National AOD Workforce Development Strategy

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Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy:

Discussion Questions

These Discussion Questions represent key priorities and issues for stakeholder consideration for the review and revision of the National AOD WFD Strategy. A comprehensive Discussion Paper and Executive Summary are also available here.

Given the breadth of topics addressed in this paper, submissions welcome to address **some or all** of the Discussion Questions,
and/or to address other issues of importance and relevance.
Guide lists have been included to reduce respondent burden, but additional suggestions are welcome, as are submissions focussed on a particular topic(s) or issue(s) as relevant to stakeholder groups.

Submissions may be written or in the form of an audio/video recording

Please email **written submissions** to ncetaconsultation@flinders.edu.au and include a coversheet available from https://nceta.flinders.edu.au/stakeholder-consultations/national-aod-wfd-strategy-stakeholder-consultation

Please contact NCETA if you wish to provide a video/audio submission
(a confidential upload link will be provided)

Submissions are due by 5pm CST Monday 28th February 2022

All materials are available to download from https://nceta.flinders.edu.au/stakeholder-consultations/national-aod-wfd-strategy-stakeholder-consultation

- Discussion Paper
- Executive Summary
- Discussion Questions
- Submission coversheet

Discussion Questions

GENERAL WFD QUESTIONS

Discussion question 1: What are the priority WFD issues that have emerged since the first Strategy (2015-2018)?

Important issues could include (but aren't limited to):

- *Changing service delivery models including as a result of COVID-19*
- *The need for more specialised skill sets to address complex presentations*
- *Growth in the proportion of the service delivery system provided by the NGO sector*
- *Growth in digital and online service provision*
- *The need for greater capacity building to support the Aboriginal and Torres Strait Islander AOD workforce*
- *Stronger emphasis on integration of the peer/lived experience workforce into service provision*
- *Increasing recognition of the importance of consumer representation and participation service delivery*
- *A larger number of early career workers in the AOD sector and the concomitant ageing of the workforce*
- *The need to address AOD workers' wellbeing, and strategies to address stress and burnout*
- *Ongoing challenges related to stigma of AOD work, which may impact worker wellbeing, recruitment and retention*

GDPSA recommends that as a priority, service delivery models and models of practice are to be made more flexible, and culturally safe. It is essential to develop AOD evidence-based approaches that are central to Aboriginal ways of working. As an example, yarning has been found to be an effective approach to build trusting relationships between AOD workers and clients. According to Aboriginal and Torres Strait Islander AOD workers in Aboriginal Community Controlled Health Services interviewed by The Centre of Research Excellence in Indigenous Health and Alcohol[1], yarning requires a flexible service delivery model because it involves:

- A friendly, relaxed style of communication.
- Information to be shared both ways so the worker is learning as much from the client as the client is from the worker, and the trust of the worker is gained by trusting the client with information.

[1] https://vimeo.com/464976088

- Following cultural protocols with respect, such as requesting permission to speak to a woman or elder before starting to speak.
- Facilitating consultations outside of the service building, nearby, or in the community, park, beach, etc. wherever the client feels safe.

GDPSA also encourages the strategy to reframe its intention for the Aboriginal and Torres Strait Islander AOD workforce from "capacity-building" to "supporting self-determination". GDPSA promotes culture as strength. Aboriginal and Torres Strait Islanders need to be involved in all stages of the policy process for self-determination to be possible (ie. Agenda-setting, consultation, policy creation, implementation, monitoring and evaluation). A 2022 Delphi Study[2] on Aboriginal and Torres Strait Islander self-determination in health found that self-determination in policy development may not be present across all stages. For example, it is possible for self-determination to be evident in some stages of the policy process and completely absent in others.

Aboriginal and Torres Strait Islander community- controlled organisations have grown from a rich history of self-determination. From an individual community level through to regional and state/territory affiliates, community-controlled organisations have long-standing systems in place to represent their local communities. They are able to contribute unique insights to develop alcohol related policy and workforce development within a health context. To ensure diversity of Aboriginal and Torres Strait Islander representation, community-controlled organisations should be included as one source, alongside a spectrum of other groups of Aboriginal and Torres Strait Islander representatives, such as Elders, consumers and carers.

