Indigenous Alcohol and Drug Workforce Challenges:

A literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout

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NCETA
Australia's National Research Centre on AOD Workforce Development

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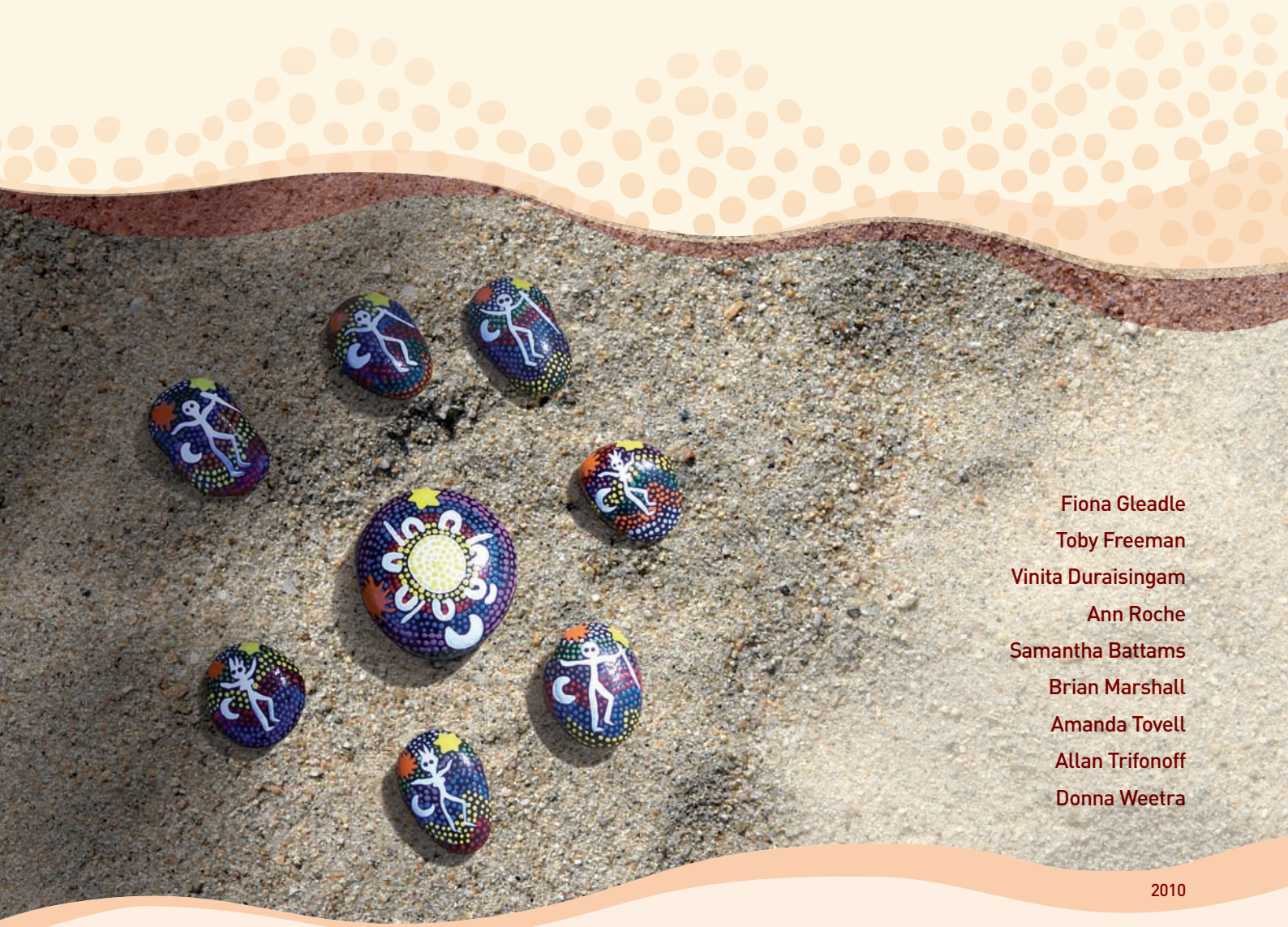

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Artwork & Talking Stones

The artwork for the report, Talking Stones, was supplied by Irene Allan.

Irene Allan is a descendant of the Tanganekald Clan from Kingston South East, South Australia. She has been painting and programming Stones to hold healing energy for over two decades. When held with faith and belief the Stone empowers the mind to focus and attract positive thoughts.

The Talking Stone

Talking Stones are special stones used to facilitate sharing and communication in groups (talking circles). The person running a talking circle starts by holding the Talking Stone and acknowledging the ancestors and traditional owners of the land. They then pass the Talking Stone to the person on the left.

The Talking Stone is used to allow people to speak freely and to share what is on their mind. You only speak when you hold the Talking Stone. Anything that is personal must stay in the circle. The more you use the Talking Stone, the more energy it will hold. The Talking Stone will become very strong. It will be very powerful, trusting and sacred.

Preface

This project was funded by the Australian Government Department of Health and Ageing and was also endorsed by the Cooperative Research Centre for Aboriginal Health (CRCAH) as an in-kind project.

The project involved several components including public submissions, a national online survey, site visits to undertake face-to-face interviews and focus groups, and a literature review addressing key issues. Major findings from the interviews and focus groups are presented here. Findings from the other components of the project are presented in separate reports:

- Roche, A., Tovell, A., Weetra, D., Freeman, T., Bates, N., Trifonoff, A., and Steenson, T. (2011). *Stories of Resilience: Indigenous Alcohol and Other Drug Workers' Wellbeing, Stress, and Burnout.* National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide SA.
- Duraisingam, V., Roche, A.M., Trifonoff, A., and Tovell, A. (2011). *Indigenous AOD Workers' Wellbeing, Stress, and Burnout: Findings from an online survey*. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide SA.

This project is part of a wider program of work by NCETA examining wellbeing, stress, and burnout among workers involved in the alcohol and other drug field. For details of related projects visit the NCETA website: www.nceta.flinders.edu.au.

Other publications in this wider program of work include the following:

- Skinner, N., & Roche, A. (2005). Stress and burnout: A prevention handbook for the alcohol and other drugs workforce.
- Duraisingam, V., Pidd, K., Roche, A.M., & O'Conner, J. (2006). Satisfaction, stress and retention among alcohol and other drug workers in Australia.
- Duraisingam, V., Roche, A.M., Pidd, K., Zoontjens, A., & Pollard, Y. (2007). Wellbeing, stress, and burnout: A national survey of managers in alcohol and other drug treatment services.

Copies of these resources are available from NCETA.

NCETA

The National Centre for Education and Training on Addiction is an internationally recognised research centre that works as a catalyst for change in the alcohol and other drugs (AOD) field.

Our mission is to advance the capacity of organisations and workers to respond to alcohol- and drug-related problems. Our core business is the promotion of workforce development (WFD) principles, research and evaluation of effective practices; investigating the prevalence and effect of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and organisations.

NCETA is based at Flinders University and is a collaboration between the University, the Australian Government Department of Health and Ageing and the SA Department of Health.

Acknowledgements

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Ms Amy Cleland - University of South Australia

Dr Colin Dillon - Queensland University of Technology

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Mr Mick Gooda - Cooperative Research Centre for Aboriginal Health

Mr Don Hayward - Drug and Alcohol Services South Australia

Ms Jacqui Malins - Australian Government Department of Health and Ageing

Ms Coralie Ober - Queensland Alcohol and Drug Research and Education Centre

Mr Scott Wilson - Aboriginal Drug and Alcohol Council SA Inc

Thanks are also extended to Ms Tania Steenson, Project Officer, NCETA for her assistance in formatting and editing this literature review.

A Note on the Terminology Used in This Document

Aboriginal and Torres Strait Islander peoples have diverse languages, cultures, and communities, and live in urban, rural, and remote settings. Many of these groups seek to maintain their particular cultural identity and preferred names as distinct from others. For the purposes of this report, and in recognition of this diversity, we have opted to use the term “Indigenous” Australians as a way of acknowledging all Australian Aboriginal and Torres Strait Islander groups, except where other terms were used by project participants in which case the authenticity of their words has been retained. We are, however, aware that this terminology has limitations.

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Executive Summary

NCETA was commissioned by the Australian Government Department of Health and Ageing to investigate the key antecedents and consequences of stress, burnout and wellbeing among Indigenous workers responding to Indigenous alcohol and other drug issues.

The project involved several components including public submissions, a national online survey, site visits for face-to-face interviews and focus groups, and a literature review addressing key issues. Major findings from the literature review are presented here. Findings from the other components of the project are reported elsewhere.[1]

The literature review forms the initial component of a project that examined Indigenous alcohol and other drug worker wellbeing, and which aimed to identify key factors that impact on the stress, burnout and wellbeing of workers who respond to Indigenous alcohol and other drug issues. The review first examines broader issues affecting the Indigenous population that contribute to alcohol and other drug problems.

The complexities of responding to Indigenous alcohol and other drug issues are explained in this context, and specific challenges facing Indigenous alcohol and other drug workers identified. This review of workforce development challenges examined over 400 reports, journal articles, and other documents relevant to stress, burnout, and wellbeing of workers responding to Indigenous alcohol and other drug issues.

The first Section of the review defines the workforce targeted by this project, as well as the concepts of stress, burnout, and wellbeing. Section 2 outlines the broader context in which responses to Indigenous alcohol and other drug issues occur. Section 3 provides an overview of key areas of concern that impact on stress levels, risk of burnout, and wellbeing of Indigenous alcohol and other drug workers at both an individual and an organisational level.

Key findings from the literature review include:

- The Indigenous population has a higher incidence of use of tobacco and other drugs compared to the non-Indigenous population. Although fewer Indigenous people drink alcohol compared with the non-Indigenous population, those who do so are more likely to consume alcohol at risky levels.
- Adverse lifestyle behaviours can be attributed in part to the impact of cultural and socioeconomic inequalities experienced by the Indigenous population historically and in contemporary Australian society.
- Patterns of alcohol and drug misuse by Indigenous people need to be understood in the context of a history of dispossession, denial of culture, and conflict. The use of alcohol and other drugs by Indigenous people contributes to compromised physical and psychosocial health status, and ongoing socioeconomic disadvantage.
- Indigenous people report high levels of stressful events, which impact on their physical and psychological health. Indigenous Australians are twice as likely as non-Indigenous Australians to experience high levels of psychological distress. Increased psychological distress contributes to and is exacerbated by alcohol and other drug use.
- Increased alcohol and other drug misuse contributes to a disproportionately higher burden of disease in the Indigenous population compared with the non-Indigenous population, and contributes to lower life expectancy and quality of life for Indigenous people.

1 Copies of all reports and materials from this project can be accessed and downloaded from NCETA's website: www.nceta.flinders.edu.au.

- Prevention and treatment of such problems offers significant scope to "close the gap" between Indigenous and non-Indigenous people. Interventions should recognise the many disadvantages and social determinants that contribute to health conditions and lower life expectancy and quality of life for Indigenous people.
- Interventions should also incorporate Indigenous collaboration and control in decision making. An example of such an approach is the recent "Close the Gap" campaign—Tackling Indigenous Smoking—involving a coalition of government and non-government Indigenous and non-Indigenous organisations.
- Despite the wide gap between the health status, hospitalisation rates and mortality of Indigenous people compared with non-Indigenous people, there is only slightly higher health expenditure on Indigenous people. Responses to the call to achieve health equality within a generation, as issued in the Social Justice Report 2005 (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2005), include the 2007 Council of Australian Governments commitment to "closing the gap".
- Against this background of disadvantage and complex alcohol and drug use, Indigenous alcohol and other drug workers face unique stressors at an individual level, including:
  - heavy work demands reflecting the high community need and a concomitant shortfall of Indigenous alcohol and other drug workers
  - dual forms of stigmatisation stemming from attitudes to alcohol and other drugs work and racism
  - lack of clearly defined roles and boundaries, particularly within an Indigenous community context
  - difficulties translating mainstream work practices to meet the specific needs of Indigenous clients
  - challenges of isolation when working in remote areas
  - dealing with clients with complex comorbidities and health and social issues
  - lack of cultural understanding and support from non-Indigenous health workers.
- Effective responses to Indigenous alcohol and other drug issues are also undermined by challenges at an organisational level, including:
  - difficulties encountered by Indigenous alcohol and other drug organisations in securing long-term funding and developing partnerships with non-Indigenous organisations
  - problems selecting and implementing treatment programs appropriate for the Indigenous population, particularly given the lack of evidence and precise data measurement in this field
  - income and wage disparities
  - difficulties accessing appropriate training, and varied qualification requirements
  - gender imbalances in the Indigenous health workforce
  - a lack of clear career paths for Indigenous alcohol and other drug workers.

Indigenous alcohol and other drug workers are affected by a range of issues, and a broad array of contextual factors that require action at an individual, organisational and sector level. An integrated approach is required to address alcohol and other drug use within the Indigenous population—and to overcome the challenges faced by the workers who tackle it—that considers all determinants of health, and offers culturally appropriate responses.

1. Introduction

> "The recent history of … Aboriginal and Torres Strait Islander communities, is one of loss of land (often accompanied by violence), forced removal, and detention of differing clans in missions and reserves, with consequent loss of culture, autonomy, identity and life skills. Many patients come from such traumatised family backgrounds. Dealing constantly with traumatised patients and the resulting problems of unemployment, poor education, substance misuse and violence can become a threat to the wellbeing of staff." (Panaretto & Wenitong, 2006, p. 528)

NCETA was commissioned by the Australian Government Department of Health and Ageing to investigate the key antecedents and consequences of stress, burnout and wellbeing among Indigenous workers responding to Indigenous alcohol and other drug issues.

The project involved several components including public submissions, a national online survey, site visits for face-to-face interviews and focus groups, and a literature review addressing key issues. Major findings from the literature review are presented here. Findings from the other components of the project are reported elsewhere.[2] The literature review examined over 400 reports, journal articles, and other documents relevant to stress, burnout, and wellbeing of workers responding to Indigenous alcohol and other drug issues.

The first section of the review defines the workforce targeted by this project, as well as the concepts of stress, burnout, and wellbeing. Section 2 outlines the broader context in which responses to Indigenous alcohol and other drug issues occur. Section 3 provides an overview of key areas of concern that impact on stress levels, risk of burnout, and wellbeing of Indigenous alcohol and other drug workers at both an individual and organisational level.

1.1 The Workforce Addressed in this Review

The workforce addressed here is Indigenous workers who respond to alcohol and other drug issues. This workforce includes, but is not limited to, Aboriginal Health Workers, Aboriginal Mental Health Workers, and Aboriginal liaison officers, as well as Indigenous doctors, nurses, community health workers, social workers, drug and alcohol clinicians, and mobile patrol staff.

The size of this workforce is difficult to estimate, as is the generic alcohol and drug workforce.[3] At June 2007, there were 248 Indigenous-specific healthcare delivery organisations, 198 of which were Aboriginal Community Controlled Health Organisations (Australian Government Department of Health and Ageing, 2008). The National Aboriginal Community Controlled Health Organisation (2006) estimated that in its 128 affiliate health organisations, 70% of employees were Indigenous, including approximately 700 Aboriginal Health Workers. As Table 1 shows, Indigenous workers in the health and community services sector are commonly employed in comparatively low status, lower paid positions such as Aboriginal and Torres Strait Islander Health Workers or community workers.

2 Copies of all reports and materials from this project can be accessed and downloaded from NCETA's website: www.nceta.flinders.edu.au.

3 The number of (Indigenous and non-Indigenous) workers in specialist alcohol and other drug agencies in 2003 was estimated at 10,190 (Roche, 2008). However, this does not account for general or allied health organisations such as hospitals or community health centres. The workforce that responds to alcohol and other drug issues is consequently much larger.

Table 1. Persons Employed in Health and Community Services Occupations: Indigenous Status [a], 2001 and 2006

Occupation	2001			2006		
	Indigenous	Non-Indigenous	% Indigenous	Indigenous	Non-Indigenous	% Indigenous
Health	3,823	437,261	0.9	5,538	539449	1.0
Medical practitioners	151	51,476	0.3	126	56,650	0.2
Generalist medical practitioners	54	31,727	0.2	90	35,221	0.3
Specialists[b]	32	15,767	0.2	14	17,563	0.1
Other medical practitioners[c]	65	3,982	1.6	9	1,936	0.5
Medical administrators	n.a.	n.a.		13	1,930	0.7
Medical imaging workers	14	8,113	0.2	16	10,421	0.2
Dental workers	155	25,604	0.6	201	29,206	0.7
Nursing workers	1,123	191,714	0.6	1,448	219,276	0.7
Registered nurses, clinical	832	148,349	0.6	1,118	171,240	0.6
Midwives	40	11,574	0.3	47	12,137	0.4
Nurse educators and researchers	11	2,596	0.4	15	3,729	0.4
Nurse managers and clinical directors	38	9,997	0.4	56	13,121	0.4
Enrolled nurses	202	19,198	1.0	212	19,049	1.1
Pharmacists	10	13,857	0.1	13	15,260	0.1
Allied health workers	303	50,584	0.6	456	64,557	0.7
Complementary therapists	48	10,852	0.4	89	16,149	0.5
Aboriginal and Torres Strait Islander health workers	853	59	93.4	967	38	96.2
Other health workers and other health services managers[d]	1,166	85,002	1.3	2,222	127,892	1.7
Community services	5,484	210,279	2.5	9,467	282,565	3.2
Child and youth services	2,174	92,583	2.3	3,072	114,072	2.6
Family services workers	681	10,938	5.9	979	13,459	6.8
Disability workers	321	29,136	1.1	425	37,433	1.1
Aged and/or disabled care	1,085	53,103	2.0	1,792	78,543	2.2
Other community services	1,136	17,369	6.2	3,030	29,798	9.2
Child care centre managers	70	6,342	1.1	121	7,966	1.5
Welfare centre manager	17	808	2.1	48	1,294	3.6
Total health and community services	**9,307**	**647,540**	**1.4**	**15,005**	**822,014**	**1.8**

NB: The number of Indigenous practitioners should be treated with caution, particularly where there are small populations. Variations occur due to randomised changes made to cells by Australian Bureau of Statistics to prevent release of identifiable information. (a) Total includes "not stated" to Indigenous status. Per cent Indigenous calculation excludes "not stated" to Indigenous status. (b) Specialist categories have been combined because individual cells are small. (c) Changes in occupation classification affect comparability. Medical administrators were included in 2001. (d) Categories of other health workers and other health services managers are combined in this table to enable comparisons. Individually, changes in the occupation classification affect comparability. Source: ABS, Census of Population and Housing, 2001 and 2006 (cited in and adapted from Australian Institute of Health and Welfare, 2009c).

