IN PURSUIT OF EXCELLENCE:

Alcohol- and Drug-Related Workforce Development Issues for Australian Police into the 21st Century

National Centre for Education and Training on Addiction (NCETA)

NCETA
Australia's National Research Centre on AOD Workforce Development

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This report is part of a new series from the National Centre for Education and Training on Addiction (NCETA) on workforce development. Various aspects of workforce development are explored in the individual reports in this series.

Reports can be downloaded from the NCETA website www.nceta.flinders.edu.au or hard copies are available on request.

In addition to this series, NCETA has produced a diverse array of workforce development-related materials (see the NCETA website for details and downloadable copies) that include the following examples:

ACKNOWLEDGEMENTS

GLOSSARY

ACPR	Australasian Centre for Policing Research
AOD	Alcohol and Other Drugs
ATS	Amphetamine-Type Stimulants
BOCSAR	Bureau of Crime Statistics and Research (New South Wales)
IGCD	Intergovernmental Committee on Drugs
MCDS	Ministerial Council on Drug Strategy
MCDS-CSFM	Ministerial Council on Drug Strategy – Cost Shared Funding Model
NCETA	National Centre for Education and Training on Addiction
NDLERF	National Drug Law Enforcement Research Fund
NDS	National Drug Strategy
TAFE	Technical and Further Education
WAPOL	Western Australia Police
WFD	Workforce Development

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Executive Summary

This document presents an initial examination of the workforce development needs of police in relation to alcohol and other drug (AOD) issues. It was undertaken by the National Centre for Education and Training on Addiction (NCETA) as part of the Centre's broader program of work in the area of workforce development.[1] The report draws on various sources of information and data to provide a synthesis of current relevant issues and recommendations in relation to workforce development. The report also critiques police training needs as one aspect of an overall workforce development approach.

While Australia has a long term and well consolidated tradition of involving police in all major AOD policy and intervention initiatives, comparatively little attention has been directed to the relevant workforce development needs of police. This report addresses this issue in some detail.

Consistent with its broader program of work, NCETA has endeavoured:

   i.   to identify AOD workforce development priorities for police

   ii. to recommend relevant strategies to address workforce development needs

   iii. to critique AOD training and professional development needs of police.

To-date, no systematic assessment has been undertaken of the AOD workforce development needs of police. At this point in time, it is unclear what constitutes priority actions or areas of need as insufficient examination has been made of relevant issues. This project provides an initial examination of a broad range of workforce development issues pertinent to police and takes a first step towards identifying what needs to be done, if anything, to enhance police responses to AOD problems.

> Workforce development entails a comprehensive systems approach that incorporates factors such as recruitment, retention, supervision, role and job descriptions, performance monitoring systems, career paths, team work, problem solving, knowledge transfer and research dissemination. Training needs are reviewed here as one small, but important, component of a broader workforce development approach. Training on its own is a very limited change strategy and even good quality training does not necessarily convert into practice change unless other factors conducive to change are also present.

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1   The reader is referred to recent NCETA workforce development reports and resources including: Roche, A. M., Duraisingam, V., Wang, P., & Tovell, A. (2008). *Alcohol & Other Drugs, Mental Health & Comorbidity: A Training Review.* Adelaide: Natio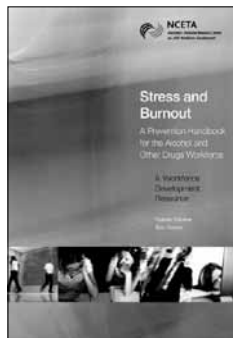nal Centre for Education and Training on Addiction (NCETA), Flinders University; Roche, A. M., & Pidd, K. (2008). *National AOD workforce development strategy: scoping paper.* Presented to IGCD July.; Skinner, N., Roche, A. M., O'Connor, J., Pollard, Y., & , & Todd, C. (2005). *Workforce development TIPS (Theory Into Practice Strategies): A resource Kit for the alcohol and other drugs field.* National Centre for Education and Training on Addiction (NCETA): Flinders University, Adelaide, Australia.

This report:

- draws on a wide range of sources
- reviews and developments over the past 10-15 years
- traces progress to-date
- identifies topical issues of particular pertinence to police.

The heavy and growing AOD-related demands on police are highlighted, as well as important moves towards the professionalisation of police and associated changes in police culture.

Two important anomalies were identified:

1. in spite of the substantial workload and considerable impost that AOD incidents create for police, comparatively little formal workforce development, in the broader sense, has been directed towards this issue;
2. although AOD work comprises a substantial, and in some cases an extremely large, component of police officers' day-to-day work, it is uncommon for police AOD roles to be clearly delineated.

A systems focus is required to bring about opportunities for enhanced police responses to AOD issues. A workforce development approach is recommended that involves three levels of action to ensure effective responses. These domains of action are:

Level 1   System-wide action

Level 2   Capacity building

Level 3   Professional development.

AOD-related issues of topical interest include the following top 10 priority areas:

1. alcohol
2. psychostimulants
3. violence and antisocial behaviour
4. comorbidities
5. child protection and youth
6. diversion
7. night time economy and public space
8. Indigenous communities
9. rural and remote policing
10. research, evaluation and prevention.

Also included are findings from three separate, but related, projects. The first is a survey of police officers undertaken in collaboration with Western Australia Police (WAPOL) and funded through the Ministerial Council on Drug Strategy (MCDS) Cost-Shared Funding Model (CSFM). The second is a 2004 NCETA workforce survey that includes data from a sample of police. The third is an examination of 1,192 AOD training courses to determine those relevant to police. Key points from these three projects are presented below, followed by a summary and recommendations.

	NCETA Police Survey 2008	NCETA Workforce Survey 2004
	N = 135	N = 96 police[2]
Demand	49% of work time involved alcohol; and 22% of work time involved drugs	Most police (56%) spent more than 20% of their time responding to AOD issues
Roles	Antisocial behaviour was the most common alcohol-related issue police dealt with	Police reported less diverse AOD roles than professionals such as nurses, youth workers and community development workers. AOD-related activities engaged in by police included referral, safety and prevention and/or health promotion, in addition to policing AOD use
Role Legitimacy	Antisocial behaviour and trafficking/possession etc most common drug-related activities	High levels of role adequacy and role legitimacy
Competence & Confidence	Officers expressed competence and confidence in their AOD abilities	–
Goals & disposition	Most organisations had clear AOD goals and objectives; and the organisations worked to improve AOD responses	Negative attitudes common
Job descriptions	Most officers did not have clearly defined AOD job/role descriptions	–
Training received	85% received AOD short course training	49% received AOD short course training
Training level	None received TAFE or University level training	None received TAFE or University level training

STUDY NO. 1 WA POLICE OFFICERS' SURVEY (2008)

A total of 135 officers completed a purpose-designed on-line survey. Mean age of respondents was 26-35 years, 80% were male, and had worked for WAPOL for an average of 12 years. Highest formal qualifications were secondary school certificates (37%) or TAFE qualifications (37%). Respondents were mostly constables (30%), senior constables (29%) or sergeants (20%).

Workload

Police respondents reported that on average, 49% of police time was spent on alcohol-related incidents and 22% of time on drug-related incidents. More than a quarter of officers reported spending 70% of their working week on alcohol-related incidents.

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2   This was part of a larger survey involving over 1,000 workers from 11 different disciplines.

Demanding Incidents

The most demanding AOD-related incidents were those that involved:

- ice/methamphetamines
- alcohol and
- other amphetamine-type stimulants (ATS).

Fifty five percent of respondents perceived incidents involving ice/methamphetamine to be very demanding and almost half perceived incidents involving alcohol to be very demanding.

Common Incidents Encountered

Antisocial behaviour was the most common alcohol-related issue that police 'always' or 'often' had to deal with. It was reported to be 'always' encountered by nearly half the respondents (48%). About a quarter of respondents reported 'always' having to deal with drink driving (28%) and alcohol-related violent crime, assault and family violence (25%).

Drug-related incidents most often encountered by respondents involved dealing with drug possession/trafficking/cultivation/manufacture, and antisocial behaviours, which included:

- noise
- disturbances
- public intoxication
- damage offences
- loitering to buy drugs
- discarded drug use equipment in public places.

Organisational Support

More than half the respondents disagreed that staff roles and responsibilities in responding to AOD-related incidents were clearly laid out in their job descriptions (53%). Further role clarification and job descriptions that more precisely identify AOD-related responsibilities are therefore suggested as warranted.

Training Received

Eighty five percent of respondents had previously undertaken AOD-related training, mainly comprising on-the-job and non-accredited training.

Alcohol-related training was perceived to be most useful. Approximately a third of AOD training received overall was considered not relevant to the role of police. None of the respondents perceived the training received to be 'very useful' in terms of dealing with AOD-related incidents. It is therefore suggested that scope exists to improve and tailor training that is designed specifically to meet the needs of police.

Training Aspirations

More than 90% of respondents stated that they would be interested in undertaking further AOD training specifically related to policing.

More than three-quarters of respondents felt the most appropriate level of AOD training for their work role was undergraduate (76%) or postgraduate degrees or diplomas (76%). Almost all respondents (97%) felt that on-the-job training was not an appropriate level for training in AOD.

The majority of respondents also stated that they would prefer to receive training at the Academy or workplace (61%) and in a classroom setting (70%). Scope for combining both options are indicated here; for example, offering accredited courses that are run by the Academy.

