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

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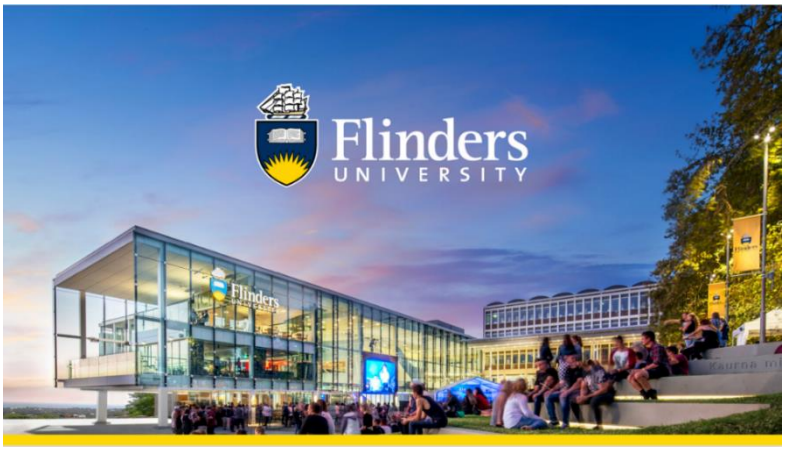

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About this Discussion Paper

The National Centre for Education and Training on Addiction (NCETA), Flinders University, has been commissioned by the Australian Government Department of Health to review and revise the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy 2015-2018.

This Discussion Paper provides an overview of issues relevant to the updating of the Strategy. It outlines the background and context for the previous Strategy and the need for a review and revision at the present time. It further provides relevant Australian and international research and data, and potential areas for action to be addressed through the Strategy. Discussion Questions are posed (Appendix B) which are intended to stimulate thought and discussion in relation to AOD WFD. An Executive Summary is also available.

The Discussion Paper draws on a wide range of sources, including stakeholder input from a Project Advisory Committee (Appendix A), a comprehensive analysis of the peer reviewed literature, and consideration of contemporary State and Territory WFD strategies and initiatives. This paper is not intended to provide a definitive coverage of issues; rather, it is intended to be thought provoking, stimulating and in some respects challenging.

Invitation for stakeholder submissions

This Discussion Paper is designed to inform and guide stakeholder consultation on the review and revision of the National AOD WFD Strategy. Discussion Questions (Appendix B, download as word or pdf here) are provided to highlight key priorities and issues for stakeholders' consideration. A large range of topics are addressed in this Discussion Paper.

Given the breadth of topics addressed in this paper, submissions welcome to address **some or all** of the Discussion Questions, and/or to address other issues of importance and relevance.

Guide lists have been included to reduce respondent burden but additional thoughts are welcome and expected, as are submissions focussed on a particular topic(s) or issue(s) as relevant to stakeholder groups.

Discussion Questions listed in Appendix B, download as word or pdf here)

The timeframe for consultation for the review and revision of the Strategy is as follows:

- Discussion Paper released December 2021
- Submissions invited from December 2021
- Stakeholder consultation: from December 2021 to Monday 28th February 2022
- Development of draft revised Strategy in early 2022
- Final draft of revised Strategy delivered to the Department of Health in June 2022.

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

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

Please contact NCETA if you wish to provide a video/audio submission

(a confidential upload link will be provided)

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

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

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

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1. About the Strategy review and revision

A highly skilled, qualified and sustainable alcohol and other drug (AOD) workforce is imperative to effectively prevent and respond to problematic AOD use and related harms within Australia. The AOD sector has experienced substantial change over recent decades, and it is vital that the workforce has the capacity and support to be dynamic and responsive to meet these changing needs.

The National AOD Workforce Development Strategy aims to be a useful resource and guide for the AOD sector to inform planning and implementation of workforce development (WFD) activities at a national, jurisdictional and organisational level. Specifically, the Strategy is designed to:

- Identify key WFD priorities, activities, gaps and challenges within the AOD sector
- Provide support and guidance for WFD programs and initiatives at a sector, jurisdictional and organisational level
- Offer a framework for ongoing monitoring and implementation of WFD programs and initiatives
- Facilitate a shared understanding of WFD concepts and applications within the AOD and related sectors.

The previous iteration of the National AOD WFD Strategy (2015-2018) was released in 2015 and sought to: 1) enhance the capacity of the Australian AOD workforce to prevent and minimise alcohol and other drug-related harm across the domains of supply, demand and harm reduction activities; and 2) create a sustainable Australian AOD workforce that is capable of meeting future challenges, innovation and reform.

In the years since its publication, extensive and important changes have impacted the AOD sector. These include:

- Changing service delivery model, including as a result of COVID-19
- Funders increasingly placing emphasis on client outcomes, rather than client output
- An expanded range of pharmacotherapies and other treatment options
- The development of new key national Frameworks and Strategies
- New patterns of AOD use
- Greater awareness of family inclusive practice issues

- Problematic use across a widened age spectrum
- Greater emphasis on cost efficiency, professional practice efficacy, improved outcomes and intersectoral collaboration
- A better understanding of effective preventive measures
- Greater recognition of the variety of workers involved in reducing AOD-related harm
- Increased awareness of the importance of addressing AOD use within Aboriginal and Torres Strait Islander communities, and the valuable role played by Aboriginal and Torres Strait Islander AOD workers
- The need for more specialised skill sets to address complex presentations (including multiple morbidities) and changing service delivery models
- Growth in the proportion of the service delivery system provided by the NGO sector
- Stronger emphasis on integration of the peer/lived experience workforce into service provision
- A larger number of young and early career workers in the AOD sector and the concomitant ageing of the workforce
- Increased attention on consumer engagement in service planning and delivery and ensuring that the WFD needs of consumers are addressed.

An imperative exists to renew and revise the first national WFD Strategy to address these current issues. A contemporary, revised National Alcohol and Other Drug Workforce Development Strategy will provide an overarching mechanism by which to identify emerging areas of need, processes by which to respond to priority areas, and a means by which to link WFD initiatives to the range of other national strategies.

2. The 2015-2018 National AOD WFD Strategy

The Australian Government Department of Health commissioned NCETA to develop the 2015–2018 National AOD WFD Strategy. This Strategy was the first of its kind in Australia and internationally, and informed a number of jurisdictional WFD strategies and initiatives addressing particular State and Territory contexts and priorities. The 2015-2018 Strategy identified 12 Outcome Areas:

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

A thorough review of the progress made in each of these areas is beyond the scope of the current document. Significant progress has been made in some Outcome Areas, whereas other issues remain a challenge and a priority for the revised Strategy. Section 3.1 provides further examples of

WFD strategies and activities developed in particular jurisdictions which complement and support the National Strategy.

Outlined below are a selection of WFD strategies and initiatives that have been informed by and/or align with the 2015-2018 Strategy, which provide examples of WFD in action. Initiatives that have further developed knowledge and understanding of the AOD workforce include regular jurisdictional surveys of the AOD workforce, for example in VIC, NSW and the ACT. In 2019-2020 NCETA also conducted a national survey of the AOD workforce. Another important initiative is the NHMRC funded University of NSW's Horizons Project, a national study of AOD services which examines how procurement arrangements and workforce characterises impacts on client outcomes of AOD treatment [1]. As discussed in Section 7, recruitment and retention of suitably qualified and experienced AOD workers remains a significant challenge, exacerbated by the ageing of the health workforce in general and the AOD workforce in particular [2].

Furthermore, a number of the Outcomes identified in the 2015-2018 Strategy relate to addressing the needs of particular client groups such as families and children, older clients, clients with CALD backgrounds, clients identifying as LGBTIQ+ and clients with complex needs such as co- and multiple morbidities. As observed in Section 6, there is still significant scope for improving services to many of these priority groups. A large selection of resources, practice guidelines, training resources and other initiatives are available to support and improve service delivery to these groups. As discussed in Sections 5 and 6, Aboriginal and Torres Strait Islander clients and workers remain high priorities for WFD initiatives and resourcing [2]. Substantial AOD resources have been developed for Aboriginal and Torres Strait Islander workers, for example by the Australian Indigenous Health*InfoNet* AOD Knowledge Centre and the WellMob website. The Lowitja Institute's Career Pathways Project provides valuable insight and WFD recommendations for the Aboriginal and Torres Strait Islander health workforce [3]. Significant developments have also been made in the recognition and prioritisation of consumer involvement and engagement in service provision, policy and planning. For example, a Partnering with Consumers Standard is included within the National Safety and Quality Health Service (NSQHS) Standards [4]. Work to engage with and develop the capacity of related sectors such as generalist health, welfare services, education and law enforcement has been ongoing, and also continues to be a priority for the revised Strategy.

3. Workforce development (WFD)

Workforce development (WFD) aims to enhance the capacity of the AOD sector, organisations and individual workers to prevent and respond to AOD-related problems, and to promote evidence-informed practice. Its importance to the AOD field is highlighted by the imperative for enhanced quality of care, effective and efficient services and increased support for worker wellbeing [5]. For the purposes of the Strategy review and revision, WFD is defined as:

> *…a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers* [6].

A key aspect of this definition is the targeting of contextual factors at the individual, organisational, structural, and systemic levels. It is widely recognised that quality service delivery is dependent on a range of organisational, structural, and systemic factors that extend beyond the knowledge, skills and capacity of individual workers [5].

