Submission to
The Senate Select Committee
on
Regional and Remote
Indigenous Communities

from

The National Centre for Education and Training on Addiction
(NCETA)
Flinders University
Adelaide

About the National Centre for Education and Training on Addiction (NCETA)

NCETA is one of three national Alcohol and Other Drug (AOD) research Centres that are funded by the Australian Government Department of Health and Ageing. The Centre is located within the School of Medicine at Flinders University, and is a collaborative venture between Flinders University and the South Department of Health.

The Centre's mission is to advance the capacity of human services organisations and workers to respond to alcohol and other drug related problems. A key element of its strategic work plan is to conduct and disseminate quality research on effective practice in responding to alcohol and drug problems in the health, welfare and law enforcement sectors. In particular, research, evaluation of effective practices, the promotion of workforce development principles, and development of high quality professional resources are NCETA's core business. NCETA is a trusted and well respected source of advice and guidance on AOD-related matters and has a proven track record in undertaking large, complex studies on AOD-related issues.

Select work of the Centre, relevant to this Inquiry, is highlighted below. The following information variously addresses the Select Committee's terms of reference b), c), and d):

b) *the impact of state and territory government policies on the wellbeing of regional and remote Indigenous communities;*
c) *the health, welfare, education and security of children in regional and remote Indigenous communities;*
d) *the employment and enterprise opportunities in regional and remote Indigenous communities.*

The following issues are addressed:

1. Indigenous AOD Workers' Wellbeing
2. Indigenous secondary school students' drug use
3. Education and literacy
4. Employment opportunities
5. Education and training opportunities
6. Indigenous employment in health and human services
7. Indigenous workforce needs

1. INDIGENOUS AOD WORKERS' WELLBEING

NCETA is currently undertaking a national research project on the wellbeing of Indigenous and non-Indigenous health workers (who see a high proportion of Indigenous clients) working in the AOD field. This project builds on NCETA's previous work in the area of wellbeing, satisfaction, stress, retention and burnout amongst workers in the AOD field, and it is funded by the Australian Government Department of Health and Ageing. This national study includes AOD specialist and generic health workers across government, non-government and community controlled organisations. The project's duration is July 2007 – June 2009.

The primary aims of the project are to:

- Identify the key antecedents and consequences of stress, burnout and wellbeing among Indigenous AOD and generic health workers.
- Identify the key antecedents and consequences of stress, burnout and wellbeing among non-Indigenous AOD and generic health workers who have a high proportion of Indigenous clients.
- Develop an information base and a range of tools (e.g., report, literature) to inform strategies to improve rural and remote worker wellbeing and ameliorate stress and burnout.

In order to achieve these aims, NCETA is utilising a range of consultative methodologies including:

- Online and paper-based surveys
- Telephone interviews
- Site visits for face to face interviews/focus groups
- Public submissions.

A key component of the project has also been to undertake an extensive literature review including an examination of:

- Indigenous client base issues
- Cultural competence for non-Indigenous health workers
- AOD workforce issues
- Indigenous health workforce issues
- Rural and remote issues.

While this project is still underway there are some general findings that have emerged that can be flagged here in a preliminary form that are of relevance to this Inquiry. To-date, an on-line survey has been completed with over 300 respondents of whom two-thirds were Indigenous. The survey addresses a range of issues related to worker welling and it will be reported on in detail later in 2009. Site visits have been undertaken in South Australia, Queensland, Alice Springs and New South Wales. A total of 21 interviews and 14 focus groups have also been conducted. Further site visits, focus groups and interviews are in preparation and will include coverage of Western Australia, the top end of the Northern Territory and Victoria.

There has been significant interest in the project from key stakeholders both in terms of willingness to participate in the various components of the project and also in relation to receiving the findings and any products developed from the project. There has been particular interest in issues around improving/enhancing worker wellbeing. This has also resulted in a number of key stakeholders requesting the project team to work with them on these issues - beyond the parameters of the project. The project clearly highlights the need for greater attention to Indigenous workers' wellbeing and the need for formal, structured attention to this key area.