1.2 Stress, Burnout, and Wellbeing

Three inter-related aspects of occupational health and wellbeing are examined here: workers' levels of stress, burnout, and wellbeing. First, a brief definition of these concepts is given, followed by a discussion regarding their potential effects on the Indigenous alcohol and other drugs workforce.

1.2.1 Stress and burnout

Stress is experienced when individuals feel unable to cope with the demands placed upon them (Farmer, Clancy, Oyefeso, & Rassool, 2002). More specifically, work stress refers to psychological, physical and behavioural responses to work-related demands over a discrete or short-term period of time (Dollard, Winefield, & Winefield, 2003).

The state of burnout is qualitatively distinct to stress. Burnout may include signs and symptoms of stress, but also has its own features over and above stress reactions. Burnout is a long-term process characterised by "chronic malfunctioning" and negative and cynical attitudes towards clients and work in general (Maslach, Schaufeli, & Leiter, 2001). Three core dimensions of burnout have been identified:

1. Emotional exhaustion (feeling overextended and drained of emotional and physical resources)
2. Depersonalisation (negative, detached or cynical view of one's work)
3. Reduced personal accomplishment (low sense of achievement, feelings of incompetence, low self efficacy) (Maslach et al., 2001).

Prolonged exposure to stressful working conditions and job demands can result in worker burnout over time. Symptoms of stress and burnout may differ but similar factors contribute to both outcomes. Workers in the health and human services field, i.e., those involved in "emotional labour", often experience high levels of work-related demands and stressors, and are therefore particularly vulnerable to stress and burnout (Dollard et al., 2003; Dollard, Winefield, & Winefield, 2001; Dollard, Winefield, Winefield, & de Jonge, 2000). Similarly, alcohol and other drug workers face many significant challenges related to:

- The client population (complex circumstances, stigmatisation of drug use, reluctance to engage in treatment)
- Community attitudes towards drug users (and the people who work with them)
- The need to continually develop and refresh knowledge and skills to manage changing treatments and complex client presentations
- Working conditions (e.g., remuneration, availability of professional development, job security, access to clinical supervision, client workloads)

  (Knudsen, Johnson, & Roman, 2003; Pierce & Long, 2002; Pitts, 2001; Roche, 2002; Schubert, Pond, Kraft, & Aguirre-Molina, 2004; Skinner, Freeman, Shoobridge, & Roche, 2003).

Research findings indicate that stress is a significant issue for the alcohol and other drugs workforce. A national survey by the National Centre for Education and Training on Addiction found that almost one in five frontline alcohol and other drug workers experience high stress levels, contributing to lower job satisfaction, and increased likelihood of leaving their job (Duraisingam et al., 2006).

In the first study undertaken to examine the rate of burnout amongst alcohol and other drug managers in Australia, Duraisingam et al. (2007) also found that nearly a third of alcohol and other drug managers experienced an elevated level of burnout, and 8% experienced a very high level of burnout. Anecdotal evidence suggests that stress for alcohol and other drug Indigenous workers is likely to be substantially greater than that experienced by their non-Indigenous counterparts. However, the extent of burnout amongst Indigenous alcohol and other drug workers in Australia is unknown.

1.2.2 Wellbeing

Indigenous Australians have developed their own comprehensive definition of health and wellbeing to capture an understanding of health from an Indigenous perspective. The National Aboriginal Health Strategy (Office for Aboriginal and Torres Strait Islander Health, 1989) defined health as: "Not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life."

This extends the World Health Organization definition of health (World Health Organization, 1946) by including a concept of health and wellbeing beyond individual health, and incorporates cultural/spiritual factors as part of health. Indigenous definitions of health are also ecological in that they highlight the interrelationship "between spiritual, environmental, ideological, political, social, economic, mental, cultural

and physical factors that make up the Aboriginal and Torres Strait Islander view of health" (Auseinet, 2007).

As Trewin (2001) indicates, this defines wellbeing as "... a state of health and sufficiency in all aspects of life" (p.6). This includes aspects at the individual level—physical, emotional, psychological and spiritual—and at the broader level—the social, material, and natural environments that surround each person. The contemporary non-Indigenous concept of wellbeing has now also been extended to cover wellness or the positive state of an individual, rather than just the presence or absence of an illness or disease (Pink & Allbon, 2008).

An important area of life that contributes to a person's wellbeing is their work, namely, how satisfying and rewarding work is at an economic and non-economic level (Trewin, 2001). More specifically, occupational or workplace wellbeing can be defined as a positive, subjective evaluation of the different aspects of one's job, including affective, motivational, behavioural, cognitive and psychosomatic dimensions (Van Horn, Taris, Schaufeli, & Schreurs, 2004).

Stress and burnout indicate a set of affective, behavioural and cognitive symptoms that reflect both short- and long-term physical and emotional strain in the workplace (Price & Spence, 1994). Thus, if an Indigenous alcohol and other drug worker is experiencing high levels of stress, or burnout, their wellbeing is negatively affected.

1.3 Summary

A broad range of issues impact on the wellbeing of Indigenous alcohol and other drug workers. The alcohol and other drugs workforce in general is characterised by high levels of stress due to stigmatisation, complex client presentations, difficult working conditions and limited training and support. Stress can lead to burnout and have a significant impact on worker wellbeing. It is likely that such issues are further exacerbated for Indigenous workers as they strive to assist community members dealing with profound and complex alcohol and other drug problems.

2. Background and Contextual Issues

This section provides details of the broader context in which Indigenous alcohol and other drug issues are located, in order to allow a comprehensive picture of factors that impact directly and indirectly on alcohol and other drug workers. First, demographic information about the Indigenous population, including geographical distribution is provided followed by indicators of wellbeing such as employment, education, literacy, health and incarcerations. This section then discusses characteristics of alcohol and other drug use in the Indigenous population, as well as the historical context of Indigenous alcohol and other drugs service provision and contemporary service provision issues.

2.1 Indigenous Population

In 2008, Aboriginal and Torres Strait Islander peoples constituted approximately 2.5% of the total Australian population, with 520,350 Indigenous people living in private accommodation (Australian Bureau of Statistics, 2009). Analysis of the 2006 national Census showed that since 2001 the Indigenous population had grown by 13% (Australian Bureau of Statistics, 2007). The Aboriginal and Torres Strait Islander population is relatively young. In 2008, just under half (49%) the population were less than 20 years of age, 16% were between 20 and 30 years of age, and only 3% were aged 65 years and over (Australian Bureau of Statistics, 2009) (see also section 2.2.1 “Physical health”).

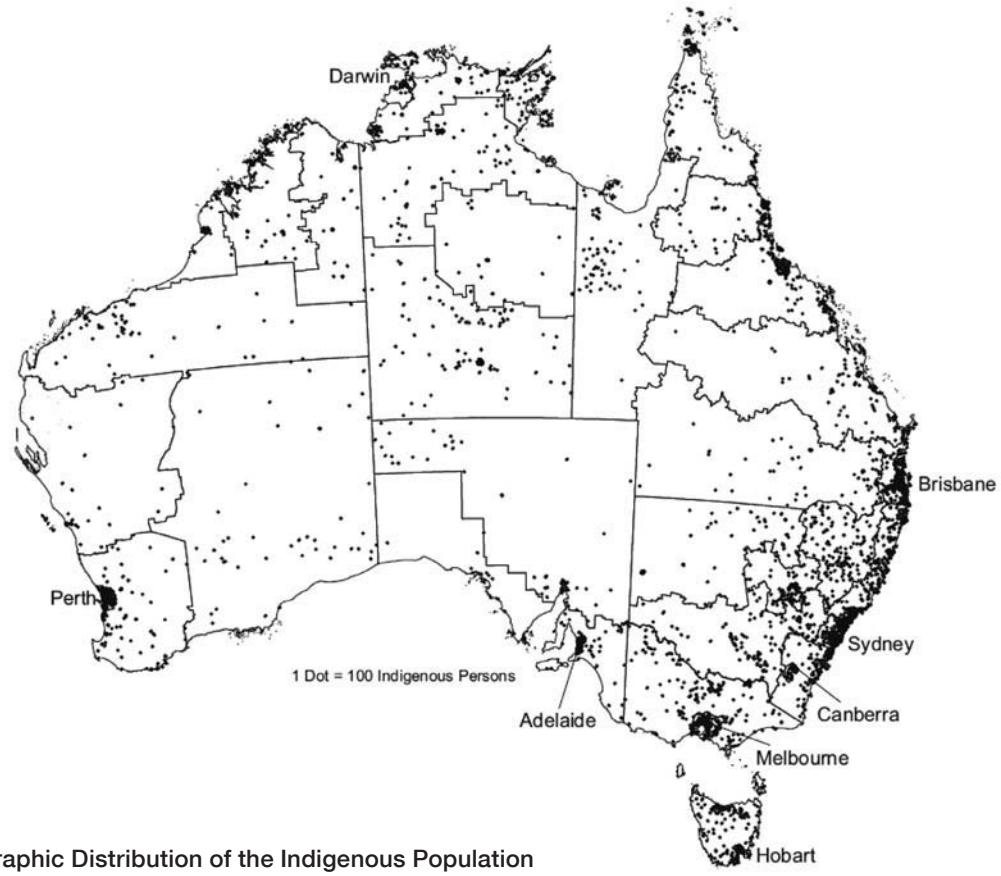

Figure 1. Geographic Distribution of the Indigenous Population
Reproduced from the Australian Bureau of Statistics (2007).

2.1.1 Geographic location

The geographic distribution of the Indigenous population in Australia is shown in Figure 1 (Australian Bureau of Statistics, 2007). The majority of Australia's Indigenous population resides in New South Wales and Queensland, with approximately 148,200 Indigenous people in New South Wales (28.7% of the total Indigenous population) and approximately 146,400 in Queensland (28.3% of the total Indigenous population) (Australian Bureau of Statistics, 2007).

Table 2 shows the distribution of Indigenous people throughout Australia by jurisdiction. In 2007, Indigenous people predominantly resided in major city centres (such as Adelaide, Brisbane, and Darwin) or larger regional centres (such as Cairns, Townsville, and Wagga Wagga) (Australian Bureau of Statistics, 2007). However, in the Northern Territory and Western Australia, large proportions of the Indigenous population lived in remote or very remote locations. In 2008, just over two-thirds (68%) of Indigenous people lived outside the major cities, with 44% living in regional areas and 24% living in remote or very remote areas (Australian Bureau of Statistics, 2009).

Table 2. Estimated Indigenous Population, by Jurisdiction, Australia, 30 June 2010

	Indigenous Population	% of Total Indigenous Population	% of Australian Population
New South Wales	165,190	29.4	2.3
Victoria	36,734	6.5	0.7
Queensland	160,514	28.5	3.6
Western Australia	76,218	13.5	3.4
South Australia	30,382	5.4	1.9
Tasmania	20,086	3.6	4.0
Australian Capital Territory	4,709	0.8	1.3
Northern Territory	68,599	12.2	30.5
Australia	562,681	100.0	2.6

NB. Sourced from the Australian Bureau of Statistics (cited in and reproduced from Thomson et al., 2010). The figures shown are the series A projections. These were derived by Australian Bureau of Statistics from the experimental estimated resident population for Indigenous people at 30 June 2006 using a number of assumptions about births, internal migration and deaths. Australian population includes Jervis Bay Territory, the Cocos (Keeling) Islands, and Christmas Island. Proportions of jurisdiction populations have used total population figures estimated from demographic information for March 2009.

2.1.2 Employment

In 2009, an estimated 161,200 Indigenous people were employed, representing 46% of the Indigenous population aged 15 years and over (Australian Bureau of Statistics, 2010b). This employment rate is far lower than for non-Indigenous Australians aged 15 years and over, which was estimated to be approximately 62% (Australian Bureau of Statistics, 2010b). This is largely due to the greater proportion of Indigenous Australians who are classified as "not in the labour force".[4] In 2009, only 56% of the Indigenous population aged 15 years and over participated in the labour force (that is, were either employed or unemployed), compared with 66% of the non-Indigenous population (Australian Bureau of Statistics, 2010b). Indigenous people in major cities (61%) and regional areas (55%) had higher labour force participation rates than those in remote areas (49%); and the participation rate was higher for Indigenous males (63%) than for Indigenous females (49%) (Australian Bureau of Statistics, 2010b).

In 2009, the unemployment rate for Indigenous people aged 15 years and over was estimated at 18%, compared with 5% for non-Indigenous people aged 15 years and over (Australian Bureau of Statistics, 2010b). The unemployment rate for Indigenous people varies across states and territories (see Table 3), with figures from 2009 showing the lowest rate in Tasmania (4.1%) and the highest rates in New South Wales, Queensland and Western Australia (approximately 21%) (Australian Bureau of Statistics, 2010b).

4 Not in the labour force refers to individuals who are not employed or unemployed, including those who are retired, no longer work, do not intend to work or are permanently unable to work.

Table 3. Labour Force Status by States and Territories—2005 to 2009 for Indigenous People Aged 15 years and Over

Year	Unemployment rate (%)	Participation rate (%)	Employment to population ratio (%)	Population living in remote areas (%)
New South Wales				
2005	14.7	56.2	47.9	5.2
2009	20.9	54.4	43.1	1.5
Victoria				
2005	23.4	63.3	48.5	0.0
2009	17.1	55.0	45.6	0.0
Queensland				
2005	14.0	62.4	53.6	22.9
2009	20.8	61.8	49.0	15.4
South Australia				
2005	19.1	50.5	40.8	25.4
2009	13.6	52.0	45.0	19.6
Western Australia				
2005	15.1	56.1	47.6	44.1
2009	20.7	49.6	39.3	44.3
Tasmania				
2005	15.5	68.4	57.8	8.2
2009	4.1	69.0	66.2	0.7
Northern Territory				
2005	19.4	40.0	32.2	80.1
2009	7.6	48.0	44.3	80.3
Australian Capital Territory				
2005	5.7	71.5	67.4	0.0
2009	19.1	65.8	53.3	0.0

Note. Adapted from the Australian Bureau of Statistics (2010b).

Among Indigenous people employed in 2006, the majority were labourers or community and personal service workers (Australian Bureau of Statistics, 2006b). These positions (see Table 4) were predominantly located within state and federal government, health and community services, and the retail sector (Australian Bureau of Statistics, 2006a).

However, Indigenous people represent only 1% of the total health workforce and are under-represented in nearly all health-related professions (Pink & Allbon, 2008) (see also section 3.2.1 "Heavy Work Demands"). Their representation in the community and welfare services sector is higher at 3.6% (Pink & Allbon, 2008).[5]

5 It should be noted that with the development of the Community Development Employment Projects (CDEP) the specific typology of employment of Indigenous workers is unclear, especially in remote and regional areas. CDEP commenced in 1977 in response to direct requests from Aboriginal communities who recognised the need to combat the debilitating effects of entrenched unemployment. Approximately 30,600 Indigenous people were employed under the CDEP scheme in 2004-2005 (Pink & Allbon, 2008). Walter and Mooney (2007) have expressed concern about the impact of the closure of CDEP for many communities and argue that this will have a drastic impact on social determinants of health.

Table 4. Indigenous Employment by Occupation

Occupation	Indigenous Persons		
	Males	Females	Persons
Managers	3,917	2,923	6,840
Professionals	5,297	8,553	13,850
Technicians & trades workers	12,490	2,237	14,727
Community & personal service workers	5,726	12,982	18,708
Clerical & administrative workers	3,306	11,938	15,244
Sales workers	2,397	5,890	8,287
Machinery operators & drivers	9,085	929	10,014
Labourers	19,831	9,296	29,127
Inadequately described/Not stated	3,493	2,462	5,955
Total	**65,542**	**57,210**	**122,752**

Note. Reproduced from the Australian Bureau of Statistics (2006b).

2.1.3 Education and literacy

In 2008, 95% of 139,400 Indigenous children aged 4-14 years reported usually attending school (Australian Bureau of Statistics, 2009). Reasons for non-attendance included being not yet eligible for school, or the cost being too high or unaffordable (Australian Bureau of Statistics, 2009). In 2002, most Indigenous students (88%) attended government schools (Australian Bureau of Statistics, 2004).

Indigenous student retention rates, despite some improvement over the last decade in the proportion of Indigenous students who complete years 10, 11 and 12, are substantially lower than the rates for non-Indigenous children (Pink & Allbon, 2008). The retention rate of Indigenous students in Year 10 rose from 83.3% in 1998 to 90.5% in 2007, while the rate for non-Indigenous students was 99.7% (Pink & Allbon, 2008). For Year 12, the Indigenous student retention rate rose from 32.1% in 1998 to 42.9% in 2007, while the non-Indigenous student retention rate was 75.6% (Pink & Allbon, 2008).

Overall, school retention rates for Indigenous students in Years 7/8 to Year 12 increased from 35% in 1999 to 45% in 2009 (Australian Bureau of Statistics, 2010a). Availability and accessibility of schools, especially secondary schools, racism at school, parents' negative experiences of schooling, wellbeing of the children (poor health, hunger, hearing difficulties, substance abuse), and the perceived quality and relevance of available schooling are potential contributors to low levels of Indigenous students' school retention rates (Penman, 2006).

There is a wide discrepancy between Indigenous and non-Indigenous people in terms of secondary school completion—in 2008, 21% Indigenous people completed Year 12, compared to 54% of non-Indigenous people (Australian Bureau of Statistics, 2009). Higher levels of education are associated with better health outcomes—in 2008, 59% of Indigenous people aged 15-34 who had completed Year 12 reported excellent or very good self-assessed health compared to 49% of those who had left school early (Australian Bureau of Statistics, 2010a). Indigenous people aged 15-34 who had completed Year 12 were also less likely to smoke, with 34% being daily smokers, compared to 68% of those who had left school early (Australian Bureau of Statistics, 2010a).

Limited information is available on the number of Indigenous students in the tertiary sector. In 2008, approximately a third (32%) of Indigenous people aged 15 years and over had a non-school qualification—an increase from 26% in 2002—compared with 54% of non-Indigenous people (Australian Bureau of Statistics, 2009). In 2008, 41% of Indigenous people aged 15-24 years were studying, either at secondary school (26%) or at a non-school institution (15%) (Australian Bureau of Statistics, 2009). Figures from the 2006 census showed that 7% of Indigenous people aged 15 years and over were studying at university or a technical or further educational institution compared with 8% of the non-Indigenous population, but Indigenous people were more likely to attend a technical or further educational institution than university (Australian Bureau of Statistics, 2010c). Figure 2 shows the distribution of non-school qualifications between Indigenous and non-Indigenous people in 2006.

