either government or non-government sectors. In addition, they also do not always include data on individuals employed in prevention roles, peer workers or needle and syringe workers. Differing criteria and terminology also mean that findings may not be comparable between jurisdictions.

There is a need to continue to work across jurisdictions to strengthen the knowledge base required for workforce development and planning. This includes issues such as employee demographics, qualifications, roles and employment intentions. Data is also needed about specialist workers within non-specialist organisations.

Once obtained, this information could be linked to the results of work currently being undertaken to estimate AOD treatment demand such as the Drug and Alcohol Clinical Care & Prevention (DA-CCP) project. The DA-CCP project aims to:

- Build the first national population-based model for AOD service planning by estimating the need and demand for services;
- Use clinical evidence and expert consensus to specify the care packages required by individuals and groups;
- Calculate the resources needed to provide these care packages; and
- Provide an AOD service planning tool for jurisdictions. (e.g. Ritter, Chalmers, & Sunderland, 2013).

Actions could include:

- *Developing a nationally agreed taxonomy of specialist AOD prevention and treatment roles as a basis for systematic workforce enhancement and workforce development.*
- *Undertaking a national census of workers employed in specialist AOD prevention and treatment roles, including those working in non-specialist organisations. The census should utilise the nationally agreed data definitions, and be supplemented with other sources of data such as that provided by Health Workforce Australia, the Australian Bureau of Statistics and peak bodies. As well as basic demographic/occupational data, the census should collect information on issues such as employment intentions, Indigenous status, ethnicity and language skills. This information could be collated to create a comprehensive picture of the current workforce.*
- *Using this workforce data along with projections of treatment demand to enhance workforce planning and identify workforce needs.*
- *Encouraging all jurisdictions to consistently adopt the workforce census data definitions in all future workforce development surveys and analyses to enable ongoing workforce monitoring and mapping.*

Key Performance Indicators could include:

- *Nationally consistent terminology to describe the roles of the specialist AOD prevention and treatment workforce.*
- *Comprehensive knowledge of the extent and nature of the specialist AOD prevention and treatment workforce.*

Outcome area 2: Create a sustainable specialist AOD prevention and treatment workforce by addressing recruitment and retention issues

The demand for workers in the health and welfare sectors is projected to increase substantially (Community Services & Health Industry Skills Council, 2013). Consequently, the AOD sector will be competing for workers with other Australian health and welfare agencies. Globalisation of the health and welfare workforce will also result in international competition for staff. The recruitment and retention of specialist staff in the AOD sector is therefore a critical issue. While there are significant gaps in our understanding of the characteristics of the AOD specialist workforce, it is understood that:

- The majority are female;
- The majority are aged 45 years or older; and
- Approximately one third are employed part time (Roche & Pidd, 2010).

Recruitment and retention strategies should be based on consideration of these demographic characteristics and refined as more detailed information becomes available. Effective strategies are particularly important in rural and remote areas and for medical and nursing staff.

Actions could include:

Improving recruitment into specialist AOD roles by:

- *Developing and implementing measures to reduce the stigma associated with working within the AOD sector;*
- *Investigating the value of registration or credentialing for the AOD sector to enhance its professionalism and desirability;*

- Promoting the AOD sector as a career of choice for suitable individuals via marketing to universities and vocational education institutions (particularly in schools of medicine, psychology, public health/policy, nursing; occupational therapy and social work);
- Increasing opportunities for placements in AOD settings during vocational, undergraduate and post graduate education;
- Better defining career pathways for workers in prevention roles;
- Develop clear articulation pathways (within and between vocational education and training (VET) and higher education systems) to ensure that workers have access to qualifications that enable career progression within the AOD field. This will include the mapping of entry points for workers from associated fields;
- Enhancing early exposure to drug and alcohol nursing as a career path among nursing students and graduates;
- Expanding the number of AOD nurse practitioner positions available and developing a structured career pathway for progression into nurse practitioner positions;
- Enhancing early exposure to addiction medicine as a career path among medical students and junior medical officers by increasing opportunities for placements/rotations through addiction medicine specialty areas;
- Increasing AOD teaching in undergraduate clinical and public health/policy tertiary courses;
- Establishing a critical mass of addiction medical specialists to enable vertical integration of teaching involving medical students, interns/junior medical officers, registrars and consultants;

- Exploring alternative pathways through which medical graduates can become Fellows of the Chapter of Addiction Medicine which do not require basic physician training, or fellowship of other colleges; and
- Examining current supervisory arrangements for trainees enrolled in the Royal Australian and New Zealand College of Psychiatrists Certificate in Addiction Psychiatry to determine the viability of broadening the range of potential supervisors.

Improving specialist workforce retention by enhancing the availability of:

- Flexible working arrangements (part time work, position sharing, time-in-lieu and working from home);
- Flexible access to education and training opportunities including enhanced use of on-line learning and other technologies;
- Parental leave;
- Comprehensive orientation programs to support transition into the sector;
- Mentoring and clinical supervision programs;
- Meaningful career pathways which do not necessarily require clinicians to move into management roles in order to gain promotion;
- Strategies to facilitate re-entry of former specialist AOD workers;
- Roles for experienced workers which focus on expanding their skills into more clinically complex areas or mentoring and transferring their skills;
- Management and leadership development programs focussing on responding to the needs and expectations of the workforce;