Discussion question 2: What are the priority actions to improve WFD at the a) systems, b) organizational, and c) individual worker levels in the short-medium (3-5 years) and longer (6-10 years) terms?

Important issues could include (but aren't limited to):

- *Reviewing and improving funding models to ensure AOD services have optimal support for capacity building and effective service delivery*
- *Addressing remuneration and other employment conditions for AOD workers to achieve parity with similar sectors (e.g., mental health)*
- *Development of a national AOD workforce census to guide workforce planning and WFD*

[2] *https://aodknowledgecentre.ecu.edu.au/healthinfonet/getContent.php?linkid=675025&title=First+Nations+Australians%E2%80%99+self-determination+in+health+and+alcohol+policy+development%3A+a+Delphi+study&contentid=44605_1*

- *Development and promotion of recruitment pathways into the AOD sector from related fields (e.g., public health, community services)*
- *Building and supporting structured career pathways within AOD organisations and the sector in general, including pathways into leadership and management roles*
- *Implementing programs and strategies to increase the accessibility of professional development, clinical supervision and practice support for the AOD workforce*
- *Developing and implementing public campaigns to address stigma associated with AOD use and AOD work*

GDPSA recommends that in addition to the above that the following important issues are prioritised.

Short term (3-5 years)

- Ensure cultural safety within all alcohol and other drug-related services so that workers understand the cultural needs of Aboriginal and Torres Strait Islander clients, including social, spiritual, emotional and physical wellbeing, and gender health needs.
- Support and promote family-based approaches in AOD workforce training and development to encourage family-inclusive service delivery
- Support and promote developing and strengthening the role of Peer Support workers in the AOD workforce

Long term (6-10 years)

- Build the evidence base with monitoring and evaluation

GDPSA further recommends that cultural safety is emphasised throughout the strategy. Cultural safety is distinguished from cultural 'awareness' and 'competency', as it relates to embedding culturally sound practices into all elements of delivery, rather than merely recognising that cultural differences exist.

Discussion question 3: Thinking about specialist AOD workers:
(a) What are the priority WFD issues for AOD specialist workers?
(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)
(c) What are the major steps in the short-medium and longer term to achieve these goals?

Priorities for specialist AOD workers could include (but aren't limited to):

- *Access to clinical supervision and practice support*
- *Increased accessibility and support for accessing advanced training (e.g., funding support for backfill costs)*

- *Programs to address wellbeing (e.g., burnout), including addressing secondary stigma that may be associated with AOD work*
- *Strategies to build and improve career development pathways*

GDPSA recommends the strategy consider more options to increase service collaboration whether through electronic records sharing or case coordination meetings. As an example, memory and executive functioning can be disturbed in recovering AOD clients so a psychologist can recommend that a diary and reminders be used for prompting by other service providers.

Discussion question 4: Thinking about generalist workers:
(a) What are the priority WFD issues for generalist workers?
(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)
(c) What are the major steps in the short-medium and longer term to achieve these goals?

Priorities for generalist workers could include (but aren't limited to):

- *Integration of AOD content into pre-employment training at vocational and tertiary levels*
- *Increased accessibility to AOD-related training and professional development for established workers*
- *Strategies, programs and support to facilitate integrated care that incorporates AOD professionals and organisations*
- *Targeted professional educational campaigns to address stigma and discrimination that may be associated with AOD use and AOD work*

GDSPA advises it is also critical for the strategy to consider as a priority options to accelerate improvements to develop:

- Culturally safe training and support mechanisms for a full range of targeted training and employment options for Aboriginal and Torres Strait Islander AOD workforce
- AOD peer support workforce

PRIORITY GROUPS

Discussion question 5: Thinking about the workforce groups who identify as Aboriginal or Torres Strait Islander:

(a) What are the priority WFD issues for these workers?

(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

(c) What are the major steps in the short-medium and longer term to achieve these goals?