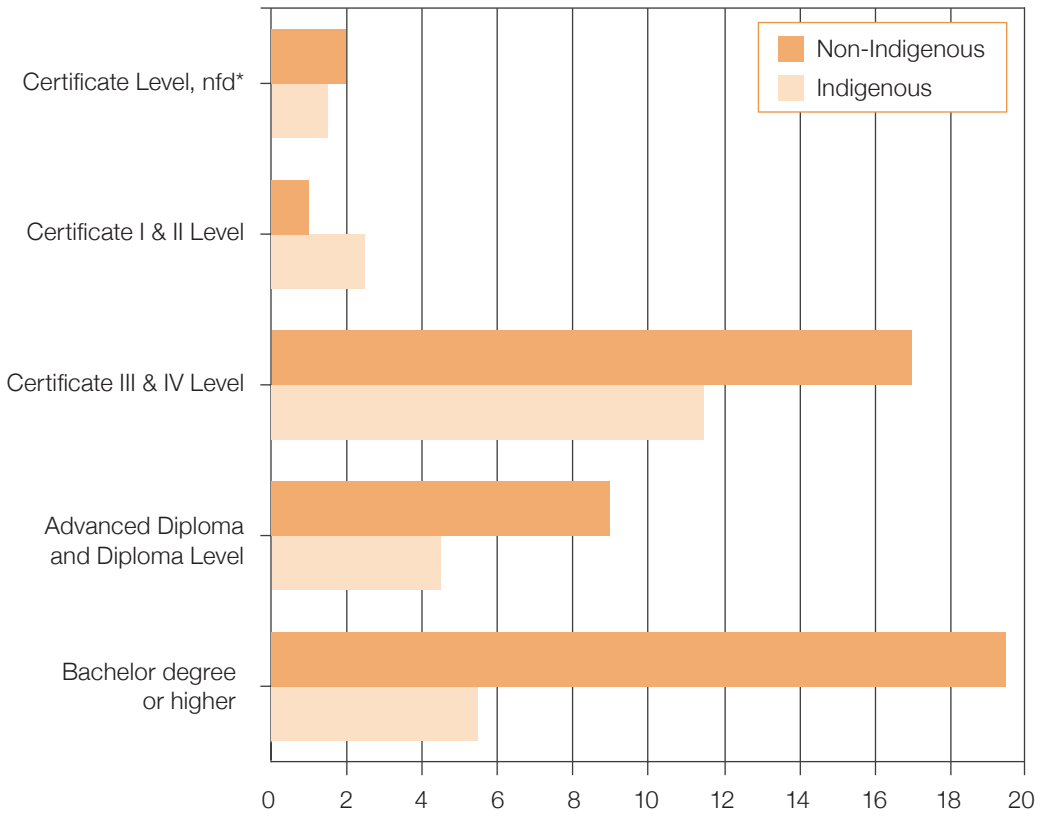

Figure 2. Percentage of Persons Aged 25-64 Years with a Non-School Qualification by Indigenous Status, 2006 (excludes level of education inadequately described or not stated)

*nfd = not further defined
Reproduced from the Australian Bureau of Statistics (2010c).

In 2008, about one in nine (11%) Indigenous people aged 15 years and over spoke an Aboriginal or Torres Strait Islander language as their main language at home (Australian Bureau of Statistics, 2009). In remote areas, almost four in nine (42%) people spoke an Indigenous language as their main language at home (Australian Bureau of Statistics, 2009). However, most Indigenous people (83%) are also proficient in English (Pink & Allbon, 2008).

Despite this, language barriers may prevent Indigenous people accessing and benefitting from appropriate health services. For example, in 2005, 11% of Indigenous adults reported difficulty in communicating with health care providers (Australian Bureau of Statistics, 2010a).

In 2009, the Commonwealth Government launched a national program designed to preserve Indigenous languages—*Indigenous Languages – A National Approach 2009*—which included funding for improved translation and interpreter services in areas with local needs, as part of its "Close the Gap" program.

Rates of English literacy tend to be lower among Indigenous Australians compared to non-Indigenous Australians. Lower levels of English literacy were demonstrated in the 2006 literacy and numeracy benchmarks conducted by the Ministerial Council on Education, Employment, Training, and Youth Affairs (2006).

While 93% of all Year 3 students achieved the 2006 national benchmarks for reading, writing, and numeracy, 80% of Indigenous Year 3 students achieved the reading benchmark, 78% achieved the writing benchmark, and 76% achieved the numeracy benchmark. The greatest disparity between Indigenous and non-Indigenous students occurred in the Northern Territory.

The literacy gap became more apparent by Year 7: for reading, 89% of all students achieved the benchmark, while 63% of Indigenous students achieved the benchmark; for writing, 92% of all students achieved the benchmark compared to 74% of Indigenous students; and for numeracy, 80% of all students achieved the benchmark compared to 48% of Indigenous students.

2.2 Social Determinants of Health

> The physical and social environments in which Indigenous people live affect their opportunities to have productive lives that are relatively free of serious illness. Many Indigenous people live today in conditions of clear social and economic disadvantage, which, along with other geographic, environmental and cultural factors, contributes to poor health in many groups of Indigenous people. (Steering Committee for the Review of Government Service Provision, 2009b)

Social determinants of health are associated with structural conditions, unequal distribution of power and income, conditions of daily life, and include access to health care, education, conditions of work and leisure, housing and inequity within communities (World Health Organization & Commission on Social Determinants of Health, 2008). Wilkinson and Marmot (2003) demonstrated a direct correlation between health outcomes and "social determinants" such as the social gradient, early life, social exclusion, stress, housing, conditions of work, unemployment, education, addiction, food and transport.

Further research by Marmot (The Marmot Review, 2010) illustrates how health inequalities resulting from inequity in a range of social and economic factors are growing. An "ecological" perspective of health is also adopted as part of a "social determinants" perspective, whereby health is seen to be affected by interrelated factors including maternal circumstances; the social environment; psychosocial factors; behaviour; biological factors; education; occupation; income; and gender.

The wellbeing of Indigenous alcohol and other drug workers is thus linked to the structural inequities they encounter, along with those experienced by their families and communities. For example, there is a disproportionate representation of unemployed people amongst the Indigenous population (Australian Bureau of Statistics, 2010b) (see section 2.1.2 "Employment"). Recent data also shows that there is growing inequity between Indigenous and non-Indigenous Australians in terms of indicators for disadvantage (Steering Committee for the Review of Government Service Provision, 2009a) and health outcomes (Eldridge, 2008).

Action on health inequalities necessitate the social and economic determinants of health to be addressed (The Marmot Review, 2010). The Marmot Review (2010) recommends a number of key policy objectives for reducing inequity and health inequalities. Several of these are particularly relevant to the wellbeing of Indigenous alcohol and other drug workers and the Indigenous population in general and include the following:

- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good working conditions for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

2.2.1 Physical health

The overall health status of Indigenous Australians in urban, regional, rural and remote areas is poor, both in absolute and relative terms, and when considering both subjective and objective health measures (Australian Institute of Health and Welfare, 2007a). Indigenous Australians are less healthy than non-Indigenous Australians, die younger, and experience more disability and lower quality of life (Australian Institute of Health and Welfare, 2010a).

Table 5 provides information about key health status measures for Indigenous Australians compared with non-Indigenous Australians, including a measure that sums years of life lost due to premature death and healthy years of life lost due to disability ("disability-adjusted life years", or DALYs) (Australian Institute of Health and Welfare, 2010a).

According to the 2008 National Aboriginal and Torres Strait Islander Social Survey and 2007-08 National Health Survey, Indigenous Australians aged 15 years and over were twice as likely as their non-Indigenous Australian counterparts to report their health as fair or poor (28% vs 15%) (Australian Bureau of Statistics, 2009). This gap has remained constant since 2002 (Australian Bureau of Statistics, 2010a).

Indigenous females, Indigenous people aged over 55, and Indigenous people in non-remote areas were especially likely to report fair or poor health (Pink & Allbon, 2008). Indigenous adults were also less likely to report very good or excellent health compared to non-Indigenous adults in similar socioeconomic circumstances (Australian Institute of Health and Welfare, 2007a).

Table 5. Measures of Health Status, Indigenous Australians Compared with Non-Indigenous Australians

Measure of health status	Year	Unit	Indigenous rate(a)	Difference between groups(b)
Self-assessed health fair/poor	2004–05	%	22	1.9
Burden of disease—males	2003	DALYs per 1,000	212.4	2.4
Burden of disease—females	2003	DALYs per 1,000	191.5	2.5
Disability prevalence	2006	%	4.3	1.8
Life expectancy—males	2005–2007	Age in years	67	–12
Life expectancy—females	2005–2007	Age in years	73	–10
Mortality(c)	2003–2007	Per 100,000	454.6	1.8
Hospitalisations(d)	2007–08	Per 1,000	549.1	2.5
General practitioner encounters	2003–04 to 2007–08	Per 100 encounters	158.1	1.1

Note. DALYs = Disability-adjusted life years. (a) Rates are crude. (b) The difference for life expectancy is in years, whereas for the other methods it is a rate ratio. Rate ratios are based on age-standardised rates and indicate the relative difference between Indigenous and non-Indigenous Australians. (c) Data are for NSW, Qld, WA, SA and NT combined. (d) Data are for NSW, Vic, Qld, WA, SA and NT combined. Sources: ABS 2009a; AIHW 2009a; AIHW National Hospital Morbidity Database; AIHW National Mortality Database; Bettering the Evaluation and Care of Health survey of general practice, AGPSCC; Vos et al., 2007 (cited in and reproduced from Australian Institute of Health and Welfare, 2010a).

The health status of Indigenous people is a poignant illustration of the inequalities that many Indigenous Australians face (Carson, Dunbar, Chenhall, & Bailie, 2007; Hunter, 1994; Saggers & Gray, 1998). In particular, higher infant mortality rates, overall death rates and lower life expectancy of Indigenous Australians compared to non-Indigenous Australians are key markers of health inequality. The Indigenous population is younger overall than the non-Indigenous population, with a median age in 2006 of 20 versus 37 years (Australian Institute of Health and Welfare, 2007b), reflecting higher fertility rates and lower life expectancy in the Indigenous population (Australian Institute of Health and Welfare, 2010a). The Indigenous age profile compared to the non-Indigenous age profile is shown in Figure 3 and it illustrates the large differences in life expectancy between these two groups.

Overall death rates for Indigenous people are twice those of non-Indigenous people (Australian Institute of Health and Welfare, 2010a). In 2005-2007, Indigenous life expectancy was 11.5 years lower for males, and 9.7 years lower for females compared with non-Indigenous Australians (Australian Bureau of Statistics, 2010a). Indigenous Australian life expectancy is the worst in the developed world—lower than any other developed countries' Indigenous population (Freemantle, Officer, McAullay, & Anderson, 2007).

The recent "Close the Gap" campaign (see 2.4.1, "Contemporary service provision issues"), Tackling Indigenous Smoking, run by a coalition of government and non-government organisations, highlights that the discrepancies in Indigenous and non-Indigenous life expectancy and mortality are underpinned by disadvantages in health conditions and determinants (Calma, 2010). The gap in mortality rates is largest in the 35-54 year age group (Benham, 2008), with most causes of death within this age group the result of preventable and treatable diseases. These include ischaemic heart disease, at 12 times the non-Indigenous death rate; liver disease, at 12 times the non-Indigenous death rate; diabetes at 30 times the non-Indigenous death rate; and intentional self-harm at 1.3 times the non-Indigenous rate (Benham, 2008). These diseases are often associated with alcohol and other drug abuse (e.g. Calabria, Doran, Vos, Shakeshaft, & Hall, 2010).

During 2003-7, Indigenous children aged 0-4 died at around twice the rate of non-Indigenous children (Australian Institute of Health and Welfare, 2010a). The majority of deaths occurred in infants aged under one year, and were commonly associated with conditions originating in the perinatal period, including birth trauma, disorders related to fetal growth, and respiratory and cardiovascular disorders (Australian Institute of Health and Welfare, 2010a). Many of these conditions are associated with alcohol and other drug abuse (see section 2.3, "Alcohol and Other Drug Use"). However, across 1991-2005, there were significant decreases in Indigenous infant mortality rates in Western Australia, South Australia and the Northern Territory, and significant declines in all-cause mortality in Western Australia (Pink & Allbon, 2008).

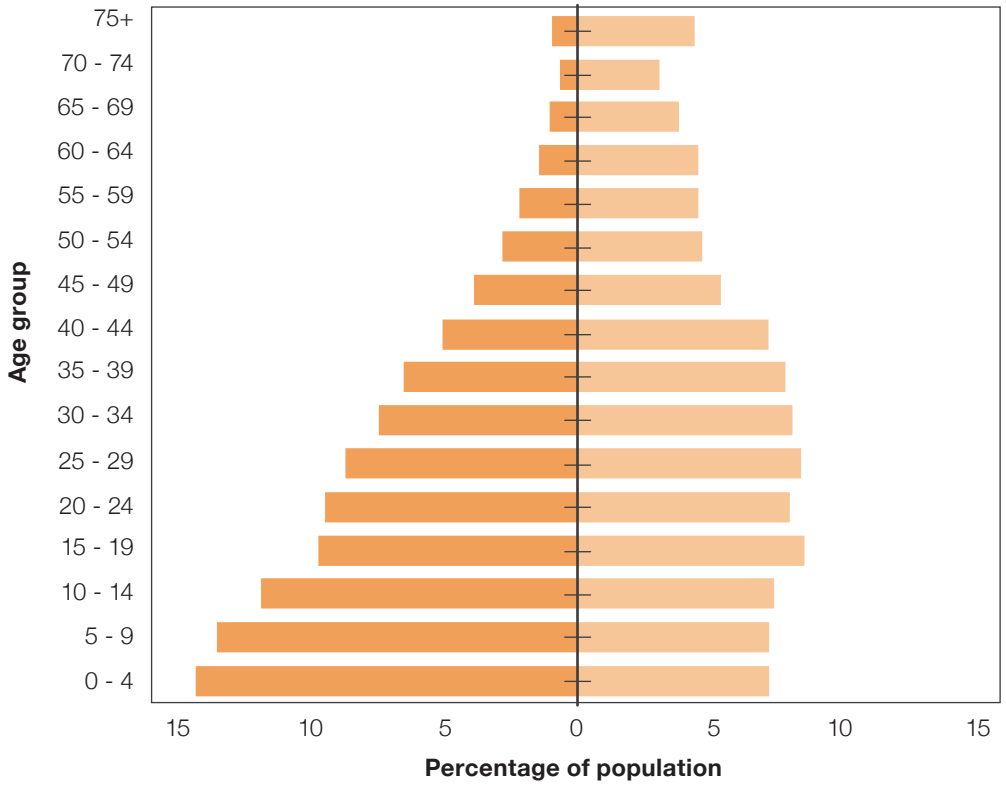

Figure 3. Population Pyramid of Indigenous (Left) and Non-Indigenous (Right) Populations, 2010
Reproduced from Thomson et al. (2010).

2.2.2 Health expenditure

Despite the health inequalities outlined above, and estimates that Indigenous Australians are hospitalised at 2.8 times the rate of other Australians (Australian Institute of Health and Welfare, 2010b), health expenditure on Indigenous people is only slightly higher per person than for non-Indigenous people, at a ratio of 1.25 (Australian Institute of Health and Welfare, 2009b). In 2006-07, average expenditure per person on health and high care residential aged care was $5,696 for Indigenous people, compared with $4,557 for non-Indigenous people (Australian Institute of Health and Welfare, 2009b).

2.2.3 Social and emotional health

Stressful events in life can have an impact on physical and psychological health, as well as an association with increased alcohol and other drug use. In 2002, 82% of Indigenous people aged 18 years or over experienced one or more life stressors in the last 12 months, with many Indigenous people experiencing multiple stressful events (44% reported three or more stressful events) (Trewin & Madden, 2005). The most commonly reported stressors among Indigenous people were:

- losing a family member or close friend
- overcrowding at home
- alcohol and other drug-related problems (Trewin & Madden, 2005).

An overview of recent surveys by the Australian Institute of Health and Welfare estimated that Indigenous Australians were twice as likely to have high or very high levels of psychological distress compared to other Australians (Australian Institute of Health and Welfare, 2010a). In the 2008 National Aboriginal and Torres Strait Islander Social Survey, nearly a third (32%) of Indigenous people aged 18 years and over reported high/very high levels of psychological distress (Australian Bureau of Statistics, 2010a).

Indigenous females (32%) were more likely to experience high or very high levels of psychological distress compared to males (21%). There were no significant differences in levels of distress between those living in remote and non-remote areas (Australian Bureau of Statistics, 2010a). Table 6 shows a breakdown of the types of stressors commonly experienced by Indigenous people with psychological distress.

Table 6. Psychological Distress[a] by Type of Stressors Experienced[b] for Indigenous Persons Aged 15 Years and Over, 2008

Stressor Experienced		Low/Moderate	High/Very High	Rate ratio (c)
Bad illness/accident	%	39.4	51.6	1.3
Death of family member or close friend	%	49.9	51.1	1.0
Alcohol/drug-related problems	%	23.8	38.9	1.6
Not able to get a job	%	23.9	36.1	1.5
Mental illness	%	17.5	27.1	1.5
Trouble with the police	%	14.9	23.9	1.6
Overcrowding at home	%	12.7	21.2	1.7
Witness to violence	%	7.6	17.3	2.3
Abuse or violent crime	%	6.5	14.0	2.1
Bad disability	%	6.3	12.9	2.1
Total experienced a stressor in last 12 months(d)	**no.**	**161 364**	**87 856**	

Note. (a) In last four weeks. (b) By self or close family/friends in last 12 months. (c) High/very high distress proportion divided by low/moderate distress proportion. (d) Multiple response item—proportions do not add to total. Source: 2008 National Aboriginal and Torres Strait Islander Social Survey (Australian Bureau of Statistics, 2010a).

High levels of psychological distress are associated with disruption to work and normal functioning—among those Indigenous people who experienced high or very high levels of psychological distress in 2008, 38% were unable to work or carry out their normal activities due to their psychological distress (Australian Bureau of Statistics, 2010a).