A common response for AOD-Indigenous workers who have contributed to this project is that they enthusiastically welcome the examination of the issue of worker wellbeing. Some have highlighted that this is the first time in many years of working in the AOD, or a related area, that they have

been asked about their experiences as a worker and about issues that impact on their wellbeing. Most have noted the highly demanding and often stressful nature of their work or work circumstances. A common feature is the 24/7 demands placed on them that extend well beyond any usual or normal work role. Moreover, many respondents have indicated that they have received insufficient training to deal with the wide range of expectations placed on them by both co-workers and their community. This is further compounded by the fact that most have not received training in setting professional boundaries that help other health and human services workers to look after their own mental health. Lack of supervisory and management support was also a common experience that often contributed to worker stress. In addition, clearly defined job descriptions were often not in place and resulted in workers often feeling like they were expected to be all things to all people.

The findings from this project are provisional as the project is not due to conclude until later in 2009. Nonetheless, some consistent patterns have emerged in relation to the sense of relative neglect reported by many Indigenous AOD workers. As highlighted in sections below, recruitment and retention of Indigenous workers is a challenging issue; even more so in regional and remote area of Australia. Workforce shortages are high and difficult to resolve in the short term. This makes strategies to support and maximise the wellbeing of existing staff an even greater imperative. This study highlights the need for further effort to be directed to this issue in a planned and systemic manner.

AOD use among Indigenous Australians is often substantially higher than among non-Indigenous counterparts. The need for well trained Indigenous workers is very high. This demand is unlikely to decrease in the near future as patterns of AOD use among the young remain comparatively high as illustrated in the following section.

2. INDIGENOUS SECONDARY SCHOOL STUDENTS' DRUG USE

Very little data is currently available about the patterns and levels of alcohol and drug use by Indigenous Australians and especially among young Indigenous Australians. To address this gap, NCETA has undertaken an investigation of data that examines the pattern of AOD use by school-aged children by Indigenous and non-Indigenous status. This collaborative investigation between NCETA and the Centre for Behavioural Research in Cancer, Cancer Council Victoria into secondary school students' illicit drug use, involving secondary analysis of the 2005 Australian Secondary Students' Alcohol and Drug survey, found that:

- Indigenous students were 1.27 times more likely to have used any illicit drug in the last year compared to non-Indigenous students (with age, gender, school type (Government, Catholic, Independent), self-rated academic performance, alcohol and tobacco use, socio-economic disadvantage, and language spoken at home controlled for).

- The most commonly used illicit drugs among Indigenous students were cannabis, inhalants, and tranquillisers (see Table 1).

Table 1: Illicit drug use in the last year by School Aged Children Aged 12-17 years by Indigenous and non-Indigenous Status (ASSAD Survey data 2005).

Substance (use in last year)	Indigenous status		
	non-Indigenous (N = 20, 712)	Indigenous (N = 881)	Design-based *F* (df_1, df_2 = 1, 371)
Cannabis	15.2%	28.2%	100.5***
Inhalants	11.8%	19.7%	40.9***
Cocaine	2.0%	7.4%	85.5***
Hallucinogens	2.3%	8.5%	107.5***
Amphetamines	4.2%	11.9%	89.2***
Ecstasy	3.0%	8.5%	61.3***
Tranquillisers	8.8%	17.3%	58.4***
Opiates	1.5%	7.7%	169.8***
Any drug	28.2%	38.7%	45.6***

Note. 'Any drug' refers to use of any of the drugs in the table.
** p < .01, *** p < .001.

The higher rates of illicit drug use among Indigenous students in mainstream schools are consistent with findings from Forero et al.'s (1999) analysis of NSW data from an earlier Australian Secondary Students' Alcohol and Drug survey. Hence, there is a long term pattern of higher use among Indigenous students which provides useful data for benchmarking purposes and from which progress in this area can be gauged.

It is noted that very little has been published in relation to the findings outlined in Table 1. NCETA is currently in the process of preparing a number of documents that report these findings to ensure

that this important information is in the public domain. Improved knowledge and understanding of data, such as that illustrated above, is important for several reasons. It allows benchmarks to be established against which programs can track progress. It allows goals to be set for improvements and it provides an empirical basis for the development of targeted interventions.

3. EDUCATION AND LITERACY

NCETA has also examined recent data on Indigenous student school performance, as there is an established bi-directional relationship between academic performance and risky alcohol use and drug use. Clearly, education and literacy levels are important for a range of important reasons for a young person; not least of which is future life prospects. But, there is also an important link between education level and overall health status and the crucial link between education level and the use of alcohol and other drugs.