Table 1 provides examples of WFD strategies and initiatives at the systems, organisational and individual levels. Particularly noteworthy is the role of systems factors in creating opportunity, support and pathways for organisational-level WFD. Systems and organisational factors enable and support individual workers to achieve and enact the skills, knowledge, values and capacities required for high quality and evidence-informed AOD work.

Table 1. Examples of WFD at the systems, organisational and individual levels

Systems level	Organisational level	Individual level
AOD law and regulation Service funding models National and jurisdictional strategies, frameworks and other policy guides and directives Workforce planning and data collection Employment law and regulation (national and jurisdictional) Renumeration and rewards (including Awards) Professionalisation of the AOD workforce Regional WFD programs and funding Cross-sector coordination and partnerships AOD education and training accreditation standards Education, training and professional development opportunities and funding AOD content in vocational and tertiary training in related fields (e.g., mental health, public health, law) Clinical and practice standards and guidelines Professional competency standards and work role definitions Career pathways Research funding Societal attitudes and norms (stigma and discrimination)	Organisational quality accreditation (National Quality Framework) and governance Organisational policies and systems (e.g., training, supervision, diversity, wellbeing) Implementation of clinical and practice standards Implementation of evidence-informed practice Family inclusive policies and practices Policies and practices on consumer participation and representation Leadership and management training and development programs and supports Worker wellbeing programs, including targeted supports for those with unique needs Career pathways and other professional development opportunities Systems, practice and cultures supportive of evidence-informed practice	Educational qualifications Professional development Work experience Knowledge, skills, attitudes, values Wellbeing and resilience (self-care)

Source: Adapted from [5, 7-10]

3.1. State and Territory WFD strategies and initiatives

A range of high quality and comprehensive WFD strategies and initiatives have been developed by the Australian States and Territories. These include:

- NSW NGO Alcohol and other Drugs Workforce Development Plan 2016–2022 [11]
- NSW Clinical Care Standards: Alcohol and Other Drug Treatment [12]
- VIC Alcohol and Other Drugs Workforce Strategy 2018 -2022 [10]
- WA Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 [7]
- Comprehensive Alcohol and other Drug Workforce Development in Western Australia [9]
- Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017 [13]
- NT Alcohol and Other Drug Workforce Development Strategic Framework [14]
- QLD Mental Health Alcohol and Other Drugs Workforce Development Framework [15]
- Development of a Tasmanian AOD Workforce Development Strategy is a Key Action under Reform Direction 8 of the Reform Agenda for Alcohol and Other Drugs Sector in Tasmania [16].

Whilst a comprehensive review of all the jurisdictional WFD initiatives is beyond the scope of this paper, select highlights of some recent developments and initiatives are overviewed below.

Victoria's Alcohol and Other Drugs Workforce Strategy 2018 -2022 [10] is focused on six key result areas addressing improving workforce availability, building workforce capabilities and quality, increasing workforce diversity, improving worker health, wellbeing, safety and engagement, strengthening leadership and collaboration, and delivering person-centred, integrated care [7]. The NSW Network of Alcohol and other Drug Agencies (NADA) has developed a Workforce Capability Framework [17] which identifies the core capabilities and expected behaviours of NSW non-government AOD workers to ensure the effective and efficient delivery of quality care. The Capability Framework is designed to inform and guide WFD activities such as workforce planning, work role design and evaluation (including recruitment, performance management), professional development, education and training. The WA Workforce Development report [9] identifies development issues at the individual, organisational and systemic levels for the WA AOD workforce. Individual level recommendations include the integration of AOD competencies into tertiary curricula and greater coordination and resourcing for training. Recommendations for organisational-level WFD include enhanced funding to support recruitment and retention, greater

accessibility of clinical supervision/practice support, increased resourcing for worker wellbeing and initiatives to support consumer and family member participation and representation. Examples of systems level recommendations include increased cross-sector coordination and engagement, more effective use of data to inform service delivery, and measurement of partnership effectiveness to support collaboration planning based on consumer and community need.

4. National policy frameworks

The revised National AOD WFD Strategy will operate within the broader national policy context of the National Drug Strategy 2017-2026 and other national policies and strategies. Select strategies are briefly reviewed here.

4.1. National Drug Strategy 2017-2026

The National Drug Strategy 2017-2026 [18] provides the framework that identifies national priorities concerning alcohol, tobacco and other drugs, guides action by governments in partnership with service providers and the community, and outlines a national commitment to harm minimisation through a balanced implementation of effective demand, supply and harm reduction strategies. The underpinning strategic principles are partnerships, coordination and collaboration, national direction with jurisdictional implementation, and evidence informed responses. The National Drug Strategy includes building the capacity of the workforce to effectively deliver services and respond to emerging issues as an evidence-based and practice-informed approach to harm minimisation.

The National Alcohol and other Drug Workforce Development Strategy will become a sub-strategy of the National Drug Strategy and will therefore be consistent with and substantially influenced by the National Drug Strategy.

4.2. National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029

The National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029 [19] aims to ensure that all Australians seeking treatment for AOD-related issues are able to access high quality services appropriate to their needs, whenever and wherever they require. The Framework

identifies six treatment principles for effective AOD treatment: person-centred, equitable and accessible, evidence-informed, culturally responsive, holistic and coordinated, and free from judgement, stigma and discrimination. The Framework acknowledges that the provision of effective services requires a skilled, qualified and fulfilled workforce. The Framework recognises the need for comprehensive WFD and planning initiatives for new and existing workers, peers and volunteers to ensure a sustainable workforce that is capable of meeting future challenges, innovation and reform.

The National Alcohol and other Drug Workforce Development Strategy will be a key mechanism through which the workforce required to implement The National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029 will be delivered.

4.3. National Quality Framework for Drug and Alcohol Treatment Services 2018

The National Quality Framework for Drug and Alcohol Treatment Services [20] aims to establish a nationally consistent quality benchmark for the delivery of treatment services. The purpose of the National Quality Framework (NQF) is to achieve positive health outcomes for consumers through continuous quality and safety improvements of AOD treatment services. One of the Guiding Principles of the National Quality Framework is Workforce, Development and Clinical Practice. This Principle concerns engaging and maintaining a qualified, skilled and supported workforce to ensure the delivery of safe and effective quality of care that is appropriate to the client cohort, and in accordance with legislative and regulatory requirements and professional codes of practice. Implementation of this principle includes actions such as merit-based recruitment and selection, ongoing staff development via management and supervision, and access to professional development that supports good clinical practices and the delivery of evidence-based treatment.

The National Alcohol and other Drug Workforce Development Strategy will be a key mechanism through which the qualified, skilled and supported workforce required to implement The National Quality Framework for Drug and Alcohol Treatment Services 2018 will be delivered.

4.4. National Alcohol Strategy 2019-2028

The National Alcohol Strategy 2019-2028 [21], a sub-strategy of the National Drug Strategy, aims to create a national coordinated approach to prevent and minimise alcohol-related harms in Australia.

One of the key priorities (Priority 3) of the National Alcohol Strategy is supporting individuals to obtain help by facilitating access to appropriate and evidence-based treatment, information and support services. This priority notes the importance of building the capabilities and capacities of the treatment service system (primary care and specialist services) regarding the prevention of alcohol-related harms and risks. The Strategy recognises the value of further education and training for health and other professionals to support the treatment of alcohol-related issues. The Strategy also recognises the importance of enhancing the capacity of generalist healthcare, community, welfare and support staff in ensuring the delivery of quality, responsive, safe and effective treatment services.

The revised National Alcohol and other Drug Workforce Development Strategy will therefore focus on developing both specialist and generalist AOD workforces which aim to reduce alcohol-related harm.

4.5. National Mental Health Workforce Strategy (NMHWS)

The National Mental Health Workforce Strategy (NMHWS) is being developed at the time of writing. The aim of the Consultation Draft Strategy [22] is 'To develop an appropriately skilled mental health workforce of sufficient size that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best meets their needs' (p. 4). The Draft Consultation Strategy has six objectives: (1) careers in mental health are, and are recognised, as attractive, (2) data underpins workforce planning, (3) the entire mental health workforce is utilised, (4) the mental health workforce is appropriately skilled, (5) the mental health workforce is retained in the sector, and (6) the mental health workforce is distributed to deliver support and treatment when and where consumers need it.

Specialist and generalist AOD workers frequently encounter clients experiencing comorbid mental health issues. The reverse is also true. It will therefore be important that the new iteration of the Strategy addresses the mental health-related developmental needs of AOD workers and the AOD-related developmental needs of mental health workers.

4.6. National Medical Workforce Strategy (NMWS)

The National Medical Workforce Strategy (NMWS) [23] is being developed at the time of writing. The NMWS will guide long-term collaborative medical workforce planning across Australia, and will

identify achievable, practical actions to build a sustainable, highly trained medical workforce. The Strategy also identifies how the use of collaborative modelling and data work will be used to make evidence-based policy interventions to improve areas of workforce undersupply now, and into the future. The Strategy will be a key driver of medical workforce reform and consists of five complementary priority areas that will drive the actions needed to achieve the Strategy's vision. These are: (1) collaborate on planning and design, (2) rebalance supply and distribution, (3) reform the training pathways, (4) build the generalist capability of the medical workforce, and (5) build a flexible and responsive medical workforce. Three cross cutting issues are also considered: growing the Aboriginal and Torres Strait Islander Workforce and improving cultural safety, adapting to and better supporting new models of care, and improving doctor wellbeing. Issues such as geographic distribution, collaborative workforce planning, and flexibility in training and education for Australia's medical workforce are also key considerations.

