NIDAC online consultation:

A professional body for Aboriginal and Torres Strait Islander Alcohol and Other Drug Workers
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Background

Currently, there are no professional bodies specifically for Aboriginal and Torres Strait Islander alcohol and other drug (AOD) workers. A number of professional bodies exist for Aboriginal and Torres Strait Islander health workers, but these may not be relevant for AOD workers in particular, and AOD workers may not be eligible to join them.

At both the inaugural and second National Indigenous Drug and Alcohol Conferences, a large number of delegates expressed the view that there should be a dedicated professional body. At the second conference in 2012, a resolution was made "that NIDAC explores the establishment of a national Aboriginal and Torres Strait Islander workforce and organisational representative body".¹

To begin exploring this, NIDAC developed and released an online survey, seeking the views of Aboriginal and Torres Strait Islander AOD workers on national representation. The survey focused primarily on questions surrounding a professional body which could represent individual workers directly, and also asked for some information on organisational representation. It was available online through Survey Monkey during February – March 2013, and was advertised through the NIDAC mailing list, the update@adca-lists listserve, and the contact lists of NIDAC members.

Respondents

There were 169 responses to the survey. Just over 75 per cent of respondents were Aboriginal or Torres Strait Islander. Most of this summary focuses on the responses from Aboriginal and Torres Strait Islander respondents, and responses of non-Aboriginal and Torres Strait Islander respondents are discussed in the penultimate section.

Among the group of 126 Aboriginal and Torres Strait Islander respondents, 94 per cent were Aboriginal, four per cent were Torres Strait Islander, and two per cent were both Aboriginal and Torres Strait Islander. Fifty six per cent of respondents were female and 44 per cent were male. Fourteen per cent of respondents were aged over 55, 29 per cent were aged between 46–55, 34 per cent were aged between 36–45, 15 per cent were aged between 26–35, and 7 per cent were aged between 20–25. No respondents were under 20 (Figure 1).

Thirty-six per cent of respondents worked in capital cities; nine per cent worked in other major cities (over 100,000 people); 25 per cent worked in regional centres (25,000–99,999 people); 15 per cent worked in rural areas (5,000–24,999 people), and eight per cent worked in remote areas (less than 5,000 people). Thirteen per cent worked in rural and remote outreach, and five per cent worked at multiple sites (Figure 2).

Forty per cent of respondents worked in NSW; 11 per cent in Victoria; 20 per cent in Queensland; eight per cent in South Australia; nine per cent in Western Australia; eight per cent in the Northern Territory; two per cent in Tasmania, and three per cent in the ACT (Figure 3).
These results were largely comparable with another recent survey of this target population, the *Indigenous AOD Workers’ Wellbeing, Stress and Burnout Survey* undertaken by the National Centre for Education and Training on Addiction in 2008 (NCETA).\(^2\) Notable exceptions were that the NIDAC survey had higher representation of workers from New South Wales (40 per cent rather than 21 per cent) and lower representation from Western Australia (nine per cent rather than 23 per cent); and lower percentages of respondents indicated working in rural and remote areas (though this may have been due to the NIDAC survey requiring respondents to select only one location, while NCETA’s survey enabled selection of multiple locations).

**Respondents’ organisations**

The next section of the survey asked for information on the organisations for which respondents worked.

Twenty-three per cent of respondents worked at an Aboriginal community-controlled health organisation (ACCHo) or medical service; two per cent worked at an Aboriginal-specific residential rehabilitation service; five per cent worked at a non-residential Aboriginal community-controlled AOD service; five per cent worked at an other Aboriginal community-controlled organisation; 10 per cent worked at a non-Aboriginal non-government organisation (NGO) providing Aboriginal-specific AOD services; 17 per cent worked at an AOD NGO that serviced the general community; 12 per cent

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worked at a non-Aboriginal community health organisation; and seven per cent worked at a non-Aboriginal medical service or hospital. Respondents could enter their organisation type if not listed among the above, which revealed that a further 11 per cent of respondents worked for government, two per cent worked for a health network, and two per cent for another community service. Among ‘other’ organisations listed by the remaining four per cent of respondents were a Medicare Local, and other (unspecified) NGOs (Figure 4).