Important issues could include (but aren't limited to):

- *Culturally safe training and support mechanisms*
- *Availability and accessibility of education, training and professional development for new and established workers*
- *Programs and actions to address the wellbeing*

GDPSA agrees that culturally safe workplaces and support mechanism are important. GDPSA recommends that a specific support mechanism should be public reporting on how an AOD service equips itself to be culturally safe and what kind of avenues there might be for either Aboriginal-specific health workers there, or people who will act as a kind of liaison to the service. Other information required would include their Aboriginal and Torres Strait Islander workforce levels, employment targets and what strategies they can demonstrate to meet those targets.

Trusting and long-lasting collaborative relationships among practitioners takes time to build. In addition to formal processes, it is also greatly aided by proximity and the opportunity to informally get to know and learn from one another through co-location by integrating AOD within a range of health and wellbeing teams, such as mental health, primary health care and youth services.

Opportunities should be sought by funding bodies to explore how flexible, co-located and integrated offerings could be established between such services, and Aboriginal and Torres Strait Islander specific teams, to enhance access and service engagement, and ultimately, improve health outcomes for Aboriginal and Torres Strait Islander communities in the region.

Discussion question 6: Thinking about other the workforce groups with unique needs (e.g. rural, regional and remote workers, peer workers, law enforcement and corrections workers):

(a) What are the priority WFD issues for these workers?

(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

(c) What are the major steps in the short-medium and longer term to achieve these goals?

(d) Are there Australian or international examples of effective WFD for these groups that could be replicated/adapted?

Important issues could include (but aren't limited to):

- *Availability and accessibility of education, training and professional development for new and established workers*
- *Strategies needed to support the recruitment and retention of workers*

- *The need for training and professional development to develop particular knowledge, skills or abilities*
- *Programs and actions to address the wellbeing of these workers that meets their unique needs*

GDPSA recommends considering place-based educational and training models for the remote and rural Aboriginal and Torres Strait Islander AOD workforce. Often gaining qualifications beyond school requires individuals to travel away from their communities with accompanying expenses. This is a barrier to employment that could be addressed more effectively with the innovations in remote and distance learning that have been an upshot of the COVID-19 crisis. While advances in digital means are clearly at the forefront currently, they should be complemented by face-to-face opportunities with cohorts undertaking similar study requirements, in part to build supportive professional networks locally and regionally.

Delivering training within remote or regional Aboriginal and Torres Strait Islander communities could link directly to local employment opportunities to build local mental health service capacity and capability for easier access.

Place based education and training options could also upskill the existing Aboriginal and Torres Strait Islander workforce where services exist.

Further, those with lived experience of mental illness, and their carer/family members could be a cohort to recruit new students from, if not at least involve in the codesign, implementation and evaluation of all workforce development activities to improve the delivery of culturally safe and trauma informed care.

There are models currently taking place in the VET Sector and the University Sector where this has been successful and should be expanded along with career pathways. For example, in NSW the NSW Aboriginal Mental Health Workforce Program utilises the education options from Charles Sturt University for Aboriginal and Torres Strait Islander people to acquire a Bachelor of Health Science (Mental Health) degree qualification while living and working locally in their own communities along with their usual support mechanisms and families.

Discussion question 7: What WFD strategies for the AOD workforce will best support and ensure effective service delivery for client groups who identify as Aboriginal and Torres Strait Islander? What are the immediate priorities for attention and action in this area?