Medical practitioners play a key role in preventing and responding to AOD-related harm. The medical workforce in Australia is facing a range of challenges which warrant consideration in the National Alcohol and other Drug Workforce Development Strategy.

4.7. National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031

An appropriately skilled, available and responsive Aboriginal and Torres Strait Islander health workforce is critical for an efficient and culturally safe national health system and the health and wellbeing of Aboriginal and Torres Strait Islander people and communities.

Aboriginal and Torres Strait Islander people are currently significantly underrepresented across the health workforce, representing only 1.8% of workers despite comprising 3.1% of the working age population (ages 15-64). By 2031, Aboriginal and Torres Strait Islander people will represent 3.43% of the Australian working age population. The National Workforce Plan aims to increase Aboriginal and Torres Strait Islander employment in the health workforce to reach 3.43% parity over the next decade.

The National Workforce Plan includes a wide range of actions that can be implemented at a national, jurisdictional or regional level across the health system to support the attraction, recruitment and retention of Aboriginal and Torres Strait Islander people across the entire health

workforce (inclusive of AOD specific roles), and in all locations, including rural, regional and remote Australians who are disproportionately impacted by health workforce shortages.

The National Workforce Plan is an example of national Aboriginal and Torres Strait Islander health policy jointly co-designed, owned and implemented in partnership between governments and the Aboriginal and Torres Strait Islander community controlled health sector.

4.8. National Preventive Health Strategy 2021-2030

The National Preventive Health Strategy (NPHS) is being finalised at the time of writing and is a key priority for the Australian Government, as outlined in Australia's Long Term National Health Plan as the third pillar with mental health. The NPHS will ultimately provide more balance to the health system by enhancing the focus on prevention and by building systemic change over a 10-year period. The final draft NPHS outlines the importance of embedding prevention into the health system, including in the AOD space, and recognises the critical role that the health workforce will play in enabling this change.

The final draft NPHS also recommends the health workforce are better educated on alcohol, tobacco and other drug issues, through training and exploring accreditation for the workforce. Strengthening the health workforce will ultimately assist in preventing disease and promoting wellness, as well as protecting Australia from emerging health threats. It is anticipated the NPHS will launch before the end of 2021.

In the 2021-22 Budget, an early commitment was made to the draft NPHS to support a stronger and more effective prevention system in Australia. This includes analysing the current public health workforce profile to establish the growth levels, training opportunities, development pathways and areas of unmet demand.

4.9. Broader policy environment

There are a number of other national policies which significantly impact the AOD workforce, and therefore have a range of implications for the WFD Strategy. These are listed below.

- National Mental Health Workforce Strategy (under development at time of writing)
- National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028
- National Ice Action Strategy 2015

- National Safety and Quality Health Service (NSQHS) Standards
- National Strategic Framework for Rural and Remote Health
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023
- National Aboriginal and Torres Strait Islander Health Plan 2013–2023
- National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019
- National Agreement on Closing the Gap
- Australia's Long Term National Health Plan
- Primary Health Care 10 Year Plan
- National Nursing Strategy and the Nurse Practitioner 10-year Plan
- Fifth National Mental Health and Suicide Prevention Plan
- National Men's Health Strategy 2020–2030
- National Women's Health Strategy 2020–2030
- National Blood Borne Viruses and Sexually Transmissible Infections Strategies 2018–2022.

5. The AOD workforce

There are a wide range of professionals who may encounter individuals who have AOD-related problems as part of their job. Similarly, the Australian community and clients of AOD services include diverse social groups, many of whom have unique experiences and needs. An important aspect of the AOD workforce profile is to ensure that the diversity of the client population is also reflected in the diversity of the workforce [7].

In order to more clearly understand and delineate the AOD workforce, it is divided here into two distinct groups:

1. Specialist AOD workers; and
2. Generalist workers from other sectors.

5.1. Specialist AOD workers

Specialist AOD workers are those whose core role is assisting people with AOD problems. AOD workers may come from a variety of backgrounds, including nurses, social workers, peer workers, addiction medicine specialists and specialist psychologists and psychiatrists. These workers may be

employed in AOD specialist organisations or in AOD programs within non-AOD specialist organisations, and in either the government, not-for-profit/non-government or private sectors. The knowledge and skills required by these workers covers many diverse areas, including an understanding of relevant social, legal and medical issues [24]. They may have specialised degrees or vocational training, and the systems and structures within which they operate may vary widely between different agencies, sectors, and jurisdictions [25].

Addiction medicine specialists

Australia has a substantial shortage of addiction medicine specialists [26]. The existing cohort of addiction medicine specialists is currently ageing, and many will soon retire or reduce their working hours. This is likely to worsen the addiction medical specialist shortage in coming years. This, in turn, is likely to impact the provision of AOD services, particularly to clients with complex needs.

5.2. Generalist workers

The Australian workforce involved in the prevention and minimisation of harmful AOD use is highly varied, spanning a diverse range of employment sectors, industries and communities. Exposure to people with AOD problems varies across this workforce. All workers involved in addressing AOD use are included within the scope of the current Strategy, including (but not limited to):

- The mental health workforce
- Nurses and nurse practitioners
- Emergency medical services and paramedics
- The broader health and medical workforce, including general practitioners, pharmacists, and other primary health care workers and hospital workers
- Aboriginal and Torres Strait Islander health workers within Aboriginal Community Controlled Health Organisations (ACCHOs) and other health organisations
- Culturally and linguistically diverse health and community service workers
- Community and support services, including workers from the welfare, child protection, disability, housing, unemployment, income support, youth and aged care
- Violence abuse and neglect (VAN) workforce
- Workers at non-profit organisations who deal with AOD- and mental health-related issues (e.g., Lifeline, ReachOut)

- Police and corrections officers.

These workers can play an important role in responding to AOD issues, for example by providing referrals to specialist services, delivering information and brief interventions, and providing treatment and/or support for treatment and recovery. Workers in all these fields and roles will need to develop the capacity to change and evolve to meet future AOD challenges.

5.3. AOD workforce profile

The 2019-2020 AOD National Workforce Survey (the National Survey) [27] provides the most recent data regarding the national AOD workforce. Respondents to the National Survey comprised 1,506 specialist and generalist AOD workers. The respondent profile from the National Survey indicated the AOD workforce is female dominated (69%), includes a substantial cohort of older workers (39% aged 50+ years) and is predominately metropolitan based (64%). Six percent of workers in the National Survey identified as Aboriginal and/or Torres Strait Islander (double the proportion in the general Australian population). Over half (58%) of National Survey respondents held an undergraduate degree or higher, with 46% reporting AOD-related qualifications at a vocational or tertiary level. While a substantial proportion of respondents (41%) had 10 or more years of experience in the AOD sector, 29% were relatively new to the sector (three or fewer years' AOD experience) [27]. The most common occupations were drug and alcohol counsellors (23%), drug and alcohol nurses (10%), social workers (8%) and nursing professionals (enrolled, registered, practitioner) (6.8%). The majority of respondents worked in the non-government sector (57%), were employed on permanent contracts (75%) and worked full-time (62%).

A number of jurisdictional AOD workforce surveys have also been conducted. Whilst there is variation between jurisdictions in a range of systemic and structural factors (e.g., service delivery and funding models, workforce size), there are similarities in many aspects of the AOD workforce profiles observed in the national and jurisdictional surveys. Observations from the National Survey regarding the sociodemographic, educational and employment profiles are reflected in jurisdictional surveys in Western Australia (WA) [9], Tasmania [28], New South Wales (NSW) [29] and the Australian Capital Territory (ACT) [30]. The size of the Aboriginal and Torres Strait Islander workforce varied across jurisdictions, with Tasmania (10%) and NSW (8%) reporting the largest representation within the AOD workforce.

As nurses are one of the largest occupational groups in the AOD workforce it is worth noting the workforce mapping project conducted by Drug and Alcohol Nurses of Australasia (DANA). The AOD nursing workforce was observed to be predominately female (81%), aged over 50 years (50%), highly qualified (67% with tertiary qualifications), employed full-time (71%) and highly experienced (average of 14 years' AOD experience) [31].

AOD workforce data

A strength of the AOD workforce is the diversity of workers' professional and employment backgrounds, training and experience. The AOD National Workforce Survey 2019-2020 [27] included workers from over 30 occupations, with around half having worked in another sector unrelated to health or human services before entering the AOD field. However, this diversity also creates challenges in obtaining AOD workforce data. At the time of writing there is no comprehensive national AOD workforce data collection system that provides accurate and representative data on the Australian AOD workforce. This is a significant gap, as high quality workforce data is essential for effective workforce, education and training planning at a national and jurisdictional level, and the planning and evaluation of WFD initiatives. For example, a regular and comprehensive AOD workforce census similar to those conducted in other sectors such as aged care, would enable evidence-based workforce planning and WFD initiatives.

5.4. Workforce groups with unique needs

It is important that the entire AOD workforce, both specialist and generalist workers, receive adequate and appropriate WFD support. Some groups of workers have unique needs and require additional or specific supports to provide the highest quality service and maintain their wellbeing. Some of these are discussed below.

Rural, regional, and remote (RRR) workers

The majority of the AOD workforce is based in metropolitan areas. Chronic workforce and WFD challenges are well recognised for rural, regional, and remote (RRR) locations, including staff shortages and difficulties accessing professional development and other WFD activities [2]. These issues compound the already complex working conditions of RRR areas, such as unique client characteristics, significant geographical distances, low population density, difficult climactic

conditions, and the importance of working in a culturally respectful, appropriate and safe way with local Aboriginal communities' culture and traditions [32].