In terms of school retention rates, available data indicate that while there was some improvement over the last decade in the proportion of Indigenous students who complete years 10, 11 and 12, Indigenous students still have substantially lower rates of school retention compared to non-Indigenous children (Pink & Allbon, 2008). The retention rate of Indigenous students in Year 10 has risen from 83.3% in 1998 to 90.5% in 2007, while the non-Indigenous student retention rate in Year 10 in 2007 was 99.7% (Pink & Allbon, 2008). For Year 12, the Indigenous student retention rate has risen from 32.1% in 1998 to 42.9% in 2007, while the non-Indigenous student retention rate was 75.6% (Pink & Allbon, 2008). Most Indigenous students (88%) attend Government schools (ABS, 2004); thus, placing the onus of responsibility on the government school system to redress the current imbalance.

Potential factors contributing to the low levels of Indigenous students' school retention rates include availability and accessibility of schools, especially secondary schools, racism at school, parents' negative experiences of schooling, wellbeing of the children (poor health, hunger, hearing difficulties, substance abuse), and the perceived quality and relevance of available schooling (Penman, 2006).

Just over a quarter (26%) of Indigenous people have completed a non-school qualification. The most common qualification was a Certificate (62%). Only limited information is available on the number of Indigenous students in the tertiary sector. Across each state, enrolment of Indigenous students is higher in the TAFE sector than University with the exception of the Northern Territory (see Figure 1).

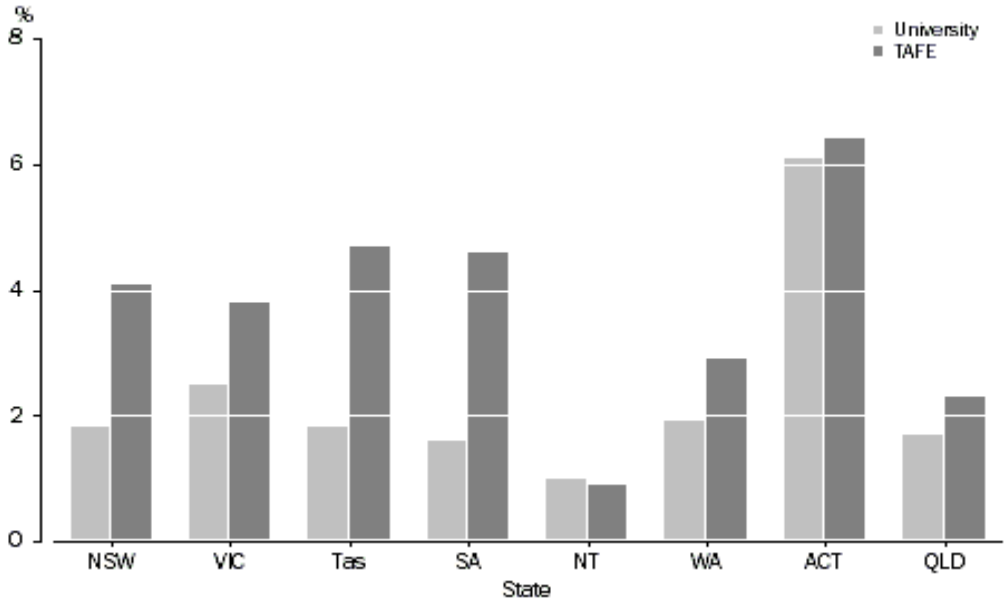

Figure 1. Percentage of Indigenous Population Studying at Tertiary Institutions by State and Educational Institution 2001.
Source: (ABS, 2001).

In both the TAFE and University sectors there is a higher proportion of Indigenous females undertaking post-secondary education than males (ABS, 2006a).

Approximately 12% of Indigenous people aged five years or over speak a language other than English as their main language at home (Pink & Allbon, 2008). However, most (83%) are also proficient in English (Pink & Allbon, 2008). Rates of English literacy tend to be lower among Indigenous Australians compared to non-Indigenous Australians. The lower levels of English literacy are demonstrated in the 2006 literacy and numeracy benchmarks conducted by the Ministerial Council on Education, Employment, Training, and Youth Affairs (MCEETYA, 2006). While 93% of all Year 3 students achieved the 2006 national benchmarks for reading, writing, and numeracy, 80% of Indigenous Year 3 students achieved the reading benchmark, 78% achieved the writing benchmark, and 76% achieved the numeracy benchmark.