Undertaking training earlier in their career to help deal with AOD-related incidents was supported by 77% of respondents. Education and training focussing on policing licensed premises was supported by 95% of respondents.

STUDY NO. 2 NATIONAL NCETA WORKFORCE SURVEY 2004

Findings from a NCETA national survey conducted in 2004 are presented and compared to the findings from the 2008 survey. A total sample of over 1,000 workers from 11 different disciplines was obtained, including 96 police officers from across Australia of whom two thirds were male with an average age of 34 years. The 2004 survey questionnaire contained 148 AOD-related items that measured factors that impact on individual worker's performance, workplaces, work teams, and organisations.

Police were in the top five professional groups reporting that they had received some AOD training. Approximately half (49%) reported undertaking short AOD training courses (32% non-accredited and 17% accredited). The majority had obtained their training via short courses as opposed to undertaking TAFE or university level courses.

In relation to AOD matters, police reported moderately high levels of role adequacy and role legitimacy,[3] but low work satisfaction and career motivation, and the lowest levels of motivation to respond to AOD issues of the 11 professional groups examined. Police also reported more negative attitudes towards responding to drug users.

STUDY NO. 3 ASSESSMENT OF AOD COURSES FOR POLICE

A review of a recently established database of 1,192 courses (including AOD, mental health and psychology courses) [external to police organisations[4]] identified only five accredited courses and one non-accredited AOD course relevant for police (see Table 1). The courses identified were external to training provided by individual police organisations.

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3   The terms 'role adequacy' and 'role legitimacy' refer respectively to the sense of one's ability and competence to carry out a role or task, and the sense of the appropriateness of that role/task to their designated position.
4   It is recognised that police organisations run a range of AOD-related staff development programs for officers but these were beyond the scope of this report.

Table 1: Accredited and Non-Accredited AOD Courses Relevant for Police

Institution	State	Course Title	Level
Adelaide University	SA	Alcohol & Drug Studies	Graduate Diploma
Adelaide University	SA	Alcohol & Drug Studies	Graduate Certificate
Edith Cowan University	WA	Drug and Alcohol Harm Minimisation	Graduate Certificate
RMIT University	VIC	Alcohol & Other Drugs / Dual Award in Criminal Justice	Certificate IV
Central TAFE	WA	Alcohol and Other Drugs Work	Certificate IV
Centre for Community Welfare Training	NSW	Working with Coerced Clients	Non-accredited

SUMMARY AND RECOMMENDATIONS

This review confirms the prominent role played by police in relation to AOD-related issues utilising a combination of supply, demand and harm reduction strategies. It provides an initial snapshot of a range of key issues and identifies potential next steps forward. It also highlights the need for more exploratory work to be undertaken, as has occurred with other professional groups but not yet for police, before embarking on specific actions.

The need for a national workforce development strategy designed to identify the specific and unique needs of police and law enforcement officers in relation to their work in the AOD area is highlighted. A range of workforce development strategies are outlined that could be examined to enhance police capacity in effectively performing their AOD-related roles. The need for such an initiative is an important next step to identify appropriate workforce development areas and strategies for police.

Moreover, this report maintains that until such an objective and comprehensive assessment is undertaken caution should be applied in the allocation of resources on the basis of assumed need.

This report takes a workforce development perspective and argues for a broad systemic approach that extends well beyond the narrow parameters of a 'training only' approach. Achieving professional practice change through training in isolation is well established to be a limited and often ineffective strategy.

Research on knowledge and skill development was also identified as a key area warranting attention. This is in line with strategic documents such as the 'Directions in Australia New Zealand Policing 2008-2011: A Policing Strategy by the Ministerial Council for Police and Emergency Management – Police' (2008) that highlight knowledge-based and research-led policing as the way of the future.

In terms of training, as one small component of a broader workforce development initiative, there was strong support for:

- more training
- training earlier in officers' careers
- training tailored to specific police roles and
- training at higher levels than has been offered to-date.

The top priority was for training in managing alcohol-related problems, particularly training in relation to the policing of licensed premises. However, little is currently known about factors that impede effective policing of licensed premises. Strategies other than training may be required, but at this stage this is unknown. A broad examination of this, and related, issues is required.

AOD-related tertiary study appears to be rare among police officers. This review identified that few opportunities exist for police to undertake training that is relevant or tailored to their needs. Nonetheless, police were in favour of undertaking tertiary level study and saw this as the appropriate level at which training should be offered to police.

Overall, the high AOD-related workloads of police which involve increasingly complex issues stand in contrast to the dearth of systematic workforce development attention directed to this area. A national, co-ordinated and comprehensive workforce development strategy for police is called for. The positive disposition toward evidence-based activities and enhanced efficiency and the growing momentum toward professionalisation of police augurs well for initiatives of the types proposed.

It is recommended that:

1. A taskforce be established to develop a comprehensive national workforce development strategy that caters for the unique, specific and jurisdictional AOD-related needs of police. It is envisaged that such a strategy should include but not be limited to the following:

    a. Adopt a multi-tiered approach that addresses the key issues of systems-wide action, capacity building and professional development.

    b. Extend well beyond a national training package / program, given the limitations and inefficiencies entailed in such an approach.

    c. Involve a top-down approach engaging support from the highest levels and including senior managers to achieve essential organisational, infrastructure and culture change.

    d. Reflect the emerging trend toward the professionalisation of policing and incorporate strategies to address leadership, management and related governance issues.

    e. Incorporate the key workforce development areas of recruitment and retention, stress and burnout (as they relate to the impact of AOD work on policing) as part of its central components.

    f. Highlight major issues such as antisocial behaviour, aggression and violence among offenders that warrant workforce development attention, including senior management support, and innovative conceptual and skill development.

    g. Identify a range of management support options to facilitate police training and professional development such as scholarships, time-off for study, mentoring programs, and creation of research training partnerships.

2. A clearinghouse function is established within a nationally based agency to facilitate efficient and effective dissemination of AOD-related research findings and resource materials into policing practice.

3. A comprehensive suite of AOD resource and support materials[5] be developed specifically for police (further to the resources that are currently available).

4. As on-the-job learning is particularly salient for police, a planned program of mentoring, job rotations and strategic placements be devised to optimise skill development and acquisition. Consideration should be given to this occurring at local, state and inter-jurisdictional levels with cross border placements where appropriate in settings that encompass supply, demand and harm reduction outcomes.

5. All police officers are provided with access to basic education and training on AOD-related issues, including the impact that these issues have on their day-to-day policing activities.

6. Specific attention is directed to the issue of training transfer to ensure that the investment made in training is translated into on-the-ground practice. Training transfer often involves senior staff, such as managers and supervisors, whose role is to create the work environment required to allow new knowledge, skills and procedures to be operationalised.

7. AOD education and training for police be developed that incorporates both an operational and problem-oriented focus, as well as more technically and conceptually sophisticated content. Such training would address evidence-based prevention and pro-active strategies, underlying causal factors associated with AOD misuse, and interventions to tackle complex issues such as AOD supply reduction, antisocial behaviour, the management of public spaces and the night time economy.

8. AOD-related education and training courses for police are delivered using a combination of delivery modes including external / online learning, attendance at TAFE / university and attendance at the Police Academies.

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5   One example of the type of resource that has proved to be very useful among health professionals is the Alcohol and Drugs Handbook for Health Professionals (National Centre for Education and Training on Addiction (NCETA) Consortium, 2004). That resource is used as a teaching text, a clinical reference guide and a general introduction to the AOD field for health workers. Few comparable resources exist for police, but such resources are pressingly needed.

Introduction

This report was prepared by the National Centre for Education and Training on Addiction (NCETA) to address the changing demands on police in relation to responding to alcohol and other drug (AOD) related matters in Australia. It examines recent shifts in:

- policing approaches
- law enforcement imperatives
- community and political expectations
- legislation and policy.

In this light, the AOD workforce development needs of police are assessed. Workforce development related recommendations are made for the identification and implementation of strategies required to provide support to police in addressing their expanding and dynamic roles in relation to AOD issues. A systems enhancement approach is called for; in contrast to the more typical and increasingly outmoded skills deficit response.

While Australia has a long term, well consolidated and highly regarded tradition of police involvement in all major AOD policy and intervention initiatives, comparatively little attention has been directed to the workforce development needs of police in relation to AOD issues. This report focuses on this issue.

The AOD field has undergone major changes over the last one to two decades. The scientific knowledge base, from which the field operates and standard and intervention protocols, has changed substantially. So too have the plethora of substances with which communities and police have to contend. These dramatic changes necessitate equally significant changes on the part of the workforces which are required to respond to these issues, not least of which is the police workforce.

The strategies required to develop an adequate workforce response to AOD problems extend well beyond the narrow traditional notion of "training". Systemic and sustainable changes at the organisational and command levels are also essential. A major paradigm shift is required to refocus thinking away from an exclusive orientation on training to one which encapsulates factors such as:

- organisational and infrastructure development
- change management
- recruitment and retention
- worker wellbeing
- research dissemination
- evidence-based knowledge transfer
- skill development at the level of organisations, teams and individuals.

The work outlined here is presented in the context of the broad range of workforce development related activities that NCETA has been engaged in over the past decade and a workforce development scoping exercise undertaken by NCETA in 2008.[6] A model for a comprehensive approach to workforce development is offered herewith. A comprehensive workforce development approach is required to avoid ineffective, costly, piecemeal approaches to achieving practice change within policing.