Targeted strategies to increase recruitment and retention are required to ensure sufficient access to AOD treatment and support for Australians living outside of major cities. For example, facilitating a 'home grown' RRR workforce that is supported by distance/online training opportunities, enhanced clinical supervision and mentoring, and stronger linkages with other services to provide support and coordinated work experience. Importantly, RRR workers are also likely to provide services to Aboriginal and Torres Strait Islander clients. Hence, access to culturally safe services and professional development is a priority for those in RRR areas, as well as in metropolitan services [2].

Aboriginal and Torres Strait Islander workers

Recruitment and retention of Aboriginal and Torres Strait Islander AOD workers is a crucial and ongoing challenge. In the National AOD Workforce Survey 2019-2020 [27], 6% of the AOD workforce identified as Aboriginal or Torres Strait Islander. Some jurisdictional surveys have reported higher estimates for the size of the Aboriginal or Torres Strait Islander AOD Workforce. Nevertheless, it is widely recognised that the size of this workforce is not sufficient to meet the needs of the approximately 17% of AOD treatment clients who identify as Aboriginal or Torres Strait Islander [33].

Aboriginal and Torres Strait Islander AOD workers face a number of unique challenges and demands in their work, including:

- Heavy work demands reflecting the high community need and a shortfall of Aboriginal or Torres Strait Islander AOD workers (and associated vicarious trauma / compassion fatigue)
- Dual forms of stigmatisation stemming from attitudes to AOD work and racism
- Lack of clearly defined roles and boundaries, particularly within an Aboriginal or Torres Strait Islander community context
- Difficulties translating mainstream work practices to meet the specific needs of Aboriginal or Torres Strait Islander 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 [34].

These challenges mean that Aboriginal and Torres Strait Islander workers have particular and unique WFD needs, and that appropriate WFD strategies are required that can be implemented in a culturally safe manner. The revised Strategy needs to support the development and maintenance of a skilled, culturally competent, and sustainable Aboriginal and Torres Strait Islander workforce in both general and Indigenous-specific services, including supporting Aboriginal and Torres Strait Islander ways of working [2]. There is also a need to promote and support recognition of the value of Aboriginal and Torres Strait Islander skill sets and cultural knowledge among non-Indigenous health professionals [35]. Appropriate strategies may include the promotion of the AOD field and related tertiary/vocational qualifications to Aboriginal students, including access to Aboriginal worker placements, traineeships and scholarships.

For the existing Aboriginal and Torres Strait Islander AOD workforce, culturally safe, accessible and ongoing WFD activities for Indigenous workers should be considered a high priority. These should be led by Aboriginal organisations and trainers to ensure all training and activities are both appropriate and relevant to local communities. Training should be evidence-informed and culturally safe, and include yarning/narrative therapies, family support therapies, social and emotional wellbeing (SEWB) and traditional healing practices and practitioners in conjunction with mainstream approaches [2]. These WFD activities should be also consistent with the principles outlined in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023: centrality of culture, health systems effectiveness, partnership and collaboration, leadership and accountability, and evidence and data [35].

Professional and career development are also key issues for the Aboriginal and Torres Strait Islander AOD workforce. Appropriate initiatives may include clearer career steps and pathways, opportunities for systematically building qualifications based on micro-credentialling, Indigenous mentors and supervisors (including clinical supervision and practice support), and encouragement and support to be involved in management, policy development, service planning and service delivery at all levels [7]. Importantly, WFD activities should not only seek to support Indigenous workers to deal with the challenges they face as part of their role, but also aim to break down the structural barriers and systemic racism which continues to pervade the health system [36].

Peer workers and workers with lived and living experience

The importance of AOD peer workers is increasingly recognised in the delivery of effective treatment services and recovery outcomes. Peer work can be understood as 'any organised support provided by and for people with similar conditions, problems or experiences' [37] (p. 5). Reflecting on their own lived experience, peer workers are able to directly relate to clients, which helps create a safe and non-judgemental environment to successfully enter, engage with and remain in treatment or other services [18, 38-40]. Peer workers can provide knowledge and insight that may lead to more efficient policies, funding allocation and service provision [10, 41, 42]. Peer workers may experience certain organisational challenges such as stigma and discrimination, power and pay imbalances, and complexities around workplace boundaries and job roles [43, 44]. Priority WFD issues for the AOD peer workforce include access to professional development, supervision and mentoring, and opportunities for skill development (e.g. study scholarships) and clear pathways for career advancement [2, 18]. Organisational capacity or readiness is a challenge in this respect; services must ensure that their systems and culture are safe, supportive of peer workers, and appreciative of the value that they bring to the sector [45].

A range of WFD initiatives within the mental health sector may also be suitable for the AOD peer workforce in relation to progressing the formalisation, professionalisation and integration of peer workers into the broader AOD workforce [46-48]. For example, Certificate IV in Mental Health Peer Work is a nationally recognised qualification for mental health peer workers that establishes their value and credibility as a recognised occupational group.

It is also important to acknowledge that a significant proportion of the AOD workforce with lived or living experience of AOD use are not necessarily in designated peer roles and may not disclose their lived experience to their workplace [27]. Initiatives to address stigma associated with AOD experience or AOD work are an important component of WFD strategies to support all AOD workers with lived or living experience, in designated or other roles. Section 5.7 addresses stigma related to AOD work.

5.5. Police and corrections professionals

Law enforcement agencies play a vital role in preventing and responding to AOD use and related harms in Australia, and it is important that their WFD needs are addressed within the revised Strategy. While it is recognised that law enforcement activities are carried out by a range of agencies, the current focus is on policing and correctional services.

Police

Police are involved not only in the enforcement of laws regarding illicit drug use, but also respond to AOD-related harms such as street and domestic violence, anti-social behaviour, serious crime and road trauma. For instance, it has been estimated that a quarter of all frontline police officers' time is taken by alcohol-related crime, and alcohol is involved in an estimated 34% of intimate partner violence incidents and 29% of family violence incidents [21].

As with other sectors, policing is facing a range of new and emerging challenges that add additional complexity to the typical difficulties encountered when dealing with AOD-related crime [49, 50]. These emerging challenges have important WFD implications for police workforce and infrastructure management, and capability development [50]. Australian law enforcement agencies need to be adaptable and resilient enough to respond appropriately to AOD-related issues within this broader context moving forward. Well developed WFD strategies designed for the policing context are essential, and should be complementary to existing policing initiatives such as ANZPAA's Police Workforce Compendium [51] and other jurisdictional strategies.

Corrections

AOD use among offenders in Australia is a pressing issue. A recent report found that three quarters of prison entrants were current tobacco smokers, almost two-thirds had used illicit drugs in the past year, and a third were at high risk of alcohol-related harm during the past year [52]. In 2020, 46% of detainees who had used substances attributed their detention to either illicit drug or alcohol use [53]. Correctional facilities offer a prime opportunity to intervene in the cycle of AOD use, related harms, and crime. They also offer access to vulnerable population groups who may not otherwise access health services.

Opioid agonist therapy prescribers

In most jurisdictions there is a shortage of opioid agonist therapy (OAT) prescribers. A recent NSW study [54] reported that the rate of prescribers ceasing OAT prescribing has been increasing over time. In addition, the highest prescriber cessation rate was among prescribers who had prescribed for shorter time periods. Approximately 87% of OAT clients were under the care of 20% of OAT prescribers, of whom half had been prescribing OAT for 17 or more years.

The number of OAT clients in Australia has only increased marginally over the past decade and the rate of Australians receiving OAT has remained at 21 / 10,000 over this period [55]. Nevertheless, there is a risk that without increased workforce capacity, current levels of demand will be unable to be met. In addition, most Australian jurisdictions are moving towards closer monitoring of opioid prescribing and dispensing. This could potentially increase the demand for OAT as patients are unable to obtain opioids from existing sources

5.6. Worker wellbeing

Employment in the AOD sector is widely recognised as offering opportunities for work that is very meaningful and engaging, as well as work experiences that can be highly stressful and demanding [56]. Workers can face many challenges, including those related to the provision of client care (e.g., vicarious trauma, compassion fatigue, stigma) and the context of work (e.g., high work intensity, job insecurity, poor remuneration). Poor worker wellbeing may result in burnout, high turnover, difficulties with recruitment and other associated costs for organisations [57]. Strategies to address AOD workers' wellbeing to prevent poor mental health (e.g., stress, burnout) and support positive mental health (e.g., engagement, satisfaction) need to be implemented at the individual, organisational and sector levels [5]. Individual level training tends to focus on developing workers' skills and capacity to effectively manage stress and work demands. Organisational level interventions may address workplace systems and structures to more effectively manage demands (e.g., workload, time pressure) and increase supports (e.g., management and supervision, mentoring).

5.7. Stigma

People who use alcohol or drugs can be subject to harmful stigmatisation and discrimination [58]. Similarly, people who work with or provide care to individuals who use AOD can be subject to

'stigma by association', whereby the stigmatisation of AOD use is extended to apply to those who are closely involved with this population [59]. Such stigma may have significant effects on workers in terms of their wellbeing and job satisfaction, but also on the AOD sector as a whole. Stigmatisation can make the AOD field a less attractive career option and poses a barrier to recruitment and retention efforts. Funding opportunities may also be impacted by this type of secondary stigma [60].