Twenty-two per cent of respondents stated their agency provided solely AOD services, 10 per cent provided mostly AOD services, and 68 per cent provided a range of services.

Respondents indicated which AOD services their working roles involved (Figure 5). Seventy-one per cent involved community education and information; 65 per cent involved AOD case management and support; 64 per cent involved AOD assessments and referrals; 54 per cent involved AOD counselling; 52 per cent involved AOD outreach support; 50 per cent involved prevention; 43 per cent involved family support services; 34 per cent undertook project work; 27 per cent involved NSP services; 26 per cent involved aftercare or ongoing care; 21 per cent involved medical services; 18
per cent involved detoxification/withdrawal management; 18 per cent involved screening; 18 per cent involved pharmacotherapy; and 14 per cent involved residential rehabilitation. Other services listed as being involved in respondents’ working roles included supporting outreach clinicians, health promotion, brief interventions, community building, smoking cessation programs, Aboriginal workforce development, linking clients to other services, AOD training and cultural awareness, and AOD support to mental health services.

Seventy-seven per cent of respondents were employed on a permanent basis, 20 per cent were on contracts, three per cent were casual, and one per cent were volunteers.

Twenty per cent of respondents had worked in the AOD field for less than a year, 42 per cent for between one and five years, 12 per cent for between six and ten years, 23 per cent for between 11 and 20 years, and three per cent for more than 20 years (Table 1).
Table 1: Length of time respondents had worked in the AOD field (per cent)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>20</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>42</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>12</td>
</tr>
<tr>
<td>11 – 20 years</td>
<td>23</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>3</td>
</tr>
</tbody>
</table>

Respondents’ qualifications

Respondents were asked about their education, and educational requirements for their current work.

Two per cent of our sample indicated their highest level of education was primary school completion, and five per cent indicated completion of year 10. Two per cent had completed a Certificate II; nine per cent had completed a certificate III; 22 per cent had completed a certificate IV; 28 per cent had a diploma; two per cent had an advanced diploma; 17 per cent had an undergraduate or honours degree; and 12 per cent had a postgraduate qualification (Table 2).

Twenty-eight per cent of respondents’ qualifications were in AOD, four per cent were in social work, seven per cent were in counselling, and 19 per cent were in health. Forty-four per cent of qualifications (this figure includes school completions) were in ‘other’ fields; those fields of study which respondents specified were:

- Certificate IV in: community services; human services training and assessment.
- Diploma in: Aboriginal and Torres Strait Islander primary healthcare (2); primary healthcare; music; education; child, youth and family interventions.
- Advanced diploma in: primary healthcare.
- Undergraduate/honours degree in: primary education; sociology; Indigenous studies and wellbeing; mental health; education; psychology.
- Postgraduate degree in: public health.
Table 2: Highest level of education completed (per cent)*

<table>
<thead>
<tr>
<th></th>
<th>AOD</th>
<th>Social work</th>
<th>Counselling</th>
<th>Health</th>
<th>Completed / Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 10</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Year 12</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Certificate II</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Certificate III</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Certificate IV</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Advanced diploma</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>University degree</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>(Undergraduate or Honours)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-graduate</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>4</td>
<td>7</td>
<td>19</td>
<td>44</td>
<td>100</td>
</tr>
</tbody>
</table>

* Errors due to rounding

A number of respondents reported holding several qualifications, either in one discipline or across related disciplines (Table 2 records only the highest level qualification). It is also worth noting that some respondents stated (in the additional area provided to note field of study) that qualifications for their current work consisted of personal experience and/or professional work experience.

Forty-one per cent of respondents reported their study had been full-time, 36 per cent that it was part-time, and others studied a combination of full- and part-time. Those with certificates were slightly more likely to have studied part time (50 per cent) than the full sample, or than those with diplomas or degrees (43 per cent).

Thirty-seven per cent of respondents stated that they had not been required to have formal qualifications for their current work. Five per cent reported that they had been required to have completed Year 10, and three per cent to have completed Year 12. One per cent had been required a completed Certificate II, 17 per cent had required a completed Certificate III, and 31 per cent had
required a completed Certificate IV. Ten per cent had needed to have a diploma, 17 per cent needed an undergraduate degree, and two per cent needed a postgraduate degree (Figure 6).