The report:

- draws on a wide range of sources
- reviews and developments over the past 10-15 years
- traces progress to-date
- identifies topical AOD-related issues of particular pertinence to police.

It also includes:

1. findings from a 2008 survey of police officers undertaken in collaboration with Western Australia Police (WAPOL)
2. survey data from a 2004 survey undertaken by NCETA that examined the views of 11 different professional groups, including police, about their work roles in relation to AOD matters
3. a review of training options relevant to police
4. recommendations for future strategies and initiatives in this area.

The report is structured in two Parts – Part A and Part B. The first section within Part A provides background details in regard to the AOD-related roles played by police and associated changes with policing. This is followed by a section which addresses factors related to workforce development. It highlights issues encapsulated under the umbrella term of workforce development and outlines the ways in which workforce development is different to training. It is stressed here that workforce development is not a synonymous term for 'training' and should not be used interchangeably with the term 'training'. While training can form an important part of a workforce development approach, it does not represent the full array of strategies entailed.

Part B presents findings from the three separate studies. The findings from these studies, together with the content of Part A, were used to inform the recommendations and conclusions made in this report.

6   Roche, A. M., & Pidd, K. (2008). *National AOD workforce development strategy: scoping paper.* Presented to IGCD July, 2008.

Part A

POLICE – A PRIORITY WORKFORCE GROUP

Police are among the key workforces identified as having a major role in AOD issues. Like other professional groups, such as doctors and nurses, police spend a disproportionately large amount of their working time dealing with AOD issues in one guise or another. It often comprises elements of the work role that are not specifically designated as AOD-related; rather, it is subsumed within offences such as assaults, domestic violence, disturbances, theft, and so on. Also like other professional groups, police have received comparativ ely little formal AOD training. In contrast to other professional groups, little attention has been directed to the AOD-related workforce development needs of police.

Australian police play a prominent, recognised and well established role in AOD issues, more so than in most other countries of the world. This role is exemplified in Australia's AOD governance structures. For example, the Intergovernmental Committee on Drugs (IGCD) is comprised of senior jurisdictional representatives from both the health and police sectors. The IGCD reports to the Ministerial Council on Drug Strategy (MCDS), which is primarily comprised of Commonwealth and Jurisdictional Police and Health Ministers. Significant political and organisational support for addressing AOD issues in Australia has been achieved through the involvement of police ministers in the MCDS and the partnership with senior police in the IGCD.

In Australia, all key AOD committees, reference groups and strategy planning processes involve both police and health representation. The collaborative and consensus based approaches that characterise key groups, such as the IGCD, necessitate a comprehensive understanding of both police and health sector approaches.

Nonetheless, the crucial input of police and other representatives of the law enforcement sector is often overshadowed by the more dominant profile of health-related issues. Increasingly however, the roles that police play in the prevention, intervention and management of AOD issues have gained greater recognition and prominence. Moreover, there is increased interest in not only highlighting the wide range of areas in which police play a pivotal role, but also in showcasing exemplars in policing and law enforcement practice and identifying best practice.

THE CENTRALITY OF POLICE IN AUSTRALIA'S DRUG POLICIES

At the highest level, police officers are signatories to and play a key role in endorsing Australia's National Drug Strategy (NDS). Examples of recent strategic developments at the national policy level that impact on the work of police include those shown in the box below.

Drug-related Strategy	Relevance to Police
The National Drug Strategy 2004-2009	Provides a national policy framework for a co-ordinated, integrated approach to drug issues in the Australian community.
	Complemented by a range of national state, territory, government and non-government strategies, plans and initiatives.
	The National Drug Strategy's success in building partnerships, particularly between the health and law enforcement sectors, has broadened the role of the police in addressing drug issues.
	Enhanced law enforcement efforts and approaches have significantly disrupted the supply of illicit drugs and reduced demand for them.
	The role of law enforcement in harm-reduction strategies is well recognised.
	The National Drug Strategy has strengthened Australia's presence among drug treatment, law enforcement and prevention service providers. Enhanced professional development of the workforce has been a significant factor in contributing to this position (Ministerial Council on Drug Strategy, 2004).
The National Alcohol Strategy 2006-2009	The prevention and minimisation of alcohol-related harm to individuals, families and communities.
	Development of safer and healthier drinking cultures in Australia (Ministerial Council on Drug Strategy, 2006a).
The National Cannabis Strategy 2006-2009	Strategy supports a comprehensive approach to drug-related harm.
	Balances demand reduction, supply reduction and harm reduction strategies (Ministerial Council on Drug Strategy, 2006b).
The National Amphetamine-Type Stimulant Strategy 2008-2011	Strategy developed within the context of the National Drug Strategy 2005-2009.
	Includes strategies designed to reduce supply, demand and harm that is associated with illicit drug use, and its impact on individuals, families and communities (Ministerial Council on Drug Strategy, 2008).

The strategy documents above were each developed under guidance from a project management group, and each included law enforcement representatives. In addition, a Law Enforcement Reference Group was established for each of these Strategies to ensure that appropriate advice regarding law enforcement priorities was included.

The important role that law enforcement plays in supporting Australia's drug policies is further highlighted by Willis, Homel and Gray (2006) who were commissioned by the National Drug Law Enforcement Research Fund (NDLERF) to develop a viable performance measurement framework for drug law enforcement in Australia. They noted drug law enforcement policy and associated strategies to be directed to supply, demand and harm reduction outcomes. While police personnel regard supply reduction as the primary goal of drug law enforcement, demand reduction and harm reduction were also seen as priorities (Willis et al., 2006).

Similarly, there has been a growing focus on the proactive role police can play in prevention (Nicholas, 2002). Expectations of national, state and territory-based drug law enforcement agencies, in relation to assessing the impact of their actions, go beyond supply reduction activities alone and extend to goals that aim to improve community wellbeing (including public amenity) and the health and wellbeing of drug-affected individuals (Homel and Willis, 2007).

Despite the key role police play in preventing and reducing drug-related harms and problems, a relative lack of exposure to drug education and training has been identified for over a decade with recommendations made that relevant tertiary education courses be established (Fowler, Allsop, Melville, & Wilkinson, 1999). In 1999 it was argued that by engaging more police officers in tertiary study, awareness and legitimisation of the National Drug Strategy framework would also increase at senior levels and would help facilitate development of clear policy guidelines and encourage management support (Fowler et al., 1999; Nicholas, 2000).

Beyond training, there is also a range of important workforce development needs of police in relation to AOD matters. These are mapped out in more detail below. This report identifies actions and progress over the intervening decade and highlights directions indicated for future workforce development. It raises fundamental questions about the role of police in AOD matters and in what areas and in what ways enhancement or improvements are needed, if at all.

THE ROLE OF POLICE

The role of police is central to Australia's AOD-related efforts and activities. National studies and crime statistics have shown that operational police spend a large proportion of their time responding to AOD-related issues. In many cases, police are the first of the frontline workers required to respond to AOD-related issues. This may involve dealing with AOD-affected individuals and consequent or associated criminal behaviour. For the most part, it is the police that bear the brunt of the responsibility for antisocial behaviour and violence, especially where perpetrated in and around licensed premises (Fleming, 2008). It also includes the policing of licensed premises (Doherty & Roche, 2003; Graham & Homel, 2008), illicit drug law enforcement, preventing / responding to drug-related acquisitive crime and preventing / responding to drink and drug-related driving. Accordingly, operational police may end up spending comparable amounts of their time dealing with AOD-related issues as workers who are specifically employed in the AOD field.

Operational police can devote as much if not more time than other professional groups in:

- dealing with AOD affected individuals and resultant public nuisance, violence and criminal acts
- policing licensed premises
- illicit drug law enforcement
- drug-related acquisitive crime
- conducting school and community based drug education programs
- drug-related intelligence acquisition
- intoxication related driving (Nicholas, 2000).

Police also play a crucial role in supply reduction and can also play a significant role in demand and harm reduction. Examples of successful demand and harm reduction strategies include roadside testing, liquor licensing legislation compliance, drug diversion schemes, cautioning schemes etc. Other harm reduction initiatives include:

- use of discretion in policing near harm reduction services

- encouraging an understanding of safer drug use practices

- police involvement in community drug education

- managing drug affected people

- encouraging entry to drug treatment programs

- continuation and enhancement of diversions schemes

(Spooner, McPherson, & Hall, 2004).

Ritter (2007) in reviewing policies related to illicit drugs noted the distinction made between *'hard end'* policing and *'public end policing'*; where the former involved trafficking, organised crime, interdiction etc. and the latter street based-policing and issues related to public amenity. These diverse policing roles require quite different workforce development strategies and responses.

While police objectives largely mirror those of other sectors involved in addressing AOD-related issues, police also have specific and unique responsibilities. In addition, their roles entail particular occupational health and safety risks. More recently, an expanded and disparate array of police roles has also emerged. These include research, evaluation, prevention, managing elevated levels of antisocial behaviour, youth and child protection issues, partnerships, the night time economy and public amenity.

