AOD Workforce Development: Current and Emerging Issues

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National Centre for Education and Training on Addiction
(NCETA)

Alcohol, Tobacco & Other Drugs Council, Tas
WFD Report Launch
Hobart 25 August 2011
Emerging Imperatives

1. Transforming the Workforce – battling for talent
2. The Knowledge Economy – learning to compete
3. Corporate Social Responsibility
4. Duty of Care – managing your risk
5. Business Continuity

(Simon Carter (2006), Sustaining the vitality of Australian businesses. The critical role of buildings and workplaces. Colliers International)
Contested knowledge

Ideological Conflicts

Stigma and Deservingness

Systems vs Individualised Focus
Diverse landscape

- Expectation and pursuit of excellence
- Focus on Quality, Quality frameworks
- Standards
- Accreditation
- Complexity of drug use
- Standardised assessment
- Case management/formulations
- Inter-sectoral collaboration
- Outcomes orientation/focus
Current Context

• The AOD sector is experiencing strong growth in demand for services.

• The AOD field has also experienced unprecedented changes over the last 20 years that have major implications for the development of a responsive and sustainable workforce.

• Provision of quality and timely AOD services has been substantially impacted by:
  – changing patterns of substance use
  – increased prevalence of polydrug use
  – a growing recognition of mental health/drug use comorbidity issues
  – an expanding knowledge base
  – advances in treatment protocols and
  – an emphasis on evidence based practice.
  – Important changes in the (ageing) workforce, and in the broader community.
The Policy Context

National Drug Strategy
The National Health Reform Agenda
National E-health Strategy
National Mental Health Strategy
National Pain Strategy
Australian Commission on Safety and Quality in Health Care
Development of clinical guidelines
National registration of health practitioners
AOD Treatment: An Historical Perspective

1950-60’s - Dedicated handful of workers, many ‘recovering’ individuals, and charitable and religious bodies. The focus was almost exclusively alcohol.


1980’s - Research began to have significant impact. Early and brief intervention found effective, increasing scope for a wider range of professionals (eg GPs, nurses) to be involved. Increasing emphasis on the broader public health model.

1990’s - No longer seen as the domain of health but now included police, the judiciary, the media, politicians, and families, especially as the types of drugs and the harms associated with their use changed.

A complex interplay of key elements required within a workforce development approach, including:

- Professional and personal attributes of workers
- Professional development and training
- Service delivery and program elements
- Organisational structures, processes, supports and resources
- System or sector features
- Workforce supply
- The knowledge and evidence base with consideration to the national context
- Policy and operational drivers.
• Workforce development includes:
  • workforce mapping, monitoring, and planning
  • recruitment and retention
  • awards, remuneration and career paths
  • professional development
  • accreditation and minimum qualifications
  • clinical supervision and mentoring
  • leadership and management
  • workforce support
  • worker wellbeing.
Health Workforce Australia

On the 8 December 2009 the Hon Nicola Roxon MP, Minister for Health and Ageing announced the appointment of the first Chief Executive Officer of Health Workforce Australia (HWA).

The CEO is Mr Mark Cormack, the former Chief Executive of the ACT Health Department. Mark commenced on 27 January 2010 and is based in Adelaide where HWA is being established.

HWA has been established to produce more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives.

The National Health Workforce Taskforce will be working closely with Mark over the coming months as Health Workforce Australia formulates the new national work program.

The website for HWA can be found at [www.hwa.gov.au](http://www.hwa.gov.au)
National Health Workforce Agenda

The need for a Strategic Framework

Over recent years, several health system trends have emerged, all of which mandate thinking more strategically about the future health workforce.

They include:

- new and varied approaches to health service delivery and the provision of care;
- more and better technology;
- new roles for old disciplines and new disciplines;
- continuing demographic change and shift;
- increased consumer participation in health care and health care decision making;
- greater availability of accurate, timely information;
- an even greater focus on quality cost efficient service provision; and
- the continued development of the global community.
Australian Health Workforce agenda vision is based on 7 principles:

1. National self sufficiency in workforce supply, acknowledging role of the global market.
2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.
3. Health care environments should be places in which people want to work and develop;
4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.
5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary.
6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.
7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders.