6. Consumers of AOD services

6.1. Consumer/client groups with unique needs

Particular groups have unique needs when accessing AOD treatment and support. Barriers to treatment may be exacerbated for these groups, which can perpetuate and widen health inequities [40]. It is important that services have the requisite resources to cater to these groups, and staff have the awareness and skills to work with them in an appropriate, sensitive, and effective manner.

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples experience a burden of disease that is 2.3 times higher than non-Indigenous Australians, with AOD use one of the key risk factors contributing to this health gap [61]. Those identifying as Aboriginal or Torres Strait Islander are 2.5 times as likely as non-Indigenous Australians to smoke daily and 1.2 times as likely to drink at risky levels [62]. These inequalities must be seen in the context of disconnection to culture, traditions and country, social exclusion, discrimination and isolation, trauma, poverty and lack of adequate access to services [63].

To effectively address AOD-related harm and health inequities among Aboriginal and Torres Strait Islander peoples, the healthcare system must be culturally respectful and non-discriminatory, and deliver clinically appropriate care that is culturally safe, high quality, responsive and accessible [64].

Specifically, health systems need to be:

- Culturally appropriate, secure and safe
- Tailored to individual health needs

- Clinically effective
- Accessible
- Integrated into a system of care where needs are complex
- Well governed, cost effective, evidence-based and accountable [64].

WFD strategies should aim to build the capacity of the Aboriginal and Torres Strait Islander and non-Indigenous AOD workforces to effectively achieve these service standards and goals. As articulated by the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019, a priority is to "build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce, as part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use" [65]. Funding models and other resourcing should also recognise and respond to the significant and long-term under-investment in Indigenous-specific AOD treatment, the greater burden of harm from AOD use experienced by Aboriginal and Torres Strait Islander peoples, and the complexity and need for holistic care of Indigenous clients [13].

Furthermore, consistent with Aboriginal and Torres Strait Islander perspectives on health, the holistic definition of "social and emotional wellbeing" should be incorporated into models of care and service delivery, with traditional healing practices and practitioners valued and offered in conjunction with mainstream approaches [2, 7]. Cultural security must be a core principle of practice; this may include a requirement for workers to undergo cultural awareness training (that is delivered by Aboriginal facilitators) [2, 7]. For example, the NSW Network of Alcohol and other Drugs Agencies' (NADA) treatment guidelines for working with Aboriginal and Torres Strait Islander people in non-Aboriginal treatment settings highlight the importance of creating a welcoming environment, providing flexible and appropriate service delivery, incorporating the voice of the community, engaging the Aboriginal organisations and workers, and having capable staff [66].

In supporting improvements in AOD service delivery and preventing and reducing AOD-related harms for Aboriginal and Torres Strait Islander peoples, the revised Strategy will contribute to a number of key targets in the National Agreement on Closing the Gap, including Targets 1 'Everyone enjoys long and healthy lives', 2 Children are born healthy and strong', 13 'Families and Households are safe' and 14 'People enjoy high levels of social and emotional wellbeing'.

People identifying as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+)

Rates of substance use are relatively high amongst LGBTIQ+ communities in Australia. In 2019, compared to people who identified as heterosexual (and after adjusting for age differences), LGBTIQ+ people were 1.4 times as likely to drink at risky levels at least monthly and 1.5 times as likely to smoke daily. Rates of past-year illicit drug use were also much higher among those identifying as LGBTIQ+ (36% vs 16%) [67]. Many LGBTIQ+ people may be reluctant to seek help due to concerns about prejudice and discrimination from treatment providers. There are also important health disparities experienced by this population that can be linked to experiences of stigma and discrimination [68]. It is important that AOD services and individual workers have the tools and understanding necessary to meet the needs and ensure the safety of their LGBTIQ+ clients. Inclusive and affirmative service delivery is essential across the entire AOD service system, with universal policies, systems and processes needed to establish and demonstrate cultural safety for LGBTIQ+ communities [69].

Young people

There are approximately 3.3 million young people (aged 15-24) in Australia, comprising 13% of the total population [70]. In 2019, 13% of 14-17 year olds and 45% of 18-24 year olds reported ever using illicit drugs, and 33% and 32% drank at risky levels at least once a month, respectively [62]. Alcohol use disorders are the second biggest contributor to the total burden of disease experienced by young men [71]. Correspondingly, 39% of clients at alcohol and drug treatment services in 2018-19 were aged under 30 [72]. Targeted WFD activities are required to ensure that AOD workers are able to respond effectively to AOD use among this cohort, at the current time and as they transition into middle and older age.

Older people

The global population is ageing at a rapid rate. Between 2015 and 2050, the proportion of the global population aged over 60 years will nearly double from 12% to 22% [73]. Australia demonstrates similar trends: in 2017 15% of the Australian population were aged 65 years or over [74]. Emerging research is highlighting the relatively high rates of AOD use amongst older people and the unique challenges of caring for older people with substance use problems [75-77]. The AOD workforce will need to be equipped with the skills and knowledge to appropriately address the increasing proportion of older clients in AOD services.

Clients with multiple and complex needs

Many clients who present to AOD treatment services have multiple needs beyond their AOD use. These may include mental health, disability, medical, housing, unemployment, education and training needs, issues with criminal justice and social services, or family and domestic violence [78]. The complex interconnections between these issues can make the effective diagnosis, management and treatment of AOD problems significantly more challenging and complex [79]. From this perspective, a broad, multifaceted, and coordinated approach across services is needed to achieve the best client outcomes [78, 80]. WFD strategies at the systems and organisational levels to address these complex client needs include appropriate referral options, support for service coordination and linkages and enhanced professional development for workers [28].

Other groups with unique needs

There are several other client groups who may have unique needs when accessing AOD treatment services. These include people from culturally and linguistically diverse (CALD) backgrounds, refugees and asylum seekers, those with disabilities, women (including women who are pregnant or who have experienced family and sexual violence), forensic clients (i.e., those who have entered treatment via the justice system), and people of low socioeconomic status or from disadvantaged backgrounds. These groups are likely to experience a disproportionate burden of disease and may find it difficult to access services. Organisations and workers need to be aware of the unique needs of these groups and have the capacity to provide appropriate care in a safe environment for all of their clients.

6.2. Consumer participation and representation

Consumer participation and representation is an essential part of an integrated, person-centred approach to health services [81]. The Partnering with Consumers Standard within the National Safety and Quality Health Service (NSQHS) Standards [4] focuses on supporting consumers, carers and their families to be actively engaged in the planning and decision-making of their care. There is evidence that effective consumer partnerships result in positive consumer experiences and increased empowerment, as well as higher quality healthcare and improved safety [4]. Consumer involvement can improve service development, communication and mutual respect between consumers and service providers [7]. Barriers to engagement such as stigma and discrimination can

also be addressed in this way. There is also an ethical obligation to facilitate consumers' meaningful participation in their own care [13].

Consumer participation in workforce planning and development initiatives can also improve service design, delivery and effectiveness. For example, consumer views and experiences can be incorporated into the design of training and accreditation programs [4, 10]. Other possibilities for consumer involvement include input into models of care, initiatives to address stigma and discrimination, and community representation at board meetings and in policy formulation and evaluations [10]. Consumer participation training may be beneficial to both staff and consumers in enabling greater participation and input [82].

7. AOD sector structures and systems

As outlined in Table 1, a range of systemic and structural issues impact on the capacity and effectiveness of the AOD workforce and workforce development initiatives. Broader global trends are also noteworthy in this context, particularly the global health workforce shortage and correspondingly competitive job markets [5, 83]; issues which have been exacerbated by the current COVID-19 crisis.

Also noteworthy is the dynamic environment in which the health workforce operates. Drivers of reform within the AOD field include concerns around poor integration of services, disconnections between AOD and broader health and welfare services, poor service planning, and concerns about quality of care [84]. Previous reforms have met with mixed success [85, 86], but have had important WFD implications in terms of contract lengths, funding models, standards and accountability measures [87]. Examples of these changing paradigms over the years include the shift from government providers (largely within hospitals or specialist treatment centres) to non-government and not-for-profit treatment providers in community settings, debates concerning the adoption of 'new recovery' treatment principles, and the alignment of AOD and mental health bureaucracies [84, 88]. This section addresses a select set of systemic and structural issues of particular relevance to WFD and the revised Strategy.

7.1. Funding models

While it is widely established that AOD services represent a worthy investment for government and other funders, the availability and security of funding remains a critical issue for AOD services [5].

Demand for AOD services is ever increasing, with the proportion of closed episodes of care almost doubling in the last decade [33]. Further, the impact of the current pandemic has also increased service demands by 40% or more in seven out of ten treatment providers, according to a recent survey of non-government agencies across the country [89]. The move towards telehealth and online specialist care will additionally require further investment into training and upskilling of current and future workers [90]. Also important is the emphasis that service funders are increasingly placing on client outcomes, rather than client output [19]. Adequate and well-designed financial resourcing and investment into workforce planning and development is crucial to meet these growing and changing demands for AOD services [5, 90].

7.2. Growth of NGO service provision

AOD services are primarily provided by government-funded public health and hospital systems, non-government organisations (NGOs) and the private sector (i.e., private health insurance covered providers attached to hospitals and private fee-for-service providers) [2]. AOD service provision across jurisdictions has been increasingly outsourced through local commissioning bodies such as Primary Health Networks [91]. There has recently been an increase in NGO service provision, with specialist clinical services now largely provided by this sector (subject to jurisdictional variations). In the past decade, the proportion of non-government agencies has increased by 13%, with the proportion of closed episodes of care provided by non-government treatment agencies increasing by 12% in 2019-2020 [33]. The NGO workforce should, therefore, be considered a priority for WFD initiatives. Such initiatives should take into account the differences in funding arrangements between government and NGO services, particularly in regard to the stability and security of funding [87].