- *Pay increments related to competency/qualification acquisition as appropriate;*
- *Opportunities for service linked scholarships and education cost payments;*
- *Employment exit interviews/surveys to better understand the reasons for leaving the AOD sector;*
- *Portability of long service and sick leave entitlements as workers move between agencies;*
- *Enhanced job security via longer-term employment contracts/permanent positions;*
- *Succession planning for staff and management;*
- *Measures to assist existing staff to embrace new technologies and new philosophies;*
- *Medicare Benefits Schedule items for professional attendances provided by addiction medicine specialists to ensure that services provided by these specialists attract equivalent remuneration to similar medical specialties;*
- *Medicare Benefits Schedule items for professional services provided by AOD nurse practitioners;*
- *Appropriate medical officer career structures in the public and private sectors which combine teaching, clinical research and public health roles to make the addiction medicine speciality more attractive; and*
- *Mechanisms to showcase the achievements of the sector.*
- *Percentage of agencies providing specialist AOD prevention and treatment services that report they are able to attract and retain requisite staff.*
- *Appropriate turnover rates in specialist AOD prevention and treatment services.*
- *Percentage of specialist AOD prevention and treatment staff receiving mentoring and support.*
- *Career paths defined and expanded for AOD workers.*
- *Career satisfaction enhanced and stress and burnout rates minimised among specialist AOD prevention and treatment staff.*

Key Performance Indicators could include:

- *Number of long-term filled positions in agencies providing specialist AOD prevention and treatment services.*
- *Level of available mentoring, clinical supervision and appraisal programs.*

Outcome area 3: Match roles with capabilities

The AOD field involves a diverse range of roles, requiring differing levels of knowledge and skills. To-date these roles have not been differentiated and fully and uniformly described on a national basis (see Outcome Area 1-nationally agreed taxonomy of specialist AOD roles), nor have the sets of capabilities required to undertake them been explicitly identified.

The establishment of a workforce development matrix involving the major roles in the specialist AOD field, and pathways to achieve them, would help to address this shortcoming. For some members of the AOD workforce, the required capabilities could be aligned with the attainment of specified competencies in the vocational education and training sector. Others would require capabilities that could be attained via tertiary study, inservice training, recognition of prior learning, assessment of clinical skills by supervisors, or completion of a professional development program (such as that provided by the Chapter of Addiction Medicine). A credentialing program (such as that provided by the Drug and Alcohol Nurses of Australasia), represents a way of measuring the attainment of these capabilities.

It will be important to ensure that these capabilities are set at comparable levels with other fields. If they are set at levels which are higher than comparative fields this could reduce the attractiveness of AOD work. In addition, it is important that the identified capabilities are not regarded as employment pre-requisites. Opportunities must be provided for new entrants and existing staff to acquire the required capability levels during their employment. In addition, it will be important not to disadvantage workers who wish to remain in their current roles for which identified capabilities did not previously exist.

Actions could include:

- *Formulating a workforce development matrix which includes the capabilities required to fulfil all roles in the specialist AOD field and defines pathways to achieve these capabilities.*
- *Ensuring that capabilities which are pivotal to the future of the AOD sector are included in the workforce development matrix. These include capabilities concerning client-centred service provision, program evaluation, inter-professional practice, responding to multiple morbidities, responding to the needs of older people, leadership skills, child and family sensitive practice and responding to special needs groups, such as those outlined in Outcome Area 7.*
- *Ensuring that workforce capabilities evolve to reflect emerging research evidence (such as drug trends and intervention effectiveness).*
- *Exploring options for the formation of national workforce development programs and resources (including web-based approaches).*
- *Ensuring that mentoring, clinical supervision and appraisal programs support the attainment of identified capabilities.*

Key Performance Indicators could include:

- *Capability requirements and the pathways to achieve these are clearly identified for all major roles in the specialist AOD field.*
- *Level of articulation between different types and levels of competencies required to work in the AOD field.*
- *Evidence of capabilities being reviewed and updated based on emerging research.*

Outcome area 4: Enhance capacity to cater for older AOD clients, as well as those with co-and multiple morbidities and other complex needs

Clients of AOD services are at risk of a range of comorbid conditions including infectious and non-communicable diseases. Multi-morbidities are the norm for people with chronic health problems, particularly among the most socio-economically disadvantaged. Mental illnesses are a particularly prevalent comorbidity among AOD clients.

The ageing of Australia's population will also lead to more older people seeking treatment for AOD problems, and the need for prevention efforts to be focussed on older people.

Older people with AOD problems can have complex needs as a result of multiple morbidities, physiological changes that occur as a result of ageing and complex interactions between cognitive impairment due to AOD use, age and conditions such as depression. Older people are also more likely to be using other medicines which may interact with their AOD use. They may also be experiencing social isolation, loneliness, loss and difficulties associated with role transition. Older injecting drug users may have particular needs which stem from long term injection, exposure to their drugs of choice as well as blood borne diseases. A further group of older people with specific needs are those living in residential care facilities. Addressing the needs of older people can be hampered by a paucity of screening, assessment and intervention tools.

Due to the recognition of the prevalence of multiple morbidities, health services based on single-morbidity approaches are increasingly examining how they can cater for individuals with multiple morbidities. This can be hampered by funding arrangements in which services are only funded to accept particular categories of clients. Alcohol and other drug services will need to develop ways of meeting the multi-morbidity needs of their clients through a combination of enhanced generalist

in-house service provision and enhanced linkages with other service providers. Planning in all sectors needs to be systems focussed. A change management approach that simultaneously incorporates individual, organisational and sector wide responses is required. At the same time, it is important not to dilute the skills of specialist AOD workers by trying to be 'all things to all people'.