This will require:
- cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
- stakeholder commitment to the vision, principles and strategies outlined in this framework;
- a nationally consistent approach;
- best use of resources to respond to the strategies proposed in this framework; and
- a monitoring, evaluation and reporting process.
The need for a national AOD workforce development strategy was also highlighted by Dr Neal Blewett (2006) who has stated that:

“In the last twenty-one years there has been the biggest expansion of drug treatment and rehabilitation services in Australian history and in this sphere the present national government has more than maintained the momentum. There has been a massive increase in the drug workforce and with it a rise in the status of that workforce, but there has been no commensurate attention to the needs of that workforce.

This quantitative change has been accompanied by qualitative changes in the demands made upon workers – increased knowledge demands, the rapid shifts and changes in drug fashions, increased range of treatment options, demand for evidence based practice, the need for partnerships with other services.”
• There has as been a massive increase in the drug workforce and with it a rise in the status of that workforce,

but there has been no commensurate attention to the needs of that workforce.

• This quantitative change has been accompanied by qualitative changes in the demands made upon workers – increased knowledge demands, the rapid shifts and changes in drug fashions, increased range of treatment options, demand for evidence-based practice, the need for partnerships with other services. I think at the (1985) Summit we were cavalier about the implications of our compromises for the workforce.

• (Neal Blewett, September 2006 paper to NDRI 21st Anniversary Symposium Perth)
• It is I think no exaggeration to say that we are facing a crisis in this area with increasing difficulties in recruiting and retaining qualified staff, particularly in regional and remote areas.

• (Neal Blewett, September 2006 paper to NDRI 21st Anniversary Symposium Perth)
National Drug Strategy
Australia’s approach to dealing with alcohol and other drugs has been governed by the philosophical and logistical imperatives established in the National Drug Strategy (NDS), together with a range of complementary strategies at both the national and state levels.

It is only in recent years that any substantial focus has been placed on WFD, although emphasis has grown over time. The current iteration of the NDS places the strongest emphasis to-date on WFD where it features large. The police and practice implications of this will be outlined.
A Decade of Growing Recognition

Examples of the growing recognition of workforce development

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>NDS evaluation refers to workforce development 17 times</td>
</tr>
<tr>
<td>2004</td>
<td>NDS makes only one reference to workforce development but an entire paragraph devoted to discussion of the issue</td>
</tr>
<tr>
<td>2005</td>
<td>Intergovernmental Committee on Drugs (IGCD) Annual Report to the Ministerial Council on Drug Strategy (MCDS) mentions workforce development 10 times</td>
</tr>
<tr>
<td>2009</td>
<td>The NDS Evaluation undertaken by Siggins Miller highlighted the extent to which workforce development had been largely overlooked in any systematic and planned efforts at the national level.</td>
</tr>
</tbody>
</table>
The New National Drug Strategy
2010-2015

• Workforce Development

• *The Strategy renews commitments to building workforce capacity, and evidence-based and evidence-informed practice. For the first time, it includes performance measures to provide broad measures of progress.*
<table>
<thead>
<tr>
<th>Workforce development audits and reviews</th>
</tr>
</thead>
</table>
| Reviews of the education and training needs of the national AOD specialist workforce | Allsop et al. (1998)  
Roche (1998) |
| Recognition of the organisational and systemic barriers to the development of the Australian AOD workforce | Allsop & Helfgott (2002)  
Roche, Hotham, & Richmond (2002) |
| Workforce Development Issues in the AOD Field: An IGCD briefing paper | Roche (2002) |
| A report on the development of a national AOD workforce strategy | Intergovernmental Committee on Drugs (IGCD) (2004) |
| An audit of the workforce development needs of the South Australian AOD workforce | National Centre for Education and Training on Addiction (2006) |
| Profiling and identifying the training needs of the NSW non-government AOD workforce | NSW Network of Drug and Alcohol Agencies (NADA) (2007) |
| Workforce in Crisis. A report on remuneration, retention and recruitment in the AOD, mental health, family and domestic violence and women’s health sectors. | WANADA et al. (2008) |
| Achieving Professional Practice Change: From Training to Workforce Development | Roche, Pidd, Freeman (2009) |
### National Surveys