Until recently, it has been difficult to quantify the specific impact that AOD-related incidents have on police time and resources with any degree of precision. There have been relatively few economic analyses. Estimates vary considerably – as the conceptual basis on which the calculations are made and the methods used differ substantially. For instance, Wiggers et al. (2004) in the Hunter Region Linkage program reported that over 70% of recorded incidents in the Hunter were alcohol-related.

A recent study undertaken by the NSW Bureau of Crime Statistics and Research (BOCSAR) to estimate the short-term cost (in salary terms) of police time spent dealing with alcohol-related crime found that it accounted for approximately $50 million dollars in 2005 – or the combined salaries of around 1,000 fulltime constables (Donnelly et al., 2007). There were substantial geographical and temporal variations, but on average, police recorded that 8.2% of their time was spent on alcohol-related activities. This increased to 18% of their time on Friday and Saturday nights. Police involved in licensing duties reported up to 50% of their time spent on alcohol-related matters. The most common alcohol-related incident type was assault.

Collins and Lapsley (2008) in their most recent assessment of the cost of policing AOD-related incidents estimate that for the year 2004/05 alcohol policing costs equated to $747 million and for illicit drugs to $1,716 million. They note that these figures are likely to be underestimates. Costs of AOD-related crime overall were estimated to be $1.7 billion for alcohol and $4 billion for illicit drugs, with a further $1.4 billion attributable jointly to alcohol and drugs.

Anomalies

Although AOD-related work commonly comprises a large part of police work, this aspect of policing is nonetheless characterised by two anomalous features:

1. in spite of the substantial workload and considerable impost that AOD-related incidents create for police, comparatively little formal training or workforce development, in the broader sense, has been directed towards this issue;

2. although AOD-related work comprises a substantial, and in some cases an extremely large, component of police officers' day-to-day work, it is uncommon for it to be explicitly delineated in duty statements or role descriptions.

Both of the above are matters of concern and require remediation. In order to address the latter point, organisational objectives concerning the role of police in drug-related issues need to be clear and operational. Once this is achieved, appropriate workforce development requirements become largely self-evident.

It is important to first delineate police roles and specify boundaries in this area. Some maintain that ongoing reviews of police staff roles and functions are fundamental to the exercise of developing the most efficient and effective organisational structures possible (Merseyside Police Authority, 2008). At the same time, it is important to note that other significant changes are occurring in the police force specifically (Fleming, 2008) and in society in general (Marmot & Wilkinson, 2005) that impact on the way police services operate today and into the future.

Cultivating an understanding of AOD issues and its acceptance as a legitimate police role has sometimes been challenging. Factors that can influence police AOD practice include:

- frameworks within which the police work (trends in policing practice)

- factors within the police sector (the police workforce and workforce development)

- external factors (community and political influences)

(Spooner & Hetherington, 2004; Spooner et al., 2004).

There is also scope to improve understanding between law enforcement and other sectors about key policing approaches such as problem-oriented policing and community policing models. As well, there is interest in exploring the efficacy of strategies such as 'broken windows' programs that entail arresting users, moving on powers, clean up areas etc. (Ritter, 2007). Overall, there is growing interest in and need for more research on effective interventions for trafficking and supply, assessing the social impact of crime, and in general more law enforcement research to which the general scientific community might contribute.

Growing Demands on Police

It is well recognised that the AOD field is particularly dynamic. The core knowledge base of this field has expanded many-fold over recent years. To illustrate the breadth of issues of specific relevance to police the reader is referred to the recent NDLERF publication - 'A Compendium of Alcohol and Other Drug-related Resources for Law Enforcement in Australia' (Trifonoff & Nicholas, 2008)[7]. The compendium provides reference to a collection of literature published between 2004 and 2008 applicable to AOD policing. It presents this collection under the following headings:

1. Alcohol law enforcement/regulation

2. Illicit drug issues

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7 A copy can be downloaded from the NCETA website www.nceta.flinders.edu.au

3. Pharmaceutical drugs

4. Volatile substances

5. Demographics of alcohol and other drug use

6. Alcohol and other drug-related crime

7. Drink driving

8. Drug driving

9. Alcohol and other drug-related social harm

10. Criminal justice responses (including diversion)

11. Alcohol and other drug-related problems among young people

12. Alcohol and other drug-related crime prevention

13. Alcohol and other drug issues in the Police Workplace/OHS

14. Alcohol and other drug-related problems among Indigenous People

15. Alcohol and other drug-related Police custody issues.

In addition to the long-term and well-established AOD-related roles that police play, recent developments have created a greater impost on police time and resources. These include, for example, developments in relation to the prevalence of AOD-mental health related comorbidity, and changes derived from different patterns of drug use such as the shift to amphetamine type substances (ATS) in recent years in preference to opioids.

A 2004 environmental scan of the alcohol and other drug issues facing police in Australia conducted by the Australasian Centre for Policing Research (ACPR) found changing demands on the role of police in relation to a wide array of AOD matters (Nicholas & Shoobridge, 2005). Particular attention was directed to methamphetamine-related behaviour and comorbidity. The following specific concerns were identified:

- a need to ensure that police and other emergency workers received adequate training and are well equipped to respond to methamphetamine-related behaviour.

- that all operational police are made aware of the risks associated with clandestine laboratories, and that educational strategies reflect a need for community education and training for police about how to best respond and manage clandestine laboratories.

- given the increasing likelihood that police will come into contact with individuals who have complex alcohol and other drug problems, as well as mental health problems, the importance of police training in dealing with these individuals, with protocols and linkages in place to facilitate referral to relevant agencies was noted (Nicholas & Shoobridge, 2005).

Changing Roles and Functions of Police

Some emerging changes in the roles and functions of police include the enhanced partnership and integration of roles with other colleagues such as those in the health sector. Initiatives in relation to antisocial behaviour and violence have resulted in the emergence of newly formed integrated roles.

Recognition of the links between antisocial behaviour and AOD use has resulted in the consolidation of key partnerships and collaborative efforts across different sectors.

Overseas examples include the Merseyside Police Authority's (2008) Drug Intervention Programme, described by the UK Home Office as trailblazing, which involved counselling and treatment to be offered to offenders to break the cycles of misuse.

Other examples of these increasingly merged roles and the creation of partnerships include Australia's exemplary work around drug diversion, the co-location of nurses in watch houses, and the expanded role of police in high risk school settings. Such initiatives entail the development of new roles and new partnerships for police.

10 Key Workforce Development Issues

Police are required to respond to existing and emerging drug markets, and changing drug-related issues. A non-exhaustive range of topical issues that impact on contemporary policing practice is outlined below. While there is a continually changing and expanding array of new areas that require attention, the following 10 key AOD-related issues are especially pertinent to police and will shape any emergent workforce development initiatives.

Topical Issues	Descriptor
1. Alcohol	Increased understanding and awareness of associated harms is needed. Proliferation of licensed premises has placed a greater demand on limited police resources and substantially altered police-to-licensed venues ratios and hampered the ability to effectively monitor and pro-actively police these settings. The emergence of new and innovative strategies (e.g. NSW Linking Program) requires training and other forms of professional development. Knowledge of appropriate strategies for different groups is required as alcohol impacts on different groups in different ways. Proactive policing of licensed premises has been demonstrated to reduce alcohol-related problems stemming from licensed premises (Doherty & Roche, 2003). Such strategies however may also result in a displacement of alcohol-related problems into either private settings or public places such as beaches and parks. The latter introduces a different set of challenges for police. The decreasing age of initiation for both alcohol and other drugs has implications for police.
2. Psycho-stimulants	Increased prevalence of the use of ATS. The Australian Government Department of Health and Ageing called for enhanced training for police in relation to psychostimulants to better equip them to deal with ATS related behaviours (Nicholas & Shoobridge, 2005). Guidelines have been developed for police in this area (Jenner, Baker, White, & Carr, 2004).
3. Violence and Antisocial behaviour	Greater levels of AOD-related violence create an impost on limited police resources. Potentially effective strategies are available to police but are often not fully implemented due to resource limitations and other factors, including insufficient training and understanding of potential options. Community problems, such as alcohol-related violence and anti-social behaviour which is increasingly reported in many jurisdictions, warrant intersectoral collaboration. The latter requires improved understanding of the approaches and perspectives of the respective sectors involved. Strategies to address problems associated with antisocial behaviour[8] require skills in partnership, cross-disciplinary collaboration with other professionals and sectors with related interests and expertise and problem solving.

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8   The issue of antisocial behaviour is generally a high priority area for police and is highlighted in several key police documents; for instance the WAPOL Strategic Plan 2007-2010 and Annual Business Plan 2008-2009. Also see Richard Eckersley's report from Victorian Police Roundtable on Antisocial Behaviour, August 2008; and the Merseyside Police Authority Action Plan 2008-2011.

Topical Issues	Descriptor

4. Comorbidities[9]

The Australian Government's National Comorbidity Initiative 2003/4-2007/8. It included professional development and training as a key aim. Until relatively recently, comparatively little attention has been directed to comorbidity training for health workers; even less attention has been directed to the training needs of other frontline workers, such as police. In 2005, Nicholas and Shoobridge highlighted the increasing importance of police training, workplace support, policies and protocols to assist them to develop effective responses to identify and manage individuals with comorbidity problems.

Increased prevalence of comorbidity and associated concerns derive from: 1. the ready availability of AOD, 2. deinstitutionalisation of people with severe mental illness, 3. increasing expectations to address comorbidity problems.