Actions could include:

Enhancing the capacity of the AOD sector to cater for older clients as well as those with co- and multiple morbidities and other complex needs by:

- *Maintaining a specific AOD specialisation, but increasingly using multi-disciplinary and multi-team approaches;*
- *Ensuring that AOD problems and ageing and co-and multiple morbidities form part of key knowledge and skills for AOD workers;*
- *Enhancing the diversity of professional backgrounds from which the AOD sector draws its staff, including from the aged care sector;*
- *Recruiting and retaining workers to the AOD sector with specialist capabilities to work with older clients and people who have multiple morbidities and complex needs;*
- *Including inter-professional practice as a key capability in specialist and generalist AOD roles;*
- *Improving coordination between primary care, ageing and specialist AOD services to facilitate 'wrap around' service provision and support a 'no wrong door' approach;*
- *Increasingly utilising specialist AOD workers in consultation, liaison and education roles with other services;*
- *Co-locating services with other agencies and encouraging interagency placements;*

- 
- *Ensuring that agency funding arrangements (for example the funding of agencies to only provide specific services) do not limit capabilities to respond to clients with multiple and complex needs;*
 - *Enhancing interagency, cross-sectoral and inter-professional education and training;*
 - *Supporting staff to increase capacity through networking and resource sharing;*
 - *Developing local maps of service referral pathways; and*
 - *Encouraging consistent approaches among AOD and other agencies to screening, assessment, clinical notes, referral, care coordination, case management, client information, data sharing and training.*

Key Performance Indicators could include:

- *Provision of workforce development resources and programs to enhance service provision for older AOD clients, those with co-and multiple morbidities and other complex needs.*
- *Proportion of specialist AOD services that have implemented measures such as multi-disciplinary and multi-team approaches, co-location, and inter-professional education.*

Outcome area 5: Improve child and family sensitive practice

There is a growing impetus for a more comprehensive approach to understanding the causes, prevention and treatment of AOD problems across sectors. The AOD and family and child welfare sectors have increasingly recognised the relationship between AOD problems, child and adolescent development, and child wellbeing and protection. The ability to identify and effectively respond to the needs of vulnerable, dependent children must be developed across AOD services and the broader system of care. This is becoming an increasingly important issue in AOD service provision.

Actions could include:

Improving child and family sensitive practice in AOD services by:

- *Ensuring that child and family sensitive practice is a key feature of the workforce development matrix;*
- *Implementing organisational policies, guidelines and working environments which support child and family sensitive practice;*
- *Ensuring that service provision arrangements are child and family friendly;*
- *Incorporating details of client parenting/ family roles and risk factors into assessment processes;*
- *Ensuring that interventions are tailored to family characteristics and needs;*
- *Ensuring that links are in place between AOD services and child wellbeing/welfare/family violence services; and*
- *Ensuring that workforce development programs are in place to support child and family sensitive practice.*

Key Performance Indicators could include:

- *Percentage of AOD roles that have child and family sensitive practice defined as a key workforce capability.*
- *Proportion of AOD agencies which have implemented organisational policies, guidelines, practices and workforce development measures to support child and family sensitive practice.*
- *Availability of workforce development resources and programs for the AOD sector focussed on enhancing child and family sensitive practice.*
- *Number of AOD agencies that have developed links with child wellbeing/welfare/ family violence services.*

Outcome area 6: Improve consumer⁴ participation in AOD service provision, policy, planning and research

The AOD field generally lags well behind other sectors in the systematic involvement of consumers in the provision and planning of services. The challenge is to turn widespread acceptance of the principle of service user participation into reality by having structures, processes and resourcing that make it both feasible and effective. The benefits of service user participation in service provision have been well documented and include: improved health outcomes; enhanced clinical decision-making; improved self-management; more accessible and effective health services; improved service development; and enhanced participation by populations traditionally marginalised by mainstream health services (Consumer Focus Collaboration, 2001). There are three aspects to improving service user participation.

The first is the employment of consumer workers. Currently the mental health sector employs consumer workers in roles such as consumer advocate, carer advocate, consumer consultant, carer consultant, consumer manager, peer support worker or mentor. These workers are engaged in systemic advocacy work, the provision of support to consumers, carers and families, and education or training roles, and add considerable benefits to service provision (Victorian Government Department of Health, 2011). While the AOD sector employs many people with lived experience, few are employed in consumer worker roles. Where service users become part of the workforce, it is important to be clear about how their roles connect to the model of service provision so as to better integrate and support them to do their work.

The second aspect of enhancing service user participation concerns the involvement of consumers in service planning, service policy making, staff recruitment and training, and research, monitoring and evaluation. This can range from:

- Consultation, in which service users are given an opportunity to provide feedback on plans developed by the service provider; to
- Partnerships in which consumers and providers are joint decision makers; to
- Consumer run organisations (such as self-help organisations) in which decisions are made by consumers (Clarke & Brindle, 2010).

The third aspect is creating an enabling environment for enhanced service user participation. For this to become a reality, more positive attitudes towards service user participation, on the part of management and staff of many AOD agencies, is needed. It must be demonstrated to service users that their participation is genuinely welcomed. Financial, personnel and training resources need to be allocated specifically to support service user participation, as experience has demonstrated that it is difficult to build and maintain such participation without adequate, dedicated resourcing.

