WORKFORCE DEVELOPMENT:
Our National Dilemma

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Australia, like many other developed and developing countries around the world, is struggling to find ways to best manage alcohol and drug related problems. Over the past one to two decades important advances have been made in terms of our understanding of the multiple factors which contribute to alcohol and other drug (AOD) problems and which may be applied to their resolution. We can now offer better responses from health and law enforcement, and indeed across the full gamut of human services interventions. However, one area that remains substantially under developed is AOD workforce development. Scant attention has been directed to ways to ensure that the responses we develop stem from, and are implemented and sustained by, a well informed and highly skilled workforce who operate within supportive environments and systems designed to sustain and optimise efforts.

This paper locates workforce development issues within the broader social and cultural context of rapid change, health inequities, social dislocation, and other problems/issues (eg hepatitis C, HIV/AIDS, mental health, early childhood development) as it is increasingly evident that "silo'ed" approaches will always be limited and need to be eradicated or at least minimised. A broad and comprehensive approach to our systemic responses to AOD issues, underpinned by an orientation towards capacity building, is essential for significant progress to be achieved. Improving our understanding of what constitutes workforce development is crucial. It is not just (or even necessarily) about education and training. Workforce development is about sustained systemic change. It requires organisational and structural support and involves policies, guidelines, management support and supervision. Central to workforce development is the translation of research findings into practical strategies, together with strategies that encourage identification, development and dissemination of standards of practice and/or competencies for groups including health, law enforcement, specialist drug, welfare and education staff, and the adoption of evidence-based practice. We ignore these factors at our peril, as indicated by the increasing difficulties in recruiting and retaining staff in AOD generalist and specialist services.

INTRODUCTION

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Some fundamental issues currently confront the alcohol and other drugs (AOD) field in Australia. Prominent among these is the role and scope that exists for an AOD workforce development strategic response. The case presented here is that the provision of high quality responses to AOD issues in Australia has been hampered by a systematic lack of attention to workforce development. To date this has been a largely

neglected and little understood area of endeavour (Single and Rohl, 1997; Baker and Roche, 2002).

At a national level workforce development has generated substantial interest and gained considerable momentum within the past one to two years. This is true in a number of health and human services areas in addition to the AOD field (Roche and McDonald, 2001). For instance, the National Public Health Partnership group has recently released the report A Planning Framework for the Public Heath Workforce (Ridoutt and Wise, 2002) and in early 2002 the report The New Zealand Health Workforce: A Stocktake of Issues and Capacity (Health Workforce Advisory Committee, 2002) was released (also see Hornblow's paper in Section 2 of this volume).

The notion of workforce, and workforce development, is an increasingly common focal point of attention in the public health sector. The Commonwealth Department of Health and Ageing's National Action Plan on Illicit Drugs 2001 to 2002-03 and the National Action Plan on Alcohol, endorsed by the Ministerial Council on Drug Strategy in July 2001, identified workforce development as critical to sustaining the strategies of the Action Plans. The Illicits Action Plan highlights the importance of education and training but also indicates that any sustained change will require organisational and structural support. These include policies, guidelines and management support and supervision. The Illicits Action Plan goes on to explain that education and training must be sustained through the development of policies, protocols, post-training support, supervision, practice and career support.

To achieve the goals of workforce development the following seven steps were highlighted in the Illicits Action Plan:

1. translation of research findings into practical strategies that can be implemented by the workforce
2. strategies to encourage the adoption of evidence-based practice
3. identification, development and dissemination of standards of practice and/or competencies for groups including health, law enforcement, specialist drug, welfare and education staff
4. identification and evaluation of models of practice change that can readily be applied in workplace settings
5. development and implementation of quality education and training programs and resources, including train-the-trainer programs
6. identification and implementation of strategies to support staff and management in the application of strategies to reduce the harm caused by illicit drug use
7. development of expertise to foster and disseminate models of practice change.

While the above is not an exhaustive list of workforce development strategies it offers a good conceptual start.