Psychological distress is also associated with poorer health outcomes; increased incidence of physical or threatened violence; and higher levels of tobacco smoking, drinking at chronic risky/high risk levels, and increased use of illicit substances (Australian Bureau of Statistics, 2010a). Higher levels of psychological distress among Indigenous people therefore have important implications in terms of contributing to the complex nature of client presentations and increased demand on Indigenous alcohol and other drug workers.

The incidence of psychological distress among young Indigenous people is also reflected in increased rates of self-harm and suicide. Between 2001-2005, suicide was the leading cause of death from "external causes" for Indigenous men, with suicide rates amongst young men higher than for non-Indigenous Australians—for Indigenous men aged 0-24 years and 25-34 years, suicide rates were respectively three and four times higher (Pink & Allbon, 2008). Suicide rates for young Indigenous women aged 0-24 years were five times higher than for non-Indigenous women in the same age group (Pink & Allbon, 2008).

Rates of hospitalisation (2005-06) as a result of self-injury have been found to be twice as high amongst young Aboriginal and Torres Strait Islander people than for non-Indigenous Australians (Eldridge, 2008). However, death rates from suicide for Indigenous people are similar to or lower than rates for non-Indigenous people in older age groups (Pink & Allbon, 2008).

The markedly higher levels of psychological distress in Indigenous people need to be understood within a historical context. The Indigenous perception of history is that the past and present exist simultaneously (Williams, Thorpe, & Chapman, 2003), and inter-generational stress caused by colonisation, the loss of land and autonomy, and the stolen generation has been described as collective trauma (Ratnavale, 2007) or cultural trauma (Halloran, 2004). Colonisation also disrupted the traditional family roles and networks of Indigenous people (Trewin, 2001).

It is argued that collective or cultural trauma has resulted in ongoing high levels of anxiety, distress, and social and psychological problems among Indigenous communities (Halloran, 2004; Ratnavale, 2007). In addition, a range of environmental, social, economic and cultural factors impact on the psychological health of Indigenous people, and therefore on the wellbeing of Indigenous alcohol and other drug workers. A report by Kelly, Dudgeon, Gee, and Glaskin (2009) identified the following factors as impacting on Indigenous social and emotional wellbeing:

- unresolved grief and loss
- trauma and abuse
- domestic violence
- substance misuse
- physical health problems
- identity issues
- child removals
- incarceration
- family breakdown
- cultural dislocation
- racism
- discrimination and social disadvantage.

2.2.4 Racism

Racism is a particularly pervasive stressor contributing to poor social and emotional wellbeing in Indigenous people—that is, racism can be viewed as a social determinant of health (Durey, 2010). Racism can occur at the interpersonal level, along with institutional and systemic levels, and has been shown to be particularly detrimental to health (Durey, 2010; Gallaher et al., 2009; Paradies, 2008; Paradies, Harris, & Anderson, 2008). Racism can also be internalised—where racist attitudes and beliefs are accepted by individuals, leading to feelings of inferiority (Paradies et al., 2008).

The prevalence of racism reported in surveys varies widely (16% to 93%) and partly reflects the items used to measure it (Paradies, 2008). Yet it is apparent that Indigenous Australians are exposed to racism in many different contexts in Australian society (see Durey, 2010). Racism can reduce access to health care and other services, and reduce opportunities for employment and other means of participating in a community (Wilkinson & Marmot, 2003).

Racism can mean that Indigenous people are less likely to receive medical and other health and social services that they require, including overall medical care, treatment for lung cancer, coronary procedures and kidney transplants (Cunningham; Hall et al.; Coory & Walsh, all cited in Paradies, 2008). A link between the experience of racism and self-reported poor physical and mental health (after adjusting for a range of factors) has also been established (Larson, cited in Paradies, 2008). It is also likely that racism contributes to lifestyle behaviours associated with poor health, such as alcohol and other drug misuse.

2.2.5 Incarceration

Indigenous people are 13 times more likely than non-Indigenous people to be imprisoned (Pink & Allbon, 2008). This disparity is most notable in Western Australia, where Indigenous people are 21 times more likely than non-Indigenous people to be imprisoned (Pink & Allbon, 2008).

Figure 4 shows that while the non-Indigenous prisoner rate remained constant between 1992 and 2006, the rate of Indigenous incarceration almost doubled during the same period, increasing from approximately 1,100 per 100,000 adults (1.2%) in 1992 to approximately 2,000 per 100,000 adults (1.9%) in 2006 (Australian Institute of Criminology, 2008).

By comparison the incarceration rate for Indigenous juveniles has stayed relatively stable over the same period (see Figure 5) (Australian Institute of Criminology, 2008). In 2008-9, the national age standardised rates of imprisonment per 100,000 Indigenous adults was 1720.3 compared with a corresponding rate of 123.8 for non-Indigenous prisoners—a ratio of 13:9 (Steering Committee for the Review of Government Service Provision, 2010).

Imprisonment is strongly linked with alcohol and other drug-related problems (Weatherburn, 2008). In an analysis of the 2002 National Aboriginal and Torres Strait Islander Social Survey, Weatherburn, Snowball, and Hunter (2006) found that alcohol and drug use were two of the strongest predictors of imprisonment. Almost one quarter (23%) of Indigenous high risk alcohol consumers had been imprisoned compared to 5% of Indigenous people who did not drink alcohol. Similarly, 12% of Indigenous people who used drugs had been imprisoned compared to 3.5% of Indigenous people who had never used drugs.

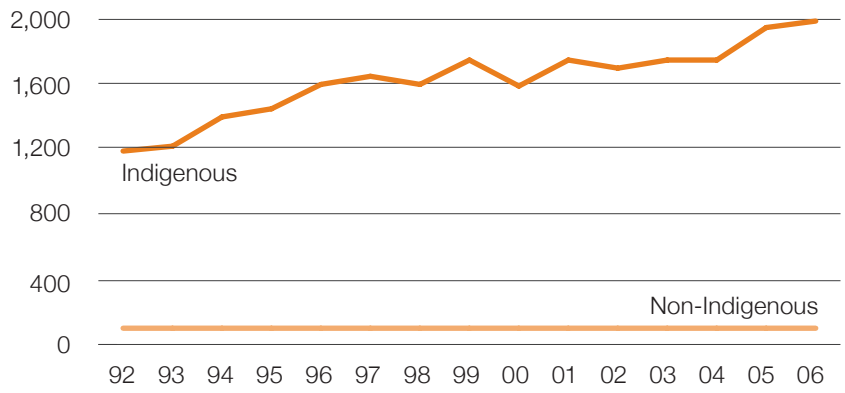

Figure 4. Indigenous and Non-Indigenous Prisoners, Rate per 100,000 Adults, 1992-2006
Reproduced from the Australian Institute of Criminology (2008).

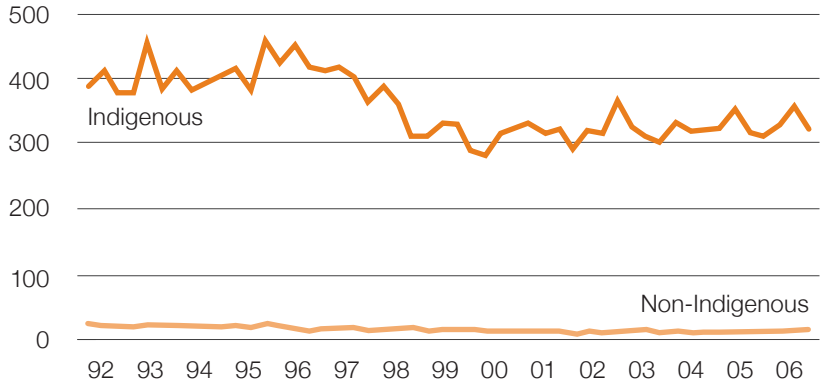

Figure 5. Persons in Juvenile Corrective Institutions by Indigenous Status, Rate per 100,000 Relevant Population, 31 March 1994–30 June 2006
Reproduced from the Australian Institute of Criminology (2008).

2.3 Alcohol and Other Drug Use

> Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health (Wilkinson & Marmot, 2003, p. 24).
>
> Smoking, poor nutrition, alcohol misuse and physical inactivity are universally recognised as key risk factors for chronic diseases … all of which contribute significantly to premature and excess mortality and morbidity among Indigenous Australians (Clifford, Pulver, Richmond, Shakeshaft, & Ivers, 2010, p. S80).

Patterns of alcohol and other drug use by Indigenous people need to be understood in a historical context that considers the effects of colonisation, dispossession, denial of culture and death from disease and confrontation (Catto & Thomson, 2008; Wilson, Stearne, Gray, & Saggers, 2010). These events have contributed directly to reactive patterns of alcohol and other drug use, as well as to widespread socioeconomic disadvantage for Indigenous people that further increases the risk of alcohol and other drug misuse. The causal link between social disadvantage, poor health and lifestyle behaviours of many Indigenous people is highlighted by the Steering Committee for the Review of Government Services Provision *" … smoking, excessive alcohol consumption and illicit drug use, are strongly associated with … socioeconomic disadvantage"* (2007a, p. 8.1). The use of alcohol and other drug substances contributes substantially to compromised physical and psychosocial health status, as well as ongoing issues such as racism and socioeconomic disadvantage.

Alcohol and other drug misuse is one of the leading causes of preventable illness and death among the Indigenous population. The rate of hospitalisation for Indigenous people for potentially preventable diseases increased by 21% between 2004-05 and 2006-08, with contributory factors related to modifiable lifestyle issues such as obesity, nutrition, tobacco and alcohol and other drug misuse (Steering Committee for the Review of Government Service Provision, 2009a). In 2006-7, the Indigenous hospitalisation rate in NSW,

Victoria, Queensland, WA, SA and public hospitals in the Northern Territory for potentially preventable chronic diseases was six times the rate for non-Indigenous people (Steering Committee for the Review of Government Service Provision, 2009a). It should be noted that the use of alcohol or other drugs is often related to the use of another substance—for example, users of alcohol often smoke tobacco—which can interact to produce higher levels of health-related harm (Wilson et al., 2010).

In 2007-8, an estimated 93,000 episodes of care were provided by government-funded Aboriginal and Torres Strait Islander substance use services (Australian Institute of Health and Welfare, 2010a). All the services provided treatment for alcohol-related issues, but varied in their levels of treatment for cannabis, tobacco, amphetamines and multiple drug use. Treatments included 3,500 episodes of residential treatment or rehabilitation, 17,300 of "sobering up" or residential respite, and 72,000 episodes of other care (Australian Institute of Health and Welfare, 2010a).

2.3.1 Alcohol

Alcohol consumption is an underlying risk factor for poor Indigenous health. Although most surveys show that Aboriginal and Torres Strait Islander people are less likely than the non-Indigenous population to drink, those who do drink are more likely than non-Indigenous drinkers to consume at risky or high-risk levels for both short-term (Australian Institute of Health and Welfare, 2008a) and long-term harm (Pink & Allbon, 2008). The 2007 National Drug Strategy Household Survey estimated that Aboriginal or Torres Strait Islander peoples were more likely to abstain from alcohol than other Australians (23.4% compared with 16.8%), but were also more likely to consume alcohol at risky or high-risk levels for harm in the short-term (27.4% versus 20.1%) (Australian Institute of Health and Welfare, 2008a)[6].

Overall, it is estimated that the prevalence of harmful alcohol use in the Indigenous population is approximately twice that of the non-Indigenous population (Wilson et al., 2010). Indigenous people, however, may not access mainstream services for alcohol treatment due to factors such as distance or culturally inappropriate services. Indigenous Australians are consequently more likely to seek help for alcohol misuse at a later stage than non-Indigenous people. In addition, they often require more advanced treatment programs to treat complex comorbidities (Wilson et al., 2010). Alcohol misuse contributes greater harm to the Indigenous population than to the non-Indigenous population—including deaths attributable to alcohol misuse, alcohol-related burden of disease and injury, and the broader impact of alcohol misuse on families and community. From 2000-2004, an estimated 1,145 Indigenous Australians died from alcohol-attributable causes, with an average age of death of approximately 35 years (Chikritzhs et al., 2007). Among the general Australian population in 2003, alcohol was attributable for 3.2%, and prevented 1%, of the total burden of disease and injury (Begg et al., 2007), while among the Indigenous population alcohol harm caused 6.2%, and prevented 0.8% of the total burden of disease and injury (Vos, Barker, Stanley, & Lopez, 2007).

The 2008 National Aboriginal and Torres Strait Islander Social Survey reported that Indigenous men were more likely than Indigenous women to drink at chronic risky/high risk long-term levels over a 12 month period (20% compared with 14%) (Australian Bureau of Statistics, 2010a). Indigenous men (46%) were also more likely than women (28%) to drink at acute risky/high risk short-term levels, or binge drink, over a fortnightly period (Australian Bureau of Statistics, 2010a). Rates of alcohol-related harm among Indigenous males are three times higher than the general Australian population, and seven times higher for Indigenous females than the general population—these figures are likely to underestimate the true proportion of alcohol-related harm (Calabria et al., 2010). Rates of risky/high risk long-term drinking were similar for Indigenous people in remote and non-remote areas, although people in remote areas were more likely to abstain from alcohol than those in non-remote areas (46% compared with 31%), and rates of binge drinking were higher in non-remote than remote areas (38% compared with 33%) (Australian Bureau of Statistics, 2010a).

The harms associated with risky levels of alcohol consumption can be physical, psychological, and financial, including: violence, social disorder, family breakdown, child neglect, loss or diversion of income, and high levels of incarceration (Australian Institute

6 The definitions of risk associated with alcohol use are based here on guidelines from the National Health and Medical Research Council (2001). Short-term risk of harm reflects levels of drinking on any drinking occasion; with consumption of up to 6 (for males) or 4 (for females) standard drinks on one occasion considered to be "low risk"; 7-10 (for males) or 5-6 for females "risky"; and over 11 (for males) or 7 (for females) "high risk". In the Australian Institute of Health and Welfare 2008 report, a monthly measure of short-term risk is used, that is, risk of harm occurring once or more a month. Long-term risk of harm reflects regular daily patterns of drinking—"low risk" reflects consumption of up to 28 standard drinks per week for adult males, or up to 14 standard drinks per week for females; 29-42 drinks per week for males or 15-28 for females is defined as "risky"; and 43 drinks or more per week for males or 29 or more for female is termed "high risk" (Australian Institute of Health and Welfare, 2008a).

of Health and Welfare, 2008a; Calabria et al., 2010; Steering Committee for the Review of Government Service Provision, 2009a; Wilson et al., 2010). Higher levels of binge drinking and long term chronic risky/high risk alcohol consumption are both associated with poorer health, higher levels of smoking, and increased use of illicit substances (Australian Bureau of Statistics, 2010a). Higher levels of short-term binge drinking are associated with an increased risk of drinking at long-term risky levels (Australian Bureau of Statistics, 2010a).

In terms of physical disease and injury, alcohol misuse is associated with heart disease, cardiovascular and vascular disease, stroke, liver cirrhosis and cancer (Calabria et al., 2010; Steering Committee for the Review of Government Service Provision, 2009a). The effects of alcohol misuse account for approximately 7% of Indigenous Australian deaths, with key alcohol-related causes of death including suicide, alcoholic liver cirrhosis, road traffic injury, assault injury and haemorrhagic stroke (Calabria et al., 2010; Chikritzhs et al., 2007). Table 7. highlights the higher rates of hospitalisation for alcohol-related problems among Indigenous people compared to non-Indigenous people in 2005-06. Indigenous men were nine times and women four times more likely to be hospitalised due to excessive alcohol use compared to the non-Indigenous population. The rate of alcohol-attributable deaths among Indigenous Australians is approximately twice that for the non-Indigenous population (Chikritzhs et al., 2007).

Table 7. Indigenous Australian to Non-Indigenous Australian Hospitalisation Rate Ratios for Conditions in which Alcohol is a Significant Contributing Factor, 2005-06

Condition	Males	Females
Mental disorders due to psychoactive substance use	4.5	3.3
Cerebrovascular disease	2.4	2.5
Hypertensive disease	4.2	5.6
Transport accidents	1.2	1.3
Intentional self-harm	2.9	1.9
Assault	6.2	33.0

Note. Data for NSW, Vic, Qld, WA, SA and NT combined. Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008) (cited in and reproduced from Wilson et al., 2010).

Higher levels of long-term drinking are also associated with higher levels of psychological distress. For many Indigenous people, the misuse of alcohol has resulted in a disproportionate number of mental health disorders. As shown in Table 7, the rates of hospitalisations for mental health disorders due to the misuse of psychoactive substances—including alcohol—were estimated to be 4.5 (males) and 3.3 (females) times the rates for non-Indigenous people (Australian Bureau of Statistics and Australian Institute of Health and Welfare, cited in Wilson et al., 2010).

Alcohol misuse by Indigenous parents has a wider impact on families (Steering Committee for the Review of Government Service Provision, 2007b). The National Aboriginal and Torres Strait Islander Survey showed that almost one in six Indigenous children (15%) live in a household with a risky drinker, compared to 11% of non-Indigenous children (Pink & Allbon, 2008). Rates of Indigenous children's exposure to risky drinking differed according to geographical region (NATSIS, cited in Pink & Allbon, 2008). Alcohol misuse during pregnancy contributes to Foetal Alcohol Spectrum Disorder, which has been linked to learning difficulties and behavioural problems in children. Such learning difficulties are also associated with "non-stimulating environments" linked to misuse of alcohol by parents (Foresight, 2008).

In addition, there is an association between alcohol consumption and representation in the criminal justice system among Indigenous people, with chronic risky/high risk drinkers more likely than low risk drinkers to have been arrested in the last five years, charged by police, and incarcerated (Australian Bureau of Statistics, 2010a). Indigenous chronic risk/high risk drinkers were also more likely than low risk drinkers to have been a victim of violence in the last 12 months (35% compared with 25%); as were binge drinkers, or those who consumed alcohol at acute risky/high risk levels (32% compared with 16%) (Australian Bureau of Statistics, 2010a). Among homicide cases from 1999-2000 to 2006-07 in the Indigenous population, 70% of cases involved both the victim and offender having consumed alcohol, compared to 23% of cases in the non-Indigenous population (Steering Committee for the Review of Government Service Provision, 2009a).

2.3.2 Tobacco

Tobacco smoking remains the leading cause of preventable ill health and death in Australia (Australian Bureau of Statistics, 2010a; Australian Institute of Health and Welfare, 2010a), and a leading risk factor contributing to death and disease in Indigenous people (Vos et al., 2007). In 2003, tobacco was estimated to be responsible for 7.8% of the total burden of disease and injury in Australia for the general population (Begg et al., 2007), while for Indigenous Australians tobacco smoking was responsible for 12.1% of the total burden, and one-fifth of deaths in Indigenous Australians (Vos et al., 2007).