Actions could include:

Enhancing the involvement of AOD consumers in service provision and planning by:

- *Ensuring that state/territory/organisational policies are in place concerning requirements for consumer participation in service provision, policy and planning, entailing genuine participation in decision-making processes;*
- *Ensuring that consumer participation standards are included in service accreditation processes;*
- *Developing a National AOD Consumer Participation Toolkit for service providers and consumers covering practical strategies and guidance on initiating and maintaining consumer participation in drug treatment services (Australian Injecting and Illicit Drug Users League (AIVL), 2008);*

⁴ Consumers may be current, former or potential service users, or their family members, carers and significant others; or members of the broader community.

- Ensuring that adequate additional resourcing is available to meet the costs associated with enhancing consumer involvement;
- Undertaking an examination of the potential for consumer worker roles in the AOD field (as has occurred in the mental health field), including the development of role definitions and capabilities;
- Encouraging AOD service providers to undertake audits of consumer participation practices and address identified gaps (e.g. Clarke & Brindle, 2010);
- Ensuring that all AOD services have a charter of consumer rights and responsibilities which outlines processes for consumer involvement;
- Developing education and training resources for AOD workers (including management boards, senior management, managers and front line staff) concerning the practicalities and benefits of consumer involvement;
- Developing education and training resources for consumers to enhance their involvement;
- Enhancing opportunities for consumers to contribute to education and training programs for staff of AOD services;
- Ensuring that consumers are involved in the planning of research programs undertaken by AOD services;
- Including a wide range of consumers and potential consumers in service provision and planning, including Aboriginal and Torres Strait Islander Australians; people from culturally and linguistically diverse backgrounds; people who are gay, lesbian, bisexual, transgender or intersex; and people with a disability; and
- Ensuring that consumer input is included as part of the monitoring and evaluation of AOD services.

Key Performance Indicators could include:

- Number of agencies with policies in place concerning consumer participation in AOD service provision, policy, planning and research.
- Availability of education and training programs and resources for the AOD specialist workforce on the practicalities and benefits of consumer participation in service provision, policy, planning and research.
- Extent of consumer participation in service provision, policy, planning and research in the AOD field.

Outcome area 7: Increase the capacity of the workforce to respond appropriately to AOD issues among Aboriginal and Torres Strait Islander peoples.

Enhancing capacity to reduce AOD harm among Aboriginal and Torres Strait Islander peoples is a major priority for the Strategy. There are two aspects to this. There is a need to enhance capacity among:

- Aboriginal and Torres Strait Islander AOD workers; and
- The specialist and generalist AOD workforce.

Actions could include:

Enhancing capacity among Aboriginal and Torres Strait Islander alcohol and other drug workers by:

- *Establishing a national professional body for Aboriginal and Torres Strait Islander AOD workers⁵;*
- *Implementing measures to promote AOD work as a career of choice for Aboriginal graduates of high school, vocational education and training and tertiary education;*
- *Ensuring that there is Aboriginal and Torres Strait Islander participation in service planning (both professionals and consumers);*
- *Ensuring, where appropriate, that there is parity of remuneration and conditions with non-Aboriginal and Torres Strait Islander AOD workers;*
- *Ensuring, where appropriate, that remuneration recognises both formal and informal qualifications and incorporates specialist loadings related to specialist skills or difficult work environments (remote, isolated, etc.);*

⁵ The professional organisation could be structured to have two (or more) streams of membership. Full membership could be available to those with minimum qualifications (for example, Certificate IV). Associate membership could be offered to those yet to attain this level.

- *Ensuring that Aboriginal and Torres Strait Islander workers, particularly in remote regions, have the infrastructure (housing, office space, computers, transport, phones etc.) they require to adequately fulfil their roles;*
- *Recognising and responding to the importance of gender balance among Aboriginal and Torres Strait Islander AOD workers;*
- *Ensuring that new Aboriginal and Torres Strait Islander AOD workers participate in culturally appropriate orientation and induction programs;*
- *Redressing literacy problems among current and potential Aboriginal and Torres Strait Islander AOD workers by offering intensive remedial education programs;*
- *Ensuring access to culturally secure AOD training and working environments which recognise the importance of Aboriginal and Torres Strait Islander ways of working⁶;*
- *Enhancing access to Aboriginal and Torres Strait Islander mentors and clinical supervisors;*
- *Offering greater job security, career and development opportunities and financial incentives (including scholarships) for Aboriginal and Torres Strait Islander AOD workers to encourage them to increase their skill levels;*
- *Enhancing the number of Aboriginal and Torres Strait Islander individuals undergoing professional training as doctors, nurses, psychologists, social workers and addiction medicine doctors; and*

⁶ Aboriginal and Torres Strait Islander ways of working refers to recognising the important impact of issues such as: Australia's post-colonial Indigenous history; kinship; commitment to community; grief, loss and sorry business; holistic approaches to health; women's and men's business; Aboriginal and Torres Strait Islander concepts of time; respect for Elders; and connection to Country and health for Aboriginal and Torres Strait Islander peoples (National Centre for education and Training on Addiction, 2013).