Illustrations of what constitutes workforce development are also to be found in other areas. For instance, in Britain at present there is a major effort directed at "workforce reform" as one strategy by which to salvage and revitalise the National Health Service (NHS) (Cochrane, 2001). Cochrane holds that:

> *Workplace change is ...aimed at facilitating service change within evidence-based practice, patient-focused service designs and resource effectiveness including addressing the supply problems in the healthcare workforce. It is also building on successful innovation to-date.* (Cochrane, 2001)

It is relevant to note that in the AOD field, very little attention has been directed to the question of workforce recruitment and retention. In very recent times, this oversight has become more evident as many service providers find it increasingly difficult to attract and retain suitably skilled and qualified staff – even when funds are available to make much needed appointments.

Despite increasing interest in workforce development in the AOD field, significant barriers hinder the capacity of policy makers, managers, and frontline workers in the AOD field to transform their enthusiasm into practical and effective workforce development strategies. Two fundamental issues for effective workforce development have yet to be addressed:

1. the lack of conceptual clarity concerning the meaning, implications and operationalisation of workforce development
2. the availability of tools, resources and supports to facilitate the development of practical and effective workforce development strategies.

At a more basic level other questions that require clarification include:

- what is workforce development?
- what does it entail?
- why does it matter?
- how can it be operationalised?

DEFINING WORKFORCE DEVELOPMENT

It is not always immediately clear what workforce development means, what it includes (and excludes), who it involves, why it is important, and in what ways it is different to the traditional notion of education and training. There is a pressing need to develop a "literacy" around the concept of workforce development. The term is not well understood, often used interchangeably (and inaccurately) with "training", and occasionally used as a synonym for workforce planning.

The term workforce development is a broad one used to encapsulate a number of key factors pertaining to individuals, the organisations within which they operate and the systems that surround them. Workforce development is a multifaceted approach which addresses the range of factors impacting on the ability of the AOD workforce to function with maximum effectiveness.

Workforce development has a systems focus. Unlike more traditional approaches, it is broad and comprehensive, and incorporates far more than just education and training of individual frontline workers. The primary aim is to facilitate and sustain the AOD workforce. It does this at different levels, targeting individual, organisational and structural factors.

It entails strategies that influence the environment which in turn impact on:

- training
- work practice
- careers of workers.

Workforce development can involve a wide range of key areas (Health Workforce Advisory Committee, 2002) including the following:

- workforce planning and development
- quality issues, eg evidence-based practice (at the individual, team, organisational, and systems level), clinical governance and credentialing
- environmental trends (eg globalisation, technology, changing consumer knowledge and expectations, labour costs)
- education and training

- service delivery developments
- recruitment
- retention
- workplace environment ("good employer issues")
- workforce capacity
- Indigenous workforce development.

At the most general level, workforce development includes policies, guidelines, management support and supervision, and the legitimisation of initiatives through organisational and structural supports. Its primary aim is to facilitate and sustain developments in the AOD workforce. It targets structural, organisational and individual factors as shown schematically in Table 1.

Table 1: Levels of Workforce Development

LEVEL	DESCRIPTOR	EXAMPLE
Level I Systems	Workforce development aims to improve the functioning of the entire AOD workforce by addressing the systems and structures that shape it. While it includes activities that impact on individuals, its focus is much broader. It involves creating environments and systems that support the full range of workforce development strategies.	Examples of systems and structural factors include: ∉ legislation ∉ policy ∉ funding ∉ recruitment and retention ∉ resources ∉ support mechanisms ∉ incentives
Level II Current Workers	At the individual level, workforce development encompasses methods of improving individual professional functioning. It means ensuring that opportunities to develop individual skills, knowledge and attitudes are of high quality, effective and well utilised.	This can include: ∉ formal education ∉ training ∉ workplace training ∉ mentoring ∉ on-the-job learning ∉ on-line learning ∉ best practice guidelines
Level III Future Workforce	Development of the workforce also involves ensuring a sufficient pool of skilled workers for the future. A range of important factors and strategies need to be considered for future planning in this regard.	These might include: ∉ recruitment strategies ∉ offers of education and training ∉ affordable and accessible education and training ∉ ensuring adequate service funding to employ staff ∉ supportive and facilitative policies

Workforce development has been largely neglected with assumptions made that market forces or other factors would adequately resolve workforce needs and issues. Table 2 maps out the approaches to the development and delivery of programs and services in the AOD field over the past four to five decades. It is clear that concerted and conscious efforts to address workforce development issues are relatively recent phenomena.