Important issues could include (but aren't limited to):

- *Systems, organisational and individual strategies that meet the requirements of the Australian Commission on Safety and Quality in Health Care National Standards for Working with Aboriginal and Torres Strait Islander People (hereafter 'Aboriginal') and promote:*

- *Recruitment and retention of Aboriginal staff*
- *A welcoming and safe environment that quickly establishes if clients identify as Aboriginal*
- *Flexible service delivery options*
- *The use of practice strategies that engage Aboriginal people and their families*
- *Community consultation and engagement and understanding local history and protocols*

GDPSA encourages the Strategy to consider the importance of peer support workers in the AOD workforce for Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander consumer feedback from the EACH's Ngarrang Gulinj-al Boordup Aboriginal Health and Wellbeing Team model of care[3] suggests peer support workers can provide positive role modelling. The presence of a support person also makes a big difference to an AOD client in the establishment of a new relationship and helps to explain complex stories and medical background that can be triggering, advocate for the right medication and help translate some of the medical speak into plain English. In flexible service delivery models, transportation to get to appointments with the AOD service provider and linked services (GP, pharmacist, etc.) have been effective for Aboriginal and Torres Strait Islander clients. Getting a lift can also help to break social isolation as there is opportunity for informal chats.

Constant communication is a feature at EACH (Ngarrang Gulinj-al Boordup). Active listening and good communication can encourage attendance. A peer support worker can also support a consumer to be more meaningly connected to community by facilitating and encouraging attendance at various programs and events. When needed they also help with educating and raising awareness on the nature of addiction with family members.

Family centric models are important for the recovery of Aboriginal and Torres Strait Islander AOD clients. Families can have a long history of intergenerational addiction or they can be a source of support. It's important to make sure family members have someone to talk to and the complex trauma of the individual client understood.

More flexibility in service delivery is important for Aboriginal and Torres Strait Islander AOD clients. The ability of the workforce to consult outside of the service building and conduct outreach is beneficial, eg. visiting a client's home, a comfortable spot in nature, or to visit clients who are attending residential detox and rehabilitation services. This would boost service responsiveness, flexibility and continuity of care, support better communication with new providers and assist care navigation through the AOD system.

GDPSA encourages the Strategy to consider Aboriginal and Torres Strait Islander consumer feedback on the SMART free mutual support group model in Australia that was gathered by

[3] https://www.each.com.au/wp-content/uploads/2020/06/EACH_NGBReport-VR3_29-4-20-HP.pdf

the Centre for Aboriginal Health and Alcohol[4]. It is important to adapt mainstream/general models for Aboriginal and Torres Strait Islander communities. Overall, the SMART model was considered helpful in replacing social connections that were lost when AOD clients recovered from their addiction, and the establishment of an Aboriginal SMART recovery program encouraged. Aboriginal and Torres Strait Islander facilitators and group members recommended the following adaptations to encourage attendance:

- Integrate cultural knowledge into the facilitator training
- Aboriginal specific and culture focused program materials
- Less clinical language and more culturally appropriate language, taking into account the literacy level, localized language and terminology
- Improve community engagement by creating culturally appealing marketing materials
- Record testimonials of Aboriginal and Torres Strait islander AOD clients that recovered through the SMART program

The provision of culturally safe environments as well as culturally safe services is also important to emphasize here. Displaying Aboriginal and Torres Strait Islander artwork and a map of Australia outlining the geography of Aboriginal and Torres Strait Islander communities are recommended ways a service can create a more welcoming environment.

Discussion question 8: What are the key WFD strategies for the AOD workforce will best support and ensure effective service delivery for client groups with specific and unique needs (e.g., younger or older people, people who identify as LGBTIQ+, clients with complex needs)? What are the immediate priorities for attention and action in this area?

Important issues could include strategies that (but aren't limited to):

- *Encourage awareness of additional barriers to accessing AOD services these groups experience*
- *Promote access and equity to services*
- *Prioritise diversity in the recruitment of workers into the AOD workforce*
- *Ensure the comprehensive implementation of diversity training in AOD organisations*
- *Collect data about diverse populations*

In addition, GDPSA would encourage greater funding towards the development of wrap around service providers and workers for Aboriginal and Torres Strait Islander client groups with specific and unique needs, so that AOD clients can be matched with a service that best reflects them. Currently feedback from our AOD partners suggests that there are not enough services for the AOD workforce to link these clients to.

[4] https://vimeo.com/617455508

INTEGRATED CARE

Discussion question 9: How can integrated care with other sectors (e.g., mental health) best be achieved in practice to support clients with multiple and complex needs? Are there Australian or international examples of best practice in this area that could be replicated?