The growing concern about comorbidity stands in contrast to deficits in staff training and organisational constraints which limit responses (Velleman, 2007). Efforts to detect comorbidity and offer interventions have been hampered not only by delays in developing workers' skills, but also by structural factors in the service delivery.[10] A broad range of professionals may potentially be involved in the management of people with comorbidity; it is not just limited to those working in the AOD and mental health fields.

Many people with comorbid conditions present in contexts other than health care settings. There are increasing presentations within the criminal justice system as well as a range of social care settings related to housing, relationships, and family problems. Workers in these social care systems also need increased awareness of comorbidity problems, and training in potential presentations and appropriate forms of intervention. This is especially the case for those working within the criminal justice system including police, courts, and correctional institutions, as well as emergency services workers, ambulance officers and paramedics, and also within the education sector.[11] High risk occupations, for instance the armed services, are also increasingly aware of the need for relevant training.[12] Workers in all these roles require appropriate training and upskilling.

Workers' job descriptions, education, training and experience also vary enormously. Consideration needs to be given to the mix of skills within and across professional groups, and how to best match expertise with the needs of those seeking care and support. Different patterns of comorbidity are also seen. For example, police are most likely to see the more prevalent disorders such as mood, anxiety and personality disorders and less likely to encounter individuals with schizophrenia and bipolar disorder (Hall, Lynskey, & Teesson, 2001). Appropriate training and workforce development responses need to be available to accommodate and match these different circumstances.

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9 NCETA completed a review of the comorbidity training opportunities available in Australia, including those available to and suitable for police (see Roche, Duraisingam, Wang, & Tovell, 2008). Details of these courses for police are presented in a later section of this report.

10 Traditionally, specialist mental health and AOD services in Australia have been separated physically, administratively and philosophically (Holmwood, 2003). More latterly, there has been a trend to co-locate mental health and alcohol and other drug services, as is occurring in New South Wales, South Australia and Queensland resulting in workers being trained to be responsive to client presentations from either a mental health or an alcohol and other drug perspective.

11 Examples of new programs include:
MindMatters: a national mental health initiative for secondary schools funded by the Commonwealth Department of Health and Ageing on the basis that positive mental health and wellbeing have been strongly linked to improving schooling outcomes for young people. MindMatters uses a whole-of-school approach to mental health promotion, based on the principles of the World Health Organization (WHO), Global School Health Initiative and the Australian National Health Promoting Schools framework, and considers a range of mental health and wellbeing determinants, including the significance of cultural context.
Headspace: established to better meet the needs of young people with emerging mental health and AOD issues, delivers a comprehensive and sustainable 'Service Provider Education and Training' program. Aims to enhance practitioners' skills in engagement and assessment, and the use of evidence based interventions appropriate for young people with mental health and substance use issues. The program delivers training to general practitioners, psychologists, occupational therapists, mental health services, drug and alcohol services, youth workers, social workers, school counsellors, teachers, police and emergency service workers, staff in the juvenile justice sectors and hospital emergency departments.

12 For example, the Australian Defence Force (ADF) has recently developed a Critical Incident Stress Mental Health Support (CMS) Training Framework for all ADF staff (Defence Health Services Division, 2008). The ADF aims to include its entire workforce in base level training in mental health literacy.

Topical Issues	Descriptor
5. Child protection and Youth	Increased attention is directed to the needs of young people in family settings where AOD use may negatively impact on their wellbeing (Dawe et al., 2007). AOD use is exacerbated by limited social support services to deal with the domestic violence, family dysfunction. Traditionally, police are in the frontline response to domestic violence. Greater support and training is needed for police in undertaking these growing and demanding tasks. Young people are at elevated risk of becoming either offenders or victims of crime. There is new knowledge about how young people see the world, how their brains develop and the range of options more suited for them compared to older people. Such new knowledge is especially relevant to police in their dealings of either a preventive or interventionist nature with young people. Young offenders present particular challenges for police and often require a different response set to those warranted by older members of the community. Young people can be a difficult group to engage with. Special youth-related training has been developed for GPs to help them develop the requisite skill set for working with young people with comorbidities (see footnotes). Similar training may be warranted for police for whom a substantial proportion of their time is devoted to dealing with young people.
6. Diversion	Implementation of a diverse array of diversion programs across most jurisdictions has resulted in a need to employ measures to ensure police are able to support diversion programs. Diversion programs have been expanded to include alcohol-related offences, specifically as they relate to young people and Indigenous Australians. These also require training and support for police in their implementation and evaluation.
7. Night time Economy	An important recent change in Australian society is the emergence of the night time economy.[13]
8. Indigenous communities	Delahunty and Putt (2006a) in their NDLERF good practice report on 'Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander Communities' highlighted the struggle for all law enforcement agencies in addressing training needs of officers working in rural and remote Indigenous environments (Delahunty & Putt, 2006a). Cross-cultural training and induction is now recognised as essential. Examples cited included the comprehensive predeployment training work undertaken in Western Australia which seeks to address critical training issues for remote area service delivery including: • Forensic skills, exhibit handling and brief preparation • Remote area training • Investigations • Child abuse investigations • Location-specific training. A commitment to education and training to foster cultural awareness is now common in Aboriginal justice agreements and policing strategies (Delahunty & Putt, 2006a). Delahunty and Putt (2006a) reported that 67% of urban and 41% of non-urban police found police training positively contributed to their development of knowledge about Aboriginal people. A further 75% and 76% respectively indicated that on-the-job training also provided this knowledge. Learning on-the-job was the way most non-urban police developed local knowledge, rather than through formal training per se.

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13 See NCETA's report on Alcohol and Young People (Roche, et al., 2008) that outlines a range of factors, including the emergence of the night time economy, that impact on changes in social norms and behaviours.

Topical Issues	Descriptor
9. Rural and remote policing	As for many workers, rural and remote location work brings with it a special set of challenges. They are often so daunting that recruitment and retention of workers become severely jeopardised.
	Getting the right staff to work in rural and remote locations is essential. An example of an innovative policing strategy was the Northern Territory's Remote Communities Drug Strategy (see Delahunty & Putt, 2006a; Delahunty & Putt, 2006b).
	Nonetheless, there are few materials and little training available to assist police in rural areas (Delahunty & Putt, 2006a, 2006b). This notwithstanding, training is the foundation of the police service delivery model in Western Australia. It was only as recently as 2004 that the first remote service training course was held for new staff. That initial 12-week course covered a variety of critical training issues.
10. Research, Evaluation and Prevention	The increased emphasis placed on the professionalisation of the police force and the growing importance of intelligence-led policing require the development of more sophisticated skills and knowledge in relation to research and evaluation. To-date, limited opportunities have existed for police to acquire skills in these areas. Most training and professional development opportunities are not designed with police in mind and often operate from an inconsistent or incompatible framework. Forming research partnerships is confounded is some cases by a lack of basic training and familiarity with research methods and concepts. Urgent strategic advances are required in this area. Increasing attention is now also focussed on the proactive role police can play in relation to prevention. Many standard operational roles of police already constitute prevention best practice. More precise role descriptions, guidelines, and training are required to enable police to more fully and effectively function in regard to AOD-related preventive activities.

JURISDICTIONAL VARIATION VS STATE AND NATIONAL STRATEGIES

To assist police to address these increasing demands there has been a range of capacity building initiatives targeting police including the adoption of guidelines for managing people affected by AOD (e.g., psychostimulant guidelines[14]) and the provision of drug diversion training. Most of these initiatives have been introduced at a jurisdictional level. A national strategy is also needed that includes a range of initiatives to facilitate organisational policies and structural support necessary to legitimise AOD police work across Australia.

While many patterns of use and their associated problems are similar and warrant responses derived from coherent and co-ordinated strategies, there are also unique and localised problems and concerns that demand local and tailored responses. Underscoring the need for locally tailored responses to AOD problems, in addition to state and national strategies, is the substantial jurisdictional variation that occurs across Australia in relation to AOD use. Such variations[15] highlight even further the need for local police to be well informed about the AOD issues they confront and the evidence of best policing options available.

Accordingly, AOD-related workforce development strategies (including training programs) for police need to be influenced and driven by coherent policy objectives that have

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14 Jenner, L., Baker, A., White, I., & Carr, V. (2004). *Psychostimulants - Management of acute behavioural disturbances: Guidelines for police services.* Canberra: Australian Government Department of Health and Ageing.
15 Note for instance the elevated levels of alcohol use in the Northern Territory compared to other states as one example.

been developed in a problem-oriented context, in much the same way as other policing responses (Nicholas, 2000).

CHANGES IN POLICE CULTURE

Policing styles and approaches have also altered substantially over recent years. Some changes have been so fundamental and profound as to constitute a culture change. This is particularly evident in areas relevant to the management of AOD-related issues. One important shift has been in relation to alcohol law enforcement and regulation where the emphasis on policing activity previously focussed on the person rather than the location or setting. Increasing attention is now directed to the latter as the source of potential problems but also as an opportunity for early intervention, preventive action and proactive policing.

An important shift in emphasis from individual perpetrator (or victim of crime or offences) to the context, setting or location has occurred. This allows greater latitude for consideration of causal or contributory factors to ensuing problems. This also has facilitated a shift to proactive as opposed to reactive policing styles. The latter allows for more strategic and proactive responses to address root causes rather than only responding to symptoms.

