Consultation paper

Renewing Queensland's Alcohol and Other Drugs Plan

Creating, sustaining and supporting the Alcohol and Other Drugs (AOD) workforce

Queensland Network of Alcohol and Other Drug Agencies (QNADA)

– Not Government Policy –

The current AOD workforce landscape

Alcohol and other drug-related harm presents serious social, health, and economic challenges for the Australian community. The AOD workforce is essential to responding to these challenges and supporting people who experience AOD-related harm to continue to lead healthy and productive lives. Good system and local level planning will help the AOD service sector to build a workforce to meet service demands and the needs of diverse groups. Workforce planning can support job creation, recruitment and retention, and the development and maintenance of professional skills. This supports the community to access services where and when they need them.

Workers who respond to AOD issues can generally be sorted into two groups, each with a different focus and scope of practice. First, there are specialists who focus on reducing AOD-related harm and demand by providing one, or a combination of, specific interventions. These include interventions such as rehabilitation, withdrawal management (detox), medication-assisted treatment (e.g. the Queensland Opioid Treatment Program) counselling, case management, and harm reduction services (e.g. needle and syringe programs, public intoxication services, AOD crowd care at events).

The second group consists of a generalist workforce that provides basic responses to AOD issues and possibly specialises in another area. Generalists play an important role, tending to provide early and targeted information and referral to people who may be at risk of AOD-related harm and collaborate with the specialist sector. Examples of the generalist workforce are workers from welfare, law enforcement, and criminal justice and education sectors, to name a few.

The specialist AOD workforce is diverse. It is primarily comprised of people employed by public health services or non-government organisations (NGO), with a small proportion of private sector workers. In Queensland, there are differences in the workforce profiles between government and NGO services, along with differing, but often complementary, service models. For example, government services provide the bulk of medically assisted treatment, while residential rehabilitation is provided solely by the NGO sector. Services such as counselling are provided by both government and NGO specialist AOD services.

The AOD workforce includes a broad range of professions, such as counsellors, social workers, psychologists, nurses, AOD workers, Aboriginal and Torres Strait Islander AOD/health workers, and addiction medicine specialists.

Nationally, the specialist AOD workforce is significantly marked by experiential knowledge of AOD use issues, with almost seven in 10 workers having either personal experience, that of a family member, or other experience. Of this group, half have their own personal experience of AOD use and nearly two thirds have disclosed their experiential knowledge to their workplace, however common reasons for non-disclosure relate to confidentiality, privacy, or concerns about stigma.

Almost 70 per cent of AOD workers are female, and more than 30 per cent are aged 50-64, meaning around one-third of the existing workforce will reach retirement age during the next 10 to 15 years.

Six per cent of the workforce and 17 per cent of clients aged 10 and over identify as Aboriginal and/or Torres Strait Islander. In order to provide culturally secure AOD practice, future workforce planning must consider cultural competence and the development of both 'mainstream' and 'community controlled' workforces across diverse locations, including urban, rural, regional and remote communities.

In addition, rates of treatment engagement in culturally and linguistically diverse (CALD) communities tend to be low. Given AOD use in these communities is less often talked about, a range of barriers to accessing treatment and harm reduction services may exist, including community stigma and access to culturally appropriate services and information. Therefore, further consideration should be given to developing a workforce that can respond to the needs of CALD clients, families and community groups.

Creating and sustaining the workforce

The development and maintenance of a qualified and experienced workforce is a key element of any effective service system. Attracting and retaining the right workers with appropriate skills and experience is crucial to the continuing delivery of quality AOD services. If too many people leave the system at one time, there is a risk that skills and experience will be lost.

Given the age profile of the Queensland workforce, the impending retirement of older workers, and the limited availability of education and training programs with an AOD focus it is important to consider how to skill new AOD workers and maintain and develop the existing workforce.

High levels of stigma associated with AOD use, particularly illicit drug use, negatively influence the way AOD work is perceived and valued. It is important that potential students perceive working with people who experience problems with AOD as a worthwhile cause, similar to other health conditions and professions.

In order to continue creating a workforce that can respond to AOD issues (both generalist and specialist), exposure to AOD content in educational settings is important. Educational institutions, such as universities, rely on students to have an interest in their course offerings. To develop more interest in the field, stigma and misconceptions around AOD need to be reduced.