Important issues could include (but aren't limited to):

- *Upskilling AOD workers in responding to other health issues and upskilling generalist and specialist workers from other sectors to respond to AOD problems*
- *Promoting within-service holistic wrap-around client care and / or improving collaboration between AOD and other health services (no wrong door)*
- *Promoting and supporting client empowerment, individualised, client-driven treatment and being comorbidity-prepared*
- *Screening at health system entry points for substance use problems*

GDPSA submits the following best practice models for integrating mental health and AOD for Aboriginal and Torres Strait Islander peoples, developed by our partners the Lowitja Institute, and Aboriginal Medical Services in the Northern Territory (AMSANT).

The Lowitja Institute's Coordinated Aboriginal Mental Health Care project[5] was to develop, implement and evaluate agreed protocols and pathways for care of Aboriginal and Torres Strait Islander people, and their families affected by mental health including AOD issues. The project team found that a systematized approach to delivering best practice Aboriginal MH/AOD care across all levels of the health system must be implemented as a matter of urgency. Proposed key steps included:

- Helping Aboriginal and Torres Strait Islander health services to re-orient their service delivery arrangements to provide holistic, client-centered, 'no wrong door' primary health care.
- Implementing a uniform triage, assessment, early intervention and referral tool process within Aboriginal and Torres Strait Islander Community Controlled Organisations and other health/human services.
- Embedding these culturally safe tools in the electronic patient information and recall system.

[5] https://www.lowitja.org.au/page/research/research-categories/cultural-and-social-determinants/mental-health/completed-projects/coordinated-aboriginal-mental-health-care-a-best-practice-model-for-rural-and-metropolitan-service-delivery

- Ensuring that all staff routinely access and document information in the electronic patient information and recall system, to enable appropriate opportunistic care, follow-up on care plans and referrals.
- Developing simple information sharing systems and protocols between services, underpinned by service agreements.
- Ensuring that quality, comprehensive data is captured and reported by services to demonstrate activity and outcomes and increase funding streams.
- Continuing to offer interagency training and resources to the workforce around shared needs, and education and resources for the community to promote shared care.
- Advocacy and lobbying for better mental health and AOD services and policies and more Aboriginal and Torres Strait Islander peoples' input into review of mental health legislation.

The AMSANT model[6] is based on a community development and cultural strengths approach, utilizing Aboriginal Family Support workers whose core function is to work with families and build resilience in communities. The Aboriginal Family Support Workers work with individuals and families with significant mental health and AOD issues in conjunction with counselors and psychologists. These workers are local people with strong community and kinship networks. Each community have at least one male and one female worker.

Counsellors and psychologists provide supervision and support for the worker to assist individual clients and families. However, the workers determine their own work priorities in health promotion and preventative activities in communities. This autonomy increases cultural strength and encourages cultural interventions. The Aboriginal Family Support Workers work with preventative services, including universal home visitation services for women with young children, and other welfare and family support services.

The AMSANT model has been at the core of the Social and Emotional Wellbeing Unit in Anyinginyi Congress in Tennant Creek for many years.

FUNDING MODELS RETENTION AND TRAINING

Discussion question 10: Considering funding models and arrangements in the AOD sector: (a) What are the priority WFD funding issues for the AOD sector? (b) What are the immediate priorities for attention and action in relation to WFD-related funding? (c) What types of funding models would best support the capacity and effectiveness of the AOD workforce?