![Figure 6: Qualifications required by respondents' employers (percentages)]](image)

Responses which specified what field of study had been required included: AOD (2), community services, early childhood, health promotion, legal qualifications, Aboriginal and Torres Strait Islander primary healthcare, social work (2), and youth work.

**Current professional body membership**

A series of questions were asked about membership of professional bodies. Twenty-one per cent of respondents (n=21) stated they were members of a professional body, and 79 per cent stated they were not.

Of the 21 Aboriginal and Torres Strait Islander individuals who were members of a professional body, five stated they were members of the National Aboriginal and Torres Strait Islander Health Worker Association (NASTIWH), one was a member of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), and three were members of Indigenous Allied Health Australia (IAHA).

Other respondents entered the following professional body memberships: Telkaya network (2), First Nations Congress, Victorian Alcohol and Drug Association (VAADA), NSW Aboriginal Drug and Alcohol Network (ADAN), the Australian Community Support Organisation’s Community Advice and Treatment Service (ACSO COAT), and a professional IT body. As some of these answers appear to
refer to AOD services and other bodies that are not focused on representation of workers, it is possible that the question may not have been posed clearly enough, and that fewer than 21 per cent of respondents were members of professional bodies which have this focus.

Respondents were also asked whether they had attempted, but been unable, to join a professional body. Thirteen per cent answered ‘yes’ and 87 per cent answered ‘no’. Those who answered ‘yes’ were asked a follow-up question regarding the difficulties they had experienced. Among the 10 responses to this question, 40 per cent stated there was no appropriate body, 20 per cent stated that the relevant bodies required qualifications they did not have, and 20 per cent stated that the relevant bodies did not recognise qualifications they did have.

Potential professional body features and setup

The next section explored issues relating to the setup of a potential professional body to represent Aboriginal and Torres Strait Islander AOD workers.

In response to a question on whether NATSIHWA membership, if it were extended to AOD workers who do not have a qualification in primary health or clinical practice, would be of benefit to Aboriginal and Torres Strait Islander AOD workers, 69 per cent of respondents stated ‘yes’, and 31 per cent stated they were not sure. There were no negative responses, although one response given to this question in text stated: “AOD work in Aboriginal communities is very specific. It can't be integrate [sic] in 'general health' unless they have a specific arm for AOD workers in particular”. This may indicate some limitations on NATSIHWA membership for Aboriginal and Torres Strait Islander AOD workers. It should be noted, however, that the majority of respondents skipped this question, perhaps due to its length (there were only 13 respondents).

Respondents were asked whether they thought a professional body specifically for Aboriginal and Torres Strait Islander AOD workers would be more effective than membership of existing bodies such as NATSIHWA. 70 per cent answered yes, four per cent answered no, and 26 per cent were not sure. Interestingly, of the five respondents who indicated they were members of NATSIHWA, four answered ‘yes’ to this question. Respondents were invited to provide the reasons for their answers. Among reasons offered by those answering ‘yes’ were:

- A body with a primary focus on AOD work would be of value and use in a number of ways and for a number of reasons, including:
Issues of support, understanding, and sensitivity can differ in the AOD field to those for health more generally;

- Such a body would itself have a better understanding of AOD specifically;
- AOD is itself diverse, implying a need for focus;
- The importance of addressing AOD issues to support Indigenous health more generally means this specific focus is important;
- There is a need for more networking opportunities and for discussion of AOD issues in different communities/workplaces;
- It would help to build a professional sense of belonging among Aboriginal and Torres Strait Islander AOD workers and support definition of roles;
- There are not currently enough professional development/networking opportunities/training/support specifically for Aboriginal and Torres Strait Islander AOD workers;
- It would provide the opportunity to develop and implement Aboriginal and Torres Strait Islander AOD-specific service standards.

- There is a need for recognition of AOD as a distinct specialty by other health professions and a danger of AOD being ‘lost’ among other specialties.
- Cultural consideration and sensitivity is important for treating AOD problems, and a separate professional body could better support this.
- Such a body could support better recognition by employers of the value of AOD qualifications.