In Queensland, there are limited opportunities for specialist and generalist AOD education in both the vocational and tertiary sectors.[1] Nationally, dedicated AOD content in professional areas such as psychology, social work, medicine and nursing has been described as patchy.[2] Interested students often need to actively seek out education the field after obtaining their professional qualification by participating in postgraduate study. If AOD content is offered within an undergraduate degree, it is likely to be brief and have a narrow focus. For example, a psychology student might

[1] Nicholas, R., V. Adams, A. Roche, M. White and S. Battams (n.d.). A literature review to support the development of Australia's alcohol and other drug workforce development strategy Adelaide, South Australia, Flinders University.
[2] Ibid.

learn about how substances interact with the brain over a lesson in neuropsychology but may not learn about AOD treatment issues and approaches.

As a result, many professionally qualified people enter the AOD workforce or transfer from other sectors with few AOD skills.[3] While many specialist AOD organisations support student work-based placements, most workers new to the sector develop expertise through on-the-job training and professional development. In Queensland, this is likely to occur through state-wide agencies such as Dovetail, Insight, the Queensland Aboriginal and Islander Health Council, Queensland Indigenous Substance Misuse Council and the Queensland Network of Alcohol and other Drugs Agencies.

The availability of and access to quality AOD training is important. Training can be built into organisational planning to support and develop workershowever, pressure to meet key performance indicators, shorter-term contracting of NGO services, and other financial limitations can reduce or undermine organisational ability to invest time and money in developing staff - especially if they are unsure whether those staff are going to be with the organisation in future[4]

Inadequate pre-employment knowledge and skills can leave some new AOD specialist workers unprepared for their role and exposed to negative impacts on their wellbeing. It can also mean clients receive poorer quality care. Some states have minimum AOD competencies and/or require new and existing workers to hold a minimum qualification to work in the sector.

However, mandating AOD-specific minimum qualifications could act as a disincentive to experienced workers already in the field, and to existing or potential staff with other health-related qualifications (e.g. social work, nursing). For example, requiring a qualified nurse to participate in further study for minimum AOD qualifications could see that person seek employment in other sectors where additional study is better rewarded or not required. Likewise, in the absence of salary award conditions commensurate with other health disciplines, experienced workers already in the field have little incentive to put time and money into obtaining an AOD qualification.

Introducing mandatory minimum qualifications would also have cost implications, raising the question of who would be expected to meet these costs for the existing workforce. On-the-job training and professional development can provide a significant and effective pathway for many workers, which can lead to further study and professional development. This pathway is particularly important in regional, rural and remote communities with limited workforces, and in Aboriginal and Torres Strait Islander communities where experiential knowledge is essential.

Aboriginal and Torres Strait Islander services and communities face greater disadvantage and are disproportionately challenged by workforce issues such as attraction and retention of workers. Although Aboriginal and Torres Strait Islander peoples play a central role in addressing higher rates of harmful AOD use in their communities, Aboriginal and Torres Strait Islander AOD workers are usually employed in relatively lower status, lower paid positions such as health workers or community workers.[5]

Against the backdrop of higher disadvantage, these workers are skilled at responding to a range of issues that are less common in metropolitan settings. This includes translating mainstream ways of working to specific cultural

[3] Roche, A., A. Trifonoff and J. Fischer (2019). Northern Territory Alcohol and other Drugs Workforce Development Strategic Framework. Darwin, Northern Territory, Northern Territory PHN.
[4] Ritter, A., L. Berends, J. Chalmers, P. Hull, K. Lancaster and M. Gomez (2014). New Horizons: The review of alcohol and other drug treatment services in Australia. Final Report. Sydney, University of New South Wales.
[5] Intergovernmental Committee on Drugs (2015). National Alcohol and other Drug Workforce Development Strategy 2015-2018.

contexts; heavier work demands due to case complexity and chronic co-occurring health and other issues; and a general shortage of workers. They have cultural, family and community obligations outside work, tend to experience isolation due to remoteness; and can face a lack of cultural understanding and support from non-Indigenous workers while also being relied on to educate those staff.[6]

Recruitment and retention in regional, rural and remote AOD services is further complicated by issues such as the cost of living, accommodation availability, and a lack of commitment to the community.[7] Workforce research indicates effective recruitment and retention strategies in regional, rural and remote areas include additional leave entitlements, flexible working arrangements, subsidised housing and utilities, increased job security, greater access to further education and training, and improved career pathway options.[8]

Generalist workers are central to supporting work to reduce AOD harm through early identification of issues and ongoing service coordination and collaborative care. However, the Queensland Mental Health Commission's *Changing Attitudes, Changing Lives* report (p. 5)[9] identified:

> "Stigma and discrimination have been found to be most pervasive in five settings:
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> 1. Health care and public health
> 2. Welfare and support services, including housing
> 3. Police, public order and criminal law
> 4. Employment
> 5. Society at large.