WHO CONSTITUTES THE AOD WORKFORCE?

A key aspect of workforce development is the initial identification of "the workforce". As self evident as this may seem this is a largely overlooked area. Nonetheless, this is a fundamental step before needs

assessments or strategic interventions can occur. Identifying who exactly constitutes the AOD workforce is a challenging task. It is made particularly challenging due to:

- the wide variety of occupational groups engaged in the AOD area
- the lack of clear boundaries between professional categories
- the complex and diverse array of initiatives involved
- an absence of professional credentialing requirements[1]
- the fact that most workers lack formal AOD training.

Table 2: AOD Workforce Development Responses: An Historical Perspective

1950-60's	Dedicated handful of workers, many of whom were 'recovering' individuals, largely involved with charitable and religious bodies. The focus of attention was almost exclusively alcohol. The target group was principally middle aged males.
1970's	Strong influence from psychiatry, and enthusiasm for the dissemination of A-clinics and the Alcoholics Anonymous (AA) model of dependence and treatment. The field became increasingly specialised, systematised, clinical and disease oriented. Growing interest in research. Some expansion in drug types and users. Growing level of clinical professionalisation.
1980's	Research began to have some significant impacts with evidence indicating the value of early and brief interventions, thus increasing the scope for a wider range of professionals (eg GPs, nurses) to be involved. An increasing emphasis on the broader public health model emerged. Growing array of substances involved and a more diverse range of users. Recruitment and training largely sporadic and ad hoc. No formal qualifications required and no courses available.
1990's	No longer seen as the domain of health but now included police, the judiciary, the media, politicians, and families, especially as the types of drugs and the harms associated with their use changed. Expansion of availability of training options at various levels. Improved articulation between training options. Few other workforce development strategies addressed.
2000's	Rapidly expanding knowledge base, increased level of use, greater awareness of the geo-political forces that impact on drug use and associated issues. More players than ever before. Substantial increase in problems and levels of complexity, but few workforce development strategies and no national strategy.

While little effort has been made toward identifying who constitutes the AOD workforce in Australia, important initiatives are underway. The paper in Section 5 of this volume by Wolinski and colleagues offers preliminary estimates of the specialist alcohol treatment workforce. It provides the first attempt to quantify and demographically characterise specialist AOD workers by discipline.

Other factors that impede progress in AOD workforce development include:

- the generally low level of educational attainment of workers in many AOD areas
- the limited range of workers with AOD specific qualifications
- limited access to high quality, affordable, accessible and relevant training experiences
- the wide variety of organisations involved in the area. For many, AOD is only one of many roles and often not the primary role
- a relatively low level of community awareness of AOD issues (other than as portrayed by the media)
- a lack of integration among those working in the area and a generally silo'ed approach to both infrastructure and disciplines
- the lack of an nationally coordinated AOD WFD strategy.

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1 While countries such as the United States of America have gone a long way towards ensuring a consistent method of credentialing workers (most notably counsellors) such mechanisms are still lacking in Australia. The recent establishment of the Chapter of Addiction Medicine within the Royal Australasian College of Physicians will go some considerable way to redress this deficit in relation to medical practitioners. For all other groups however there remains little indication of progress in this area.