- *Enhancing access to appropriate vocational education and training and higher education programs supported by block release times and backfilling for education and training purposes.*

Enhancing capacity among the specialist and generalist workforce to reduce AOD harm among Aboriginal and Torres Strait Islander peoples by:

- *Implementing structures, policies, and programs that move the specialist and generalist AOD workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, and ultimately to cultural safety (Australian Indigenous Doctor's Association, 2013); and*
- *Enhancing capacity among Aboriginal and Torres Strait Islander primary health care workers to provide screening, assessment, brief intervention and referral services for Indigenous clients; and*
- *Improving linkages and better supporting Aboriginal and Torres Strait Islander AOD services and workers via consultancy, mentoring and clinical supervision arrangements.*

Key Performance Indicators could include:

- *Number of long term filled positions and staff turnover rates among Aboriginal and Torres Strait Islander AOD workers.*
- *Percentage of Aboriginal and Torres Strait Islander AOD workers receiving mentoring and support.*
- *Number of Aboriginal and Torres Strait Islander individuals undergoing training as AOD workers, doctors, nurses, psychologists, social workers and addiction medicine doctors.*
- *Number of workforce development programs among the broader AOD workforce that address culturally safe services to Indigenous Australians.*

- *Extent of involvement of Aboriginal and Torres Strait Islander peoples in service planning.*
- *Career satisfaction, stress and burnout rates among Aboriginal and Torres Strait Islander staff providing AOD services.*

Outcome area 8: Increase the capacity of the workforce to respond appropriately to AOD issues among culturally and linguistically diverse (CALD) groups

In Australia culturally and linguistically diverse groups are less likely than other community groups to access AOD prevention and treatment services. This may be due to a lack of awareness of services, language barriers, or a lack of understanding or trust of services. This group may also be less likely to be retained in services because of unrealistic client expectations of service outcomes or as a result of inappropriate referral to other services (Drug and Alcohol Multicultural Education Centre, 2010). There are a number of measures which can be taken to enhance access and remove barriers for this group.

Actions could include:

Enhancing the capability of the workforce to improve service provision to CALD groups by:

- *Enhancing linkages between AOD services and multicultural/ethno-specific agencies at clinician and management levels;*
- *Ensuring that appropriate interagency referral processes are in place;*
- *Ensuring that there is CALD representation and participation in service planning;*
- *Ensuring that all workers have access to the training and support they need for culturally aware and competent practice;*
- *Increasing consultation with CALD groups to identify their concerns in relation to AOD, as well as their prevention, informational and treatment needs;*
- *Developing procedures which encourage the recruitment of bilingual/bicultural workers;*
- *Including CALD representation in the development and focus-testing of prevention campaigns and in positive role models selected for campaigns;*
- *Developing prevention programs with, and for, particular CALD communities, using CALD media channels and CALD community organisation-based programs; and*
- *Developing appropriate CALD training and resources for all AOD workers.*

Key Performance Indicators could include:

- *Number of workforce development programs to enhance linkages between AOD and multicultural/ethno-specific agencies.*
- *Number of bilingual and bicultural workers recruited.*
- *Extent of involvement of CALD individuals in service planning.*
- *Career satisfaction, stress and burnout rates among bilingual and bicultural workers providing AOD services.*

Outcome area 9: Increase the capacity of the workforce to respond appropriately to AOD issues among lesbian, gay, bisexual, transgender and intersex individuals

There is increasing evidence linking lesbian, gay, bisexual, transgender, intersex (LGBTI) individuals with high levels of problematic AOD use. While part of the reason for this is cultural, particularly for younger gay men, much of the higher levels of use can be attributed to the discrimination and marginalisation faced by LGBTI communities in Australia (National Lesbian Gay Bisexual Transgender Intersex Health Alliance, 2010).

Actions could include:

Enhancing the capability of the workforce to improve service provision to LGBTI groups by:

- *Improving linkages between AOD services and LGBTI specific agencies at clinician and management levels;*
- *Ensuring that appropriate interagency referral processes are in place;*
- *Ensuring that there is LGBTI representation and participation in service planning;*
- *Ensuring that all workers have access to the training and support they need for culturally aware and competent practice with LGBTI clients;*
- *Better targeting LGBTI communities with AOD prevention/harm reduction campaigns and including LGBTI representation in the development and focus-testing of prevention campaigns; and*
- *Developing procedures which encourage the recruitment of LGBTI workers.*

Key Performance Indicators could include:

- *Number of workforce development programs to enhance linkages between AOD and LGBTI specific agencies.*
- *Career satisfaction, stress and burnout rates among LGBTI staff providing AOD services.*
- *Number of LGBTI workers recruited.*
- *Extent of involvement of LGBTI individuals in service planning.*

Outcome area 10: Enhance the capacity of generalist health, community, welfare and support services workers to prevent and reduce AOD harm

Alcohol and other drug problems are common in the Australian population, and generalist providers need the ability to recognise and assist individuals experiencing AOD harm. Many of these individuals do not attend specialist AOD services. In rural and remote areas specialist AOD services may not be accessible. Given the extent to which AOD problems co-occur with other health and social problems, people experiencing AOD harm are highly likely to present to other human service providers who can be in a position to provide assistance and/or refer appropriately.

Enhancing generalist workers' understanding of the needs of AOD clients would facilitate a 'no wrong door' approach to screening and intervention and greatly assist in the provision of appropriate interventions, particularly at a population health level. In this context, it is especially important for generalist workers to have a good understanding of the evidence base concerning screening and brief interventions, so that they can incorporate these strategies into their practice. At present, however, the dearth of education and training opportunities at pre-vocational, undergraduate and inservice levels is a major impediment to better engaging the generalist workforce in reducing AOD harm.

There is also an important inter-relationship between the capabilities of the specialist AOD sector and its ability to influence practice among generalist workers. A specialist AOD sector that is practicing from a strong evidence base and 'outwards looking' is in a stronger position to influence the practice of generalist workers.