Four respondents answered ‘no’ to this question. The main reason given was the need for an integrated approach to health.

Among those who were unsure, responses in text indicated that respondents would like to have further discussion and information on this issue.

The next question asked what sort of organisation respondents thought a professional body should be, with choices offered of ‘an independent body, funded by membership fees’ (31 per cent), ‘a government-funded body’ (59 per cent), and ‘a competitive grant-funded body’ (19 per cent).

Further thoughts on what sort of organisation a professional body should be that respondents provided included:

- The need to maintain the independence of such a body, which was mentioned by many of the responses. Considerations in this regard included: the need for such a body to be able to
engage with government; the possibility of political agendas influencing the body through funding structures; what conditions might be imposed along with government funding; and the value and importance of having a body for workers that remained in their control.

- Sustainability of the body.
- That funding decisions would depend on other features of the body yet to be decided (objectives, outcomes, etc).
- The use of periodic membership fees to help fund the body independently.
- The possibility of partial government funding.
- Having staff / management elected by member voting, with a board of directors or other appropriate governance structure.
- Initial government funding working towards independence.
- Other organisations that might be used as models mentioned were the Telkaya network, and Allied Health Professionals Australia.

Twenty-six per cent of respondents indicated that they would only join such a body if membership were free. A further 24 per cent stated they would pay $20 per year, 29 per cent stated they would pay $50 per year, 14 per cent stated they would pay $100 per year, and seven per cent stated they would pay $200 per year (Table 3).

<table>
<thead>
<tr>
<th>Table 3: Respondents' indications of the most they would be prepared to pay for professional body membership (percentages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would only join if membership is free</td>
</tr>
<tr>
<td>$20 per year</td>
</tr>
<tr>
<td>$50 per year</td>
</tr>
<tr>
<td>$100 per year</td>
</tr>
<tr>
<td>$200 per year</td>
</tr>
<tr>
<td>More than $200 per year</td>
</tr>
</tbody>
</table>

The final question in this section asked what roles respondents thought a professional body should fulfil, with a number of suggested answers listed (Figure 7). Ninety-three per cent that it should represent and advocate for the interests of Aboriginal and Torres Strait Islander AOD workers; 86 per cent indicated the body should provide and distribute information on practice; 84 per cent that it should contribute to workforce development; 82 per cent that it should provide support networks; 78 per cent that it should provide practice guidelines; 77 per cent that it should develop
accreditation standards; 73 per cent that it should distribute notices of news and events relevant to the sector; and 70 per cent that it should develop professional conduct codes.

Respondents could supply further information, and other proposed roles for a professional body included:

- qualifying workers who have experience but no educational qualifications;
- seeking to ensure culturally appropriate services and reducing/eliminating racist attitudes;
- acting as a training organisation;
- serving as an information pool for mentoring and supervision;
- facilitating (local) men’s and women’s health groups;
- liaising with service managements on behalf of members;
- study and professional support; and
- linking members to other support networks.
Organisational representation

Although the survey focused on a professional body for individual worker representation, some questions relating to organisational representation were included.

Forty-four per cent of respondents indicated that their organisation was a member of an organisational body. Twenty per cent indicated they were not, and 36 per cent were not sure.

Figure 8: Respondents indicating membership of their agencies' organisational representative body membership
Among the respondents who did know, the following bodies were indicated: NACCHO (29 per cent); ADCA (37 per cent); ATCA (3 per cent); ADAC (3 per cent); AH&MRC (11 per cent); NADA (8 per cent); ADAN (11 per cent); QAIHC (16 per cent); QISMC (8 per cent); QNADA (8 per cent); AHCWA (3 per cent); WANADA (5 per cent); SANDAS (3 per cent); VACCHO (13 per cent); ATDC (3 per cent); ATODA (3 per cent); and others 13 per cent (Figure 8).

Respondents were asked whether they thought there should be a dedicated national body to represent Aboriginal and Torres Strait Islander AOD organisations, as well as individual workers. Seventy-eight per cent said ‘yes’, seven per cent said ‘no’ (57 per cent of these had indicated their organisations were members of other representational bodies), and 14 per cent were not sure.