7.3. Collaboration and partnerships

There is increasing emphasis on integrated care, collaborations and partnerships, both within the AOD sector and across related sectors [9]. The WHO defines integrated care as 'an approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care' [92] (p. 10). Breaking down traditional 'siloed' ways of

working is beneficial for clients and also offers opportunities for workers to learn from colleagues in adjacent organisations and sectors. Better collaboration between the AOD sector and education and training providers in health and human services also has potential benefits for recruitment into the AOD sector [28].

7.4. Recruitment and retention

Recruitment and retention are well recognised challenges for the health sector in general, and the AOD sector in particular. The global health workforce shortage has led to correspondingly competitive job markets [5, 83], with the AOD sector in competition with other related fields for the recruitment and retention of skilled staff.

Numerous challenges exist in recruiting appropriate AOD workers, including:

- Low renumeration, including lack of parity with other sectors such as mental health
- Stigma attached to working in the AOD field
- Perceived lower status of AOD workers compared to other helping professions
- Lack of qualified applicants
- Lack of resources to fund service provision
- Lack of career pathways
- Job insecurity
- High turnover and concomitant lack of role models for new staff
- Remoteness of services
- Inconsistent training and credentialing
- Lack of “work ready” staff [28, 93, 94].

Retention of existing staff is also a significant challenge for many AOD organisations. High turnover can result in substantial costs in terms of loss of knowledge and experience (and consequent risks to care quality) as well as the financial burden associated with training new staff [95]. Recent research found turnover intentions among AOD workers in the NGO sector to be high, linked with low pay, fixed term contracts, poor work/life balance, high workloads, and tenuous employment status [95]. Other important issues for staff retention include stress and burnout [28] and lack of well defined career steps and pathways [2].

Establishing a sustainable 'pipeline' of workers is important for the future of the AOD sector. Targeted strategies and funding structures may need to be considered to set up programs that create employment entry points and progressive career steps for an effective and sustainable 'pipeline' of new workers into the sector. This should include initiatives to make the AOD sector both desirable and easy to enter (e.g., student placement programs, volunteer programs) [9].

It is important to note the particular challenges with recruiting and retaining staff in certain workforce groups (e.g., rural, regional and remote workers, Aboriginal and Torres Strait Islander workers). These groups may have unique risk factors for turnover and should be the focus of targeted recruitment and retention strategies. Formal strategies for recruiting workers in these groups would be beneficial, including recruitment targets and initiatives to support newly recruited workers [30]. A large body of research examines the challenges faced by these groups in more detail and can provide guidance on strategies to mitigate these issues (e.g., [96-98]).

7.5. Renumeration and rewards

Poor remuneration is a major barrier to recruiting and retaining staff in the AOD sector. A closer alignment between qualifications and pay rates is needed to ensure AOD workers are appropriately compensated for their educational investment [2]. Recognition and financial compensation for extra-educational qualifications such as lived experience similarly needs to be addressed, given the growth in the AOD peer workforce. A related issue of equal importance is insecure and short-term funding arrangements, which underpin short-term contracts and insecure employment [2]. Benefits such as flexible working times/locations, professional development opportunities and enriched work (e.g., opportunities to work in special interest areas, autonomous teams) can create more attractive jobs [7, 30]. However, these benefits are not likely to completely mitigate the impact of inadequate renumeration.

7.6. Leadership and management

The leaders and managers of the AOD workforce are responsible for the recruitment, engagement, and development of AOD workers. More broadly, they support and coordinate the services provided within their organisations [99]. Enhancing their capacity to do so efficiently and effectively is a key component of WFD [5]. High quality leadership and management are important factors in promoting employee wellbeing, retention, and effectiveness, and enhancing workplace morale and

efficiency [5, 100-102]. Supporting leaders and managers within AOD services must therefore be a priority WFD activity. Priorities for leadership and management skill development in the AOD sector include change management, service partnerships and leadership capability [10].

8. Service delivery priorities and challenges

Service delivery in the AOD sector is complex and dynamic, involving a range of challenges. This section highlights a selection of contemporary and emerging issues of particular relevance to the Strategy review and revision.

8.1. Clinical supervision

Clinical supervision is essential to high quality service delivery and effective treatment provision [19, 20]. It involves an experienced practitioner guiding the practice of a less experienced worker, and aims to bridge the gap in professional experience to ensure both client care and worker wellbeing are not affected by inexperience [103]. Related strategies such as practice support, coaching, and mentoring have similar goals. Supervision has been increasingly utilised in the health sector in Australia over the past decade, since Health Workforce Australia published the 'Clinical Supervision Support Program (CSSP) Discussion Paper' in 2010 [104], followed by the 'CSSP Directions Paper' in 2011 [105]. Research supports the effectiveness of clinical supervision for client and worker outcomes [106-108], but notes that its efficacy is dependent on factors such as the skills and attributes of the supervisor and the degree of organisational support [103].

8.2. Increased complexity

The AOD sector and workforce is increasingly being called on to respond to highly complex issues and client presentations. This growing complexity is due to a range of social, geographical, economic and health-related factors, and has important implications for services and workers.

Examples of complex issues facing the AOD field include:

- Ageing client cohorts
- New and more potent drugs
- Expanding drug markets
- New treatment modalities
- Comorbid physical and mental health concerns and other social issues (e.g., violence, finances, housing, gambling)
- Population groups with unique and complex needs
- HCV identification and treatment
- Clients with disabilities
- Intergenerational patterns of AOD use
- Management of PTSD and trauma
- Prescribed medications and management of chronic pain
- Increasing misuse of gabapentinoids
- Cross-sector coordination (e.g., child protection, housing, aged care)

AOD workers need to be able to adapt and work flexibly to meet the challenges of these and other emerging issues. To do so, they will be required to have not only high levels of knowledge and skills but also the capability to work with other fields and sectors to ensure clients' needs are met [2]. Workforce development initiatives should focus on supporting the capacity of AOD organisations and workers to effectively address these complexities in the context of AOD service provision.

8.3. Substances of particular concern

According to the World Drug Report 2021, Australia has one of the highest past year prevalence of cannabis, cocaine, amphetamine, ecstasy and opioid use in the world [109]. Between 2010 and 2019, Australia observed significant increases in past year illicit drug use (12.0% vs 14.1%) and for the use of cannabis (10.3% vs 11.6%), cocaine (2.1% vs 4.2%), inhalants (0.6% vs 1.4%) and ketamine (0.2% vs 0.9%) specifically [62]. Australians' patterns of licit and illicit drug use have also changed since 2019 due to the COVID-19 pandemic, with increased national use of nicotine, alcohol, cannabis, cocaine, MDMA and heroin, and reductions in methylamphetamine use [110]. These patterns vary between capital city and regional locations. This increasing prevalence of drug use poses challenges to the AOD workforce, particularly in relation to demand for treatment.

Over the past decade there have been significant changes in the demand (or at least capacity) for Australians accessing publicly funded AOD treatment. Between 2010/11 and 2019/20, the number of treatment episodes increased 51% from 144,002 to 218,139. The profile of substances for which Australians are seeking treatment has also changed. As a proportion of all treatment episodes:

- Reductions have occurred for alcohol (47% vs 34%), cannabis (22% vs 18%), heroin (9% vs 5%) and pharmaceuticals (6% vs 3%) as the principal drug of concern and;
- Increases have occurred for amphetamines (9% vs 28%) and cocaine (0.3% to 1.0%) as the principal drug of concern [33].

The use of e-cigarettes is also an emerging issue of concern in Australia. In 2019, 11.3% of Australians had used e-cigarettes (an increase from 8.8% in 2016), with a marked increase in use among young adults [62].

In addition to increased treatment demand for problematic drug and alcohol use, Australia also experienced significant increases in AOD related morbidity and mortality [111, 112].

8.4. Evidence-informed practice

Evidence-informed practice is essential to ensure high quality, effective and appropriate prevention, early intervention and treatment practices in the AOD field. Whilst clinical guidelines, practice standards and other evidence-informed resources are available and accessible, there is often a 'gap' between research evidence and 'real-world' practice. To achieve this, education and training are necessary but are often not sufficient in the AOD sector to ensure consistent implementation of evidence-informed practice by AOD workers and organisations. There is also an important role for education and training in related sectors, for example within law enforcement, health and medical training, to improve AOD-related skills and knowledge and reduce stigma.

Systemic factors (e.g., funding arrangements) and organisational factors (e.g., cultures, systems) clearly have a major influence on AOD workers' everyday work practices, including their capacity and opportunity to engage in evidence-informed practice. Factors that can support or inhibit evidence-informed practice include workplace systems and cultures that are resistant to change, lack of resources, high workload, and lack of confidence or skills [5] [113, 114]. In addition, workers need to possess the skills to be able to critically evaluate new innovations, and measure/evaluate outcomes to ensure that their own work practices are consistent with the best contemporary evidence.

8.5. Evolving approaches to service provision

Approaches to AOD prevention and treatment are constantly evolving, both in response to changing social and political contexts, emerging trends and drugs of concern and to incorporate

new evidence-informed practices as they become available. A full review is beyond the scope of this Discussion Paper, however, two examples of evidence-informed practices that are increasingly being adopted within the AOD sector are highlighted here, demonstrating the links between approaches to service delivery and WFD.