Despite a decline in levels of smoking among the Indigenous population between 2002 and 2008 from 49% to 45%, Indigenous people remain twice as likely to smoke as non-Indigenous people (Australian Bureau of Statistics, 2010a). The 2007 National Drug Strategy Household Survey reported higher levels of smoking (34.1% versus 19%), and higher numbers of cigarettes smoked per week (115 versus 97) for Indigenous people compared with non-Indigenous people (Australian Institute of Health and Welfare, 2008a). Gray et al. (Gray, Stearne, Wilson, & Doyle, 2010) estimated the prevalence rate of smoking among Indigenous people was 2.4 times that of the non-Indigenous population.

As shown in Figure 6, a similar number of Indigenous females and males were current daily smokers in 2008, but smoking varied by age group. Indigenous people in remote areas were more likely to be current daily smokers than those living in non-remote areas, at 49% versus 43% (Australian Bureau of Statistics, 2010a). There is, however, some evidence to suggest that while smoking prevalence may be high in remote areas, frequency of consumption may be lower than in the wider Australian community, possibly as a result of difficulty in obtaining cigarettes (Butler, Chapman, Thomas, & Torzillo, 2010).

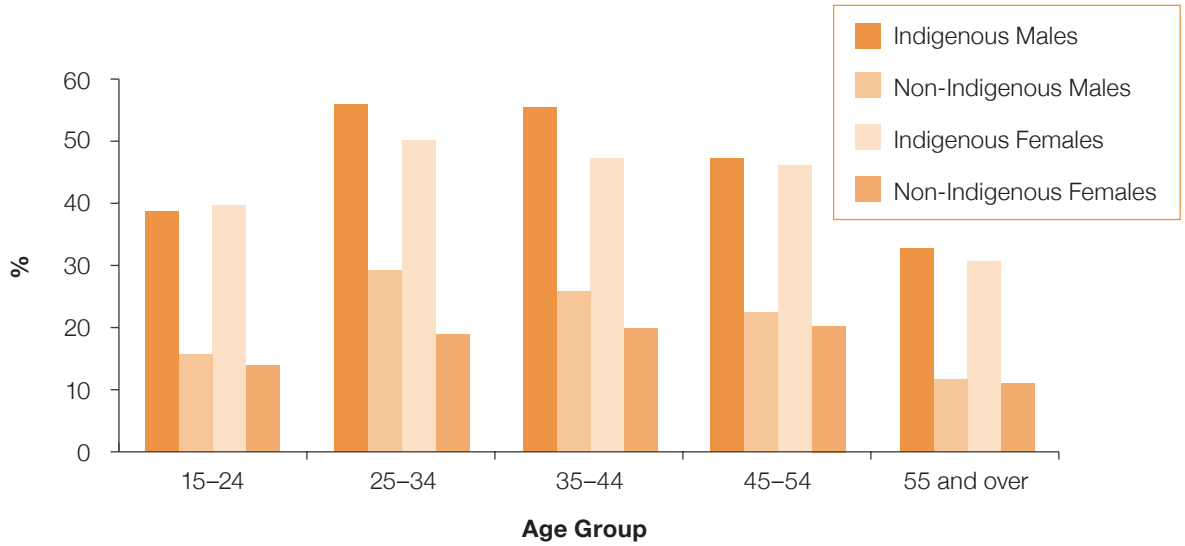

Figure 6. Current Daily Smokers by Indigenous Status, 2008

Source: 2008 National Aboriginal and Torres Strait Islander Social Survey, 2007–08 National Health Survey (Australian Bureau of Statistics, 2010a).

Indigenous people who were current daily smokers reported poorer health outcomes, higher levels of psychological distress, and higher rates of alcohol and substance abuse than non-smoking Indigenous people (Australian Bureau of Statistics, 2010a).

Smoking is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer, chronic obstructive pulmonary disease, and cardiovascular disease (Australian Bureau of Statistics, 2010a; Australian Institute of Health and Welfare, 2010a). In addition, smoking during pregnancy is associated with increased levels of fetal abnormalities and complications such as restricted growth, and increased incidence of miscarriage and perinatal death (Australian Institute of Health and Welfare, 2004). In 2006, Indigenous mothers were three times more likely to report smoking during pregnancy than non-Indigenous mothers—52% compared with 16% (Australian Institute of Health and Welfare, 2010a).

The effects of passive smoking also pose health risks. Passive smoking is associated with increased risk of respiratory disease, lung cancer, and heart disease in adults, and increased health problems in children such as infections, asthma and sudden infant death syndrome (see Australian Bureau of Statistics, 2010a; Australian Institute of Health and Welfare, 2010a for overview). In 2004-5, 28% of Indigenous children were exposed to passive smoking in the home compared

with 9% of non-Indigenous children (Australian Institute of Health and Welfare, 2008b). In 2008, 68% of Indigenous people aged 15 years and over lived in a household with a daily smoker, with those living in remote areas more likely to live with a daily smoker than those in non-remote areas (76% compared with 65%) (Australian Bureau of Statistics, 2010a).

As shown in Table 8, Indigenous people are four times more likely than non-Indigenous people to be hospitalised due to tobacco-related illnesses (Steering Committee for the Review of Government Service Provision, 2009a). Conventional anti-smoking campaigns appear to have had a limited impact on Indigenous Australians (Adams & Briggs, 2005; Ivers, 2001).

Table 8. Age Standardised Hospitalisations related to Tobacco Use in NSW, Victoria, Queensland, WA, SA and Public Hospitals in the NT, 2006-07 (per 1,000 population)

State	Males		Females		People	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
NSW	4.3	1.4	4.2	0.8	4.2	1.1
Victoria	1.4	1.2	6.8	0.7	4.1	0.9
Queensland	2.1	0.7	1.1	0.4	1.6	0.5
WA	2.8	1.3	2.7	0.7	2.7	1.0
SA	4.0	1.1	7.6	1.7	5.7	1.4
NT (public hospitals only)	8.2	5.7	4.6	1.1	6.2	3.3
Total	**3.7**	**1.2**	**3.5**	**0.8**	**3.6**	**1.0**

Note. The hospital separation rates (per 1,000 population) were directly age standardised to the Australian population as at 30 June 2001. A hospitalisation is the discharge, transfer, death or change of episode of care of an admitted patient. Principal diagnoses of hospitalisations are based on codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). Non-Indigenous data include separations where Indigenous status was not reported. Data are based on state of usual residence. Source: AIHW National Hospital Morbidity Database (unpublished); table 7A.4.3 (Reproduced from and cited in Steering Committee for the Review of Government Service Provision, 2009a).

2.3.3 Illicit drugs

While misuse of alcohol and tobacco has the largest overall negative impact on the health of Indigenous Australians; illicit substance use also contributes to ill-health, injuries, violence, criminal behaviour, workplace problems and disruption of family and community (Australian Health Ministers' Advisory Council 2006, cited in Catto & Thomson, 2008). Illicit drug use accounts for a large proportion of the burden of disease and injury among Australia's young people (Pink & Allbon, 2008). In 2003, illicit drug use accounted for 2% of the total burden of disease and injury among the general Australian population (Begg et al., 2007); but 6.9% of the total burden in the Indigenous population (Vos et al., 2007).

Illicit substance use among Indigenous people is almost double that of non-Indigenous Australians (24.2% compared with 13%) (Australian Institute of Health and Welfare, 2008a). The average age of first use for illicit drugs is up to six years younger for Indigenous people than non-Indigenous people, at 12-17 years for cannabis (compared with 18 years); and 17-18 years for injecting drug use (compared with 21 years) (Australian Institute of Health and Welfare, cited in Catto & Thomson, 2008).

Table 9. Indigenous Persons Aged 18 Years or Over Residing in Non-Remote Areas: Status of Substance Use (per cent), from 2004-05 National Aboriginal and Torres Strait Islander Health Survey

Condition	Males	Females	People
Used substance in last year:			
Analgesics or sedatives (a)	3.7	7.9	6.0
Amphetamines or speed	10.1	4.9	7.3
Marijuana, hashish or resin	28.6	17.5	22.5
Kava (b)	1.6	0.2	0.8
Total used substance in last year (c)	32.4	24.4	28.0
Used substance but not in last year	22.4	20.8	21.5
Total used substance (d)	55.6	45.6	50.1
Never used substances	42.4	52.7	48.0

Note. Reproduced from Steering Committee for the Review of Government Service Provision (2007a). (a) For non-medical use (includes pain killers, tranquilisers and sleeping pills).
(b) The relative standard error for the estimates for kava use were greater than 25 percent and should be used with caution.
(c) Includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone, and other inhalants.
(d) Includes "whether used in last 12 months" not known.

In 2004-05 the most commonly used illicit drug in remote areas was marijuana (cannabis), followed by amphetamines (see Table 9). Illicit drug use was more prevalent among males than females, except for non-medical analgesics. National comparisons of adult drug users also indicate that a higher proportion of Indigenous (14.0%) than non-Indigenous adults (6.7%) consume cannabis (Steering Committee for the Review of Government Service Provision, 2007a).

Adelaide-based research of 307 Indigenous intravenous drug users found that polydrug use was common (Williams, Nasir, Smither, & Troon, 2006).

The most commonly used drugs were heroin (97%), speed (methamphetamine) (68%), alcohol (66%), yarndi (cannabis) (63%), tobacco (55%), benzodiazepines (34%) and methadone (34%) (Williams et al., 2006).

A secondary analysis of the Australian Secondary Students' Alcohol and Drug Survey indicated elevated rates of use among Indigenous students for all the drugs studied (see Table 10). Use of illicit drugs was significantly higher for Indigenous students than non-Indigenous students. The data also suggest that polydrug use may be high among Indigenous students.

Table 10. Percentage of Indigenous and Non-Indigenous Students Using Each Drug in the Last Year

Substance (used in last year)	% non-Indigenous students (n= 20,712)	% Indigenous students (n=881)	Design-based F (df1, df2 = 1, 371)
Cannabis	15.2%	28.2%	100.5***
Inhalants	11.8%	19.7%	40.9***
Cocaine	2.0%	7.4%	85.5***
Hallucinogens	2.3%	8.5%	107.5***
Amphetamines	4.2%	11.9%	89.2***
Ecstasy	3.0%	8.5%	61.3***
Tranquilisers	8.8%	17.3%	58.4***
Opiates	1.5%	7.7%	169.8***
Any drug	28.2%	38.7%	45.6***

Note. Reproduced from Roche et al. (2007). *df* = degrees of freedom. "Any drug" refers to use of any of the drugs appearing in this table. *** $p < .001$.

Information from the 2004-05 National Aboriginal and Torres Strait Islander Health Survey indicated that Indigenous young people aged 18-34 who had recently used illicit substances were also more likely to smoke than those who had never used illicit substances (66% compared with 34%), and to binge drink on a weekly basis (28% compared with 13%) (Pink & Allbon, 2008). Thus, illicit drug use is often combined with alcohol and tobacco use, representing additional complications in terms of treatment and health risks. Recent users of illicit substances were less likely to report being in good or excellent health than those who had never used these substances, at 41% compared with 58% (Pink & Allbon, 2008).

2.4 Historical Context of Alcohol and Other Drug Service Provision

In order to understand the context in which Indigenous alcohol and other drug services are provided and the wide range of factors that impact on the day-to-day pressures of Indigenous alcohol and other drug workers, it is important to examine the historical context of government policy on Indigenous alcohol and other drug issues, and alcohol and other drug service provision to Indigenous communities.

Indigenous health policy and funding historically has been characterised by disparity and friction between state and commonwealth government departments and local Indigenous community health organisations (Anderson, Baum, & Bentley, 2004; Bartlett & Boffa, 2005; Brady, 2007). Health policy specifically directed towards the development of Indigenous-controlled services began with the establishment of the Redfern Aboriginal Medical Service in 1971 (Bartlett & Boffa, 2005, p. 53). The emergence of other Aboriginal community health centres followed suit. Community control is a process that allows the local Aboriginal community to be involved in a manner determined by the local community. An Aboriginal Community Controlled Health Service is an incorporated Aboriginal organisation, initiated by and based in a local Aboriginal community, governed by an Aboriginal body elected by the local Aboriginal community to deliver holistic and culturally appropriate health services to the community that controls it (National Aboriginal Community Controlled Health Organisation, 2008).

The first organised "peak" Indigenous health body was formed under the banner of the National Aboriginal and Islander Health Organisation in the mid 1970s (Bartlett & Boffa, 2005), and called for "a coordinated and collaborative approach" to improving Aboriginal health (Foley, 1982 in Bartlett & Boffa, 2005, p. 54). The National Aboriginal and Islander Health Organisation was replaced by the National Aboriginal Community Controlled Health Organisations in 1992 in an effort to unite all Aboriginal Medical Services (Bartlett & Boffa, 2005).

Specific funding to address Indigenous drug and alcohol issues began in the early 1970s (Alati, Peterson, & Rice, 2000; Brady, Nicholls, Henderson, & Byrne, 2006). Funding was primarily directed towards abstinence models and biomedical approaches, and to organisations that followed this philosophy (Alati et al., 2000; Bartlett & Boffa, 2005). Financial support was initially provided for the implementation of rehabilitation centres and Alcoholics Anonymous groups (Alati et al., 2000; Bartlett & Boffa, 2005; Brady, 2007; Brady et al., 2006; Gray, Saggers, Atkinson, & Strempel, 2004).

The first Aboriginal-run residential program to specifically address alcohol misuse was developed in the Sydney area (Brady, 2002). Similar residential programs were then established nationally that followed Alcoholics Anonymous principles in the management of alcohol dependence (Brady, 2002). Initial programs were motivated by a need for action by government, and began a trend in government practice but reportedly lacked strategic direction or long-term planning (Alati et al., 2000). Nonetheless, this impetus for action enabled the establishment of alcohol rehabilitation clinics operated by Indigenous organisations.

By the 1980s, with many state governments decriminalising public drunkenness, "sobering-up centres" were established "as a humane form of care for the publicly intoxicated" (Brady et al., 2006, p. 201). These centres performed a valuable service, and "provided opportunities for brief interventions by drug and alcohol workers, referrals for further assistance, as well as respectful and humane treatment of a vulnerable population" (Brady et al., 2006, p. 201).

By the 1990s, the Commonwealth Government began promoting harm minimisation in contrast to former abstinence policies. This change was difficult for some Indigenous organisations who still saw alcohol as a disease that required rehabilitation (Brady, 2007). At times, friction arose between Aboriginal Medical Services and Indigenous drug and alcohol services as a result of Commonwealth funding being directed to drug counselling (Brady, 2007). By the early 1990s intervention programmes for Indigenous alcohol misuse were fragmented and under-resourced (Brady, 2007).

The 2000s saw a series of general health and welfare reforms and increases in expenditure on alcohol and

other drug services. In 2001, the Australian Health Minister's Advisory Council agreed to the development of an Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework aimed at providing a collaborative approach to workplace reform for health workers. In 2002, the Council of Australian Governments (COAG) made a commitment to collect information measuring policy changes that impacted upon Indigenous people, including key indicators of Indigenous disadvantage and health. The National Strategic Framework for Aboriginal and Torres Strait Islander Health was introduced in 2003 (complementing the 1989 National Aboriginal Health Strategy).

Indigenous mental and social and emotional health was specifically considered through the 2005 Social and Emotional Wellbeing Framework: a national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing 2004-09. In 2006, controversial health checks for Indigenous Australians were implemented (as part of the Northern Territory intervention), following the (2007) *Little Children are Sacred* report on child abuse in Northern Territory communities. In 2007, the new federal government apologised to Aboriginal people on behalf of all Australians, for the Stolen Generation.

In terms of drug and alcohol policy, an agreement was made in 2007 to "double the funding of $49.3 million previously pledged by COAG for services dealing with substance and drug rehabilitation and treatment" (Australian Indigenous Health Infonet). One initiative from COAG was the Illicit Drug Diversion Initiative in Rural and Remote Australia, designed to divert offenders with little prior history of drug use into drug treatment and education services, as an early intervention initiative.

The National Drug Strategy (2010-2015) (Ministerial Council on Drug Strategy, 2011) provides the national framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs. The National Drug Strategy (2010-2015) also highlights the importance of addressing workforce supply issues and in particular the nature of the small Indigenous AOD workforce (Ministerial Council on Drug Strategy, 2011). *The National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009* provides direction for Indigenous Australians to address drug-related problems. The National Alcohol Strategy 2006-2011 (Ministerial Council on Drug Strategy, 2006) targets alcohol misuse at a national level, in conjunction with the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*.

2.4.1 Contemporary service provision issues

Resources directed towards treating Indigenous alcohol and other drug issues continued to increase—between 1999-2000 and 2006-07 the number of Indigenous-specific alcohol and other drug intervention projects increased by 23%, with a 110% increase in operational expenditure from $42.6 million to $89.4 million (Gray, Stearne, et al., 2010). Programs addressing contemporary issues include the Australian Government's petrol sniffing prevention program; increased services treating illicit drug use and diversion and prevention programs; and increases in community patrol and sobering-up shelters (Gray, Stearne, et al., 2010).

Alcohol and other drug prevention and treatment programs encompass strategies at primary, secondary and tertiary levels. Primary interventions aim to prevent use of alcohol and other drugs; secondary programs aim to reduce the risk of alcohol and other drug use reaching problematic levels, or minimising harm from use; while tertiary intervention provides treatment for alcohol and other drug issues once misuse is established (Catto & Thomson, 2008; Wilson et al., 2010). Examples of primary intervention include education programs; provision of alternative sporting, recreational and cultural activities; and restricting the supply of alcohol (Wilson et al., 2010). Primary prevention programs are often run in conjunction with secondary strategies designed to minimise harm from alcohol misuse, such as sobering up shelters and night patrols.

Over the last two decades there has been a shift in emphasis from treatment of dependent users to a combined primary and secondary approach targeting at-risk individuals (see Roche & Freeman, 2004). There is increasing recognition that secondary level strategies—including early and brief intervention, for example through screening and early detection in primary health care settings—offer scope for cost-effective and potentially effective interventions for alcohol and other drug misuse, although adoption of these strategies can sometimes be challenging (Clifford et al., 2010; Roche & Freeman, 2004; Shakeshaft, Clifford, & Shakeshaft, 2010). Despite this, such interventions may translate more easily, and present fewer risks to an Indigenous population than primary or tertiary level interventions (Shakeshaft et al., 2010).