<table>
<thead>
<tr>
<th>Year</th>
<th>Survey Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>National NGO survey (43 respondents)</td>
<td>Pitts (2001)</td>
</tr>
<tr>
<td>2005</td>
<td>An NCETA national survey of 1,345 specialist AOD workers</td>
<td>Duraisingam, Pidd, Roche, &amp; O’Connor (2006)</td>
</tr>
</tbody>
</table>

### Jurisdictional Surveys

<table>
<thead>
<tr>
<th>Year</th>
<th>Survey Description</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>A survey of 745 Victorian AOD workers employed in agencies funded by the Victorian Department of Human Services</td>
<td>Victorian Department of Human Services (DHS) (2005)</td>
</tr>
<tr>
<td>2005</td>
<td>A survey of 136 Northern Territory AOD workers employed in 18 AOD specialist treatment agencies and AOD intervention programs</td>
<td>NT Department of Health and Community Services (2005)</td>
</tr>
<tr>
<td>2007</td>
<td>An NCETA survey of 167 South Australian AOD workers employed in 18 non-government AOD specialist agencies and 26 non-government mainstream agencies with AOD programs</td>
<td>Tovell, Roche &amp; Trifonoff (2009)</td>
</tr>
<tr>
<td>2008</td>
<td>WA survey of 207 AOD workers from 35 NGO services – part of the 2007 Sector Remuneration Survey</td>
<td>WAAMH et al. (2008)</td>
</tr>
<tr>
<td>2009</td>
<td>A survey of 132 ACT workers from 9 AOD agencies</td>
<td>ACT AOD Sector Project (2009)</td>
</tr>
</tbody>
</table>

Key demographic workforce features extracted from eight of these surveys are shown in the summary table below. This table provides the most comprehensive overview of the AOD workforce currently available.
Drivers of Change

- ageing population
- competition with other fiscal and social priorities
- workforce shortages
- international market for medical professional services
- commoditisation of medicine
- growth in number and cost of medications
- evidence-based decision-making
- quality use of scarce resources
- managing appropriate demand
- government need for certainty
- achieving a public/private balance
- waiting lists
- managing and funding technology
Challenges and Drivers of Change

• Increased complexity of AOD issues
• Rapidly expanding and increasingly technical knowledge base
• Increasing demand for treatment services
• Limited funding and resources
• High workloads and high levels of stress among AOD workers
• Low salaries and limited career paths
• Difficulty in recruiting and retaining skilled and qualified staff
• Public stigma and misunderstanding of the nature of AOD problems and their resolution
The mental health and other needs of homeless people and those at risk of homelessness

- Homeless or at risk of homelessness
- Other needs
- Other mental health disorders
- Substance use related disorder

Areas of overlap:
- A
- B
- C
- D
- E
Emerging Areas/Issues

- Indigenous Australians
- Social Equity issues
- Women and alcohol
- Pharmaceutical misuse
- Child protection
- Missed Prevention Opportunities
The Prevalence of Mental Illness is Higher in More Unequal Rich Countries

Health and Social Problems are Worse in More Unequal Countries

Index of:
- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility

HOW COME YOU'RE RICH AND I'M POOR?

MUM AND DAD HAVE HIGHLY PAID JOBS WORKING ON THAT VERY PROBLEM.
Levels of Change

- **Healthcare system** — resources, policies
- **Political environment** — ideology
- **Social environment** — disadvantaged groups
- **Educational environment** — curricula
- **Practice environment** — time, resources, organisational structure
- **Practitioner** — knowledge, beliefs, attitudes
- **Patient/client** — demands, perceptions
What’s the Problem Represented To Be (Bacchi)

• How one frames the ‘problem’ or ‘issue’ changes the solution sought and, therefore, the actors responsible for creating transformation

• Answers to the questions:
  – What is the problem?
  – What is a solution to the problem?
  – Who/what can solve it?
  – Where / what are sources of information for understanding / solving the problem?
Traditional approach to improving work practice

**Challenge:**
Effective AOD work practice

**Solution:**
Improve skills & knowledge

**Strategy:**
Education & Training

Estimated that as little as ten percent of training expenditures in the US pays off in on-the job-performance. (Baldwin and Ford, 1988)
The Traditional Response...