DISTINGUISHING BETWEEN WORKFORCE DEVELOPMENT AND WORKFORCE PLANNING

As noted above, the term workforce development is often used synonymously with workforce planning. In reality the terms are related but different. A recent UK report (Department of Health, 2000 cited in Ridoutt and Wise, 2002) places workforce planning as a component part of the broader context of workforce development and advocates for a more holistic approach to workforce planning than hitherto. It argues the full range of human resource policies (including education, training, pay, skill mix, recruitment and retention, and career structure issues as well as technical supply and demand modelling) need to be brought together in a process of workforce development. Workforce planning as traditionally defined (ie supply and demand modelling) is only a part, albeit an important part, of this process (Ridoutt and Wise, 2002).

WHY THE IMPERATIVE FOR AOD WORKFORCE DEVELOPMENT?

There is a pressing need to address the issue of workforce development in the AOD sector. Research indicates changing patterns of alcohol and drug related problems. There is growing concern about the capacity of treatment services to respond effectively to these changes and to increasing levels of service demand. In addition, there is also concern regarding the adequacy of service provision for alcohol related problems. These factors combined with significant staff shortages and the stigma attached to the AOD field create an imperative for research into areas such as recruitment and retention of frontline workers.

There is a range of crucial workforce development issues that currently limit workers' ability to meet existing and future challenges. These include, at a minimum, the following ten factors:

1. an increase in complexity of AOD issues, including clients' treatment needs
2. particular policy and program challenges resulting from polydrug use
3. the emergence of treatment and policy priority groups such as youth, young women and Indigenous populations
4. a rapidly expanding knowledge base of increasing technical sophistication
5. present and future increases in demand for alcohol and polydrug treatment services
6. concern about the effectiveness with which agencies can respond to alcohol and polydrug trends
7. lack of funding and resources
8. high stress work, low salaries, limited career paths and options
9. difficulty recruiting and retaining staff
10. public stigma and misunderstanding of the nature of AOD problems and their resolution.

These issues cannot be addressed unless the AOD field has a trained, experienced and supported workforce. At present there is a demonstrated need to increase the capacity of the AOD workforce to meet the needs of its constituents. Research into strategies that target recruitment and retention of frontline workers in the AOD field is a priority area.

Australia's current National Drug Strategic Framework and associated governance structures have no specific provision for addressing AOD workforce development issues. Consequently, efforts to achieve strategic and national initiatives may be difficult.

The demands placed on the AOD field in general, and frontline workers in particular, are becoming increasingly difficult and complex. There is an increasing prevalence of problematic alcohol and other drug use in the Australian community, experienced by particularly vulnerable groups and individuals such as youth, Indigenous people, women (Roche and Deehan, 2002) and those with co-existing disorders (Teesson, Hall, Lynskey and Degenhardt, 2000). Treatment services report increasing complexity in presentations including those associated with concomitant mental health disorders. The latter require particularly specialised skills on the part of treatment providers, skills that are not necessarily readily available or easily acquired by many members of the existing AOD workforce (Saunders and Robinson, 2002).

In addition, there is increasing sophistication in the interventions available to manage alcohol related problems. Note for instance the increased use of pharmacotherapies such as acamprosate and naltrexone for the management of alcohol problems. Across the AOD field there has also been a substantial shift in orientation towards evidence based practice. This requires significantly greater skill and understanding of the research literature and its implications for programs and services. Box 1 presents a summary overview of key predicted developments in the AOD field in the near future. There are clear workforce development implications for all issues delineated in Box 1.

Box 1: Current and Predicted Changes in Drug Use

1. Levels of **tobacco use** will decrease in developed countries, but increase dramatically in developing countries

2. Patterns of **alcohol consumption** will continue to improve for older people and continue to decline for younger people. In developing countries, globalisation will result in increased levels of use with predictable adverse consequences (eg Russia in mid to late 1990's) if handled inappropriately

3. **Illicit use** will continue. The trend for younger people and increasing numbers of females to use illicits will continue, as will risk taking behaviours generally

4. **Patterns of illicit drug use** will vary with increasing rapidity

5. **Polydrug use** will continue, as will the level of sophistication of drug knowledge of drug users further outstripping the current knowledge of many workers in the field