Actions could include:

- *Establishing nationally consistent minimum capability requirements for generalist professional groups (e.g. doctors, nurses, pharmacists, psychologists, social workers, emergency workers, Aboriginal and Torres Strait Islander primary health care workers and other health and welfare workers) to enable them to effectively detect and respond to individuals experiencing AOD harm. This will involve building on the existing competency framework used in the vocational education and training sector and on higher education sector qualifications.*
- *Using the nationally-consistent minimum skill and knowledge requirements as the basis to develop resources and enhance pre-service and inservice education and training programs for generalist workers.*
- *Ensuring that these education and training programs focus on issues such as referral pathways, harm minimisation, early/brief intervention, reducing the stigma associated with AOD problems and the often chronic and relapsing nature of AOD problems.*
- *Further developing the capacity for specialist AOD professionals to act as consultants at key points in the health and welfare systems.*
- *Improving linkages and coordination between AOD services and other specialist, primary care and welfare services to enhance the capacity of generalist workers to identify, intervene and refer individuals experiencing AOD harm.*
- *Establishing regional partnerships of funders, service providers, consumers and carers and relevant stakeholders to develop local solutions to meet AOD needs of communities.*

Key Performance Indicators could include:

- *Capability requirements and the pathways to achieve these capabilities are clearly identified for generalist health, community, welfare and support workers.*
- *Level of capability among generalist health, community, welfare and support services workers to prevent and reduce AOD harm.*
- *Availability of workforce development resources and programs for generalist workers to increase their capacity to prevent and reduce AOD harm.*
- *Availability of specialist AOD professionals to act as consultants to generalist staff.*
- *Number of implemented and effective linkages between specialist AOD services and generalist agencies.*

Outcome area 11: Continue to develop the criminal justice workforce to prevent and reduce AOD harm

A. Police

Police play a major role in preventing and responding to AOD-related harm. Alcohol and other drug issues also represent a considerable impost on police agencies. Policing roles, for example, include the reduction of harm associated with licensed premises, dealing with intoxicated individuals and groups, AOD-related traffic issues and illicit drug supply reduction measures. Additional important roles include the diversion of minor drug offenders into the health and education systems and the referral of victims and offenders experiencing AOD-related harm (and multiple morbidities) to health and welfare agencies as well as the important roles played by youth liaison officers and Aboriginal community liaison officers. Police also play a role in supporting illicit drug harm reduction outcomes via policies:

- *that minimise interference of access by injecting drug users to needle and syringe programs; and*
- *that ensure priority is given to the wellbeing of victims of non-fatal overdoses over the prosecution of drug related offences, so as to increase the likelihood that those in attendance will call an ambulance.*

General duties police officers spend a considerable proportion of their time dealing with AOD issues; however police agencies also have a significant number of personnel who undertake specialised AOD-related roles. These include illicit drug investigators, those working in AOD-related road safety and those involved in liquor licensing activities. Generalist and specialist police will therefore have different workforce development needs.

Opportunities to further strengthen the AOD workforce development needs of police can be explored given the important role police play in reducing AOD harm.

Actions could include:

- *Undertaking a national study to:*
 - » *Identify the range of roles in which police are currently, or could potentially be involved in, which reduce AOD-related harm in the community including prevention, early intervention and harm minimisation;*
 - » *Examine the current status of AOD-related education and training workforce development activities available for police in Australia at pre-service, general duties, specialist and executive levels. This examination should include workforce development activities available within and beyond policing agencies (such as in the vocational education and training sector) and address roles undertaken in urban, rural and remote environments;*
 - » *Highlight gaps between current/potential police roles and workforce development opportunities;*
 - » *Develop mechanisms to address those gaps; and*
 - » *Explore the inclusion of AOD modules in all public safety training packages.*
- *Explore opportunities for the development of national AOD learning resources for police to avoid duplication of effort.*
- *Develop models of good practice which enhance cooperation and referral arrangements between health, welfare and policing agencies to enhance systemic responses to individuals experiencing AOD-related harm and multiple morbidities.*
- *Develop models of good practice to enable the timely sharing of information between police and relevant agencies concerning illicit drug trends and local referral options for those experiencing AOD harm.*

B. Correctional officers

A substantial proportion of offenders within correctional facilities, community correctional services and under the jurisdiction of juvenile justice have experienced AOD-related harm. Correctional environments pose particular risks of harms such as the transmission of blood-borne viruses and both fatal and non-fatal overdose on release (National Corrections Drug Strategy 2006–2009 [NCDS, 2008]). Aboriginal and Torres Strait Islander Australians remain grossly over represented in the correctional system. In 2012–13, Aboriginal and Torres Strait Islanders made up more than a quarter of the prison population, and their national age standardised imprisonment rate per 100,000 adults was 1,861.9 compared with a corresponding rate of 155.9 for non-Indigenous prisoners (Steering Committee for the Review of Commonwealth/State Service Provision, 2012) .

Despite these challenges, the contact between offenders and the correctional system presents a unique opportunity to address the range of problems facing this population, who do not adequately access health care in the community. The provision of services to offenders in correctional and community-based facilities requires collaboration between health and justice jurisdictions. Effective partnerships with community service providers will deliver effective through-care and ease the transition from highly structured custodial environments to the community (NCDS, 2008).