While alcohol and other drug prevention and treatment strategies are often designed at a national level, they require culturally appropriate implementation when targeting the Indigenous population (Gray, Saggers, Wilkes, Allsop, & Ober, 2010; Shakeshaft et al., 2010; Wilson et al., 2010). There is, for example, only limited evidence regarding the effectiveness of most strategies

in reducing alcohol-related harm within the Australian Indigenous context (Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006; Shakeshaft et al., 2010). Effective interventions appear to be most potent when there is some degree of Indigenous control or collaboration (Loxley et al., 2004; Wilson et al., 2010).

However, the effectiveness of interventions and the capacity of Indigenous Australians to respond to Indigenous alcohol and other drug issues are often undermined by non-recurrent funding, a decrease in resourcing of Indigenous community-controlled services, and an increase in tendering of such services to non-Indigenous NGOs (Gray, Stearne, et al., 2010). Inflexible funding guidelines and tendering processes limit the ability of Indigenous alcohol and other drug organisations to secure funding and address local or regional needs (Gray, Stearne, et al., 2010). Many areas remain under-resourced in terms of Indigenous-specific alcohol and other drug services or culturally sensitive and appropriate services (Gray, Stearne, et al., 2010; Roche, Pidd, & Duraisingam, 2009). A need has been identified for resources to be more appropriately directed to areas of greatest need, such as tobacco smoking prevention programs, and community and residential based services for women, families, young people, and people with comorbid mental disorders (Gray, Stearne, et al., 2010).

2.4.2 The "Close the Gap" Initiative

Since 2007, the collaborative "Close the Gap" campaign has called on the federal, state and territory governments to close the gap between Indigenous and non-Indigenous life expectancy by increasing access to primary health care, and addressing the social determinants of health. In 2008, a response came in the form of the "Close the Gap" Statement of Intent, endorsed by the Australian Government and Aboriginal health leaders, outlining a commitment to achieve equality of health status and life expectancy by 2030 (cited in Close the Gap Steering Committee for Indigenous Health Equality, 2010). This was followed by the Council of Australian Government's National Indigenous Reform Agreement (Closing the Gap) and Integrated Strategy for Closing the Gap on Indigenous Disadvantage, an inter-governmental approach.

Objectives included closing the life expectancy gap within a generation; halving the gap in mortality rates for children under five; and addressing Indigenous disadvantage in areas of education and employment (Council of Australian Governments, 2009). The agreement acknowledged the need to share responsibility in an integrated and multi-pronged approach to Indigenous health and wellbeing, by working in partnership with Aboriginal and Torres Strait Islander peoples. The agreement was underscored by a COAG commitment of $4.6 billion in Indigenous-specific funding over 10 years to support reforms in remote housing, health, early childhood development, jobs and improvement in remote service delivery (Council of Australian Governments, 2009).

In 2010, the "Close the Gap" Steering Committee for Indigenous Health Equality examined the government's progress in achieving the objectives outlined in the Statement of Intent. Achievements included: annual reports to Parliament by the Prime Minister on progress made towards "closing the gap"; creation of a National Indigenous Health Equality Council; the National Indigenous Reform Agreement and Integrated Strategy for Closing the Gap on Indigenous Disadvantage and associated funding; appointment of a Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery; an unprecedented number of reforms in health policy, specifically Indigenous health policy; and the establishment of a national Indigenous representative body (National Congress of Australia's First Peoples) (Close the Gap Steering Committee for Indigenous Health Equality, 2010).

The Shadow report identified objectives that had not yet been addressed and that require attention, including commitments to: develop a long-term plan of action to target need using evidence-based strategies to address existing inequalities in health services; to ensure full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs; and supporting and developing Aboriginal and Torres Strait Islander community controlled health services to achieve lasting improvements in Aboriginal and Torres Strait Island health and wellbeing (Close the Gap Steering Committee for Indigenous Health Equality, 2010). These are recognised as critical for the long-term success and sustainability (Close the Gap Steering Committee for Indigenous Health Equality, 2010).

Increasingly, there is recognition that policy needs to focus not just on decreasing Indigenous mortality[7], but to also target underlying risk factors contributing to the burden of disease experienced by the Indigenous population (Calma, 2010; Zhao, Condon, Guthridge, & You, 2010). There is evidence that even in the face of decreasing mortality rates—for example in the Northern Territory between 1994-1998 and 1999-2003, years

7 Indigenous population estimates are likely to be imprecise, although this has improved in recent years (Thomson et al., 2010).

of life lost decreased by about 10% in the Indigenous population, equivalent to an increase in life expectancy at birth by about one year—the Indigenous population is experiencing a greater increase in years lost to disability than the non-Indigenous population (60% increase among the Indigenous population between 1994-1998 and 1999-2003, compared with 10% among the non-Indigenous population) (Zhao et al., 2010). Thus, the Indigenous population may be living longer, but they are experiencing lower quality of life and increased disability through increased prevalence of problems such as diabetes, depression, nephritis/nephrosis, suicide and sense organs disease (Zhao et al., 2010).

Socioeconomic disadvantage and unhealthy lifestyle behaviours are recognised as major contributors to the increased incidence of chronic diseases and suicide among the Indigenous population (Catto & Thomson, 2008; Steering Committee for the Review of Government Service Provision, 2010; Vos et al., 2007; Wilson et al., 2010; Zhao et al., 2010). Vos et al. (2007) acknowledged that the Indigenous "health gap" indicates potential for health gain and a useful guide for health policy makers. They calculated that if Indigenous Australians had experienced the same rate of mortality and disability as the total Australian population, the burden of disease in this population in 2003 would have been 59% lower (Vos et al., 2007). It is increasingly clear that policy needs to focus on:

> Addressing the underlying causes of disease, including socioeconomic determinants (low income, poor education, high unemployment and poor living conditions) and related risk factors of disease and injury (physical inactivity, smoking and alcohol abuse) through emphasis on public health and primary prevention in parallel to continuing commitment to secondary prevention and high quality tertiary care (Zhao et al., 2010, p. S97).

Policy needs to be guided by appropriately evaluated research that pinpoints specific sub-populations and disease types rather than just targeting Indigenous Australians overall (Calabria et al., 2010). For example, alcohol-related interventions that specifically target ways to reduce homicide and violence in Indigenous males and females, suicide in Indigenous males, and the incidence of alcohol use disorders in Indigenous females, may be most effective at reducing alcohol-related harm for Indigenous Australians (Calabria et al., 2010). Appropriate evaluations of Indigenous health problems and interventions are required to assess the impact of such programs, that would ideally incorporate the Iga Warta principles (see below).

Targeted interventions also need to consider the impact on families and communities rather than the individual alone (Calabria et al., 2010). This broader focus is apparent in some of the more recent alcohol and other drug policies. For example, under the National Illicit Drug Strategy, a Strengthening Families Program (Department of Families Housing Community Services and Indigenous Affairs, 2009) has been operating since 2005 to provide family support to high-risk families through various national and state level funded projects. A Community Partnerships Initiative and Indigenous Communities Initiative are part of this strategy. In 2009, the federal government announced funding for programs to support drug dependent parents. In 2010 a new "Kids in Focus" program of funding made grants available for each state and territory, aimed at providing support and minimising the impact of drug use in families with substance using parents.

The Iga Warta principles established in South Australia in 1999 encapsulate an ideal and inclusive approach to Indigenous health care. These principles "should be explored to determine their relevance to every intervention to improve Aboriginal health":

- The project must be sustainable—i.e. funding/leadership/coordination/continuously evaluated
- It must have a pro-active/preventative approach—i.e. addresses the need to "get in early"
- It must address the environmental determinants of health—i.e. food, water, housing, unemployment, etc
- It must have an Aboriginal and community and family approach—i.e. it must address the need to empower Aboriginal communities and families and enhance their traditional guiding function over Aboriginal people
- It must respect Aboriginal time and space—i.e. it should be culturally sensitive
- It must address the need for co-ordination and continuity between regions and Adelaide—i.e. strategies must be coordinated with other activities in other sectors, e.g. transport, housing, education which offer the potential to strengthen health outcomes ("Iga Warta Principles," 1999).

2.5 Summary

Compared to non-Indigenous people, Indigenous people have lower levels of employment, school retention and literacy; poorer general physical health status with lower life expectancies; and higher levels of psychological distress. These inequalities reflect a history of trauma and neglect that have led to increased Indigenous disadvantage in terms of social health determinants and physical health. As a recent report on the State of the World's Indigenous People noted: "Although some progress has been made in Australia in recent years, particularly in education, the gap between Indigenous and non-Indigenous peoples' quality of life by virtually all standards is still very significant" (United Nations, 2009, p. 23).

Such social inequalities reflect environmental conditions and contribute to a pattern of adverse lifestyle behaviours. As with all Australians, the lower the socioeconomic status of Indigenous Australians, the more likely they are to experience health risk factors (Australian Institute of Health and Welfare, 2010a). Compared to the non-Indigenous population, the Indigenous population has elevated rates of drug use, more than double the proportion of tobacco smokers, and high levels of risky drinking. These behaviours are associated with increased socioeconomic disadvantage, a higher incidence of mental disorders, family breakdown, violence, and higher rates of poorer physical health, hospitalisation and mortality compared to the non-Indigenous population.

These issues may have a direct and personal impact on the wellbeing of Indigenous alcohol and other drug workers. They also affect the nature of their work in terms of the issues faced by their clients and communities. The high numbers of Indigenous clients who require treatment for alcohol and other drug issues, combined with the relative shortage of Indigenous alcohol and other drug workers, impacts on workers' wellbeing in various ways including heavy workloads and time pressures. In addition, Indigenous alcohol and other drug workers may need to help clients deal with social and economic issues specific to the Indigenous population, and which contribute to complex substance misuse presentations that require comprehensive treatment programs.

At an organisational level, the history of government policy and alcohol and other drug service provision to Indigenous communities has had a substantial impact on the nature of contemporary alcohol and other drug Indigenous intervention programs and services. Conflict between government and Indigenous perceived needs has resulted in fragmented programs. Disjointed funding and inadequate strategic planning continue to impact on the wellbeing of Indigenous alcohol and other drug workers. Despite growing recognition of the importance of the involvement of Indigenous communities and associations in treating alcohol and other drug issues, and greater allocation of resources towards this goal, program tenders are increasingly granted to non-Indigenous organisations.

To "Close the Gap" between Indigenous and non-Indigenous health and life expectancy, comprehensive national action is required that targets not just mortality rates, but also the burden of disease, by promoting early intervention and holistic primary public health care, increasing access to culturally acceptable health treatment programs, reducing limitations exacerbated by funding issues, and through partnerships with Indigenous organisations.

The human rights issues at the heart of Indigenous disadvantage also need to be addressed with a focus on redressing past neglect as well as treating the resultant adverse lifestyle behaviours that impact Indigenous health and mortality (Calma, 2010) and contribute to increased alcohol and other drug use and the wellbeing of the Indigenous population in general. Such interventions should be culturally appropriate and evaluated, targeted to specific risk groups, and developed in consultation with Indigenous community members (Calabria et al., 2010). All of the above strategies have direct and indirect implications for the improvement of Indigenous alcohol and drug services and the workers within them.

3. Issues Facing the Indigenous Alcohol and Other Drugs Workforce

> The causes and consequences of harmful alcohol and other drug use are complex and strategies to address them must be multidimensional (Gray, Stearne, et al., 2010, p. 34).

The alcohol and other drugs workforce is confronted by many challenges. They include, but are not limited to, the stigmatisation of clients and workers, heavy workloads, continually changing demands and expectations of their role, and increased risk of stress and burnout (Dollard et al., 2003; Dollard et al., 2001; Dollard et al., 2000; Duraisingam et al., 2006; Roche & Richard, 1991; Skinner, Feather, Freeman, & Roche, 2007). Indigenous alcohol and other drug workers face these issues as well as a range of additional unique challenges. Racism; lack of culturally appropriate support and understanding; working in remote rural communities; and the dilemma with setting appropriate boundaries constitute some of the issues specific to Indigenous alcohol and other drug workers. In addition, a lack of clearly defined roles and limited human and other resources place further demands on Indigenous health and alcohol and other drug workers. This section provides an overview of some of the challenges facing the generic alcohol and other drugs workforce and discusses specific issues that impact Indigenous alcohol and other drug worker wellbeing at both an individual and organisational level.

3.1 Alcohol and Other Drugs Workforce Issues

The alcohol and other drugs workforce in general must contend with factors that may affect their capacity, responsiveness and sustainability. In addition to growing demands for services, the alcohol and other drugs field also experiences difficulties in recruiting and retaining qualified staff, particularly in rural and remote areas (Duraisingam et al., 2006; Pitts, 2001; Roche & Pidd, 2010; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003). Excessive job demands (e.g., heavy workloads, client pressure, complexity of clients' problems) and lack of job resources (e.g., lack of job autonomy, limited workplace support, inadequate salaries) increase levels of stress and burnout within this workforce and jeopardise worker wellbeing (Duraisingam et al., 2006; Duraisingam et al., 2007).

The relationship between mental health, employment, unemployment and working conditions is complex. In a review of factors contributing to mental health, Battams (2009) explored this relationship:

> Mental health problems have been associated with insecure/precarious employment and perceptions of insecure employment (Artazcoz et al., 2005; Kim et al., 2006, in WHO 2008; Ferrie et al. 2002, in WHO 2002), and poor working conditions can have as much effect on mental health as loss of work (Bartley, 2005; Muntaner et al., 1995; Strazdins et al., 2007, in WHO 2008), or unemployment. Risk factors for poor mental health include jobs with high demands, low autonomy and effort-reward imbalances (Stansfeld & Candy, 2006, in WHO 2008). A recent Australian study (Butterworth & Leach, 2009) which considered job quality measures of job demand, job control and job security showed that there was no difference between the mental health of those with poor quality jobs and people who are unemployed. Moving from a poor quality job to unemployment was associated with no difference in mental health. Moving from unemployment to an optimum quality job increased mental health, but moving from unemployment to a poor quality job decreased mental health (Butterworth & Leach, 2009).
>
> Overworking and poor work-life balance is associated with poor health (Felstead et al., 2002, in WHO 2008). Informal work such as high-demand, unpaid caregiving work is also associated with poor physical and mental health

and wellbeing. A range of studies have linked such caregiving work to poor mental health and wellbeing in carers (Ballard et al., 1996; Wooff et al., 2003; Hirst, 2004; Wilson & Menon, 2004; AIFS, 2006, cited in Edwards 2009; Cummins, Hughes et al. 2007; see Battams, 2009).

Research undertaken by NCETA in 2006 and 2007 reviewed factors associated with stress, burnout and retention for mainstream alcohol and other drug frontline workers and managers (Duraisingam et al., 2006; Duraisingam et al., 2007). Nearly one in five alcohol and other drug frontline workers reported above average levels of stress (Duraisingam et al., 2006). The main predictors of high work stress were role overload, low job autonomy, high client-related pressure, low workplace social support, and limited professional development opportunities (Duraisingam et al., 2006). Major problems associated with the retention of frontline workers were also identified. One in five workers stated that they intended to look for a new job outside the alcohol and other drugs field in the next 12 months. Predictors of turnover intention were low job satisfaction, low workplace social support, and dissatisfaction or inequity with pay (Duraisingam et al., 2006).

However, it was also noted that 78% of workers reported high levels of job satisfaction (Duraisingam et al., 2006). Similar findings were identified in NCETA's investigation into managers' experiences in the alcohol and other drugs field (Duraisingam et al., 2007). The majority of alcohol and other drug managers were satisfied and committed to their organisations, even though 61% of managers had thought about leaving their jobs and 29% planned to look for a new job over the next 12 months (Duraisingam et al., 2007). The moderate to high levels of job satisfaction experienced by alcohol and other drug workers and managers were attributed to altruistic factors such as contributing to successful client outcomes and doing meaningful work that contributes to the betterment of society, rather than rewarding job conditions such as equitable remuneration and professional development opportunities. Nonetheless, a key barrier to seeking employment in the alcohol and other drug field noted by survey respondents was low salary and poor benefits (Duraisingam et al., 2006).

Issues that have a substantial impact on organisations and workers in the drug and alcohol sector overall, include:

- salary, terms and conditions for alcohol and other drug workers
- training
- supervision and support
- professional and career development
- complexity of roles
- evaluation, and
- public profile of the alcohol and drug sector (VAADA, NADA, WANADA, NCETA, & ADCA, 2003).

In addition to on-going recruitment and retention problems, which are linked to low salary and poor benefits; stigma associated with alcohol and other drug work; and lack of career paths (Roche & Pidd, 2010), other workforce development difficulties involve the delivery of alcohol and other drug training and education, with inconsistencies noted in the quality and assessment of programs, and a lack of minimum competency standards (see section 3.2.9, "Training"). Workers in the alcohol and other drugs field need regular training to stay up-to-date with new developments, and develop leadership and management skills, but distance, time, lack of flexibility in delivery, lack of replacement staff, and financial costs can curtail the up-take of training programs (Roche & Pidd, 2010). High workloads and work-related stress can lead to low job satisfaction and performance, increased absenteeism and turnover (Roche & Pidd, 2010).

3.2 Indigenous Alcohol and Other Drug Worker Issues

The high demand for alcohol and other drug treatment services among the Indigenous population and the complex array of associated issues, accompanied by low labour participation rates of Indigenous peoples in the health field, are likely to have negative implications for Indigenous alcohol and other drug workers' health and wellbeing. Indigenous alcohol and other drug workers not only have to endure discrimination based on their Indigeneity, but also cope with the stigma attached to people who use alcohol and other drugs (Roche & Richard, 1991; Skinner et al., 2007). Anecdotal evidence indicates that Indigenous alcohol and other drug workers experience a greater range of stressors and pressures in their work roles than their non-Indigenous counterparts.

Workforce issues confronting Australian Indigenous human service workers located in Indigenous communities may be similar to issues faced by Indigenous alcohol and other drug workers. The availability and appropriateness of training and support for these workers is often limited and many are overworked and are reported to suffer from burnout (Stanley, Tomison, & Pocock, 2003). In addition, constantly dealing with traumatised clients

and problems of unemployment, poor education, substance use and violence may also represent a threat to the wellbeing of Indigenous health staff (Panaretto & Wenitong, 2006).

Indigenous workers are often isolated and have high expressed needs for workplace support and supervision. However, until relatively recently there has been "a lack of supervisory culture in the Indigenous alcohol and other drugs field", reflecting both a dearth of senior support staff and workplace cultures unfamiliar with supervision (Gray, Haines, & Watts, 2004). These issues in turn affect staff retention rates, staff skills development, and provision of education and training (Gray, Haines, et al., 2004).