TRAINING
Training

Training is not the driver of change, but an operational response to other change drivers which include workplace change, the introduction of new technology and quality assurance.

In this sense, education and training are not an end in itself, rather only one means by which to achieve a particular outcome.

(Gore, 2001)
A Systematic Review of Training Efficacy
(Walters et al., 2005)

17 evaluations of workshops found training tends to:
- Improve knowledge, attitudes and confidence.
- Skills acquired are not always maintained over time.
- Extended contact, follow-up consultation, supervision and feedback needed for long-term adoption of skills.
Workforce development

Moves the focus from individual learners to systems change.

Targets systems enhancement, not skills deficit.
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, it is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers.
Workforce Development Defined

• Workforce development is defined as those activities which increase the capacity of individuals to participate effectively in the workforce throughout their whole working life

and

which increase the capacity of firms to adopt high-performance work practices that support their employees to develop their potential skills and value.

(Scholfield, in Buchanan, Workplace Research Centre, University of Sydney)
Workforce Development vs training & education

Education and Training are necessary ...

but not sufficient
The ‘Litany’

Social Causes & Policy

Worldview & Discourse

Metaphor & Myth

The ‘Layered Analysis’

Official public description of issue:
- Trends, problems, issues, mainstream news, events, data & statistics quoted ad nauseum

Social science & policy analysis:
- Social, economic, cultural, political & historical factors examined; quantitative interpretations of data; technical explanations & academic analysis; op-ed editorial pieces

Unquestioned assumptions:
- About ‘how the world is’; the influence of worldviews & the types of ‘discourses’ which legitimate & perpetuate these

The deep unspoken & unseen:
- Archetypes, stories, images, symbols, myths & metaphors at the core of worldviews; ‘touches heart not head’; the deep ‘collective unconscious’

The different levels and components of workforce development
Key Workforce Development Issues

A SYSTEMS PERSPECTIVE

1.1 Design and Implementation of Workforce Development Policies
1.2 Managing Organisational Change
1.3 Resources and Partnerships

ORGANISATIONAL CAPACITY BUILDING

2.1 Workforce Sustainability
   2.1.1 Recruitment
   2.1.2 Motivation
   2.1.3 Stress and burnout
   2.1.4 Job satisfaction
   2.1.5 Career paths
   2.1.6 Turnover
   2.1.7 Job redesign

DEVELOPMENT OF A SKILLED AOD WORKFORCE

3.1 Information Management
   3.1.1 Evidence-based practice
   3.1.2 Accessing information effectively

3.2 Development of Knowledge, Skills and Abilities

3.3 Transfer of Training to Work Practice
Addiction Technology Transfer Centers (ATTC’s)

‘The Change Book: A Blueprint for Technology Transfer’

ATTC National Office
University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, MO 64110
http://www.nattc.org
Technology transfer is a behaviour change process.

It involves modifying the thinking and behaviours of individuals in organisations.

And, it involves modifying the policy and/or practices of organisations.
Any workforce development strategy needs to not only consider funding arrangements, but also factors such as:

- employment conditions
- industrial awards
- the relationship between qualifications and remuneration, and
- career pathways.
Workforce development issues (positives)

- High autonomy
  - Freedom to make own decisions (76%)
  - Control in work role (58%)

- High job satisfaction (79%)
  - Successful outcomes, client interactions

- High social support
  - Supervisor & co-workers (75%)

- Low to moderate stress levels (81%)
Workforce development issues (negatives)

- **Pay**
  - 49% not satisfied

- **Contractual arrangements**
  - 24% not satisfied

- **Professional development**
  - Provided with opportunities (61%)
  - No provision of back-up staff (55%)

- **Clinical supervision**
  - \( \approx 40\% \) did not receive supervision on a regular basis and/or level received was not adequate to needs

- **Substantial proportion with high stress levels**
  - 19% emotionally exhausted
Recruitment and Retention Issues

There are numerous reasons why the AOD field is facing workforce retention difficulties and recruitment difficulties.

