Building a sustainable AOD workforce

Windana's position statement

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1. Introduction

A sustainable alcohol and other drug (AOD) workforce is one that can meet the complex and co-occurring needs of Victorians who require support with their substance use now and into the future.

Instead, the current AOD workforce is at a tipping point where urgent action is needed to address critical challenges. Current funding, workforce size and structures, and macro pressures on Victoria's (and Australia's) entire 'caring workforce' are compounding to create significant risk to the AOD workforce. If nothing is done, we risk more people falling through the cracks and not receiving the care they require.

Victoria's AOD workforce model and strategy must reflect the specialised skills and lived experience the sector required to provide the specialised services people need.

Windana welcomes the opportunity to collaborate with the Victorian Government on how to sustainably grow the workforce and provide remuneration that matches the level of experience and qualifications the AOD sector needs. This will enable more people to receive the support they need earlier to recover from their substance use concerns.

Below is a summary of Windana's positions and recommendations for building a sustainable AOD workforce.

2. Windana's positions and recommendations

Building a sustainable workforce

A sustainable AOD workforce is one that's valued and supported by Government so it can provide the increasingly complex care people need for their substance use concerns.

The Victorian Government's new AOD Workforce Strategy must include:

- A model for the AOD workforce that reflects the realistic qualifications needed to provide the specialist care service users need. This should include structured career pathways and a competency framework.
- Proper remuneration structures that reflect the required qualifications via a fit-for-purpose funding model (see funding model for more information).
- A plan to attract new people and skills into the AOD workforce.
- Formalised structures and support processes designed to retain and professionally develop current and new members of the AOD workforce.
- A state-wide strategy to build closer relationships with education institutions to create student placements/internships to ensure graduates and early career be exposed to all facets of AOD sector.
- A focus on the lived experience workforce, including the establishment of a peak body to support everyone with lived experience of alcohol and other drug issues, similar to the Victorian Mental Illness Awareness Council (VMIAC) model. Options of establishing a new peak body or extending the remit of an existing organisation (Eg. SHARC or VAADA) should be explored.

3. Evidence summary

A snapshot of Victoria's AOD workforce

As of 2018, the AOD workforce in Victoria was made up of more than 1500 people (DHHS 2018, p. 4).

The most current data shows that:

- 66% female, 31% male and 3% are non-binary/non gendered.
- 23% were born overseas
- 2.1% identify as Aboriginal and Torres Strait Islander (DH 2021a, p. 4)
- 69% are located in metropolitan catchment areas
- 27% work in rural catchment areas (DHHS 2018, p. 5)

Before their current role:

- 46% of workers worked in another AOD role
- 45% worked in another sector
- 9% were from student placements (DHHS 2018, p. 5).
- 71% hold a formal AOD qualification,
- 80% hold a formal 'health, social or behavioural science' qualification' (DHHS 2018, p. 5).
- Around 80% of workers have more than three years AOD experience (DHHS 2018, p. 6).

As we are in the final year of the department's current AOD workforce development strategy, we anticipate that new data on workforce statistics will be released soon.

As of 2019, 66% of Victorian AOD workers intended to seek advancement in the sector or stay in the same role over the next three-year period, while 27% wanted to leave or reduce their hours (DH 2021a, p. 16).

The Network of Alcohol and Other Drug Agencies has also highlighted the need for AOD agencies to reflect the diversity of residents and prospective residents, so that providers can better meet the needs to people accessing AOD services (NADA 2016, p. 8).

The Victorian AOD workforce strategy states that CALD (Culturally and Linguistically Diverse) populations are less likely than other groups to access AOD services, possibly stemming out from language barriers, lack of trust or awareness (DHHS 2018, p. 18). This is consistent with reports from VAADA stating that people from CALD communities may feel that AOD programmes are too 'Anglocentric' and do not reflect their cultural practices and understandings (VAADA 2016, p. 73).

As a result, ensuring that people from a broad range of cultural and ethnic backgrounds are attracted and recruited in the AOD sector may help provide more culturally safe and appropriate services and ensure better access and treatment for CALD groups (DHHS 2018, p. 18).

Similarly, as Aboriginal and Torres Strait Islander Victorians are more likely to experience substance related issues, the Department of Health's workforce strategy also sees the increase in the number of Aboriginal AOD workers as a main workforce development priority (DHHS 2018, p. 19).

Challenges facing the Victorian AOD workforce

Currently, the Victorian AOD workforce is facing multiple challenges including high rates of attrition and not enough workers to meet demand (VAADA 2022, p. 33). There is competition from other sectors, especially the growing mental health sector, as workers are attracted to it due to an overlapping skill set with AOD, and anecdotally, there is the feeling that the mental health sector gives better pay and stability (VAADA 2022, p. 33). The mental health sector is also seen as more clinical and more professional than the AOD sector (360Edge 2020, p. 32).