Police are increasingly moving towards the implementation of non-criminal justice related outcomes for minor drug offences. Police increasingly refer offenders to health and welfare services and to other forms of early and brief intervention. This has important workforce development implications for police in relation to team work, partnerships, collaboration and problem solving. Moreover, it raises important issues about the working relations required with key partners from other sectors such as health, human services and community services.

ENHANCING THE PROFESSIONAL ROLE OF POLICE

The recently released document 'Directions in Australia New Zealand Policing 2008-2011: A Policing Strategy by the Ministerial Council for Police and Emergency Management – Police' (2008) highlighted enhancing police professionalisation as one of its top four directions. Enhancing the professionalisation of policing, respect within policing, and improving confidence in and respect for the police were identified as priorities in the strategy.

The document identified Workforce Planning as a key priority area for action, specifying that:

> *"Police should plan and develop a strategy that responds to the policing needs of Australia and New Zealand into the future by:*
>
> *2.3.1 identifying the skills, knowledge and personal attributes required to meet future organisational and operational needs*
>
> *2.3.2 developing early strategies to attract and retain an educated and skilled workforce*
>
> *2.3.3 understanding the expectations of the future workforce and developing organisational strategies that will ensure policing remains an employer of choice and opportunity*
>
> *2.3.4 providing ongoing career development opportunities and supportive working environments for all who work in policing."*

The document also highlighted the importance of 'knowledge-based policing' indicating that this should be attained through continued development of policing as a research and knowledge-based profession by:

> *4.1.1 undertaking research to identify and share operational and organisational best practice in policing developing a repository of knowledge on policing policy and practice, and disseminating relevant research findings within policing environment enhancing strategic alliances within the higher education system in order to further develop policing as a research and knowledge discipline and integrate research requirements into courses and qualification frameworks.*

In relation to professional development, the document noted that for police to be an employer of choice the following was required to be demonstrated as an ongoing commitment to professional development:

> *4.2.1 continuing to develop an Australian and New Zealand strategy for police education and training*
>
> *4.2.2 developing an independently recognised education framework for policing*
>
> *4.2.3 continuing to enhance development of police employees*
>
> *4.2.4 working towards recognised common standards and accredited skills in policing across Australia and New Zealand*
>
> *4.2.5 ensuring equitable access to leadership training and career progression opportunities and transparency in succession management and planning.*

Increasing Research Skills and Focus

An area of growing relevance to police involves the field of evaluation and research (Fleming, 2008). Although funds have been made available over recent years for police-specific research endeavours (for example through NDLERF and the ACPR, such initiatives have often been overshadowed by comparable work of colleagues in other disciplines; and, in some instances projects have been hard to instigate due to lack of expertise, knowledge or interest in research. One factor (among many) that has contributed to the failure to flourish in this area stems from insufficient attention being directed to basic training and professional development that provides the foundation building blocks from which workers could then move on to develop research skills and an enhanced appreciation of the research literature.

With growing interest in program evaluation and related research activities there is an increasing imperative for police to be supported through a range of appropriate workforce development strategies that would facilitate development in these crucial areas.

THE MULTI-FACETED DETERMINANTS OF AOD ISSUES

There is accumulating research that indicates that drug use is not an isolated phenomenon; rather, it is a product of the social, cultural, economic and physical environments within which we live (Spooner & Hetherington, 2004; Marmot & Wilkinson, 2005). The social determinants perspective of drug use recognises the complex interplay of factors that

impact on the level and nature of drug use in a community. It also acknowledges that individuals both shape and are shaped by their environments (Spooner, 2005). AOD-related problems are not caused by specific problems in isolation but are influenced by multiple social and environmental factors. Effective modern day policing requires an understanding of this broader range of causal and contributoryfactors.

The historical context and contemporary array of AOD-related factors outlined above highlight the need for a national comprehensive workforce development strategy for police. Elements and key concepts contained within a workforce development approach are outlined in the next section.

A WORKFORCE DEVELOPMENT (WFD) PERSPECTIVE[16]

Workforce Developments To-Date

Over the past 10-15 years, a number of key police and law enforcement initiatives have focused on AOD-related workforce development. In addition, there has been increased interest in workforce development in its broadest sense for police (see Lynch, 2005, 2006), and embedded within that approach are numerous issues of relevance to AOD matters.

Table 2 displays details of key reports and reviews undertaken since the late 1990's that are of relevance to AOD police workforce development. There are several distinguishing features of this body of work. Firstly, there is only a modest level of attention that has been directed to workforce development. This is particularly noticeable in comparison with the emphasis placed on workforce development among other professional groups. Secondly, the body of work spans a range of diverse and disparate areas; reflecting the complexity and breadth of issues involved. This notwithstanding, there is a high degree of consistency in the overall thrust of findings and recommendations of these documents. Thirdly, and perhaps most importantly many of the issues raised and recommendations made in these earlier reports appear not to have been fully embraced nor implemented.

An opportunity exists to garner momentum generated from work undertaken over the past decade that consistently indicates the need to establish a comprehensive AOD workforce development strategy for police. The present report was undertaken with cognisance of the work that has preceded it, and aims to further advance and consolidate previous initiatives in relation to AOD workforce development for police.

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16   For further details of AOD WFD see NCETA's website www.nceta.flinders.edu.au

Table 2: A Chronology of Recommended AOD Workforce Development Strategies for Police

Year	Publication/Report	Focus	Recommended Actions/Strategies
1999	*Drug Harm Minimisation for Police In Australia* (Fowler et al., 1999)	• National strategic approach • Harm minimisation • Education and training for police	• There is a need for a national strategic approach for police in relation to drug harm minimisation • A process should be developed and implemented to operationalise harm minimisation in relation to education and training for police • The police national competency standards should be reviewed to identify those that have relevance for drug harm minimisation • AOD tertiary education courses need to be established that are relevant to and accessible by police officers
2000	*Education and training for police on the broad range of drug issues* (Nicholas, 2000)	• Development of education and training programs	• AOD-related education and training programs that are developed for police will need to acknowledge the relative emphasis that police place on supply, demand and harm reduction activities • The development of education and training programs should be shaped and driven by coherent policy objectives developed in a problem oriented manner, in a similar way to other policing issues
2002	*The impact of the national focus on harm minimisation on the uptake of illicit drugs in Australia* (Nicholas, 2002)	• Prevention • Harm minimisation	• Greater emphasis on primary, secondary or tertiary prevention programs • Ensure that primary prevention is clearly identified and articulated under the National Drug Strategy
2004	*The role of police in preventing and minimising illicit drug use and its harm* (Spooner et al., 2004)	• Harm minimisation strategies	• Establish a position in each local area with a dedicated liaison role with health services and drug-user organisations to facilitate communication, development of local protocols, implementation of guidelines and policies, education and training, and incident management • Education, training and guidance on participating in partnerships be provided to police involved in collaborative projects (including Drug Action Teams) • Provision of training and management support for evidence-based policing • The provision of education, training and management support in planning and evaluation methods to police at the local level • Development of user-friendly guidelines for local police on evidence-based proactive policing strategies, using research from a range of disciplines • Recognition to be given to the training and skills required for many of the tasks required for effective proactive policing and harm minimisation strategies

Year	Publication/Report	Focus	Recommended Actions/Strategies
2004	*Psychostimulants – Management of acute behavioural disturbances: Guidelines for police services.* (Jenner et al., 2004)	• Psychostimulants • Harm minimisation strategies	• Guidelines developed to assist all police staff when dealing with psychostimulant-affected individuals including youth, Indigenous people, women and people with suspected co-existing mental health issues • Acknowledge that acute psychostimulant toxicity is a medical emergency • Recommend a collaborative response between police, ambulance and emergency services
2005	*Alcohol and other drug issues facing policing in Australia* (Nicholas & Shoobridge, 2005)	• Clandestine laboratories • Methamphetamine • Comorbidity	• Essential for all operational police to be aware of the risks associated with clandestine laboratories, and that educational strategies reflect a need for community education and training for police about how to best respond and manage clandestine laboratories • Police and other emergency workers should receive adequate training and are well equipped to respond to methamphetamine-related behaviour
2006	*The policing implications of cannabis, amphetamine and other illicit drug use in Aboriginal and Torres Strait Islander communities* (Delahunty & Putt, 2006b)	• Aboriginal and Torres Strait Islander communities • Recruitment and support • Cross-cultural awareness training	• Training and induction programs needed to improve the capacity of police to work more effectively with Aboriginal and Torres Strait Islander communities on illicit drug issues • Identify and reward skills needed by officers to police effectively in sparsely populated but high need locations • Recruit, support and develop Aboriginal and Torres Strait Islander staff • Provide cross-cultural awareness training to police working with Aboriginal and Torres Strait Islander communities
2006	*Good practice framework: Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities* (Delahunty & Putt, 2006a)	• Recruitment and preparation • Mentoring and support	• Recruit the right staff to work in rural and remote settlements • Develop strategies to identify and prepare officers who are suited to working in isolated communities, including providing them with specialised training, pre-transfer visits to communities and high-level mentoring and support
2006	*Policing, volatile substance misuse, and Indigenous Australians* (Gray et al., 2006)	• Volatile substance misuse	• Standardise police training and protocols for dealing with volatile substance misuse between jurisdictions especially in the tri-state area of Western Australia, South Australia, and the Northern Territory