Important issues could include (but aren't limited to):

[6] https://www.aph.gov.au/DocumentStore.ashx?id=5060b6b1-0ccc-46a0-8045-5ba36ff8172d

- *Activity-based funding models adversely impacting WFD resources (particularly the additional WFD costs associated with providing services in rural and remote areas)*
- *WFD implications of funders moving to outcomes-based funding approaches*
- *Meet e-health and enhanced service integration challenges*
- *Approaches to reduce the stigma experienced by AOD clients attending specialist and non-specialist services*

GDPSA advises that there needs to be more flexible funding for ACCOs to develop an AOD workforce that delivers self-determined and community-based solutions. The 2021 Parliamentary Inquiry into Mental Health and Suicide Prevention[7] received a consistent recommendation to allow sufficient flexibility to meet the needs of community by providing a 'block funding model'. The benefit of block funding as opposed to grants-based or fee for services is that it allows for flexibility to spend more time with the individual patient and to tailor the interface with the patient around the patient's needs rather than the service provider's needs. This is particularly relevant to the treatment of AOD because it is often difficult to determine whether people with a mental illness are using drugs and alcohol to self-medicate, or whether the drug and alcohol problems are causing the mental health problems.

Discussion question 11: Considering recruitment and retention in the AOD sector: (a) What are the key issues and challenges? (b) What are the immediate priorities for attention and action? (c) What initiatives would best support effective recruitment and retention in the AOD sector?

Priority actions could include (but aren't limited to):

- *Reviewing and addressing remuneration, especially for frontline workers, to achieve greater parity with similar sectors (e.g., mental health)*
- *Supporting and increasing the capacity of AOD organisations to ensure adequate resourcing and staffing*
- *Developing and promoting clear AOD career steps and pathways*
- *Developing and promoting entrance pathways into AOD work, incorporating training and credentialling pathways*
- *Supporting programs to orientate, train and develop workers new to the AOD sector*
- *Increasing availability and accessibility of professional development opportunities*
- *Implementing strategies and programs to reduce stigma associated with AOD work*

7 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report/c02

GDPSA encourages the strategy as a priority to identify the remuneration of Aboriginal and Torres Strait Islander AOD workers in a recommended review. A 2013 national survey[8] among Aboriginal and Torres Strait Islander AOD workers published in the Journal of Substance Abuse found that respondents had significantly lower salaries compared with non-Indigenous respondents (2013, p.20). The survey also found that Aboriginal health workers were significantly more likely to have lower wages than other occupational groups.

Most Aboriginal and Torres Strait Islander workers in the sample listed a salary increase as the most important retention strategy (2013, p.23). Even though Aboriginal and Torres Strait Islander workers were more likely to have a vocational education qualification or lower they are not remunerated for their cultural knowledge which should be more highly valued across all AOD settings. Cultural knowledge is not just beneficial and healing to Aboriginal and Torres Strait Islander people but to all Australians.

Addressing Aboriginal and Torres Strait Islander workforce wellbeing and burnout in a holistic approach is another important factor to address in the strategy that is currently missing. The 2013 survey found that Aboriginal and Torres Strait Islander respondents were more likely to report that work affected their home life (work imbalance) and that home life affected their work (family imbalance). Aboriginal and Torres Strait Islander reported higher levels of emotional exhaustion and lower levels for mental health and wellbeing than non-Indigenous respondents.

Discussion question 12: What substances should be considered of particular concern for the AOD sector at the current time and into the future and what are the implications for AOD WFD to ensure effective responses?

Important issues could include (but aren't limited to):

- *The impact of enhanced real time monitoring of Schedule 8 and relevant Schedule 4 medicines on treatment demand*
- *Increased cocaine use, either on its own or in combination with alcohol (the cocaethylene effect)*
- *Increased supply and use of drugs such as Ecstasy which may have been stockpiled as a result of Covid 19-related reduction in demand*
- *Increased use / misuse of gabapentinoids in response to concerns related to prescribing opioids*
- *Increased use of fentanyl, fentanyl analogs and other novel synthetic opioids on their own or to adulterate heroin*
- *Gamma Hydroxybutyrate (GHB) (and its precursors, gamma-butyrolactone [GBL] and 1,4-butanediol [1,4-BD]).*

[8] http://www.atoda.org.au/wp-content/uploads/JSAT-Paper-Jan-20131.pdf

GDPSA recommends that easily available substances such as Alcohol and Marijuana should not be overlooked.