The argument that the mental health sector gives higher remuneration than the AOD sector is made frequently, but there is a lack of data to state that mental health workers are being paid more for the same of equivalent role of an AOD worker.

This is something which may only be further complicated as the mental health sector seeks to rapidly expand, likely creating more competition for these roles. Differences in pay between the mental health and AOD sector may be partly due to the fact that the mental health sector has more workers of a higher educational qualification, such as psychologists, psychiatrists and nurses (DH 2021b, p. 16).

Nonetheless, AOD organisations are reporting that they are having to hire under-qualified workers and spend resources training them on the job (VAADA 2022, p. 33). VAADA states that many of the workers receiving extra training on the job and being upskilled are then leaving the AOD sector for better paying jobs in other sectors (VAADA 2022, p. 33).

This is far from a Victoria-only issue. According to NADA, organisations across Australia are losing experienced staff, some of whom are retiring earlier than planned and others to different sectors, all of which has been exacerbated by COVID (NADA 2022, p. 2). This is creating a skills and knowledge gap which is difficult to fill.

As a result of these workforce shortages, VAADA estimates that at least 243 full time workers will need to be hired in the AOD sector to meet current levels of demand in the sector (VAADA 2022, p. 33). If Victoria is to increase its AOD bed numbers and be at parity with the national average, capacity would have to be increased. However, capacity cannot be increased, and parity cannot be reached, without having more properly trained and educated staff in the AOD sector (VAADA 2022, p. 33).

Other states are also aware of the difficulties facing the AOD workforce and are taking steps to further ensure its development. Queensland's 'Connecting Care to Recovery' seeks to:

- Expand structures of AOD clinical supervision and improving access to supervisor training
- Review mechanisms for the development and provision of mental health, AOD workforce training programs and education
- Implement specific AOD training for Indigenous primary healthcare and other community-controlled organisations
- Deliver state-wide culturally appropriate training for staff in service delivery and improve the use of interpreters for people from CALD backgrounds (Queensland Health 2016, p. 19).

Dual Diagnosis and co-occurring conditions upskilling

As AOD and mental health are intertwined, developing the AOD workforce's understanding of mental health through dual diagnosis and other mental health training will enhance the capacity of the AOD workforce.

In 2001, Dual Diagnosis Teams were set up by the Victorian government to assist mental health and AOD services across the state (DHS 2007, p. 12). In 2005, the state government set up a new

initiative of a reciprocal rotations program which rotated staff between the mental health and AOD and mental health sector for 12 weeks (DHS 2007, p. 19).

It was argued that the rotations program would enhance the development of the AOD sector and would give AOD workers greater knowledge and understanding of dual diagnosis and the mental health sector, along with giving mental health workers a greater understanding of AOD issues (DHS 2007, p. 19).

However, a review by Australian Healthcare Associates in 2011 found that the reciprocal rotations program did not have a significant impact on the 'employing organisation', although some workers appreciated the benefits, and was not value for money (AHA 2011, p. 57). Further, the reciprocal rotations program was discontinued because it created a skills drainage from the AOD sector to the mental health sector (360Edge 2020, p. 41). The reason given for this was due to differences in pay scales (360Edge 2020, p. 41).

The Peer and Lived Experience Workforce

Peer and lived experience workers are people who are employed on the basis of their lived experience with substance use and recovery (SENSWPHN 2019, p. 11). They draw on their lived experience in 'conversations, documentation, decision-making and advocacy' (SENSWPHN 2019, pp. 11-12). The most common role that peer support workers undertake is supporting people by sharing their own experiences with others in treatment (SENSWPHN 2019, p. 12). Formal peer support worker roles were established in the mental health sector well before they were introduced in the AOD sector, and as such, much of the existing research focuses on peer and lived experience workers in the mental health sector (MacLellan et al. 2015).

64% of Victorian AOD workers reported as having lived experience of AOD issues, one third of those reporting having experience of personal AOD issues, with others having experience of a family member having AOD issues (DH 2021a, p. 11). However, most of these do not work in lived experience roles, with data suggesting less than 10% of those with lived experience working in a lived experience or peer role (SENSWPHN 2019, p. 12).

Evidence for and Benefits of the Peer and Lived Experience Workforce

Being employed in a lived experience role can make peer workers themselves feel empowered in their own recovery journey and can give greater confidence, self-esteem, positive sense of self and identity and reduce the effects of stigma (Repper et al. 2013, p. 10). It also provides a crucial avenue of meaningful employment for people coming out of recovery and who might struggle with employment post-treatment, thereby making it a positive way to re-enter the job market and integrate into the community (Repper et al. 2013, p. 10).