The small Indigenous health workforce often lacks formal qualifications and, in some instances, lacks support and respect from colleagues. Issues of funding and managerial support, wage disparity, training, gender balance, career paths, and work demands may contribute to the stress, and risk of burnout, experienced by this workforce. However, little first-hand information has been available to document and record Indigenous workers' views and experiences in regard to their work roles.[8] The following section outlines some of the particular difficulties confronting individual workers in the Indigenous health and human services—including alcohol and other drugs—sector.

3.2.1 Heavy work demands

As noted above, there are comparatively few Indigenous people employed in the health and human services fields relative to the size of the Indigenous population. A breakdown comparing Indigenous and non-Indigenous workers in the health sector shows that Indigenous health professionals comprised only 1% of the total health workforce in 2006 (Australian Institute of Health and Welfare, 2009d). This contrasts with the proportion of the Australian population who are Indigenous, which is 2.5% (Australian Bureau of Statistics, 2007). The proportion of Indigenous workers in community services (2.5% in 2001, 3.2% in 2006) better reflects the proportion of the Australian population who are Indigenous (Australian Institute of Health and Welfare, 2009c). There is a large shortfall in the number of available Indigenous healthcare workers, and this, combined with high community need, contributes to pressures on Indigenous alcohol and other drug workers (Gray, Saggers, et al., 2004).

Work-related stressors have been identified as risks for Indigenous doctors and others who work in Aboriginal Community Controlled Health Services. These stressors relate to high workloads and job demands, including working with communities suffering profound grief and trauma (Panaretto & Wenitong, 2006). Clinic environments may also have "poor infrastructure, multiple and chaotic medical records, lack of structured clinical sessions with no appointment systems, patients arriving en masse in bussed transport and apparently poor patient compliance" (Panaretto & Wenitong, 2006, p. 527).

Information about Indigenous alcohol and other drug workplace demands is largely anecdotal, but there are poignant illustrations of situations that contribute to worker stress. Dr Mark Wenitong, an Indigenous doctor at the Wuchopperen Health Service in Far North Queensland, for example, described how his time was "divided into clinical, population health, administration, policy and academic areas [and] many local health committees and organisations" (Wenitong, 2004, p. 11). Wenitong stressed that most clients had complex problems that required intensive and extensive support, and this placed heavy demands on the limited time available in treatment services.

3.2.2 Multiple roles

A large proportion of Indigenous workers in the health sector are employed as Aboriginal Health Workers or nurses. The role of Aboriginal Health Workers is not consistent across jurisdictions and organisations, and it is a position title applied to workers with differing levels of clinical training who may undertake clinical, transport, liaison, or advocacy functions (Australian Government Department of Health and Ageing, 2008; Genat et al., 2006). Aboriginal Health Workers often serve multiple roles. They may act as "cultural brokers", health educators, mental health and alcohol and other drug counsellors, community health action agents, and providers of basic personal medical care (Genat et al., 2006).

Similarly, the title of Aboriginal Mental Health Worker also covers a range of roles that are often poorly defined for workers who have a range of qualifications and levels of experience (Parker, 2003). Aboriginal Mental Health Workers may be nurses, social workers, psychologists, or workers still undertaking formal qualifications in mental health (Parker, 2003).

8 Please see the two accompanying reports that form part of this project: Roche, A.M., Tovell, A., Weetra, D., Freeman, T., Bates, N., Trifonoff, A. et al. (2010). *Stories of resilience: Indigenous AOD workers' wellbeing, stress, and burnout*. Adelaide: National Centre for Education and Training on Addiction, Flinders University; and, Duraisingam, V., Roche, A.M., Trifonoff, A., & Tovell, A. (2010). *Indigenous AOD Workers' Stress, Burnout and Wellbeing: Findings from an online survey*. Adelaide: National Centre for Education and Training on Addiction.

Alcohol and other drug qualifications for Indigenous workers are a relatively recent development (Roche, Duraisingam, Wang, & Tovell, 2008b) (see 3.2.9. "Training"), and responding to AOD issues often falls to workers such as Aboriginal Health Workers with general health qualifications.

The specialist services that Indigenous healthcare and alcohol and other drug workers provide are not just clinical. They provide a multitude of valued roles to the local Indigenous and non-Indigenous community and health organisations. This stems from their unique understanding of local Indigenous culture, history, language and speech as well as being key members representing their community. In addition, they have the ability to understand and interpret "mainstream" issues for their Indigenous community (Panaretto & Wenitong, 2006).

3.2.3 Rural/remote versus urban issues

Working in remote and isolated locations, as many Indigenous alcohol and other drug workers do, presents a further set of challenges. Rural and remote workers may face isolation, limited resources, lack of privacy and unrealistically high expectations. Access to training, support networks and communication resources are often limited, contributing to workers' sense of isolation and responsibility. In addition, alcohol and other drug workers in remote Indigenous communities are required to understand and acknowledge the laws and customs specific to that particular community. The Australian National Council on Drugs' report from a Rural and Regional Alcohol and Other Drugs Consultation Forum (2001) concluded that high levels of community needs and the limited number of service providers contributed to difficulties experienced by alcohol and other drug workers in the rural and remote sector.

Evidence suggests that patterns of alcohol and other drug misuse by the Indigenous population in rural and remote communities may vary when compared to those in non-remote areas. For example, Indigenous people in remote areas were more likely to be current daily smokers or living with current daily smokers, but were more likely to abstain from alcohol compared to those in non-remote areas (46% compared with 31%) and less likely to binge drink (38% compared with 33%) (Australian Bureau of Statistics, 2010a) (see also section 2.3, "Alcohol and Other Drug Use"). However, use of cannabis in remote communities has increased significantly during the last two decades, and Indigenous males in remote communities are estimated to use cannabis at twice the level as those in non-remote areas, and use by Indigenous females in remote communities is almost a third higher than those in non-remote communities (Catto & Thomson, 2008).

It is likely that Indigenous alcohol and other drug workers in remote and rural areas may sometimes require intervention strategies with a somewhat different focus to those in non-remote areas; yet research shows little difference in substances targeted by region (Gray, Stearne, et al., 2010). Gray et al. (2010) acknowledge that it is not necessarily desirable to have substance-specific interventions, given the high correlation between levels of alcohol, tobacco and drug use, yet recognise that staff should be equipped with the skills necessary to address specific problems. Indigenous alcohol and other drug workers may therefore have a need for training programs and resources to help them deal with the specific issues presented by clients in rural and remote, or alternatively urban, areas.

In contrast to rural challenges and despite common problems inherent in alcohol and other drug use across geographical settings, it is also important to recognise the "rural bias" in research and intervention programs regarding Indigenous alcohol and other drug misuse, and to also acknowledge the need for culturally appropriate treatment programs tailored to the needs of Indigenous clients in an urban setting (Taylor, Thompson, & Davis, 2010).

3.2.4 Indigenous client base issues

Supporting Indigenous clients presents diverse challenges for Indigenous and non-Indigenous alcohol and other drug workers. These include the importance of community acceptance, literacy and language issues, the need for Indigenous-specific resources, and pressure arising from dealing with often complex and distressing presentations. Treatment is often complicated by comorbid physical and mental health issues, and substance abuse. Suspicion of mainstream services, together with incompatible concepts, health practices and treatment expectations may also undermine treatment of Indigenous clients.

Community acceptance is crucial for Indigenous alcohol and other drug health services, but may be difficult to achieve. For example, in a report on the Yolngu communities in Arnhem Land, Trudgen (2000) noted that if health workers lacked traditional authority, community acceptance may be jeopardised.

Health workers not recognised as *marrngitj*[9] (Trudgen, 2000, p. 153) may experience problems as community "frontline" workers. Some Indigenous communities may not readily accept Western medicine and may be reluctant to attend health clinics if they are perceived to have no authority under traditional law (Trudgen, 2000), or if they are only staffed by female workers (also see 3.2.10).

Approaches that recognise the value of community representation treat the community with respect and acknowledge that it is the community who must live with substance misuse. Consultation processes which help to identify priority issues specific to the community, while employing Indigenous alcohol and other drug workers from within the community, foster empowerment. Such initiatives can also afford community representatives and Elders an equal standing with government representatives in addressing substance misuse within their community.

The provision of culturally appropriate services to Indigenous clients requires Indigenous-specific materials such as informational resources for clients, handbooks and guides for workers, and screening tools. It is unclear how much access workers have to such Indigenous-specific materials. A recently developed Indigenous-specific screening tool is the Indigenous Risk Impact Screen (IRIS). The IRIS is a 13-item screening tool that assesses alcohol and other drug use and mental health risk, and has demonstrated reliability and validity with Indigenous populations (Schlesinger, Ober, McCarthy, Watson, & Seinen, 2007). Screening tools such as the IRIS are invaluable for workers treating Indigenous clients to make appropriate and accurate risk assessments of alcohol and other drug use and mental health. However, while Indigenous-specific materials have advantages over "mainstream" materials, the heterogeneous cultures of Aboriginal and Torres Strait Islander people complicate the local application of any materials in a particular Indigenous community. Many materials may need to be further adapted and localised in order to ensure their cultural appropriateness for different communities.

Indigenous clients may have different expectations and treatment preferences than non-Indigenous clients—for example, Indigenous Australians often prefer residential rehabilitation services, yet views vary on the best approach to treatment of Indigenous Australians in residential programs (see Taylor et al., 2010). In addition, activities and schedules within mainstream programs may be inappropriate, or based on a model of substance misuse that does not apply to an Indigenous client population (Taylor et al., 2010). Evidence suggests that a spiritual and holistic approach that supports cultural redevelopment is important for treatment success within the Indigenous population (Taylor et al., 2010).

3.2.5 Cultural competence for non-Indigenous health workers

> Cultural issues and values need to be core business at every level of the health system otherwise the damaging effects of racism on health will continue. Organisations can play an integral role in reducing racist practices by modelling and actively promoting non-racist standards of practice .... given that mainstream health providers have a responsibility to deliver culturally appropriate care to Aboriginal clients, engaging Aboriginal Australians meaningfully at all levels of health system design, governance and delivery is an important strategy to achieve this (Durey, 2010, pp. S89-90).

Although clearly important, offering separate culturally appropriate services to Indigenous Australians does not address the racism which may be encountered in mainstream health services (Durey, 2010). This issue must be met through cultural education and the delivery of culturally respectful—or culturally competent—health services within a broader framework of a multi-tiered commitment to reducing race-based inequities in the health care system (Durey, 2010). Cultural competence translates to "the integration of attitudes, values, knowledge, understanding and skills that enable effective interventions with people from a culture different to their own" (Victorian Aboriginal Child Care Agency, 2008, p. 23).

Culturally competent practice in the Indigenous alcohol and other drugs field accommodates Indigenous values, beliefs and social structures, which may vary significantly from mainstream ways of working and impact on the needs of alcohol and other drug clients and Indigenous alcohol and other drug workers. For example, Indigenous kinship systems differ from non-Indigenous concepts of family, and define particular roles, expectations and consultation protocols that need to be upheld. The Aboriginal Cultural Competence Framework report (Victorian Aboriginal Child Care Agency, 2008) suggests examples of culturally competent practice at both an individual level—such as considering the family's experience of

9 Marrngitj means healer for the Yolngu people, and performs a similar role as a Western doctor (Trudgen, 2000).

racism and inter-generational trauma when assessing a client—and at a systems level—for example, including statements about respecting cultural differences in an organisation's code of conduct.

The National Health and Medical Research Council also emphasises that cultural competence is not just about individual workers' awareness of cultural differences, and requires "culturally competent" policies and systems. The National Health and Medical Research Council (2006, p. 7) defines cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations" (Cross et al., 1989, cited in National Health and Medical Research Council, 2006). In addition, cultural competence needs to be integrated into health service delivery systems. The National Health and Medical Research Council states that to become more culturally competent, a system needs to:

- value diversity
- have the capacity for cultural self-assessment
- be conscious of the dynamics that occur when cultures interact
- institutionalise cultural knowledge and
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures
  (Royal Australasian College of Physicians, cited in National Health and Medical Research Council, 2006, p. 7).

Cultural competence for non-Indigenous alcohol and other drug workers means that they understand and acknowledge Indigenous ways of working and the particular needs of Indigenous alcohol and other drug clients, as well as their Indigenous colleagues. However, despite increased recognition of the need for and development of cultural competence training (e.g., Farrelly & Lumby, 2009), there is still a clear need to develop culturally sensitive understanding among non-Indigenous alcohol and other drug workers. For example, non-Indigenous GPs in remote areas of the Northern Territory report a great deal of pressure to adequately attend to the needs of their Indigenous clients, but insufficient cross-cultural up-skilling of non-Indigenous GPs to help spread the load (Harris & Robinson, 2007).

Indigenous workers have reported that dealing with non-Indigenous staff with low cultural competence is a great source of stress (Howard, 2007). Lack of cultural understanding by colleagues, peers and managers can impact on the experience of Indigenous alcohol and other drug workers in various ways. For example, Indigenous workers may be discomforted by the need to justify their grieving processes for community or kinship members to non-Indigenous people. Lack of suitable resources makes culturally appropriate treatment for Indigenous clients difficult; while failure by others to recognise the importance of community consultation, gender roles, the need to respect Elders, and different concepts of time add to difficulties in managing and treating clients.

The Aboriginal Cultural Competence Framework (Victorian Aboriginal Child Care Agency, 2008) identifies several concepts to guide cultural competence development in individuals and organisations. These include:

- Cultural awareness—understanding the role cultural difference and diversity plays
- Commitment to Aboriginal self-determination and building respectful partnerships
- Cultural respect—valuing Aboriginal peoples and their cultures
- Cultural responsiveness—having the ability and skills to assist people of a different culture
- Cultural safety—creating a service environment that is safe and welcoming for Aboriginal peoples
- Cross-cultural practice and care—being able to relate and provide services to Aboriginal peoples
- Self-reflection—being able to see how your culture and dominant culture generally impacts on Aboriginal peoples.

It is increasingly recognised that in order to improve outcomes for Indigenous alcohol and other drug clients and provide a comprehensive and on-going program of care, effective partnerships need to be formed between Indigenous and mainstream services (Gray, Stearne, et al., 2010; Taylor et al., 2010). As well as benefitting clients, such programs assist alcohol and other drug workers by offering a larger network of support (Gray, Saggers, et al., 2004). Cultural competence training that promotes shared concepts of health and increased awareness of culturally-appropriate health practices between Indigenous and non-Indigenous alcohol and other drug workers, and that is properly evaluated, is essential. However, even within a culturally competent context, there are further issues for consideration, such as meeting the specific needs of individual clients rather than applying a collective formula to treatment—"the main requirement is to locate individual autonomy within Indigenous cultural tradition if treatment outcomes are to be strengthened" (Taylor et al., 2010, p. S37).

3.2.6 Funding and managerial support

Limited, short-term and fragmented funding is an on-going problem for Indigenous alcohol and other drug workers and service providers. Clapham et al. (2007) noted that the continuation of successful health projects is often constrained by limited funding. For example, Indigenous injury prevention research found that "the major problems identified for existing programs were the high cost of running projects—particularly in remote and large rural areas—as well as the short-term nature of available funding and the lack of certainty about ongoing funding" (Clapham et al., 2007, p. 280). Lack of job security, the inability to make long-term plans, and constant requirements to procure continued funding are some of the problems inherent in short-term funding.

In 2006-7, a total of 340 Indigenous-specific alcohol and other drug treatment projects were funded by 494 separate grants, and 24% of the projects were completely funded by non-recurrent funding (Gray, Stearne, et al., 2010). Only 52% of organisations conducting Indigenous-specific alcohol and other drug projects in 1999-2000 were still doing so in 2006-7 (Gray, Stearne, et al., 2010). In 2006-7, a total of $100.7 million in funding was spent on Indigenous alcohol and other drug projects, of which 72% was expended by Indigenous community controlled organisations, 10% by non-Indigenous non-government organisations, with the remainder by government (Gray, Stearne, et al., 2010). Funding for community controlled health services is characterised by fragmented funding, more so than other health services (Dwyer, O'Donnell, Lavoie, Marlina, & Sullivan, 2009). As Gray et al. (2010) noted, relatively high levels of non-recurrent funding undermine the ability of Indigenous alcohol and other drug organisations to implement long-term programs and provide continuous service.

Another difficulty inherent in short-term funding is the time spent preparing and processing financial and performance accountability reports, sometimes to multiple funding providers. In 2006-7, 64% of funding for Indigenous alcohol and other drug intervention programs was provided by the Commonwealth Government, with state and territory governments contributing 33% (Gray, Stearne, et al., 2010). Although reporting requirements differ between government levels and departments, financial reports are often required quarterly or six-monthly, along with annual financial audits (Dwyer et al., 2009). Performance reports include activity levels and indicators of effectiveness or impact (Dwyer et al., 2009). This high reporting burden has been identified as a significant issue impacting on Indigenous alcohol and other drug service providers (Gray, Stearne, et al., 2010), and by extension impacts on the wellbeing of Indigenous alcohol and other drug workers.

Inadequate funding at an organisational level is linked to a number of key factors that impact on worker wellbeing. Reviews of Indigenous-specific alcohol and other drug interventions have found a common theme of difficulty in recruiting appropriately qualified staff, related to insufficient funding (Gray, Saggers, Sputore, & Bourbon, 2000; Gray, Stearne, et al., 2010). Restricted funding impacts on an organisation's ability to retain staff, who are often frustrated by limited access to training, as well as a lack of clear career pathways (Gray, Stearne, et al., 2010). Gray, Haines, and Watts (2004) noted that only a small proportion of organisational funding was made available for alcohol and other drug-specific training. For over a decade, it has been highlighted that Indigenous drug and alcohol workers often encounter uncertainty regarding their status in the workplace, and that they experience limited support and access to training opportunities, and insufficient clarity around roles and responsibilities (Pearce & Savage, 2001).