The greatest disparity between Indigenous and non-Indigenous students occurred in the Northern Territory. The literacy gap becomes more apparent by Year 7: for reading, 89% of all students achieved the benchmark, while 63% of Indigenous students achieved the benchmark, for writing: 92% of all students achieved the benchmark compared to 74% of Indigenous students, and for numeracy: 80% of all students achieved the benchmark compared to 48% of Indigenous students.

4. EMPLOYMENT OPPORTUNITIES

Employment status and employment opportunities are key factors in the health and wellbeing of individuals and the communities in which they live. Employment status and opportunities are also heavily implicated in the risk of problematic alcohol and other drug use. So, from a prevention perspective, the need to ensure that adequate employment options exist is of fundamental importance.

Just over half (51%) the Indigenous population are in employment (AIHW, 2007). This employment rate is far lower than for non-Indigenous Australians (75%, AIHW, 2007). This is largely due to the greater proportion of Indigenous Australians who are classified as "not in the labour force."[1] As **Table 2** shows, employment is lowest in the Northern Territory, and highest in the ACT. There is no difference in Indigenous employment levels between remote and non-remote areas of Australia (AIHW, 2007).

Table 2: Labour force status of Indigenous persons aged 15-64 years, by state/territory, 2004-05. Reproduced from AIHW (2007)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Labour force status	%	%	%	%	%	%	%	%	%
In the labour force	59	64	66	60	55	61	71	50	60
Employed CDEP	5	4[(a)]	9	21	12	0[(b)]	1[(b)]	24	11
Employed non-CDEP	45	51	46	29	36	48	64	19	40
Total employed	*50*	*54*	*55*	*50*	*48*	*49*	*65*	*43*	*51*
Unemployed	9	9	11	9	7	12	6[(a)]	6	9
Not in the labour force	41	36	34	40	45	39	29	50	40
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

[(a)] Estimate has a relative standard error between 25% and 50% and should be used with caution.
[(b)] Estimate has a relative standard error above 50% and is considered too unreliable for general use.

The majority of Indigenous people are employed as labourers and community and personal service workers (see Table 3). These positions are predominately located within state and federal government, health and community services and the retail sector (ABS, 2006a).

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

Table 3: Indigenous Employment by Occupation. Source: (ABS, 2006b).

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

5. EDUCATION AND TRAINING OPPORTUNITIES

While there are often calls for further training to be made available for particular groups, it is also often difficult to locate with any degree of precision the range of courses and training options that are currently available. NCETA recently undertook an extensive review and critique of AOD, Mental Health, Co-morbidity and Psychology training courses (Roche, Duraisingam, Wang, & Tovell, 2008).

It is encouraging to note that there is a growing and substantial level of education and training courses being offered to Indigenous workers who are employed across the alcohol and other drug (AOD), co-morbidity (CM) and mental health (MH) sectors. As part of that review, 80 accredited courses were identified as relevant for Indigenous workers employed in the health and human services.

Courses were identified as 'Indigenous-related' if they were either specifically designed for Indigenous students, promoted as being suitable for Indigenous health workers, contained content relevant to Indigenous issues, or if the curriculum material specified 'an understanding of Indigenous culture' as an entry requirement.

The proportion of Indigenous-related courses in comparison to the total number of accredited AOD, mental health and co-morbidity courses that are offered across Australia is shown in Figure 2. As a proportion of all courses, more courses focused on Indigenous AOD issues (n=63, 79%) than mental health issues (n=14, 18%). Three Indigenous-related courses were CM courses.