The most common reasons cited include:

- Poor salary, terms and conditions
- Lack of professional and career development opportunities
- High workloads and work stress
- Complexity of roles
- Poor public profile (stigma of work)
- Difficult work environments
- Uncertainty of tenure due to short-term funding
- Limited clinical supervision and managerial support
- Limited recognition for effort

(Duraisingam et al., 2006; NADA, 2003; VAADA, 2003; WANADA, 2003a, 2003b).
Turnover Intention

- 54% had thought about leaving
- 31% intended looking for a new job in the next 12 months
- 20% intended to look for new job outside the AOD field
Retention & Barriers to Entry

- Retention strategies:
  - Salary increases (21%)
  - Recognition / appreciation of effort (15%)
  - Career opportunities (12%)
  - Training opportunities (11%)
  - Supportive workplace (11%)

- Barriers to entry:
  - Low salary / poor benefits (28%)
  - Perceptions of difficult clients (20%)
  - Stigma / lack of respect (17%)
Demands of Emotional Labour

Often overlooked

‘The Unbearable Fatigue of Compassion’
(Fahy, 2007, Clin Soc Work J)
Stress-Related Factors:

- **Client presentations**
  - Violent & aggressive clients cause “a lot” to “extreme” pressure (50%)
  - Co-morbidity presentations cause “a lot” to “extreme” pressure (28%)

- **High workloads**
  - 41% never have enough time to get everything done
Stigma

…alcohol and drug use problems are heavily moralized territories, often resulting in stigma and marginalization,

….and these factors are important in adverse outcomes.

Room, 2005 Drug and Alcohol Review
Models of AOD Education &
Minimum Qualifications

1. the bolt-on, post basic training model
2. the integrated pre-service training model
3. on-the-job training
4. basic qualifications (e.g. Cert IV)
5. Combinations of 1-4

Note also the accredited vs non-accredited courses issue
Figure 1: Competencies are workplace driven and consistent with the AQF

- VET Sector:
  - Vocational Graduate Diploma
  - Vocational Graduate Certificate
  - Advanced Diploma
  - Diploma
  - Certificate IV
  - Certificate III
  - Certificate II

- National Competencies

- Higher Education Sector:
  - Doctoral Degree
  - Masters Degree
  - Graduate Diploma
  - Graduate Certificate
  - Bachelor Degree

- Notes:
  > HLT07 and CHC08 include some of the competency standards needed at high levels
  > HLT07 and CHC08 include most of the competency standard needed for work at low and mid levels

Future directions for Training Packages to address competency gaps at all levels.
The role of VET in alcohol and other drugs workforce development

NATIONAL CENTRE FOR EDUCATION AND TRAINING ON ADDICTION
Ken Pidg
Ann Roche
Amanda Carne

A NATIONAL VOCATIONAL EDUCATION AND TRAINING RESEARCH AND EVALUATION PROGRAM REPORT
Minimum Qualifications

Survey AOD managers (n=186; 44% NGO sector)

- Most managers (82%) support a Minimum Qualification
- VET quals are considered ‘sufficient’, but more than half think it should be higher than Cert IV
- One in three support quals at undergraduate or postgraduate level
Reasons for Dissatisfaction

• Poor/variable quality training and assessment quality
• Lack of correspondence between what was learned and skills required on-the-job
• Training content out-of-date or out-of-touch with industry developments
• Lack of practical experience/work placements
Comparison of salary disparity between similar positions in the Public Service Sector and the Community Service Sector (WAAMH et al., 2008)