Year	Publication/Report	Focus	Recommended Actions/Strategies
2006	*Developing and implementing a performance measurement framework for drug law enforcement in Australia* (Willis et al., 2006)	• Performance measurement • Reducing crime • Improving public health • Improving community amenity	• High level drug law enforcement outcomes include: reducing drug crime and drug-related crime; reducing organised crime; and improving public health and community amenity • Drug law enforcement performance measures need to assess the efficacy of not only supply reduction but also demand and harm reduction initiatives
2007	*Monograph 15: Priority areas in illicit drug policy: Perspectives of policy makers* (Ritter, 2007)	• Distinction between "hard-end" policing and "public-end" policing	• There is a need for a clear conceptual framework in relation to the terms prevention and harm minimisation • Need to acknowledge the distinction between "hard end" policing (i.e. targeting high level drug trafficking and organised crime) and "public end" policing (i.e. street-level policing and policing aimed at addressing community amenity issues)
2008	*Directions in Australia New Zealand Policing 2008-2011* (Australia New Zealand Policing Advisory Agency, 2008)	• Workforce planning • Professional development	• Workforce Planning: ○ Identifying the skills, knowledge and personal attributes required to meet future organisational and operational needs ○ Providing ongoing career development opportunities and supportive work environments for all who work in policing • Knowledge based policing: ○ Undertaking research to identify and share operational best practice in policing ○ Enhancing strategic alliances within the higher education system in order to further develop policing as a research and knowledge discipline and integrate research requirements into course and qualifications frameworks • Professional development: ○ Developing an independently recognised education framework for policing ○ Continuing to enhance development of police employees
2008	*Guidelines for police services.*	• The Needle & Syringe Program Guidelines for Police • Methadone and Other Pharmacotherapy Guidelines for Police • Police Attendance at Overdose Guidelines	• In very recent years a number of new guidelines on AOD-related topics relevant to police have emerged that provide directions for interventions and referral

For over a decade, the importance of workforce development has been noted in MCDS-endorsed National Drug Strategy (NDS) documents and strategic plans with growing emphasis. Workforce development has been identified as critical to sustaining the strategies embedded within the NDS Action Plans. For example, the National Action Plan on Illicit Drugs 2001-2003 highlighted the importance of education and training but also indicated that any sustained change would require organisational and structural change and support. This included policies, guidelines, and management support that valued and legitimised AOD roles and functions. However, insufficient interest in workforce development has been generated to achieve the momentum required for substantial progress to be made.

In the late 1990's, Single and Rohl (1997), in undertaking the evaluation of the National Drug Strategy 1993-1997, made a total of seven specific recommendations. Of these seven recommendations, two (#3 & #5) had clear and direct implications for workforce development, albeit with a focus restricted to training and data collection in contrast to the now well endorsed broader focus of workforce development:

Recommendation #3

Train mainstream health, law enforcement and community officials to effectively minimise drug-related harm.

For doctors, nurses, psychiatric workers, prison officials, social workers, pharmacists and law enforcement personnel to effectively deal with the problems of substance misuse, special training programs should be developed or enhanced. Medical schools, nursing schools and other professional education institutions should give greater attention to specialised education and training in alcohol, tobacco and illicit drugs.

Recommendation #5

Improve the ability to monitor the performance of the NDS and make new developments in prevention, treatment and research more readily available to health care practitioners, law enforcement officers and the public at large.

In order to improve the utilisation of research and successful NDS programming, it is recommended that an Australian National Clearinghouse on drugs be created. The clearinghouse would create an inventory of drug programs and develop an electronic network of key resource centres for front-line professionals. It would develop a website on the Internet and present information in a non-technical fashion on recent developments in prevention, treatment, research and policy targeted at doctors, other health workers, social workers, law enforcement officers and government policy makers.

(Single & Rohl, 1997, pp. 83-85)

Single and Rohl (1997) also noted that:

"The development of education and training initiatives was limited in the early phases of the Strategy by the paucity of research and well-trained professionals in the field of substance abuse. Now the NDS has developed a critical mass of talented and highly qualified specialists and contributed to the development of a much improved knowledge base. Having reached this more mature state, it would seem appropriate that education and training be given more emphasis in the next phase of the NDS".

Single and Rohl (1997) recognised that a significant investment in workforce development was a necessary and crucial element to improve outcomes and quality in Australia's response to drug problems. A similar recognition underpinned the Directions in Australasian Policing (Australasian Police Ministers' Council, 2000) report which outlined three key directions, the second of which emphasised strategies for professionalism and accountability in police. This direction incorporated a goal related to education and training to enhance "employee competence and performance and on-going career development", with an emphasis on the development of best practice policies and guidelines for police.

AOD WORKFORCE DEVELOPMENT - A CURRENT PRIORITY

More recently, workforce development has been identified as a priority area in the 2004-2009 National Drug Strategy: Australia's Integrated Framework (Ministerial Council on Drug Strategy, 2004). This strategy recognises that a multifaceted approach is required to develop the AOD workforce and calls for action to:

> "…develop a framework for a national strategy that will prepare the workforce for future challenges, raise their professional status and improve their capacity to adopt more effective innovations" (p8).

The need for a national AOD workforce development strategy was also recently underscored by Dr Neal Blewett (2006). While referring largely to needs related to the health sector, much of what Blewett identified is relevant to police and law enforcement. He stated that:

> "In the last twenty-one years there has been the biggest expansion of drug treatment and rehabilitation services in Australian history and in this sphere the present national government has more than maintained the momentum. There has been a massive increase in the drug workforce and with it a rise in the status of that workforce, **but there has been no commensurate attention to the needs of that workforce.**[17]
>
> This quantitative change has been accompanied by qualitative changes in the demands made upon workers – increased knowledge demands, the rapid shifts and changes in drug fashions, increased range of treatment options, demand for evidence-based practice, the need for partnerships with other services.
>
> It is, I think, no exaggeration to say that we are facing a crisis in this area with increasing difficulties in recruiting and retaining qualified staff, particularly in rural and remote areas".

Concern about lack of attention to workforce development expressed above is equally applicable to police as it is for workforces in other sectors.

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17 Emphasis added.

Defining Workforce Development

We define workforce development as:

> *"A multifaceted approach which addresses the range of factors impacting on the ability if the workforce to function with maximum effectiveness in responding to alcohol and other drug-related problems. Workforce development should have a systems focus. Unlike more traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of mainstream workers."*
>
> *(Roche, 2002)*

The above definition of workforce development was endorsed by IGCD in 2003 and this definition has been adopted by state-based AOD workforce development strategies in a number of jurisdictions including New South Wales and Victoria. In essence, workforce development is about systemic approaches to enhancing the efficiency and effectiveness of the workforce.

This broad definition of workforce development highlights the importance of infrastructure, systems and organisational issues and positions training as merely one aspect of a much broader array of essential elements (see Figure 1). The primary aim of workforce development is to facilitate and sustain the workforce by targeting organisational and structural factors, as well as individual factors (Roche, 2002). While not an exhaustive list, examples of individual versus organisational and structural factors include those shown in the box below.

Individual factors	Organisational and structural factors
• knowledge • skills • attitudes	• policy • funding • recruitment and retention • accreditation • resources • support mechanisms • incentives

(Roche, 2001; Allsop & Helfgott, 2002)

Figure 1: The different levels and components of workforce development

A Systems Approach

Central to the definition of workforce development adopted by IGCD is the focus on the systems within which the workforce operates. The basic premise of a systems approach to workforce development is that while education and training are important, more attention needs to be given to the organisational context in which workers operate and the wider systems at large which may ultimately determine whether specific policies or practices can be put in place (Roche, 2001).

This approach to workforce development focuses on the need for systemic approaches to organisational, services and structural change in order to build the capacity of individual workers. Capacity building refers to:

> *"strategies and processes which have the ultimate aim of improving … practices which are sustainable"*
>
> *(Crisp, Swerissen, & Duckett, 2000, p. 99)*

A systems approach to workforce development has two important implications for the development and implementation of a national AOD workforce development strategy. It involves:

1. supporting the sustainability of the AOD workforce
2. facilitating and supporting frontline workers to effectively apply their knowledge and skill to work practice.

Issues to be captured in a national strategy that extend well beyond a focus on education and training alone include:

- Recruitment and retention
- Professional and career development
- Leadership and supervision
- Knowledge transfer and research dissemination
- Mentoring and supervision
- Workforce wellbeing
- Workplace support
- Evidence based practice
- Information management
- Legislation
- Policy
- Clarification of staff roles and functions.

For an examination of broader issues captured under the umbrella of workforce development the reader is referred to the NCETA's workforce development Theory Into Practice (TIPS) resource,[18] which covers issues such as:

- Supervision
- Effective teamwork
- Evaluating AOD programs and projects
- Goal setting
- Mentoring
- Organisational change
- Recruitment and retention[19]
- Professional development
- Workforce wellbeing[20]
- Workplace support.