Research indicates that if peer support workers are properly trained, supported and supervised, they can provide a whole range of benefits to people in recovery (Viking 2022). The ability of peer and lived experience workers to engage with clients on the same level through an understanding of the challenges of their situation is a key feature of their effectiveness (MacLellan et al. 2015, p. 2). Peer and lived experience workers can provide increased guidance and support to individuals as they

have personalized experience of AOD issues, but also how to navigate care service systems, which can be confusing and confronting (Viking 2022, p. 7).

Peer support workers can help act as a bridge between clinicians and clients and have been found to ensure better understanding and trust between clinicians and clients, leading to better outcomes for clients (Viking 2022, p. 7). The use of peer support workers has been associated with a reduction of hospital and re-admissions among clients (Repper and Carter 2011, p. 396).

In follow up reports, clients who were involved in programs with peer support indicated higher levels of community integration, more friends and more social support than those in programs not including peer support workers (Repper and Carter 2011, p. 397). The use of peer support workers has also been associated with overall reductions in the number of major life problems experienced for clients and creating savings in terms of bed days and costs (Miyamoto and Sono 2012, p. 24).

Clients who receive support from peer support workers are also more likely to make connections to primary medical care and have a more validating and positive relationship with staff and the service provider (Miyamoto and Sono 2012, p. 24). Other benefits for clients using peer support workers include increased problem solving skills, sense of empowerment, improved access to work and education, reduced self-stigmatisation and having a more positive feeling about the future (Repper et al. 2013, 10).

Peer and Lived Experience Workers and the Royal Commission into Victoria's Mental Health System

The use of peer support and lived experience workers is a major focus of the Royal Commission into Victoria's Mental Health System (RCVMHS 2021a). The Royal Commission criticised the fact that systems were not properly informed by people with lived experience and that it needs to be ensured that people with lived experience are leading and partnering with others in reform efforts and are foundation to the future system (RCVMHS 2021, p. 29). As such, many of the recommendations of the Royal Commission focused on the use of peer support and lived experience workers.

- **Interim Recommendation 6**: That the lived experience workforce be further expanded and developed, including better support, understanding and training opportunities for lived experience and peer workers, including that the Certificate IV in Peer Work be added to the free TAFE list (RCVMHS 2021a, p. 107).
- **Recommendation 23**: That a new statewide trauma service be implemented with peer workers at core (RCVMHS 2021a, p. 59).
- **Recommendation 26**: That more lived experience workers need to be employed in suicide prevention and response (RCVMHS 2021a, p. 62).
- **Recommendation 28**: That there should be more roles, leadership and development opportunities for people with lived experience (RCVMHS 2021a, p. 64).
- **Recommendation 29**: That a new non-government agency chaired by and consisting of a majority of people with lived experience be formed to further develop the lived experience workforce and other mental health and wellbeing services (RCVMHS 2021a, p. 65).
- **Recommendation 45**: That the Department of Health's Mental Health and Wellbeing Division employs people with lived experience, including in leadership positions (RCVMHS 2021a. p. 81).

The call for services and policy to be codesigned and co-delivered with people with lived experience is found multiple times in the royal commission (RCVMHS 2021a).

Given that the peer and lived experience workforce will likely be a core part of mental health system reforms in Victoria, it should follow that, given the sector's interconnectedness with the AOD sector, this will have an impact on the AOD sector, which will likely also have to better develop support and expand its peer and lived experience workforce as a result.

Limitations of and the supports needed for the Peer and Lived Experience Workforce

All research supporting the use of peer and lived experience workers also emphasises the limitations and the significant support and management that is required for the peer and lived experience workforce.

Boundaries come up as a major challenge for peer workers across multiple reports and studies. Because of the nature of their job, the fact that they are disclosing sensitive personal information about themselves to clients, some clients may see peer workers more as friends than a professional member of staff (Tisdale et al. 2021; Repper and Carter 2011). While that may come with positives, it can lead to stress and uncertainty for peer workers, as they have to balance maintaining professional relationships with their desire to assist, help and form meaningful connections with clients and residents (Tisdale et al. 2021, p. 406). Among other issues such as stigma and lack of variability in roles, there is also the concern that peer and lived experience workers may be exposed to stress and triggers in their role, which could lead to a reoccurrence of their substance use issues or a mental health episode (Repper and Carter 2011, p. 399).

Workers with lived experience, no matter whether they are peer support workers or are in other roles, should be provided with initiatives which include training, mentoring, supervision and professional development so that they can be given to the tools required for advancement and progression (RCVMHS 2021b, p. 36). The Royal Commission has recommended the use of 'clinical practice supervision' and regular 'formal and informal debriefings', along with tailored professional practice supervision, to support peer and lived experience workers and ensure that distress is minimised (RCVMHS 2021c, p. 478). The Royal Commission also highlights the importance of career progression for lived experience workers, hence why training and supports are so crucial (RCVMHS 2021c, p. 540).