Among those answering ‘yes’, reasons given included:

- The need to support both organisations and workers
- The value of a national organisation run by Aboriginal and Torres Strait Islander people
- Representation of organisations could be undertaken by a separate arm of the body
- Workers may lack any support mechanisms if there are issues with management at their organisation

Among those answering ‘no’, reasons given included:

- A national body would have limitations in representing organisations, given differing local needs, and would need independence
- Representation could be achieved through NATSIHWA with altered membership rules or structure
- Workers may move between organisations and should be able to take their membership with them

Only one ‘unsure’ respondent provided further detail:

- “I see the value in each state having a peak body then delegates representing their states on a National Forum however a National body could fail to have time to realise the unique problems each small corner of each community and misrepresent these communities.”

Respondents were then asked whether they thought that a body to represent organisations should be separate to that for representing workers. Forty-two per cent said ‘yes’, 25 per cent said ‘no’, and 33 per cent were ‘not sure’.
Among those who said ‘yes’, reasons given included:

- Organisations and workers often have different viewpoints and needs (this was noted in many of the responses)
- Workers need a separate organisation as separation would support impartiality
- Separation could mean the body could better address the interests of Aboriginal and Torres Strait Islander AOD workers who work within mainstream services
- Separation of representation would enable a broader worker experience to feed into the body, while organisations would be more focused on issues faced in their location

Among those who said ‘no’, reasons given included:

- One body could be more efficient and streamlined, less expensive
- Workers could be represented through their organisation
- Bodies would likely do largely the same things so centralising them is more appropriate

One ‘unsure’ response noted that workers and organisations need different kinds of support, but suggested that separate representations might work under the same central body. Similarly, one ‘yes’ response suggested that individual members could feed input into a more general national body.

Other comments

Lastly, respondents were given the opportunity to provide further comments about these topics. Several respondents here expressed the need for some representational body to be formed, and the pride and respect that they would associate with it. Others noted: that there is a need for accountability, transparency, and upholding of values and principles in any such body; and the need for focus in such a body and passionate staff.

Respondents who were not Aboriginal or Torres Strait Islander

Forty-one respondents were not Aboriginal or Torres Strait Islander. Thirteen of these respondents indicated that they worked for an ACCHO, an Aboriginal-specific or controlled AOD service, or a non-Aboriginal NGO providing Aboriginal-specific AOD services. Sixteen worked for non-Aboriginal AOD
or health organisations. Others indicated that they worked for Government, in corrective services or crime prevention, and in an ‘Indigenous welcome’ residential facility.

While recognising the small sample size, some differences are noted in these respondents’ answers. A higher proportion of these respondents indicated they had under- or postgraduate degrees (65 per cent) than Aboriginal and Torres Strait Islander respondents (29 per cent). They were also more likely to hold positions that required under- or postgraduate degrees (42 per cent compared with 19 per cent), and less likely to hold positions that did not require any formal qualifications (11 per cent compared with 37 per cent).

Members of this group were more likely to belong to a professional body (51 per cent compared with 20 per cent). Professional bodies to which these respondents stated they belonged included the Australasian Professional Society on Alcohol and Other Drugs (APSAD), Australian Association of Social Workers (AASW), Drug and Alcohol Nurses of Australia (DANA), ADCA, Western Australian Service User’s Association (WASUA), Nurses Registration Board, Australian Professional Counsellors, Telkaya, Australian Nursing Federation, Australian Smoking Cessation for Professionals Association, Australian Health Promotion Association, Human Factors and Ergonomics Society of Australia, Safety Institute of Australia, and the Australian Counsellors Association. (Again, respondents included peak and other bodies here, perhaps reflecting lack of clarity in the question).

The proportion of respondents who had unsuccessfully attempted to join a professional body was the same as among Aboriginal and Torres Strait Islander respondents (13 per cent). Although there were few responses to the question about why they had not been able to join a body, two respondents noted that they had been unable to do so because they were not Aboriginal or Torres Strait Islander.