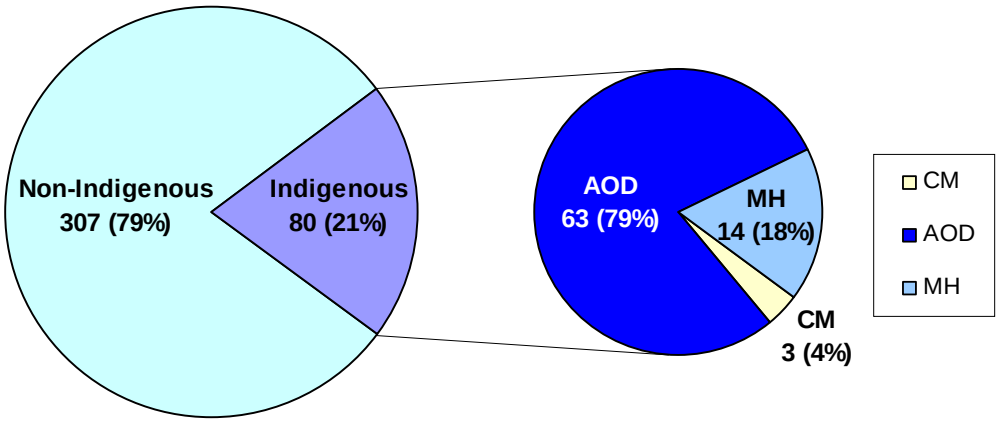

Figure 2: Proportion of Indigenous-Related Accredited AOD, MH and CM Courses

Of the 80 courses that were identified as being relevant for Indigenous workers, 33 were defined as being 'Indigenous-specific' as they were specifically designed for Indigenous students/workers and/or were offered by Indigenous training providers.

Figure 3 shows the distribution of the 33 Indigenous-specific accredited courses by content area. More than half were AOD courses (n=20, 61%), approximately a third were MH courses (n=12, 36%) and one was a CM course.

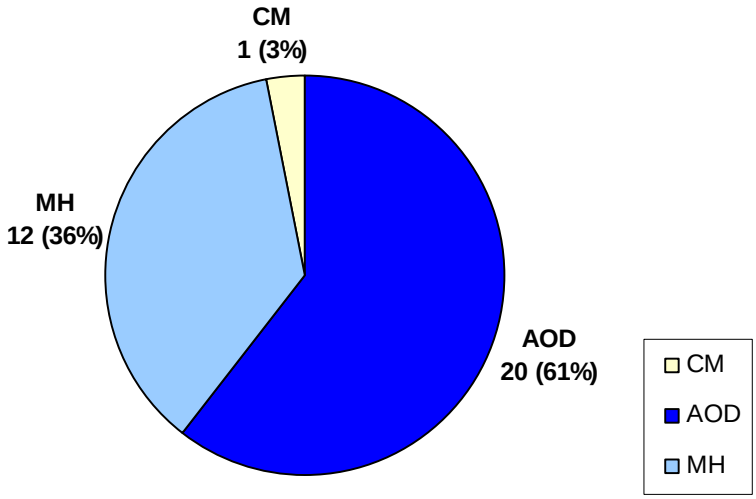

Figure 3: Accredited Indigenous-Specific Courses Available in Australia

Twelve institutions provided the 33 accredited Indigenous-specific courses (see Figure 4). Registered Training Organisations (RTOs) accounted for half of all training institutions and they also provided 25 of the 33 available courses.

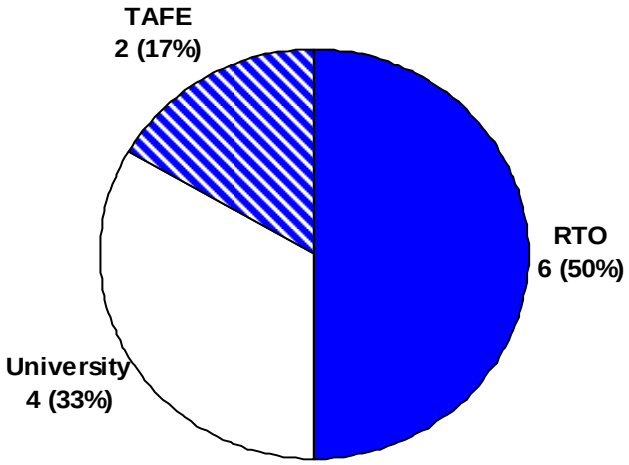

Figure 4: Number and Types of Institutions Offering Accredited Indigenous-Specific Courses

The majority of the Indigenous-specific courses were located in NSW (n=14) and Queensland (n=8) (see Table 4).

Table 4: Distribution of Indigenous-Specific Courses by Location of Institution

State/Territory	Number of Courses (%)
NSW	14 (42%)
NT	6 (18%)
QLD	8 (24%)
SA	2 (6%)
WA	3 (9%)
Total	**33 (100%)**

More than half of the Indigenous-specific courses identified were offered at the Certificate III to Certificate IV level (n=21) (Table 5).