6. **New illicit** drugs will continue to emerge with advances in creative pharmacology and in an effort to stay ahead of legal restrictions

7. **Problems** associated with drug use will depend on:
   a) types of drugs used (eg increase in psychostimulants and problems of aggression)
   b) how the drugs are used (injection vs other potentially less harmful routes of administration)
   c) where they are used (on the street, in clubs, at home)

8. Problematic drug use does not occur in isolation. It is a function of a broad range of individual, contextual, socio-political factors and it requires equally complex and multi-factorial responses.

THE WIDENING GAP BETWEEN AOD SCIENCE AND PRACTICE

Although change at both the personal and organizational level is constant and universal, making it intentional and positive requires attention.
(Simpson, 2002)

A principal area of concern for the AOD field is the translation of research findings into practice. It is increasingly recognised that the process of change, whether it be with an individual professional or an organisation, is difficult to achieve. The disconnection between research and practice has amplified calls for greater emphasis on technology transfer (Dansereau and Dees, 2002; Carroll, 1997; Morgenstern, Morgan, McCrady, Keller and Carroll, 2001). The transfer of new treatment techniques, for instance, into the practice of substance abuse treatment is an issue of concern as the twenty first century begins (Roman and Johnson, 2002). The United States of America has been particularly focused on this issue for some time (see the paper by Landis and Johnson in Section 4).

Simpson (2002) has highlighted that a better conceptual understanding of the process of program change and barriers that might be encountered is needed for effectively transferring research to practice. Traditional training approaches are fraught with difficulty and most common training methods are associated with levels of transfer failure in the range of 80-90%, that is in 80-90% of cases the content of the training programs is not translated into professional practice (Simpson, 2002). Several papers in Section 4 address the pivotal area of training transfer.

- a recent report from the Institute of Medicine (IoM) (Lamb, Greenlick and McCarty, 1998) highlighted the widening gap between scientific knowledge and AOD treatment practice in community based settings. It further highlighted the negative implications of not merging science and practice. The IoM report made recommendations which called for:
- research in which community treatment innovations are involved as collaborators and planning partners
- better monitoring systems of treatment delivery outcomes
- more knowledge about how 'technology transfer' occurs, taking into account the structure of treatment and the diversity of patients and providers
- more effective dissemination and training strategies for implementing innovations.

BORROWING FROM PROGRESS IN OTHER AREAS

In many ways, the directions needed for the development of AOD workforce have parallels that can be found in other areas. As outlined above there are comparable developments underway in a range of other health and human services areas. At a broader level there are interesting parallels that can be drawn with the developments that have occurred in areas such as the health promotion field over the past one to two decades. The Ottawa Charter, which offers a set of guiding principles around which health promotion activities can be developed, provides a useful springboard for AOD workforce development. Outlined in Table 3 is the Ottawa Charter and adjacent to it are the corresponding principles that could be developed in relation to AOD workforce development.

Table 3: Workforce Development Parallels With the Ottawa Charter

Ottawa Charter	AOD Workforce Development Parallels
1. Build public policies which support health	1. Develop policies that support workforce development
2. Create supportive environments	2. Create supportive work and management environments
3. Strengthen community actions	3. Strengthen community involvement
4. Develop personal skills	4. Develop professional skills
5. Re-orient health services	5. Re-orient health and welfare services to better support AOD issues

CONCLUSION

Over the past one to two decades specific efforts have been developed to strategically target alcohol and drug problems. These efforts have largely focussed on a number of select areas of attention including demand and supply control and treatment and, more recently and to a lesser extent, prevention. Efforts to upskill the diverse workforces that are directly and/or indirectly involved with the management or containment of alcohol and drug related problems have been even less prominent. Overall, the area of workforce development has received considerably less systematic attention than most other areas intended to impact on the alcohol and drug "problem".