Actions could include:

- Undertaking a national study to:
 - » *Examine the current status of AOD-related education and training workforce development activities available for correctional officer and professional/allied health employees of correctional services in Australia. The study should focus on training to:*
 - o *refer offenders to available AOD treatment programs, both in correctional centres and in the community; and*
 - o *implement evidence-based interventions in correctional environments.*
- *The study should also make recommendations to address identified education and training gaps and where possible identify opportunities for national program and resource development, consistent with the correctional services training package.*
- *Build and strengthen partnerships with key agencies to advise and provide support to address AOD harm among offenders. This could include AOD agencies, Aboriginal and Torres Strait Islander services and mental health service providers and government agencies for assisting offenders with health issues both pre-release and in the community.*
- *Highlight workforce development opportunities, and develop mechanisms to address them.*

Key Performance Indicators could include:

- *Police and correctional roles have capabilities defined to reduce AOD related harm in the community.*
- *Availability of workforce development resources and programs for criminal justice workers to enhance their capacity to reduce AOD harm.*
- *Number of workforce programs to develop effective linkages between criminal justice and specialist AOD agencies.*

Outcome area 12: Promote the ability of the education sector to reduce AOD harm

Education sector workers play a major role in preventing and reducing AOD harm. It is important to note that the education sector includes not only primary and secondary schools, but vocational and tertiary institutions. Education institutions provide an excellent setting for prevention programs and an increased level of student connectedness to educational institutions is protective against AOD use and harm. Most educational institutions are likely to need a combination of universal and targeted programs. The former would have a preventive focus and address the needs of the majority of students. The latter would tackle more complex issues confronting the relatively small number of students engaged in risky AOD-related behaviours.

Actions could include:

- Ensuring that education sector workers have access to effective professional development, support and resources that enable them to:
 - » Provide accurate and age-appropriate programs about AOD for students;
 - » Assist students to gain the knowledge and skills to help them make informed decisions, solve problems and create closer links to education institutions and their families and peers;
 - » Increase student awareness of risky situations and strategies to reduce risks and harms;
 - » Create institutional environments which are safe, stable and discourage harmful AOD use;
 - » Implement policy frameworks which prevent and reduce AOD harm and respond appropriately to AOD-related incidents; and
 - » Create partnerships with specialist and generalist community agencies to facilitate referral if problems arise.

- Provide education sector workers with a clearer synthesis and better dissemination of the current evidence base to enable them to make more informed decisions and choices concerning AOD education programs and activities.
- Develop a tool to allow educational institutions to determine which approaches to AOD education will fit best with their priorities, demographics, location, budget, human resources, culture and profiles of risk behaviour.

Key Performance Indicators could include:

- Availability of workforce development resources and programs for the education sector enabling them to enhance their capacity to prevent and reduce AOD harms among students.
- Number of workforce programs to develop effective linkages between the education sector (primary, secondary, VET, tertiary) and specialist AOD sector (service providers, registered training organisations and research agencies).

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APPENDIX: Links to other Strategies

This Strategy was prepared in the context of, and supports the directions of, a range of other national Strategies. The table below highlights the linkages between each of the actions under this, and relevant parts of other, strategies.

National Alcohol and other Drug Workforce Development Strategy Outcome areas	National Drug Strategy 2010-2015	National Alcohol Strategy 2006-09	
Understand the specialist AOD prevention and treatment workforce	Supporting Approach: Workforce	Where to from here?: Workforce.	
Create a sustainable specialist AOD prevention and treatment workforce by addressing recruitment and retention issues	Supporting Approach: Workforce	Where to from here?: Workforce.	
Match roles with capabilities	Supporting Approach: Workforce		
Enhance capacity to cater for AOD clients with co- and multiple morbidities and other complex needs	Pillar 1: Objective 2 – Reduce the use of drugs in the community Supporting Approach: Workforce	Where to from here?: Workforce. Where to from here?: Developing Partnerships and Links	
Improve child and family sensitive practice	Pillar 3: Objective 2 - Reduce harms to families Supporting Approach: Workforce		

	National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011	National Pharmaceutical Drug Misuse Framework for Action (2012-2015)	National Cannabis Strategy 2006-2009	National Tobacco Strategy 2012-2018
	Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems	Priority Area 7: Treatment and harm reduction		
	Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems	Priority Area 5: Structural factors	Priority Area 4: Responding to problems associated with cannabis Where to from here?: Workforce development	Priority Area 5: Strengthen efforts to reduce smoking among populations with a high prevalence of smoking Priority Area 9: Provide greater access to a range of evidence-based cessation services to support smokers to quit
	Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems			



National Alcohol and other Drug Workforce Development Strategy Outcome areas	National Drug Strategy 2010-2015	National Alcohol Strategy 2006-09	
Improve consumer participation in AOD service provision, policy and planning	Pillar 1: Objective 3 - Support people to recover from dependence and reconnect with the community		
Increase the capacity of the workforce to reduce AOD harm among Aboriginal and Torres Strait Islander peoples	Pillar 1: Objective 2- Reduce use of drugs in the community Supporting Approach: Workforce	Where to from here?: Workforce. Priority Area 3B: Health Impacts	
Increase the capacity of the workforce to respond appropriately to AOD issues among culturally and linguistically diverse (CALD) groups.	Pillar 1: Objective 2-Reduce the use of drugs in the community Supporting Approach: Workforce	Where to from here?: Workforce Priority Area 3B: Health impacts	
Increase the capacity of the workforce to respond appropriately to AOD issues among lesbian, gay, bisexual, transgender and intersex individuals.	Pillar 1: Objective 2-Reduce the use of drugs in the community Supporting Approach: Workforce	Where to from here?: Workforce Priority Area 3B: Health impacts	