Table 5: Accredited Indigenous-Specific Courses by Award Level

Award Level	Number of Courses (%)
Statement of Attainment	1 (3%)
Certificate III	9 (27%)
Certificate IV	12 (36%)
Diploma	3 (9%)
Bachelor	1 (3%)
Graduate Certificate	2 (6%)
Graduate Diploma	1 (3%)
Masters	1 (3%)
Other*	3 (9%)
Total	**33 (100%)**

**Other: unable to determine award level.*

From a rural and remote perspective, key issues that were identified as part of the review of education and training courses included:

1. workers who are located in rural and remote areas are provided with insufficient opportunities for training in their own region,
2. staff working in non-government organisations find the cost of travel to attend training is often prohibitive.

In addition, distance learning was not always considered to be an appropriate alternative to face-to-face training because of the requirement to develop specific skill sets which could only be achieved by personal attendance.

6. Indigenous Employment in Health and Human Services

Relative to the size of the Indigenous population, there are comparatively few Indigenous people employed in the health and human services fields. Indigenous health professionals comprised only 1% of the total health workforce in 2001 (Pink & Allbon, 2008). This contrasts with the proportion of the Australian population who are Indigenous, which is 2.5% (ABS, 2007).

The total number of Indigenous health workers is estimated at 9,342 (Australian Government Department of Health and Ageing, 2008). There is clearly a large shortfall in the number of available Indigenous healthcare workers. This places an excessively heavy load on the limited number of available workers. This disparity is further illustrated in an examination of the ratio of Indigenous staff to Indigenous clients at the Royal Darwin Hospital where 60% of inpatient beds are occupied by Indigenous people, but only 3% of the hospital's 1300 staff are Indigenous (Bauert, 2005). This results in an excessive load for most Indigenous workers.

The disproportionately heavy workload of Indigenous healthcare workers is especially problematic for Indigenous doctors and other health workers who choose to work in Aboriginal Community Controlled Heath Organisations so they can support their community (Panaretto & Wenitong, 2006). The total number of Indigenous doctors is relatively small: for example, in 2005, the number of Indigenous doctors working in Aboriginal Community Controlled Heath Organisations was estimated to be between eight and ten (Panaretto & Wenitong, 2006).

At June 2007, there were 248 Indigenous-specific healthcare delivery organisations, 198 of which were Aboriginal Community Controlled Health Organisations (Australian Government Department of Health and Ageing, 2008). The National Aboriginal Community Controlled Health Organisation (NACCHO, 2006) estimates that in its 128 affiliate health organisations, 70% of employees are Indigenous, including approximately 700 Aboriginal Health Workers.

The majority of Indigenous workers in the health sector are employed as Aboriginal Health Workers or nurses. The role of Aboriginal Health Workers is not consistent across jurisdictions and organisations, and Aboriginal Health Workers may be required to undertake a range of tasks including clinical, transport, liaison, or advocacy functions (Australian Government Department of Health and Ageing, 2008; Genat et al., 2006). Aboriginal Health Workers often serve multiple roles including having to act as 'cultural brokers', health educators, mental health and AOD counsellors, community health action agents, and providers of basic personal medical care (Genat et al., 2006).

In general, there is a need for greater attention to be directed to the recruitment and retention of Indigenous workers in general; and improved role descriptions with greater precision in terms of the range of tasks to be undertaken, particularly for Aboriginal Health Workers.

7. INDIGENOUS WORKFORCE NEEDS

In addition to the above, there is a range of other complex issues with which the Indigenous AOD workforce has to contend. These include the following.

1) Rural/remote issues
For rural and remote AOD organisations or Aboriginal Controlled Community Health Services, finding and recruiting appropriate and qualified staff can be very difficult with remote workers facing isolation, fatigue, harassment, lack of privacy and unreal expectations. The Australian National Council on Drugs' report 'Rural and Regional Alcohol and Other Drugs Consultation Forum' (ANCD, 2001) concluded that a contributory factor to difficulties experienced by AOD workers in the rural and remote sector was the high level of community need and the limited number of service providers.

2) Indigenous client base issues
Dealing with Indigenous clients raises unique and important challenges for Indigenous and non-Indigenous workers. These include:

- the need for community acceptance
- literacy and language issues
- stress arising from dealing with often complex and emotional presentations.

Community acceptance is a crucial goal for health services, but can be difficult to achieve. In a report on the Yolngu communities in Arnhem Land, Trudgen (2000) noted that if health workers do not have traditional authority then their acceptance by the community is jeopardised and they are unable to adequately help community members.