Problems relating to alcohol and drug use have been an area of growing concern in Australia for some time. Prevalence data over the past decade show increasing levels of use across all major psychoactive drug types (results from the recently released 2001 National Household Survey, which show decreased prevalence across a number of drug types, notwithstanding). In general terms, AOD problems today are increasingly characterised by their diversity and complexity, often stemming from polydrug use, the decreasing age of users of both licit and illicit substances, and associated comorbidity and social dislocation. This increasingly complex array of problems requires more sophisticated responses on the part of policy makers, preventionists and treatment providers; many of whom feel under growing pressure to do more with less. Without appropriate and strategically targeted workforce development approaches Australia's AOD efforts will be increasingly compromised.

REFERENCES

Baker, A., Roche, A.M. (2002) From training to workforce development: a large and important conceptual leap. *Drug and Alcohol Review*, 21:205-208.

Carroll, K. (1997) Manual-guided pyscho-social treatment: a new virtual requirement for pharmacotherapy trials? *General Psychiatry*, 54:923-928.

Cochrane, D. (2001) *The Future Healthcare Workforce Project and its Influence on Workforce Reform in the United Kingdom.* Paper presented to the Health Leaders Network, Sydney, 16 March 2001.

Commonwealth of Australia (2001) *National alcohol strategy: A plan for action 2001 to 2003-2004.* Canberra: Commonwealth Department of Health and Aged Care.

Dansereau, D.F., Dees, S.M. (2002) Mapping training: the transfer of a cognitive technology for improving counseling. *Journal of Substance Abuse*, 22:219-230.

Health Workforce Advisory Committee (2002) *The New Zealand Health Workforce: A stocktake of issues and capacity.*

Lamb, S., Greenlick, M.R., McCarty, D. (1998) *Bridging the gap between practice and research: forging partnerships with community-based drug and alcohol treatment.* Washington DC: National Academy Press.

Morgenstern, J., Morgan, T.J., McCrady, B.S., Keller, D.S., Carroll, K.M. (2001) Manual-guided cognitive-behavioural therapy training: a promising method for disseminating empirically supported substance abuse treatments to the practice community. *Psychology of Addictive Behaviors*, 15:83-88.

National Public Health Partnership (2001) *Factors in Public Health Workforce Development: Investment Decisions*. Available from: <http://www.nphp.gov.au/factors.htm>.

Ridoutt, L., Wise, M. (2002) *Planning Framework for the Public Health Workforce*. Discussion paper. National Public Health Partnership, June 2002.

Roche, A.M., Deehan, A. (2002) Women's alcohol consumption: emerging patterns and public health implication. *Drug and Alcohol Review*, 21:169-178.

Roche, A.M. (2002) *Workforce development issues in the AOD field*. Adelaide: National Centre for Education and Training on Addiction.

Roche, A.M., McDonald, J. (Eds) (2001) Systems, Settings, People: Meeting Workforce Development Challenges for the Alcohol and Other Drugs Field. Adelaide: National Centre for Education and Training on Addiction.

Roman, P.M., Johnson, J.A. (2002) Adoption and implementation of new technologies in substance abuse treatment. *Journal of Substance Abuse*, 22:211-218.

Saunders, B., Robinson, S. (2002) Co-occurring mental health and drug dependency disorders: workforce development challenges for the AOD field. *Drug and Alcohol Review*, 21:231-238.

Simpson, D.D. (2002) A conceptual framework for transferring research to practice. *Journal of Substance Abuse Treatment*, 22:171-182.

Single, E., Rohl, T. (1997) *The National Drug Strategy: Mapping the Future. An Evaluation of the National Drug Strategy, 1993-1997*. A report commissioned by the Ministerial Council on Drug Strategy, Canberra, April, 1997. AGPS.

Teesson, M., Hall, W., Lynskey, M., Degenhardt, L. (2000) Alcohol- and drug-use disorders in Australia: implications of the National Survey of Mental Health and Well-being. *Australian and New Zealand Journal of Psychiatry*, 34:206-213.

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