Aboriginal and Torres Strait Islander peoples that do drink alcohol, are more likely than other Australians to:

- Drink at dangerous levels – both over a lifetime and on a single occasion
- Go to hospital for alcohol related conditions (eg. liver disease), mental illness and poisoning[9]

There is a high prevalence of marijuana use in the Aboriginal and Torres Strait Islander population.

- Marijuana was the most common illicit substance used in the last 12 months for Aboriginal and Torres Strait Islanders aged 15 and over in 2018-19[10].
- From 2008 to 2018-19 the proportion of Aboriginal and Torres Strait Islanders who reported using marijuana increased from 14% to 25% in remote areas and from 18% to 24% in non-remote areas[11].

Discussion question 13: Should minimum educational qualification standards for specialist AOD workers be implemented in all jurisdictions?

Important issues could include (but aren't limited to):

- *What level should minimum educational qualification standards for specialist AOD be at?*
- *Should minimum educational qualification standards for specialist AOD workers be nationally consistent?*

GDPSA does not suggest a minimum educational qualification for specialist AOD workers is the only way employment in the field should occur. GDPSA recommends that culture and lived experience are valued as expertise of employment into positions and specialized qualifications as well. However there needs to be targeted programs that increase the qualifications across all fields of health and human services for Aboriginal and Torres Strait Islander people, including the AOD workforce.

[9] https://www.health.gov.au/health-topics/alcohol/alcohol-throughout-life/alcohol-and-aboriginal-and-torres-strait-islander-peoples
[10] https://www.indigenoushpf.gov.au/measures/2-17-drug-other-substance-use-including-inhalants
[11] As above ibid.

Discussion question 14: How well is the current vocational education system meeting the needs of the AOD workforce and sector? What are the immediate priorities for action in this area?

Important issues could include (but aren't limited to):

- *How accessible are the current AOD vocational qualifications (Cert IV/ Diploma I AOD, AOD skills set)*
    - *What are key barriers to workers gaining these qualifications?*
    - *How can accessibility be improved?*
- *What are the major gaps in the current set of AOD qualifications that impact on workers' capacity and effectiveness?*
    - *Are there particular skill sets that need to be added?*
    - *Are there particular areas of knowledge that need to be added?*
- *How well is competency-based training meeting the needs of the AOD sector and consumers?*
    - *Are there other training approaches/modalities that are needed to complement a competency-based approach? What might this look like?*

GDPSA recommends that AOD education and training must be based on the needs of Aboriginal and Torres Strait Islander workers and AOD clients. The VET sector has a great potential to develop culturally safe training models for Aboriginal and Torres Strait Islander AOD work with community involvement in course design and content.

The VET sector must recognise prior experience and skills acquired outside of formal learning settings (such as volunteering and lived experience) to overcome the barrier of the low retention rates among Aboriginal and Torres Strait Islander high school students after Year 10, and the educational status of Aboriginal and Torres Strait Islander people in general, which have a significant impact on the ability of Aboriginal and Torres Strait Islander people to access later vocational education and training.

The distance of vocational educational institutions from Aboriginal and Torres Strait Islander communities can be a physical barrier to accessing education. GDPSA advises that the Strategy consider recommending an increase in the availability of digital place-based education and training models that have developed in response to the COVID-19 pandemic to overcome geographical proximity issues.

Further mainstream AOD training need to reflect cultural strengths and learning styles to inform non-Indigenous AOD workers of their Aboriginal and Torres Strait Islander co-worker and client needs, to improve the quality of their relationships and care. A number of distinct strategies have been advocated to promote and support Indigenous ways of learning[12], including:

[12] https://www.adac.org.au/resFILE/res33.pdf

- An increased focus on work experience and practical learning in training programs
- Flexible delivery and access
- Flexible pacing of content progression and
- Education service providers coordinating placements in rural and remote communities

This also applies to AOD specialist training. Almost all AOD workers have a counselling role. Counselling Aboriginal and Torres Strait Islander clients requires a trauma-informed and culturally safe approach that considers Aboriginal and Torres Strait Islander concepts of Social and Emotional Wellbeing.