People with lived experience should not be confined to only working in peer support roles and should be encouraged and supported to work in all roles, including in leadership positions, across the AOD sector. To quote the Royal Commission, 'Career progression must be developed in order to retain lived experience workers so that they may be able to share their expertise and provide supervision to more junior lived experience workers, as well as develop their own careers' (RCVMHS 2021c, p. 540).

To better support and expand the peer and lived experience workforce, the Royal Commission (RCVMHS 2021c, p. 540) recommends:

- Access to specific supervision
- Access to lived experience specific training
- Access to roles beyond peer support
- That roles and responsibilities are well defined and understood
- That structural supports are established

Key Result Areas from the Department's AOD Workforce Strategy

The Department's current AOD workforce strategy, '*Victoria's alcohol and other drugs workforce strategy 2018–2022',* outlined six Key Result Areas in order to improve the capacity and capabilities of the Victorian AOD workforce (DHHS 2018).

Key Result Area One is to 'Improve Workforce Availability' (DHHS 2018, p. 8). This reflects the previously mentioned concerns that there are not enough workers, and not enough of certain types of workers in particular, in the AOD workforce. The Primary Actions are:

- Attraction campaign based on reducing AOD stigma and raising awareness of the sector (DHHS 2018, p. 9).
- Development of a sector-wide jobs board supported by VAADA (DHHS 2018, p. 10).
- Targeting workers with tertiary qualifications in health, social or behavioural sciences (DHHS 2018, p. 10).
- Encouraging workers to access SkillsFirst subsidies for AOD studies (DHHS 2018, p. 10).
- More student placements in the AOD sector (DHHS 2018, p. 10).
- Providing AOD training for nurses and recruiting more nurse practitioners to AOD and addiction medicine physicians (DHHS 2018, p. 11).

Key Result Area Two is to 'Build workforce capabilities and quality' to ensure that AOD workers have the appropriate skills and knowledge to provide better AOD services (DHHS 2018, p. 12). The Primary Actions are:

- Introducing the minimum qualification of a Certificate IV (DHHS 2018, p. 13).
- Upskilling workers in areas such as dual diagnosis (DHHS 2018, p. 14).
- Short courses for people with undergraduate qualifications in health, social or behavioural sciences to help them transition to work in AOD (DHHS 2018, p. 14).
- More training to respond better to youth and LGBTI groups (DHHS 2018, p. 15).
- Expanding capability to respond to forensic clients including more training and shared case management model with correctional services (DHHS 2018, p. 16).
- Responding better to family violence through introducing specialist family advisors, minimum standards for screening, risk management and the implementation of relevant frameworks (DHHS 2018, p. 17).

Key Result Area Three is to 'increase workforce diversity' so that the workforce reflects the diversity of the people it works with and can respond better to those communities (DHHS 2018, p. 18). The Primary Actions are:

- Hiring more workers of CALD, LGBTI, refugee and Aboriginal backgrounds through better support, peer connections and attraction campaigns (DHHS 2018, p. 19).

Key Result Area Four is to 'improve worker health, wellbeing, safety and engagement' to ensure that AOD workers are properly supported and risks are promptly addressed (DHHS 2018, p. 20). The Primary Actions are:

- More training for staff (DHHS 2018, p. 21).
- More coordination in AOD education and training (DHHS 2018, p. 21).

- Training specifically surrounding the risk to workers from people who use methamphetamine (DHHS 2018, p. 21).
- More clinical supervision and practice support for workers (DHHS 2018, p. 22).
- Tailored supervision for Aboriginal practice, forensic clients and lived experience workers (DHHS 2018, p. 22).

Key Result Area Five is to 'strengthen leadership and collaboration' to drive outcomes, reforms, improve practice, accountability and reduce preventable harm (DHHS 2018, p. 23). The Primary Actions are:

- More postgraduate studies and scholarships in addictive behaviour (DHHS 2018, p. 23).
- Recognition for subject matter experts (DHHS 2018, p. 24).
- More support for management and leadership development in the AOD sector (DHHS 2018, p. 24).
- Continuing support for the 'Change Agent Network' to support emerging leaders in the AOD sector, increase clinical skills and better translate evidence into best practice (DHHS 2018, p. 25).

Key Result Area Six is to 'deliver person-centred, integrated care' to ensure the best outcomes for service users and improve AOD organisation's collective practice (DHHS 2018, p. 26). The Primary Actions are:

- Providing more training under the Ice Action Plan (DHHS 2018, p. 26).
- Expanding and supporting the peer workforce (DHHS 2018, p. 28).

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