<table>
<thead>
<tr>
<th>Community Drug Service Team Counsellor</th>
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</thead>
<tbody>
<tr>
<td>Community Service Sector SACs Award</td>
</tr>
<tr>
<td>Award</td>
</tr>
<tr>
<td>2003 SACS Level 5.1</td>
</tr>
<tr>
<td>2004 SACS Level 5.2</td>
</tr>
<tr>
<td>2005 SACS Level 5.3</td>
</tr>
<tr>
<td>2006 SACS Level 5.3</td>
</tr>
<tr>
<td>2007 SACS Level 5.3</td>
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</table>
### Preferred AOD specialist worker qualifications

<table>
<thead>
<tr>
<th>AOD specialist workers’ qualifications</th>
<th>Most preferred N (%)</th>
<th>Least preferred n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational education and training AOD qualifications</td>
<td>17 (13.8)</td>
<td>56 (66.7)</td>
</tr>
<tr>
<td>Relevant university undergraduate degree PLUS non-accredited AOD training</td>
<td>9 (7.3)</td>
<td>13 (15.5)</td>
</tr>
<tr>
<td>Relevant university undergraduate degree PLUS accredited AOD training (statement of attainment)</td>
<td>27 (22.0)</td>
<td>1 (1.2)</td>
</tr>
<tr>
<td>Relevant university undergraduate degree PLUS accredited VET AOD qualifications</td>
<td>29 (23.6)</td>
<td>-</td>
</tr>
<tr>
<td>Undergraduate degrees with explicit AOD content</td>
<td>14 (11.4)</td>
<td>3 (3.6)</td>
</tr>
<tr>
<td>Postgraduate AOD qualifications</td>
<td>27 (22.0)</td>
<td>11 (13.1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123 (100)</strong></td>
<td><strong>84 (100)</strong></td>
</tr>
</tbody>
</table>

Not answered = 59
Preferred AOD specialist worker qualifications

- Vocational education and training AOD qualifications: 66.7%
- Relevant university undergraduate degree PLUS accredited VET AOD qualifications: 23.6%
- Relevant university undergraduate degree PLUS accredited AOD training (statement of attainment): 22%
- Undergraduate degrees with explicit AOD content: 11.4%
- Postgraduate AOD qualifications: 13.1%
- Undergraduate degrees with explicit AOD content: 3.6%
Managers’ levels of satisfaction with vocational education and training provided by technical and further education colleges, universities and private training providers

[1 in 4 dissatisfied with VET training]
Suggestions for Remediation

• Greater emphasis on:
  - Counselling, motivational interviewing, assessment
  - Interventions
  - Mental health/co-morbidity
  - Provision of clinical work placements
Statistics are like a bikini.

What they reveal is suggestive, but what they conceal is vital.

(Aaron Levenstein)
10 Contributors to Work-related Stress among Indigenous Alcohol and Other Drug Workers

<table>
<thead>
<tr>
<th>Factors</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workloads</td>
<td>Workloads were invariably high and not commensurate with the resources available to meet the needs.</td>
</tr>
<tr>
<td>2. Expectations</td>
<td>Workers consistently demonstrated high levels of personal commitment to their work role and their community. In addition, there is a complex set of community obligations that workers need to fulfil.</td>
</tr>
<tr>
<td>3. Boundaries</td>
<td>Many workers saw being available 24/7 was part of a cultural obligation; others were increasingly learning to place appropriate limits and boundaries in culturally secure ways to prevent burnout.</td>
</tr>
<tr>
<td>4. Recognition, Respect and Support</td>
<td>Workers reported that recognition or respect was often not afforded to them. They also were often solo or isolated workers with insufficient support.</td>
</tr>
<tr>
<td>5. Working Conditions</td>
<td>Difficult and stressful working conditions were common, especially among workers in rural and remote settings.</td>
</tr>
<tr>
<td>6. Racism and Stigma</td>
<td>High levels of stigma were associated not only with alcohol and other drug work but also the Aboriginality of the clients and the workers. Racism was commonly experienced from co-workers and mainstream community and constituted a major source of stress.</td>
</tr>
<tr>
<td>7. Complex Personal Circumstances</td>
<td>Many workers were single parents or responsible for dependent children, elderly and other family members. Many had experienced significant bereavements, domestic violence, and previous problems with alcohol or drugs. Family members were also often alcohol and other drug clients.</td>
</tr>
<tr>
<td>8. Loss and Grief and Sorry Business</td>
<td>Heavy community losses through premature deaths including suicides. Traditional bereavement leave was rarely adequate. The importance of Sorry Business, and loss overall, was also often not understood.</td>
</tr>
<tr>
<td>9. Culturally Safe Ways to Work</td>
<td>Although noted to be improving, there was a significant lack of understanding about Indigenous ways of working. This created regular conflict and clashes with mainstream colleagues and services and undermined the health and wellbeing of both clients and workers.</td>
</tr>
<tr>
<td>10. Funding, Job Security and Salaries</td>
<td>Short term funding and short term appointments with low salaries contributed to high stress levels and high turnover rates.</td>
</tr>
</tbody>
</table>
Workforce Development Strategies (TIPS Kit)