Funding limitations may also contribute to limited managerial support, which has been identified as a factor that may further disenfranchise Indigenous workers (Whiteside, Tsey, McCalman, Cadet-James, & Wilson, 2006). Lack of backup by appropriately qualified people restricts the ability of managers to take leave, while a dearth of resources and culturally appropriate support also impact on managers' wellbeing. The importance of managerial support is demonstrated in the following case:

> A young Aboriginal woman who has completed a university-accredited diploma in Indigenous mental health is appointed as an Aboriginal mental health worker in a rural town. She is given an office in the local hospital to see Aboriginal clients of the health service. Her work in the office is limited and very few Aboriginal people visit her there because the local Aboriginal population do not like coming to the hospital. However, when she goes shopping after work or goes to a sport event on the weekend, she is constantly approached by members of the local Aboriginal community about social, emotional and mental health issues that affect them. The manager of the health service notes that the worker is seeing only a limited number of the patients required for formal accreditation and retention of her position. Further, her ability to access a motor vehicle allocated to her position is limited because her job description is considered to primarily involve hospital-based work. After a while, the young

> woman who had hoped to make a contribution to the Aboriginal community through her training and work, becomes disillusioned and leaves the position (Parker, 2003, p. 295).

3.2.7 Implementing best practice

Selecting and implementing the most appropriate and cost-effective treatment programs for Indigenous alcohol and other drug clients also presents a challenge to Indigenous alcohol and other drug organisations and their workers. Evidence for the effectiveness of applying successful non-Indigenous treatment strategies to the Indigenous population is limited, and restricted by a lack of culturally appropriate evaluation models and a rural bias in existing Indigenous-specific studies (Sanson-Fisher et al., 2006; Shakeshaft et al., 2010; Taylor et al., 2010). Cultural differences and concern about the generalisability of results has further inhibited the dissemination of national drug and alcohol, and other health-related, policies to Indigenous communities (Shakeshaft et al., 2010).

Within a general health care setting, problems arise in incorporating evidence-based changes to clinical practice due to lack of time and expertise by individual workers, inefficient systems and lack of organisational level resources, and alternative preferences by clients (Shakeshaft et al., 2010). The prevalence of such issues among the Indigenous alcohol and other drugs workforce limits the ability of Indigenous alcohol and other drug organisations and workers to provide the most effective and efficient care to alcohol and other drug clients. For example, research highlights the untapped potential for incorporating brief interventions for alcohol use into Indigenous-specific routine health care services (see also section 2.4.1, "Contemporary service provision issues") (Shakeshaft et al., 2010):

> There are two primary negative outcomes associated with the lack of dissemination research in the alcohol-related Indigenous health field in Australia: the evident lack of progression from describing Indigenous health problems to effectively implementing evidence-based interventions to address them; and Indigenous Australians' disproportionately poor access to evidence-based interventions relative to the alcohol-related burden of harm they experience (Shakeshaft et al., 2010, p. S44).

3.2.8 Income and wage disparity

The literature indicates that there are wage disparities 1) between Indigenous and non-Indigenous workers, and 2) between workers in Aboriginal Controlled Community Health Services and workers in mainstream services (Australian Institute of Health and Welfare, 2008b; Curtin Indigenous Research Centre, Centre for Educational Research and Evaluation Consortium, & Jojara and Associates, 2001; Panaretto & Wenitong, 2006). In 2004-5, approximately 42% of Indigenous respondents (compared to 21% of non-Indigenous respondents) aged 15 years and over were in the bottom 20% of Australian gross weekly income earners (Australian Institute of Health and Welfare, 2008b).

In a comparison of 12 selected community service occupations (Australian Services Union, 2007), Aboriginal Health Workers received the lowest average weekly pay ($547.76): lower than children's care workers (second lowest at $570.09), social workers ($909.89), welfare and community workers ($877.54) and counsellors ($905.95):

> Despite the non-monetary rewards of work in community services such as satisfaction and interest in the role and a greater degree of family-friendly policies, evidence suggests the relatively low pay for work in community services leads to higher numbers of people leaving community services, taking on second jobs or being dissatisfied with the financial rewards for their work (Australian Services Union, 2007, p.33)

Wage disparity has been reported by Aboriginal Health Workers in South Australia and Queensland as a major issue (Curtin Indigenous Research Centre et al., 2001; Panaretto & Wenitong, 2006). Aboriginal Health Workers in South Australia maintained that the disparity between the non-government and government sectors needed to be addressed and described the inequity in awards as frustrating and confusing (Curtin Indigenous Research Centre et al., 2001). Similarly, General Practitioners working for Indigenous Community Controlled Health Services reported dissatisfaction with their remuneration levels; indicating that in some instances they would be better paid working for a mainstream organisation (Panaretto & Wenitong, 2006). The significant disparity between salaries of Indigenous workers and non-Indigenous workers shown in Figure 7 below highlights the need for remediation (see (Duraisingam, Roche, Trifonoff, & Tovell, 2010).[10]

10 For further details about wage disparity refer to the second NCETA report in this series: Duraisingam, V., Roche, A.M., Trifonoff, A., & Tovell, A. (2010). *Indigenous AOD Workers' Stress, Burnout and Wellbeing: Findings from an online survey.* Adelaide: National Centre for Education and Training on Addiction.

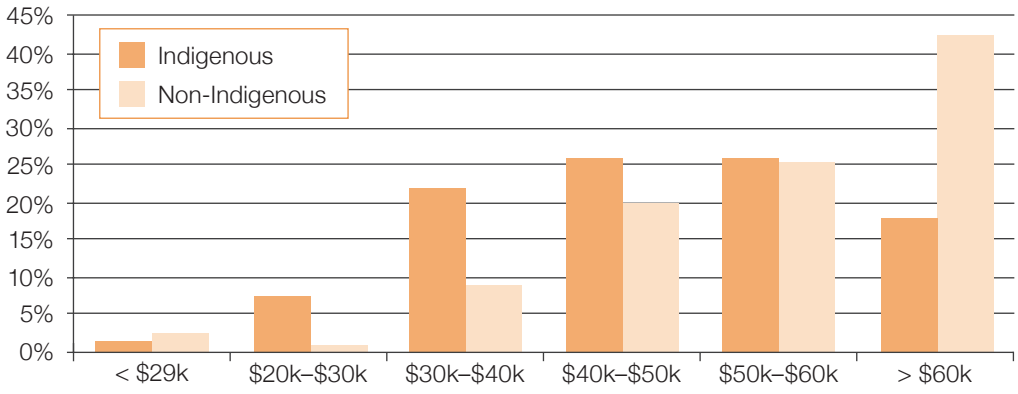

Figure 7. Annual Salaries of Indigenous and Non-Indigenous Respondents
Source: Indigenous AOD Workers' Stress, Burnout, and Wellbeing: Findings from an online survey (Duraisingam et al., 2010)

3.2.9 Training

Adequate training for alcohol and other drug workers has been identified as a crucial issue for the development of this workforce and to maximise the effectiveness of treatment (Gray et al., 2000). There has been an improvement in training opportunities for the general alcohol and other drugs workforce over the last decade at both accredited and non-accredited levels (Roche & Pidd, 2010). This progress reflects increased recognition of the value of workforce development, consistent approaches across sectors, and better outcomes for clients and the community (Roche & Pidd, 2010). In addition, there has been an attempt to align formal qualification requirements to promote a consistent skill base in the alcohol and other drugs sector, previously characterised by workers from a broad spectrum of backgrounds and training, many with a personal history of problems with alcohol and other drug misuse and few formal qualifications (Gray, Haines, et al., 2004). For example, in 2006 Victoria introduced minimum qualification strategies for alcohol and other drug workers (Victorian Government Department of Human Services, 2004), with the Australian Capital Territory following suit in 2009 (ACT Alcohol and Other Drugs Sector, 2010).

Yet much of the need for training and workforce expansion in the Indigenous alcohol and other drugs workforce remains unmet, due to difficulties such as lack of funding to support attendance at training programs, and to supply back-fill staff while other members are attending training (Gray, Stearne, et al., 2010). A key resolution at the inaugural conference of the National Indigenous Drug and Alcohol Committee (NIDAC) in 2010 was that greater resources be provided to increase the level of training to Indigenous workers in the alcohol and other drug sector (National Indigenous Drug and Alcohol Committee, 2011). There are a number of additional barriers that prevent Indigenous alcohol and other drug workers from utilising and benefitting from training. Gray et al. (2004) identified five key areas for consideration in terms of Indigenous alcohol and other drugs training, each with potential barriers for Indigenous workers. These were the development and delivery of training, content of training, quality of training, post-training and organisational support, and culturally appropriate evaluation methods (Gray, Haines, et al., 2004).

Inconsistent qualification requirements and poorly defined roles contribute to the difficulty of creating a consistent skill base, and meeting the needs of workers through training. Aboriginal Health Workers in South Australia, for example, have argued that clarifying workers' roles and requirements is a fundamental step in the professional development and capacity building process (Curtin Indigenous Research Centre et al., 2001). The occupational category of Indigenous "AOD" worker is relatively new. This is not always a clearly defined role or a category that is often utilised, and such workers are found in a variety of contexts, such as treatment agencies, and primary and mainstream health care settings (Gray, Haines, et al., 2004).

In addition, it is important that training for Indigenous alcohol and other drug workers is delivered in a culturally sensitive manner and context, by Indigenous trainers where possible, and focuses on addressing the specific needs of Indigenous clients (Gray, Haines, et al., 2004). A good example of this is the nationally accredited Aboriginal Alcohol and Other Drug Worker Training Program: CHC30802 Certificate III in Community Services Work offered by the Drug and Alcohol Office of Western Australia as part of the Indigenous National Alcohol and Other Drug Workforce Development Program. The program is unique and different from other alcohol and other drug training programs in that is has been specifically developed for Aboriginal alcohol and other drug workers. It is a

12-month course, comprising face-to-face learning and on-the-job training, designed by Aboriginal professionals and introduces evidence-based Aboriginal models of practice and cultural ways of working (Drug and Alcohol Office, 2011).

As illustrated through the social determinants of health, socioeconomic disadvantage impacts on the ability of Indigenous people to access and participate in training (Gray, Haines, et al., 2004). Other training barriers for Indigenous workers include different perspectives on the importance of life experience versus formal qualifications compared with non-Indigenous workers, although there is increasing acknowledgement by Indigenous leaders of the importance of formal education and training (Roche et al., 2010). Other challenges include difficulties accessing courses from remote locations, and the need to continually stay up-to-date with new treatment problems and issues. Further challenges to maximising the impact of training include the high turnover of Indigenous staff, and the need for an organisation to assist workers to implement subsequent changes in workplace practices (Gray, Haines, et al., 2004; Roche, Duraisingam, Wang, & Tovell, 2008a).

Research has identified access to training as a crucial issue for rural or remote health workers. It has been argued that it is more beneficial for training to be undertaken at rural or remote locations (Curtin Indigenous Research Centre et al., 2001). Gray et al. (2004) have suggested that training for alcohol and other drug workers has largely focused on rural and remote workers, rather than workers in urban and regional settings where the majority of Indigenous people live. They recommend that "alcohol and other drug training needs to be available to all groups of Indigenous workers and should not restrict its focus to addressing the training needs of rural and remote workers". They also suggest a need for more flexible training options with easy access for the rural and remote workforce. There has been significant movement towards achieving these goals (Roche et al., 2008b).

Nearly a decade ago, Aboriginal Health Worker courses were found not to meet the requirements or standards necessary for remote Australia (Curtin Indigenous Research Centre et al., 2001). In some circumstances, Indigenous alcohol and other drug training was conducted in an *ad hoc* manner (Curtin Indigenous Research Centre et al., 2001). Some progress has been made since then. There has been an increase in the number of training schemes available to Indigenous alcohol and other drug workers. In 2008, Roche et al. found that of 387 accredited alcohol and other drug, mental health and co-morbidity courses, 80 were relevant to the Indigenous health field (Roche et al., 2008a). Of the 80 courses identified as Indigenous-related, 33 were defined as "Indigenous-specific" in that they were specifically designed for Indigenous students or workers, or were offered by Indigenous training providers (Roche et al., 2008a). Twenty (61%) were alcohol and other drug courses, 12 (36%) were mental health courses, and one was a co-morbidity course (Roche et al., 2008a). Six non-accredited courses offered by two institutions, one in South Australia and one in Western Australia, and two psychology courses, were identified as relevant to Indigenous workers including Aboriginal health workers in mental health, alcohol and other drugs and community work (Roche et al., 2008a).[11]

3.2.10 Gender balance in the Indigenous health workforce

The ratio of male to female Aboriginal Health Workers is a significant issue for many Indigenous alcohol and other drug workers. Indigenous female workers are represented in higher numbers than males across all age groups of workers in the health sector (Australian Institute of Health and Welfare, 2007a). In 2006, there were 961 Aboriginal Health Workers, 71% of whom were female (Australian Institute of Health and Welfare, 2009a).

Insufficient numbers of male workers could result in breaches of traditional laws and cultural protocols in rural and remote areas due to traditional divisions of knowledge and responsibilities of care (Bartik & Dixon, 2005; Trudgen, 2000). For example, according to Yolgnu laws and protocols, women are the keepers of information about reproduction and blood, while men are the keepers of information about political and economic law and rights (Trudgen, 2000). Rules about where new knowledge may come from have important implications for health service delivery and health education (Trudgen, 2000). Breaking gender taboos can result in men not using health centres (Boustany, 1999). To address this challenge, it has been suggested that both a male and female Aboriginal Mental Health Worker are employed to work in tandem to ensure that gender-appropriate service delivery is provided (Bartik & Dixon, 2005).

11 Further information about Australian training courses for workers in the alcohol and other drugs field is available on a CD-rom resource produced by the National Centre for Education and Training on Addiction (Roche et al., 2008b).

3.2.11 Career paths

Several factors contribute to limited career pathways for Indigenous alcohol and other drug workers. For example, a lack of professional acceptance by peers creates a substantial divide between Indigenous and non-Indigenous staff (Parker, 2003). In Alice Springs and Darwin, health workers have reported that they were not treated or accepted as professionals, but instead were used as "cultural brokers" and only used when absolutely necessary, and otherwise ignored (Curtin Indigenous Research Centre et al., 2001). Lack of recognition translates to limited acknowledgement and lack of opportunity for professional advancement.

Funding shortages, high staff turnover and lack of appropriate training and qualifications further restrict career opportunities for Indigenous workers in the alcohol and other drugs field. Pearce and Savage (2001) maintain that in order to adequately address Indigenous workforce issues around career paths, systems change needs to be implemented. When workers feel as though no career advancement is possible, they can become disenchanted and leave an organisation (Duraisingam et al., 2006; Skinner et al., 2003). Limited options for career development may result in the loss of academically qualified staff, as illustrated below:

> A young Aboriginal man, a recovered alcoholic, obtains the position as a bus driver with a health department servicing Aboriginal people in an urban location. After a while he perceives a role for himself in contributing to the health needs of the local Indigenous community and those affected by substance abuse in particular. He takes three years off work to do a university accredited diploma in Indigenous mental health and his attendance at the course is part funded by the department that he works for. On completing the diploma, he returns to his old section and is greeted by the words 'Welcome back, here are the keys to the bus. Off you go then.' After a period of frustration with no perceived opportunity for career advancement or ability to exercise his new knowledge or skills within his current position, he resigns from his work (Parker, 2003, p. 295).

Recent developments have begun to address the issue of career pathways for Indigenous workers in the alcohol and other drugs sector. In 2010, the National Aboriginal and Torres Strait Islander Health Worker Association was established to help members develop career aspirations and pathways. In addition, programs such as the National Aboriginal Alcohol and Other Drug Worker Training Program, and Indigenous alcohol and other drug worker networks such as Koori AOD and ADAN Leadership, will assist workers' career progression. At a more junior level, national strategies such as Indigenous Cadetship Support programs are now available to facilitate linkages between Indigenous tertiary students and potential employers. Such a strategy entails funded placements for Indigenous students (up to 12 weeks), along with ongoing guidance and mentorship for students, with the view to organisations creating ongoing employment placements.

3.3 Summary

The alcohol and other drugs workforce in general encounters significant challenges that impact on worker wellbeing. Heavy workloads and client pressure; inadequate resources, pay, training, support and autonomy; stigmatisation; and difficulties with staff retention and recruitment, particularly in remote and rural areas, can all contribute to worker stress and risk of burnout. The Indigenous alcohol and other drugs workforce faces these difficulties and more, including particularly complex client needs to be addressed in a culturally appropriate manner, a need often made difficult by a lack of culturally appropriate resources or support from mainstream organisations. These challenges are further exacerbated by intermittent and uncertain funding; comparatively low salaries; and the lack of clearly defined roles, training protocols, and career opportunities for Indigenous health and alcohol and other drug workers. On a more positive note, many alcohol and other drug workers find altruistic and intrinsic reward in their work. Importantly, new developments have begun to address some of the day-to-day practical and logistical difficulties facing the Indigenous alcohol and other drugs workforce.

4. Conclusion

Identifying factors that affect Indigenous alcohol and other drug workers' levels of stress, burnout and wellbeing promotes an understanding of such issues, and highlights areas for future intervention. A review of the relevant literature has identified several issues that promote worker wellbeing in the workforce: reducing workloads; providing clearly defined roles; ensuring adequate backup and organisational support; securing stable, ongoing funding; provision of culturally adequate training at all levels, including managerial, and especially in rural and remote locations; promoting gender and culturally appropriate services; and provision of opportunities for professional development.

In addition, factors beyond the workforce also play an important role in determining Indigenous alcohol and other drug worker wellbeing both directly and through issues encountered in the workplace. Inequality in determinants of social and physical health between Indigenous and non-Indigenous people can be understood within a historical and a contemporary sociocultural context, and include ongoing racism and marginalisation; lack of cultural awareness, respect and support; and grave inequities in socioeconomic circumstances. Such disadvantages contribute to increased alcohol and other drug use, lower incidence and later seeking of treatment for such issues, complex comorbidities in clients, and a higher rate of mortality alcohol and other drug-related diseases.

Thus, for Indigenous alcohol and other drug workers to reach an optimum level of wellbeing, Indigenous-specific issues need to be addressed at an organisational, community, and national level. Furthermore, such an approach needs to emphasise increasing the capacity of Indigenous organisations to respond to community alcohol and other drug issues, while expanding the cultural competence of mainstream organisations to provide effective partnerships and networks of care that benefit both Indigenous alcohol and other drug workers and clients.

This literature review provides an overview of issues and research relevant to the wellbeing of workers in the Indigenous alcohol and other drugs field. It forms part of a broader project examining the key antecedents and consequences of stress, burnout and wellbeing among Indigenous alcohol and other drug workers, and is a companion document to a report examining the views of Indigenous alcohol and other drug workers in *Stories of Resilience—Indigenous AOD Workers: Wellbeing, Stress, and Burnout* (Roche et al., 2010).

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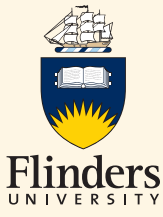
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