Discussion question 15: What are the key issues and challenges for professional development (PD) in the AOD workforce? This may include issues related to accessibility, quality, modalities (e.g., supervision, training), content (e.g., priority KSAs) or other matters.

Important issues could include (but aren't limited to):

- *Strategies to increase accessibility of PD, for example:*
    - *Scholarships and other programs to reduce financial burden on workers and organisations*
    - *Increasing the availability of online delivery*
    - *Funding programs to support regional and remote workers to access face-to-face training (e.g., travel, accommodation and backfill costs)*
    - *Development of a centralised register of professional development opportunities*
- *Development and support of other approaches to PD that extend beyond training, such as professional placements, conference attendance and mentoring*
- *Conduct of a national review of AOD professional development programs and opportunities to identify major gaps and strategies for improvement*

GDPSA has found that staff and funding shortages have limited the professional development opportunities of the Aboriginal and Torres Strait Islander workforce in Aboriginal and Torres Strait Islander AOD service providers. There is often not enough funding to hire a staff member to facilitate the other completing a training program or travelling to one.

DIGITAL AND ONLINE PLATFORMS

Discussion question 16: What WFD strategies will best support AOD services, workers and clients to engage effectively with digital and online service provision? What are the immediate priorities for attention and action in this area?

Important issues could include (but aren't limited to):

- *Elements of service delivery that work particularly well (or particularly poorly) when delivered remotely*
- *Specific client/consumer groups for whom remote service delivery is particularly beneficial (or particularly inappropriate)*
- *The ideal ratio of remote: face-to-face service delivery and how this should this be established for different groups*
- *Key infrastructure changes/upgrades that are needed to support increased remote service delivery*
- *Training priorities for upskilling staff to effectively utilise new technologies*
- *The barriers preventing more effective use of new technologies, and how they can be addressed*

GDPSA recommends that any AOD digital and online service provision to remote and rural areas should be co-designed with rural and remote communities and available in their local languages.

DATA SYSTEMS, MONITORING AND EVALUATION

Discussion question 17: To what extent is the development of a national AOD workforce data collection a priority (e.g., an AOD workforce census)? How could this data collection be integrated with, and leverage, existing jurisdictional AOD workforce data collections? What existing data collections could be used to monitor progress?

Important issues could include (but aren't limited to):

- *The current gaps in workforce data at a national and jurisdictional level that impact on WFD planning and implementation*
- *The extent to which a national data collection could add value to existing jurisdictional data collections*
- *The potential for greater coordination across jurisdictional data collections to enhance comparability of data*
- *The parameters and scope of a potential national data collection (e.g., frequency of data collection, essential data to be collected)*

GDPSA recognises that good data is needed as an evidence-base to inform workforce developments. We recommend that it is important to co-design the census to be culturally safe, specifically relevant and of value to the Aboriginal and Torres Strait Islander AOD workforce.

Discussion question 18: What are the priority actions for effective and timely monitoring and implementation of the revised Strategy?

Priority actions could include (but aren't limited to):

- *Development of an implementation plan*
- *Development and implementation of a monitoring and evaluation plan*
- *Additional consultations with national and jurisdictional stakeholders to address monitoring and implementation*

GDPSA recommends that there be a co-design and development of a specific Aboriginal and Torres Strait Islander AOD workforce implementation plan to support self-determination and a greater focus on the very unique needs of this AOD workforce group.

FINAL

Are there any other questions or comments?

ABS data in 2016 indicated that Aboriginal and Torres Strait Islander peoples make up 3.3% of the population in Australia. However Aboriginal and Torres Strait Islander peoples are overrepresented in AOD statistics indicating higher levels of need than non-Indigenous Australians.

- According to the AIHW[13] in 2019-20, 17% of clients seeking alcohol and other drug treatment services aged 10 and over were Aboriginal and Torres Strait Islander peoples.

A needs-based rather than population-based formula must be applied to all commissioning arrangements to ensure funding is sufficient in driving service delivery, recruitment and retention strategies for Aboriginal and Torres Strait Islander peoples.

[13] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people