Family inclusive practice

Family inclusive practice recognises the impact of an individual's AOD use on their entire family, and as such addresses the needs of all family members. This includes identifying and addressing the needs of adult clients as parents, as well as the needs of their children, in order to ensure that as parents they are supported and child wellbeing and safety are maintained. A recent review [115] found positive results for family inclusive interventions, but identified a number of barriers to its inclusion in routine practice; most notably lack of staff knowledge and training, individualised focus in service provision, unsupportive service factors (e.g., administration systems, management, high caseloads), and inadequate supervision, among others. Importantly, many of these factors are amenable to change through WFD efforts. For example, a number of Australian frameworks and resource guides for working with families already exist [e.g. 116, 117, 118]. Additional resourcing and capacity building is also required to support AOD organisations and workers to extend service delivery to include family members [119] [120].

Trauma-informed care

Trauma can be common among people accessing AOD services and treatment. Trauma-informed care (TIC) recognises that past trauma can affect clients' present perspectives and responses [7]. TIC provides psychosocial treatment for trauma-related symptoms and adapts all aspects of service delivery to meet the needs of the trauma-affected client and avoid re-traumatisation [121]. Importantly, TIC should consider cultural factors, as culture influences how trauma may be experienced and most effectively addressed [122]. For example, when working with Aboriginal and Torres Strait Islander peoples, TIC approaches should build on the strength of Indigenous families, communities, and knowledge, and encompass traditional concepts of social, emotional, cultural and spiritual wellbeing [123]. Interventions should be holistic, community-led and culturally safe, and conducted with an understanding of intergenerational trauma [123].

Services seeking to implement TIC are advised to base all interactions with clients around five guiding principles: safety, trustworthiness, choice, collaboration and empowerment [124]. Research

has demonstrated the benefits of doing so in terms of organisation, staff, and client outcomes [125]. Similar to family inclusive practices, WFD strategies to support capacity building of AOD organisations and workers are needed to ensure high quality and effective delivery of TIC.

8.6. Technology and digital upskilling

New technologies have been progressively harnessed to support and promote long-distance healthcare [126]. This trend towards the use of e-health services has been hastened by the COVID-19 pandemic, where face-to-face service provision has not been possible. Virtual care models have many advantages for clients and practitioners, including providing greater and more flexible access to services, combating stigma, expanding community-based outreach and engagement, supporting self-management of illness and regulating medication distribution [127]. Virtual delivery models can also be used to support workers in the form of online professional development [2].

Virtual services face barriers to both delivery and reception, and remain inappropriate for some groups and services [2]. In particular, the utility of digital services can be limited by lack of access to appropriate technologies, digital illiteracy, and inability/unwillingness to engage with services remotely – issues disproportionately experienced by more vulnerable groups [128]. Those living in rural/remote communities, Aboriginal and Torres Strait Islander peoples, disadvantaged populations, women experiencing family and domestic violence or those in unstable housing are some of the groups most likely to be affected by this 'digital divide' [2]. There are also ongoing concerns about data security and privacy [127]. A hybrid model offering both in-person and virtual services is likely to provide the greatest coverage and access at the current time [2].

In light of these current trends, the digital literacy of the AOD workforce has become a critical issue. Emerging priorities in this area include upskilling workers in the use of new technologies, the purchase of new hardware and software, and the integration of new digital tools into organisational systems and practice [2]. These important changes will necessitate the investment of significant time and resources, and WFD supports will have an important role in ensuring the integration and delivery of virtual service provision is accomplished smoothly and effectively.

8.7. Impact of COVID-19

The COVID-19 pandemic has had far-reaching impacts on AOD workers, services, and clients. Access to and provision of treatment services have been hampered by reduced capacity to provide face-to-face consultations and take on more complex/high-risk cases or new clients [129-131]. At the same time, changes have occurred in the availability, supply methods and usage patterns of substances [132], with increased need for services seen in some areas [129].

A recent report [131] documented the impacts of the pandemic on the AOD NGO sector in four categories: business practice, workforce, service delivery, and treatment demand (Table 2). It is important to acknowledge that there have also been some unexpected positive changes as a consequences of the pandemic, including better use of technology, improved collaboration with other parts of the health system, and more flexible working arrangements [131]. In this context, there is a need for a comprehensive evaluation of the most appropriate and effective technologies that can be used to support workforce capacity building and service provision. To date, the technology requirements and corresponding upskilling of the AOD sector have not been comprehensively assessed [2].

It is important to note that the impact of COVID-19 cannot be examined in isolation from other issues facing the AOD sector. In particular, long-standing issues related to funding models, recruitment and retention have exacerbated the negative impacts of the pandemic [131]. The increased strain on workers' wellbeing should also be acknowledged, with the pandemic profoundly affecting both work and personal life. Hence the importance of WFD activities to build the capacity of the workforce is highlighted, to strengthen the ability of the sector to respond to future unexpected challenges.

Table 2. Impacts of COVID-19 on the AOD sector

Business practice impacts	Workforce impacts	Service delivery impacts	Treatment demand impacts
Increased costs (due to requirements for more ICT infrastructure, workforce training, personal protective equipment, cleaning products and services)	Decrease in number of volunteers	Adaptions to service delivery, including innovative new programs	Decline in new episodes of care (EOC), particularly for methamphetamine presentations and female clients, and in metro services (this varied by treatment type)
Reductions in donations and client contributions due to reduced bed numbers and occupancy rates	Loss of experienced staff due to early retirement/staff not returning	Increased working from home and use of technology	Longer waiting lists in metropolitan and regional services
Financial support from Government (e.g., JobKeeper) often insufficient to offset costs	Increased workload (due to more sick leave for cold symptoms, additional tasks related to COVID, receiving more referrals from services that had closed)	Specific barriers and challenges for residential services (e.g., lack of outdoor/external activities, risk of outbreak and shutdown, client boredom, isolation and lack of engagement)	Compounding effects of COVID on already disadvantaged populations (e.g., Aboriginal and Torres Strait Islanders)
Changes to risk management practices	Increased stress and anxiety and decreased wellbeing among staff	Use of technology to maintain continuity of care	Service gaps for special population groups exacerbated
Adjustments to contracted deliverables or Key Performance Indicators	Challenging conditions for managers due to staff being under strain	Technological challenges and unsuitability for some client groups	

Source: [131]

9. Education, training, and professional development

Whilst WFD involves coordinated multi-level strategies and initiatives to develop and support the AOD workforce, education and training is one of the keystones of an effective workforce that has the capacity to deliver high quality and effective AOD treatment and prevention services. It is important to note that appropriate education and training may be challenging to access for some workers and groups. For example, workers in regional, rural and remote areas, workers from disadvantaged backgrounds, and Aboriginal and Torres Strait Islander workers. Programs, policies, and resources are needed to ensure that education and training are equitably available for all AOD workers.

9.1. Education and training for AOD specialists

There are a range of matters to be considered in relation to education and training for AOD specialists. Particular focus is drawn to four central issues:

1. Establishing minimum educational qualifications for AOD workers
2. Issues surrounding competency-based training
3. Availability of foundational and advanced education and training programs to meet the needs of both early career/entry level workers and experienced workers
4. Availability and accessibility of specialised training to address specific areas of competency (e.g., trauma, family sensitive practice, new and emerging patterns of AOD use) [7].

Minimum qualifications

The adoption of a minimum qualification standard can be a useful WFD strategy as it establishes a baseline level for AOD skills and competencies and allows for transportability of skills between jurisdictions and organisations. Currently, there is no formal minimum qualification standard for AOD work that applies nationally. At the time of writing only Victoria and the Australian Capital Territory have a minimum qualification strategy (MQS) for AOD workers. The advantages of a minimum qualification standard include supporting the ongoing professionalisation of the AOD specialist workforce and contributing to the consistency and quality of service delivery. Minimum qualification requirements may also create some additional workforce challenges, such as additional financial costs for employers (e.g., backfill costs) and inadvertently creating a disincentive to the recruitment of new workers or workers qualified in other fields (e.g., psychologists, social workers). With regard to workers qualified in other related fields, the Victorian AOD Minimum Qualification Strategy [10] requires workers qualified in a health, social or behavioural science field to complete, at minimum, four core induction competencies in the Community Services Training alcohol and other drugs skill set. Completion of a specialist AOD qualification at Certificate IV or higher level also meets the minimum qualification requirement for these Victorian workers. It is also worth noting that the Victorian government has a funding program to support workers to access training to meet the minimum qualification standard without attracting a cost to themselves or their employer [10].

Competency-based training

The aim of competency-based training is to ensure that workers possess the knowledge, skills, attitudes, values and ethics to work effectively, ethically and safely [133]. Consistent with education and training in health, medicine, human services and other related fields, AOD vocational education and training is based on the achievement and demonstration of a particular set of competencies. Competency-based training focusses on assessment of the application of particular knowledge and skills to a standard required in a workplace, including the capacity to apply these to new situations and activities [134]. Competencies may also be referred to as professional capabilities, professional attributes or standards of practice [134].

It is important to acknowledge the ongoing discussion and reflection around competency-based training. For example, in complex service delivery environments such as medicine and health, competency-based training has been critiqued for being insufficient to capture more sophisticated or nuanced decision-making and action that may be required in complex real-life situations that vary in terms of client characteristics and the context of care delivery (e.g., contrast care delivery in a remote clinic compared to a hospital based in a high SES urban area). Consumer input is also an important consideration to ensure competencies, and the associated training and assessment programs, effectively address the needs, priorities and preferences of consumers [133].