A decade ago, Atkinson and Jessen (1999) reported on progress achieved in terms of community acceptance by AOD services in the Northern Territory through the Living With Alcohol program. This program was led by community members concerned with the misuse of alcohol in their communities. The project was based on community development principles, and was built on identified community needs. Under the Living With Alcohol program, community and government worked together to identify priorities and develop action plans to address substance misuse. The project operated within a consultative framework that recognised community elders, traditional owners, senior family members, and the community council, as the people who are the decision-makers within the community.

This approach recognised the value of community representation and treated the community with respect. It also acknowledged that it is the community who must live with substance misuse. Indigenous AOD workers were employed from the community, thus providing jobs as well as increasing the degree of empowerment exercised by local residents over this issue. Whilst not without some problems, this initiative nonetheless provided community representatives and elders input into strategies to address substance misuse in their community.

3) Indigenous health workforce issues
The small Indigenous health workforce often lacks formal qualifications and, in some instances, lacks support and respect from colleagues. Previous work has found that workers often feel disempowered, disgruntled and disrespected (Hecker, 1997). Issues of funding and managerial support, wage disparity, training, gender balance, career paths, and work demands may also contribute to stress and risk of burnout among this workforce.

4) Lack of Managerial Support
Lack of managerial support has been identified as a factor that may further disenfranchise Indigenous workers (Whiteside, Tsey, McCalman, Cadet-James, & Wilson, 2006). Pearce and Savage (2001) found that Indigenous drug and alcohol workers often encounter uncertainty

regarding their status in the workplace, and that they experience a lack of support and access to training opportunities, and a lack of clarity in terms of roles and responsibilities.

5) Wage Disparities
The available literature indicates that there are wage disparities between Indigenous and non-Indigenous workers, and between workers in Aboriginal controlled community health services and workers in mainstream services (Curtin Indigenous Research Centre, Centre for Educational Research and Evaluation Consortium, & Jojara and Associates, 2001; Panaretto & Wenitong, 2006). In a comparison of 12 selected community service occupations (Australian Services Union, 2007), Aboriginal health workers received the lowest average weekly pay ($547.76): lower than children's care workers (second lowest at $570.09), social workers ($909.89), welfare and community workers ($877.54) and counsellors ($905.95).

Wage disparity has been reported by Aboriginal Health Workers in South Australia and Queensland as a major issue (Curtin Indigenous Research Centre et al., 2001; Panaretto & Wenitong, 2006). Aboriginal Health Workers in South Australia maintain that the disparity between the non-Government and Government sectors needs to be addressed as the inequity of the difference in awards was frustrating and confusing (Curtin Indigenous Research Centre et al., 2001). General Practitioners working for Indigenous community controlled health services also reported dissatisfaction with their remuneration levels; indicating that in some instances they would be better paid working for a mainstream organisation rather than an Aboriginal controlled community health service (Panaretto & Wenitong, 2006).

6) Culturally Appropriate Training
It is imperative that training for Aboriginal Health Workers is adequate and delivered in a culturally appropriate style and context. In some circumstances, Indigenous AOD training has been conducted in an *ad hoc* manner (Curtin Indigenous Research Centre et al., 2001). Aboriginal Health Workers in South Australia have argued that clarifying workers' roles and requirements is a fundamental step in the professional development and capacity building process (Curtin Indigenous Research Centre et al., 2001).

7) Professional Acceptance
A lack of professional acceptance by peers creates a substantial divide between Indigenous and non-Indigenous staff (Parker, 2003). Rural and remote Aboriginal Health Workers have expressed frustration at not being accepted by other health professionals (Hecker, 1997). Many health workers have reported that they were not treated or accepted as professionals and were instead used as 'cultural brokers', only used when absolutely necessary, and the rest of the time ignored (Curtin Indigenous Research Centre et al., 2001). Pearce and Savage (2001) maintain that in order to adequately address Indigenous AOD workforce issues in relation to career paths, systems change needs to be implemented.

When workers feel as though no career advancement is possible, they are more likely to become disenchanted and many leave an organisation (Duraisingam, Pidd, Roche, & O'Connor, 2006; Skinner, Freeman, Shoobridge, & Roche, 2003). Limited options for career development may result in the loss of the limited number of qualified and experienced staff.

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