In these settings stigma and discrimination negatively impact people's access to services (including health care), fair treatment in the justice system, employment opportunities, relationships with family and friends, their feelings of social inclusion, and their drug use."

In particular, generalist workers with less experience in AOD, require training and support to stay abreast of good practice responses to AOD issues including stigma reduction. The specialist AOD sector often absorbs the expense of training generalist workers, but other avenues to provide and fund such training should be considered.

The specialist AOD workforce often works with people experiencing other stressors in addition to AOD issues such as trauma, domestic and family violence, and homelessness. Substantial research indicates workplace overload, stress, stigmatising negative community attitudes, and vicarious trauma (experiencing secondary trauma as a result of client work) affect a significant proportion of the AOD workforce, impacting staff retention. Reducing stress, compassion fatigue and burnout are important factors in maintaining and developing the AOD workforce.

Workers who receive ongoing professional support (e.g. clinical / practice supervision, employee assistance programs, opportunities for learning and development, and processes that build staff connection to each other and

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[6] Ibid.
[7] Ibid.
[8] Western Australian Network of Alcohol and other Drug Agencies (WANADA) (2017). Comprehensive Alcohol and other Drug Workforce Development in Western Australia. Perth, WANADA.
[9] Queensland Mental Health Commission (2018). Changing attitudes, changing lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use. Brisbane, Queensland Mental Health Commission.

to management[10]) tend to be better equipped to manage the challenges of working in the AOD field. However, workforce context, availability, education, employment conditions, contracting arrangements, and stigma present challenges to both sustaining and creating the AOD workforce to meeting future need.

Supporting organisations

A 2014 review of AOD treatment services in Australia estimated a return to society of $7 for every dollar invested.[11] This underscores the need to plan for a treatment system that supports organisations to provide quality services and to grow to meet service demand. The way funding is calculated, planned and distributed and under what requirements influences the types of services delivered, including the quality, quantity and scope of treatment services available.[12]

Despite recent increased investment in the AOD sector, demand continues to outstrip availability of services provided by government and NGO sectors. People can face long waits to get into a service, and in some regions cannot access services at all.

There may be opportunities to improve the way organisations are supported by providing greater certainty around funding and by reducing administrative burdens. This could include:

- longer contracting arrangements to support job security
- ensuring funding grows in line with the consumer price index (CPI), which is a measure of changes in the cost of goods and services, to support increases in salaries and operational costs
- joint planning for services involving specialist and generalist AOD workforces and state and commonwealth agencies with responsibility for service planning and funding.

Coordination, collaboration, and identifying community need are key principles for effective, accessible and equitable AOD treatment service planning and funding. This has strong ramifications for the AOD workforce. Planning for stable funding, proportionate to CPI could better support organisations to build and retain a skilled workforce and provide quality care to clients.

It is clear that a range of approaches and initiatives could support and strengthen the AOD workforce, but that any one approach taken in isolation would be likely to have limited impact. Unlike other traditional approaches that predominantly address the immediate education and training needs of individual workers, a systems approach is broad and comprehensive and targets individual, organisational and structural factors (p. 443).[13] Systemic, multi-faceted, and coordinated approaches to workforce planning are vital if the workforce is to continue providing effective responses to AOD issues.[14]

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[10] Ibid
[11] Ettner et al in Ritter, A., L. Berends, J. Chalmers, P. Hull, K. Lancaster and M. Gomez (2014). New Horizons: The review of alcohol and other drug treatment services in Australia. Final Report. Sydney, University of New South Wales.
[12] Ibid.
[13] Roche, A. and R. Nicholas (2017). "Workforce development: An important paradigm shift for the aclohol and other drugs sector." Drugs: Education, Prevention and Policy **24**(6): 443-454.
[14] Ibid.

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