Foundational and advanced education and training

The AOD workforce comprises substantial cohorts of both early career workers new to the AOD sector, and highly experienced and established workers. The AOD National Workforce Survey 2019-2020 [27] estimated that around 40% of workers had 10+ years of AOD experience, while 20% of workers reported three or fewer years' of AOD experience. The education and training needs of these groups, and mid-career workers, are substantially different from those with greater experience. For example, highly experienced workers may benefit from advanced training and education on particular treatment modalities, substances or client groups. Specific training priorities have been identified as advanced clinical skills and clients with complex needs, although a number of barries to accessing such training exist, notably time, money, and access constraints [135]. Postgraduate qualifications in Addictions are available (e.g., Master of Science in Addiction Studies, Masters of Addictive Behaviours) in addition to specialised training for particular professions such as the RACGP Advanced Training in Addiction Medicine for physicians. However,

these formal qualifications may require up to three years to complete, representing a substantial investment of time and resources for workers and their employers. Shorter, more targeted courses and programs may be beneficial for experienced AOD workers looking to upskill in particular areas.

Early career workers can also benefit from undertaking advanced studies, as well as more foundational level training. Research has identified that many early career AOD workers have been exposed to relatively little AOD-specific training, with these skills often being taught on-the-job [28]. Promoting more AOD content within relevant training courses, and also supporting organisations to upskill new workers where necessary, is an important WFD priority [28].

Specialised training

As with other areas of health, the AOD workforce addresses a complex and changing landscape, with new and emerging substances, treatment and prevention approaches, client populations and other dynamic factors. Specialised training is one approach to supporting and enabling AOD workers to upskill and improve the effectiveness of their responses to contemporary and evolving issues (e.g., trauma-informed care, family sensitive practice, LGBTQI+ clients and comorbid mental health and AOD issues). Identifying priority areas in which specialised training should be developed and/or made more accessible is an important issue for the revised Strategy. For example, the Victorian AOD Workforce Strategy 2018-2022 includes the development of an advanced practice series of short courses addressing key skills such as intake and assessment, counselling and recovery-orientated approaches [10].

9.2. AOD education and training for generalist workers

There are many health and human service workers whose core role does not involve the provision of AOD services, but who nonetheless may regularly come into contact with individuals who use AOD problematically (e.g., psychologists, social workers, nurses and doctors). In order to facilitate timely and appropriate identification and management of AOD issues, it is imperative that these workers have sufficient knowledge of AOD use, treatment, and referral pathways. Despite this, health and human service workers are often exposed to little or no AOD content during their training [2].

Undergraduate and pre-registration education and training are key sites for the inclusion of AOD-related content. Embedding training in AOD issues at these levels would have numerous benefits,

including not only increasing the knowledge and skills of health workers, but also establishing the legitimacy of AOD issues (and de-stigmatising them), and raising awareness of and interest in career paths within the AOD sector [2, 31, 136, 137]. There have consequently been calls for substantial input of AOD issues into general health and human services education as a priority WFD activity [2]. Establishing an agreed set of core AOD competencies for workers outside the AOD field is one approach to ensuring the relevance and consistency of AOD training [7].

9.3. Professional development

Access to regular, ongoing professional development (PD) is important to ensure workers' skills remain honed and responsive to emerging issues. Mandatory continuing professional development is one of six standards set out by the Australian Health Practitioner Regulation Agency [138]. PD should be relevant, purposeful, and encompass a range of activities from personal development to work-based learning or formal education [139]. Examples include professional placements and secondments, conference attendance, mentoring and upskilling, education and training. While there is relatively limited research addressing these activities specifically within the AOD sector, evidence from the broader health sector highlights the positive effects of comprehensive PD for both workers and clients [140, 141]. PD is also a valuable recruitment and retention strategy for organisations: research shows that AOD workers nationally are seeking greater PD opportunities[142].

A number of barriers to AOD workers accessing PD have been identified. These include the financial costs involved, insufficient time or staff, unsupportive organisations or managers, and access difficulties [142]. Given its importance for both personal and professional outcomes, organisations and managers should prioritise PD and actively encourage and support workers to access relevant activities and programs. A centralised register of available PD and training opportunities may be useful in this regard [9]. Technology and social media are also providing new ways to access PD that substantially reduce barriers to entry [143].

10. Future steps

The review and revision of the National AOD WFD Strategy will be based on a comprehensive stakeholder consultation process and through input from the AOD sector and other related sectors. Based on this process, a robust draft Strategy will be developed and delivered to the Department of Health in mid-2022 for review and feedback. It is also anticipated that the Australian National Advisory Council on Alcohol and Other Drugs (ANACAD) members will also be consulted as part of this process. This feedback will then be incorporated into the final version of the Strategy.

Implementation and monitoring of the revised Strategy is considered to be a shared responsibility between the Commonwealth, jurisdictions and other identified stakeholders within the Strategy. Stakeholder input on the effective implementation and monitoring of the revised Strategy is welcome.

11. Conclusion

Addressing and reducing AOD-related harm requires a skilled and sustainable workforce that has the capacity to respond effectively to problematic AOD use and related harms in a dynamic and often challenging social and economic environment. This Discussion Paper has highlighted a range of factors to be considered in the revision of the National AOD WFD Strategy (2015-2018).

Underpinning this analysis is an understanding of workforce development as a multi-level approach addressing systemic, organisational and individual factors that impact on the capacity of the AOD workforce to deliver high quality and effective AOD prevention and treatment responses. The current Strategy revision is focused on identifying priority WFD areas for strategic planning, resourcing and action that will have the greatest impact on supporting and improving the effectiveness of AOD systems, structures, organisations and individual workers.

Appendix A: Project Advisory Group

The Project team acknowledges the valuable input and guidance of the Project Advisory Committee. The members of the Committee are listed below.

Representative	Organisation
Ms Sarah Ferguson Ms Alyce Hall	Australian Government Department of Health
Ms Jennifer Duncan	Australian Alcohol and other Drugs Council (AADC)
Mr Robert Stirling	Network of Alcohol and other Drug Agencies (NADA)
Mr Michael White	South Australian Network of Drug and Alcohol Services (SANDAS)
Ms Anna Louise Kimpton	National Aboriginal Community Controlled Health Organisation (NACCHO)
A/Professor Apo Demirkol	Australasian Chapter of Addiction Medicine (Chapter of the Royal Australasian College of Physicians)
Mr Jack Nagle	Australian National Advisory Council on Alcohol and Other Drugs (ANACAD)
Mr George Clarke	Tasmanian Department of Health
Mr Alan Philp	ACT Health
Ms Cecelia Gore	Northern Territory Department of Health
Ms Caroline Heffer	Western Australia Mental Health Commission
Ms Helen Taylor	Queensland Health
Ms Debbie Kaplan	New South Wales Ministry of Health
Ms Jo Driscoll	Victorian Department of Health
Ms Marina Bowshall	DASSA: SA Health
Ms Yvonne Uren	National Indigenous Australians Agency

Appendix B: Discussion Questions

GENERAL WFD QUESTIONS

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

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

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

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

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

- *Reviewing and improving funding models to ensure AOD services have optimal support for capacity building and effective service delivery*
- *Addressing remuneration and other employment conditions for AOD workers to achieve parity with similar sectors (e.g., mental health)*
- *Development of a national AOD workforce census to guide workforce planning and WFD*
- *Development and promotion of recruitment pathways into the AOD sector from related fields (e.g., public health, community services)*
- *Building and supporting structured career pathways within AOD organisations and the sector in general, including pathways into leadership and management roles*
- *Implementing programs and strategies to increase the accessibility of professional development, clinical supervision and practice support for the AOD workforce*
- *Developing and implementing public campaigns to address stigma associated with AOD use and AOD work*

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

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

- *Access to clinical supervision and practice support*
- *Increased accessibility and support for accessing advanced training (e.g., funding support for backfill costs)*
- *Programs to address wellbeing (e.g., burnout), including addressing secondary stigma that may be associated with AOD work*
- *Strategies to build and improve career development pathways*

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

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

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

PRIORITY GROUPS

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

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

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

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

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

- *Culturally safe training and support mechanisms*

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

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

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

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

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

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

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

- *Availability and accessibility of education, training and professional development for new and established workers*
- *Strategies needed to support the recruitment and retention of workers*
- *The need for training and professional development to develop particular knowledge, skills or abilities*
- *Programs and actions to address the wellbeing of these workers that meets their unique needs*

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

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

- *Systems, organisational and individual strategies that meet the requirements of the Australian Commission on Safety and Quality in Health Care National Standards for Working with Aboriginal and Torres Strait Islander People (hereafter 'Aboriginal') and promote:*
    - *Recruitment and retention of Aboriginal staff*
    - *A welcoming and safe environment that quickly establishes if clients identify as Aboriginal*
    - *Flexible service delivery options*
    - *The use of practice strategies that engage Aboriginal people and their families*
    - *Community consultation and engagement and understanding local history and protocols*

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

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

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

INTEGRATED CARE

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

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

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

FUNDING MODELS RETENTION AND TRAINING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DIGITAL AND ONLINE PLATFORMS

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

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

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

DATA SYSTEMS, MONITORING AND EVALUATION

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

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

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

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

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

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

FINAL

Are there any other questions or comments?

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