1. Capacity Building
2. Salary
3. Recruitment, Retention and Turnover
4. Career Paths
5. Role Clarity
6. Qualifications and Training Issues
7. Mentoring
8. Clinical Supervision
9. Debriefing
10. Team and Co-Worker Support
<table>
<thead>
<tr>
<th>Factors</th>
<th>Descriptor</th>
<th>Response Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Capacity Building</td>
<td>Building capacity of workers, organisations and communities to provide culturally appropriate (Indigenous) and culturally safe (mainstream) alcohol and other drug services is a crucial social determinant of health.</td>
<td>Address organisational funding issues to provide continuity of funding, provide sufficient funds to allow appointment of adequate numbers of staff, implement appropriate workforce planning, and management and leadership training programs.</td>
</tr>
<tr>
<td>2. Salary</td>
<td>Recognition of work demands and the unique role played by this workforce to improving the overall health status of Indigenous people through more equitable salaries across all sectors.</td>
<td>A move to parity of salaries for all levels of staff across all sectors including government, community controlled and non-government health services.</td>
</tr>
<tr>
<td>3. Recruitment, Retention and Turnover</td>
<td>Complex and difficult work and employment conditions, especially in remote areas, create a constant strain on alcohol and other drug workers and acts to discourage new recruits from entering the field and fuels high turnover.</td>
<td>Promote a positive image of the alcohol and other drug field. Recruit Indigenous high school students into tertiary education pre-employment workshops, support for literacy and numeracy, pre-vocational courses, introductory, job rotations, and flexible traineeship and apprenticeship on-the-job programs that involve managers in additional responsibilities.</td>
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<tr>
<td>4. Career Paths</td>
<td>Lack of career pathways and opportunities for professional advancement for Indigenous people in alcohol and other drug work was commonplace and compounded recruitment and retention challenges.</td>
<td>Create new staffing categories that workers can aspire to that provide incentives and promotional and further skill development opportunities.</td>
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<td>5. Role Clarity</td>
<td>Very broad and overly inclusive roles and lack of role clarity were common.</td>
<td>Better definition of worker’s roles within their organisations are required. Providing resources to support workers through clinical supervision, mentoring and debriefing could be achieved at relatively low cost.</td>
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<tr>
<td>6. Qualifications and Training Issues</td>
<td>Alcohol and other drug workers often did not have sufficient knowledge or adequate access to training. Training at higher levels was also indicated.</td>
<td>Extend the focus beyond the Indigenous workers at the level of Certificate III and Certificate IV and provide management training.</td>
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<td>7. Mentoring</td>
<td>Mentoring was recognised as a valuable professional development tool.</td>
<td>Implement mentoring as a standard support strategy.</td>
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<td>8. Clinical Supervision</td>
<td>Clinical supervision was recognised as an effective strategy to prevent or manage stress but was not widely implemented.</td>
<td>Implement clinical supervision as a standard strategy to prevent or manage stress. Develop Indigenous-specific clinical supervision guidelines for the alcohol and other drug sector.</td>
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<tr>
<td>9. Debriefing</td>
<td>Debriefing was recognised as an effective mechanism to reduce stress; however debriefing opportunities and preferences were highly varied and were often found to be non-existent.</td>
<td>Identify and promote various forms and sources of debriefing suitable for Indigenous workers and their working contexts.</td>
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<tr>
<td>10. Team and Co-Worker Support</td>
<td>The need for diverse forms of support for workers was a priority.</td>
<td>Worker support is needed at various levels and in various forms and includes mentoring, clinical supervision, formal and informal debriefing opportunities as well as recognition of good work.</td>
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<tr>
<td>Challenge</td>
<td>Workforce development implications</td>
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</table>
| Shift towards service models that emphasise prevention, primary, community and home-based services | > Training packages to integrate skills as they emerge  
> Increase in funding and coordination to meet skills and qualifications requirements within sectors, especially where qualification requirements are mandated  
> Increase in e-learning and simulation centres to train staff more cost-effectively |
| Need to build management capacity                                          | > Greater uptake of supervision/management streams in training packages and changes to packages where required  
> Improved career pathways and remuneration                                 |
| Increased complexity of client needs                                      | > Increase in demand for workers with higher-level skills, especially higher-level clinical skills  
> Increase in funding and coordination to meet the skills and qualifications requirements within sectors |
| Increased use of assistant and advanced practitioner roles                | > Development of career paths into specialist and professional service-delivery roles  
> Strengthening assistant roles across the community services and health industries  
> Supplementing certificate – and diploma-level qualifications with higher-level qualifications, such as advanced practice and management roles and other skill sets  
> Development of multi-specialty practice or multidisciplinary teams within primary care that involve allied health, nursing and medical practitioners  
> Working with and reforming of occupational licensing arrangements |
| Policy focus on integrated models of service delivery                     | > Further development of training packages to promote cross-sectoral/industry skill and competency clusters  
> Development of cross-sectoral/industry career paths  
> Development of a system of registration and accreditation to assist in labour flows of health professionals across states and territories |
| Need to address conditions, recruitment and retention in community services | > Harmonising of pay inequity between government and not-for-profit agencies  
> Development of classification structures within awards that promote well-developed career pathways and include skill formation/training drivers  
> Development of better VET–higher education articulation pathways that map onto career structures |
| Labour shortages in rural and remote areas                               | > Changes in skills mixes and work practices to address shortages of doctors, nurses and allied health professionals  
> Improvement in technologies that provide remote access to specialist advice  
> Increase in e-learning and simulation centres to improve access to training  
> Increase in clinical placements in rural and remote areas |
NCETA WFD Tools