	National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011	National Pharmaceutical Drug Misuse Framework for Action (2012-2015)	National Cannabis Strategy 2006-2009	National Tobacco Strategy 2012-2018
		Priority Area 6: Health information and other consumer responses		
	Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems		Priority Area 4: Responding to problems associated with cannabis Where to from here?: Workforce development	Priority Area 4: Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people Priority Area 9: Provide greater access to a range of evidence-based cessation services to support smokers to quit
	Priority Area 5: Organisation and system capacity to prevent and respond to ATS problems		Priority Area 4: Respond to problems associated with cannabis Where to from here? Workforce development	Priority Area 9: Provide greater access to a range of evidence-based cessation services to support smokers to quit.
	Priority Area 5: Organisation and system capacity to prevent and respond to ATS problems		Priority Area 4: Respond to problems associated with cannabis Where to from here? Workforce development	Priority Area 9: Provide greater access to a range of evidence-based cessation services to support smokers to quit.



National Alcohol and other Drug Workforce Development Strategy Outcome areas	National Drug Strategy 2010-2015	National Alcohol Strategy 2006-09	
Enhance the capacity of generalist health, community, welfare and support services workers to prevent and reduce AOD harm	Pillar 1: Objective 2 – Reduce the use of drugs in the community Supporting Approach: Workforce	Where to from here?: Workforce. Priority Area 3: Health Impacts Where to from here?: Developing Partnerships and Links	
Continue to develop the criminal justice workforce to prevent and reduce AOD harm	Pillar 2: Supply reduction Supporting Approach: Workforce	Where to from here?: Workforce. Priority area 1: Intoxication Priority Area 2: Public Safety and Amenity Where to from here?: Developing Partnerships and Links	
Promote the ability of education sector workers to reduce AOD harm	Supporting Approach: Workforce	Where to from here?: Workforce. Priority Area 4: Cultural Place and Availability	

	National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011	National Pharmaceutical Drug Misuse Framework for Action (2012-2015)	National Cannabis Strategy 2006-2009	National Tobacco Strategy 2012-2018
	Priority Area 4: Problems associated with ATS use Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems	Priority Area 2: Supporting prescribers Priority area 3: Supporting pharmacists and other health professionals Priority Area 5: Structural factors	Priority Area 4: Responding to problems associated with cannabis Where to from here?: Workforce development	Priority Area 5: Strengthen efforts to reduce smoking among populations with a high prevalence of smoking Priority Area 9: Provide greater access to a range of evidence-based cessation services to support smokers to quit
	Priority Area 2: The supply of ATS Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems	Priority Area 4: Regulation and monitoring	Priority Area 2: Preventing the use of cannabis Where to from here?: Workforce development	Priority Area 5: Strengthen efforts to reduce smoking among populations with a high prevalence of smoking
	Priority Area 3: The use of ATS Priority Area 5: Organisational and system capacity to prevent and respond to ATS problems		Priority Area 2: Preventing the use of cannabis Where to from here?: Workforce development	

Glossary of terms

Alcohol or other drug dependence refers to the need for repeated doses of AOD to feel good or to avoid feeling bad. It also refers to a cluster of cognitive, behavioural and physiological symptoms that indicate a person has impaired control over their AOD use and continues to use despite adverse consequences.

Brief intervention is a strategy involving short, structured therapy, which primarily aims to assist an individual to stop, reduce or minimise the harm associated with AOD use.

Child and family sensitive policy and practice involves raising awareness of the impact of substance use problems upon families, addressing the needs of families and seeing the family - rather than the individual adult or child - as the unit of intervention. It necessitates identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of treatment and intervention processes.

Clinical supervision is a process by which two or more professionals formally meet to reflect on and review clinical situations with the aim of supporting and enhancing the clinician in their professional activities.

Cultural security refers to the provision of services in a way that respects the cultural rights and values of clients and offers them the best available services.

Drug diversion refers to the diversion of minor drug offenders from the criminal justice system into drug treatment or education.

Early interventions are proactive strategies that combine early detection of hazardous or harmful AOD use with interventions to reduce use and/or harm.

Evidence-based practice refers to applying validated research results (evidence) when making decisions about a particular issue.

Evidence informed practice involves using the best available research and practice knowledge to guide decision making. It recognises the fact that validated research results are not always available to guide decision making.

Fetal alcohol spectrum disorders (FASD) is an umbrella term which describes a continuum of permanent birth defects caused by maternal consumption of alcohol during pregnancy. It includes, but is not limited to, foetal alcohol syndrome.

Generalist workers are employed in the mainstream workforce and have non-AOD-related core roles, but nonetheless have substantial scope to prevent and minimise AOD harm.

Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

Multiple morbidities in this context refers to the co-existence in an individual of two or more long-term medical, psychiatric or psychological conditions in addition to a substance use problem.

Peer workers provide social, emotional, or practical support to people experiencing AOD harm. Peer workers have generally experienced similar AOD problems to those they are supporting. This support may be provided on a paid or unpaid basis.



Prevention programs are services or other measures designed to prevent harmful AOD use. There are three levels of prevention: primary prevention (preventing uptake of AOD use), secondary prevention (preventing problematic and/or increased AOD use) and tertiary prevention (reducing use and harms associated with AOD use).

Specialist AOD workers are those whose core role involves preventing and responding to AOD harm. They include AOD workers, nurses, social workers, doctors, peer workers, needle and syringe program workers, prevention workers and addiction medicine specialists and specialist psychologists and psychiatrists.

Workforce development is a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug-related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing the education and training of individual mainstream workers.



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