Sixty per cent of this respondent group thought that membership of NATSIHWA would be beneficial for Aboriginal and Torres Strait Islander AOD workers, with 40 per cent unsure. Thirty-nine per cent of respondents thought that a professional body specifically for Aboriginal and Torres Strait Islander AOD workers would be more effective than membership of existing bodies, 14 per cent thought it would not, and 47 per cent were unsure. Reasons given for these answers were similar to those raised by Aboriginal and Torres Strait Islander respondents, as discussed above. Concerns about the proliferation of different bodies in particular were expressed, but other answers noted that there would be important outcomes serviced by making the body specific to AOD, as well as to Aboriginal and Torres Strait Islander membership, with some responses noting that the body may not be useful otherwise.
A higher proportion of non-Aboriginal or Torres Strait Islander respondents thought that the body should be independently funded (57 per cent compared to 31 per cent), and reasons for responses here again echoed those discussed above, with recognition of the needs for both independence and sustainability. One response to this question suggested that there would be a value in having membership open to non-Aboriginal or Torres Strait Islander people.

A lower proportion of non-Aboriginal and Torres Strait Islander respondents than Aboriginal and Torres Strait Islander respondents (52 per cent compared to 78 per cent) stated that there should be a dedicated national body for Aboriginal and Torres Strait Islander organisations, as well as individual workers. Again, reasons given for these responses mainly echoed those noted above. Some respondents may have interpreted this question as relevant to whether or not the organisation would be Aboriginal and Torres Strait Islander-specific, rather than worker/organisation specific, noting the need for Aboriginal and Torres Strait Islander workers to have more of a voice in the sector, to represent their interests as well as to best meet the needs of the communities they service.

**Conclusions**

This survey was intended as a consultation survey and we recognise that it is unlikely to be representative of all Aboriginal and Torres Strait Islander AOD workers. Nonetheless, the information collected on respondents’ organisations and working activities indicate that they represented perspectives from a range of different organisation types and service modalities.

Overall, survey responses show a high level of support for establishing a dedicated professional body for Aboriginal and Torres Strait Islander AOD workers, with responses elaborating a range of important roles it could play, and outcomes it could promote. There was also support for establishment of a peak body representing organisations, although many organisations were already members of other peak bodies, and reasons to focus on individual representation were given.

These overall findings affirm the feedback that had been provided at both the inaugural and 2\textsuperscript{nd} National Indigenous Drug and Alcohol Conferences and support NIDAC in progressing the establishment of a professional body for Aboriginal and Torres Strait Islander AOD workers, on behalf of the workers.
The survey answers have also identified a range of other considerations for NIDAC to address in moving forward with the establishment of a national Aboriginal and Torres Strait Islander workforce and/or organisational representative body:

- While the majority of respondents did have formal qualifications – in fact a significantly higher proportion held qualifications than were apparently required to by employers – some workers held no formal qualifications and noted the relevance of personal or work experience to their work in the AOD sector. A potential professional body may need to take this into account, as well as that there are a range of different qualifications that are relevant to diverse roles within the sector.
- Although membership of an existing body such as NATSIHWA may be more beneficial than being unable to join any professional body, there was a perceived need for a body specific to Aboriginal and Torres Strait Islander AOD workers, and many reasons offered to support the idea that this need could not be met (or best met) by a more generalist body. However, there may also be benefits to being able to join more generalist bodies, such as networking with health professionals from other disciplines.
- While many respondents supported having a government-funded body, some issues of independence, and the value of a worker-controlled or operated body, were noted.
- If membership fees are to be charged, cost may be an important consideration.
- Main reasons offered for having separate worker and organisational bodies were the differing interests and perspectives of each, and the inclusion of Aboriginal and Torres Strait Islander AOD workers who are employed by mainstream AOD services. The main reason noted against separate bodies was that of efficiency.
About NIDAC

The National Aboriginal and Torres Strait Islander Drug and Alcohol Committee (NIDAC) was established in 2004 by the principle advisory body to the Prime Minister and the Australian Government, the Australian National Council on Drugs (ANCD), to provide advice to the ANCD and government on addressing Aboriginal and Torres Strait Islander drug and alcohol issues in Australia.

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