- Practical tools:
  - Stress & Burnout Booklet
  - Clinical Supervision Resource Kit
  - TIPS Kit – WFD Tools & Resources
Stress and Burnout
A Prevention Handbook for the Alcohol and Other Drugs Workforce
A Workforce Development Resource
Natalie Skinner
Ann Roche

Satisfaction, Stress & Retention
Among Alcohol & Other Drug Workers in Australia
Vinta Dunshegan
Ken Pidd
Ann M. Roche
John O’Connor

Identifying and Preventing Burnout
In Alcohol and Other Drug Managers: A National Survey
Vinta Dunshegan
Andrea Zoonkps
Yvette Poland
Ken Pidd
Ann M. Roche
Workforce Development
New guidelines for A&D/AOD workers (Dec 09)

- NDARC ($ from DoHA): management of co-occurring mental health conditions in alcohol and other drug (AOD) treatment settings. (best available evidence + experience and knowledge of clinicians, researchers, consumers and carers).

Aim to:
- > AOD workers’ knowledge and awareness of mental health conditions.
- Improve confidence and skills of AOD workers with these clients.
- Provide guiding principles.
- Improve AOD workers’ ability to ID mental health conditions.
- Provide practical info. re management & info. re treatment of comorbid mental health conditions.
- Provide info re referral processes.
- Provide resources to facilitate the above.

Ann Roche,
National Centre for Education and Training on Addiction (NCETA)

www.nceta.flinders.edu.au