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18 Skinner, N., Roche, A. M., O'Connor, J., Pollard, Y., & , & Todd, C. (2005). *Workforce development TIPS (Theory Into Practice Strategies): A resource kit for the alcohol and other drugs field*. National Centre for Education and Training on Addiction (NCETA): Flinders University, Adelaide, Australia. Available at http://www.nceta.flinders.edu.au/wdt/

19 *Recruitment and Retention*
Like many other professional groups in Australia, police face increasing challenges related to recruitment and retention. Current projections are that by the year 2012 Australia will have reached a major workforce crisis across the board – police are not unaffected by this scenario. In this light, recruitment and retention of the workforce becomes an even more crucial workforce development issue than previously the case and one with important implications for AOD-related work. It is important to consider short term and limited strategies such as 'training only' in the context of staff turnover by attrition or promotion; and also to consider recruitment profiles to match the emerging needs of modern policing.

20 *Worker Wellbeing and Stress and Burnout*
A central workforce development issue is worker wellbeing and subsumed within it are issues related to stress and burnout. This clearly is an area of growing importance to police and it forms a fundamental building block of any workforce development strategy for self-evident reasons. It also is clearly not related to training in the traditional sense of skill development/acquisition, but it is very much aligned with issues related to role legitimacy, clear job descriptions and expectations, appropriate supervision, workplace team and supervisor support, and recruitment and retention. Increased levels of antisocial behaviour, violence and aggressive behaviour (often AOD-related) inevitably impacts on worker wellbeing and can induce elevated levels of worker stress.

TRAINING AND PROFESSIONAL DEVELOPMENT

To-date, limited emphasis has been directed toward the tertiary level training and professional development needs of police involved in AOD issues, with a few notable exceptions. As the studies in Part B of this report reveal, extremely limited options are available for anything other than short term non-accredited training. This has meant that more advanced study and training options have generally been less available to police than their professional peers and colleagues.

While police officers increasingly undertake post-academy tertiary study to advance their policing careers, they tend to enrol in courses perceived to be more generally relevant to their profession, such as business or management studies. The availability of a wider range of AOD-related tertiary courses relevant for and available to police would allow them to pursue this field of study for professional development.

Obviously, professional development and training are central elements of workforce development, and as such they are addressed in detail in this report. However, it is also stressed that training as an isolated strategy or a single-pronged response to complex workforce issues is very limited and ultimately is unlikely to achieve the desired objectives of organisational and practice change.

A further limitation of much training received by professionals in the form of in-service training or professional development is that it is often in the form of short non-accredited courses. This is also the case with policing. There has been a substantial increase in the availability of short courses for police, together with the emergence of a range of other forms of professional development activities. Note for example, the Police AOD Strategy Conferences the first of which was held in Adelaide in 1999. These important conferences continue to be conducted with a high degree of support every 2-3 years; the most recent of which was held at the Gold Coast in September 2007 and was attended by Commissioners of Police from each jurisdiction.

There are both strengths and weaknesses to short training options. The strengths include the scope that such courses offer in terms of their ability to be:

- tailored
- specific
- timely and
- locally relevant.

The weaknesses of short non-accredited courses include:

- unnecessary duplication
- inefficient use of resources
- no common benchmarks
- standards of variable quality
- levelled at lowest common denominator
- hinders more advanced skill development
- antithetical to other than concrete issues
- does not foster sophisticated, conceptual thinking and problem solving skills.

Why training is not a "silver bullet"

'When you pit a bad system against a good performer, the system almost always wins.' (Rummler, 2004)

Education and training is a necessary but not sufficient strategy for effective workforce development. Training does not occur in a vacuum. A range of factors related to the individual, the style of training and the workplace influence the extent to which training impacts on work practice (O'Donovan & Dawe, 2002). Further, work practice is influenced by range of factors beyond training. For example, in a U.S. study of drug and alcohol treatment programs McLellan et al. (2003) identified three key issues that impact on the sustainability and effectiveness of (in that instance, treatment) programs:

1. inadequate organisational and administrative infrastructure,
2. unstable workforce (high turnover) at all levels of the organisation from frontline workers to directors, and
3. high administrative burden for data collection and reporting.

These three factors are also echoed in many police settings. McLellan et al. (2003) argued that these issues called into serious doubt the capacity of existing programs to implement new and innovative interventions. Solutions suggested included:

- financial incentives to encourage professionals to pursue a career in the AOD field

- programs to support and train directors of centres in organisational and program management and

- a universal streamlined data collection system based on relevant information.

McLellan et al. (2003) concluded that the AOD field needs "…financial and technical investment as well as incentives to raise quality and attract the best personnel" (p. 121).

TRAINING TRANSFER

The ultimate aim of training is to either improve existing work practice, or introduce new work practices. An effective training program should impact on knowledge, skills and attitudes *and* work practice. To achieve this, training programs need to go beyond the mere provision of instruction. A wide range of individual factors may influence trainees' capacity to benefit from education and training including motivation to learn, expectations, needs, attitudes, existing knowledge, and learning styles. Moreover, education and training programs do not occur in isolation, rather they operate as sub-systems of much larger organisational systems. Factors in the work environment, such as the availability of support and encouragement from coworkers and supervisors, and organisational practices, policies and structures may also impact on the uptake of training and the influence training has on work practice.

The challenges associated with applying newly gained knowledge, skills, abilities, and attitudes to the workplace are widely recognised and within the training literature are referred to as the "transfer of training problem" (Salas & Cannon-Bowers, 2001). Training transfer concerns the extent to which knowledge, skills and attitudes gained from training

are applied, generalised, and maintained over time in the work environment (Baldwin & Ford, 1988). In this respect, the post-training environment is just as important as the pre-training and training environments. A consistent recommendation within the training transfer literature is for organisations that wish to enhance their return on investment from education and training to develop an understanding of the key factors that affect transfer of learning, and then implement strategies to facilitate transfer.

A broad range of factors at the individual, team, workplace and organisational levels can influence the transfer of knowledge, skills, and attitudes gained from training into work practice (Pidd et al., 2004). Individual factors include the personal characteristics, beliefs and views of individual workers. Team factors include team culture, structure, communication and morale. Workplace factors include workplace conditions such as workplace feedback, workloads, availability of support and general working conditions (e.g., job security, remuneration). Organisational factors include those that make up the overall organisational culture including, organisational role legitimacy, professional development opportunities, and opportunity for staff input. Organisational factors also include wider systems factors that may influence the functioning of the entire organisation such as government policies and strategies.

The importance of workplace and organisational factors for alcohol and other drug work practice change is acknowledged in reviews that have identified lack of time, heavy workloads and lack of funding or financial reward as common barriers to intervention (McRobbie et al., 2008; Sinclair, Bond, & Stead, 2004; Ulbricht et al., 2006). These findings highlight how system, organisational and individual factors beyond training play a role as illustrated in the diagram below.

WHAT WORKFORCE DEVELOPMENT ENTAILS

Education and Training are *necessary...*
But not *sufficient*

Systems Factors

Individual Factors

Education & Training
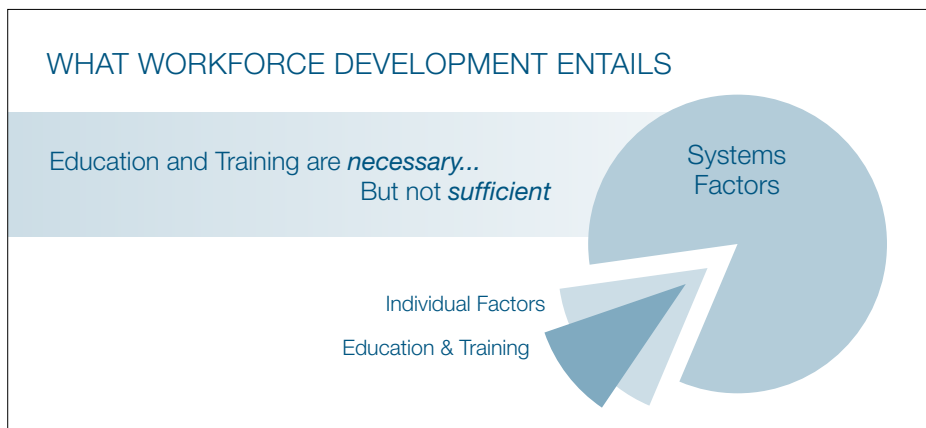
Four main factors likely to negatively impact training transfer have been identified as:

1. Failure to consider trainees' personal characteristics when designing training

2. Conducting training in isolation from the job trainees perform

3. Failure to consider strategies that may potentially enhance or detract from the trainee's ability to translate new skills into practice

4. Failure to consider the role or aims of the organisation

(Goldstein & Ford, 2002).

Goldstein and Ford (2002) argue that three key areas are crucial for effective training transfer:

1. *Instructional Design*
   - objectives
   - instruction plan
   - learning principles
2. *Trainee Factors*
   - readiness and motivation to learn
3. *Work Characteristics*
   - opportunity for practice
   - organisational climate that values the training
   - supervisor support to ensure trainees can access resources and strategies that will facilitate transfer of learning to work practice.

Factors that can negatively impact the uptake of training also include access to training constrained by distance and time, lack of flexibility in delivery, lack of backfill staff, and financial costs involved in attending training (Roche, O'Neill, & Wolinski, 2004; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003)

The recent Workforce Development Action Plan from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States highlights many similar workforce development issues as those encountered within Australia (Substance Abuse and Mental Health Services Administration (SAMHSA), 2007). In relation to AOD-related training they consistently found:

1. training content often not relevant to contemporary practice;
2. ineffective teaching methods to change actual practice; and
3. access to training and education was often quite limited, particularly in rural communities and for culturally diverse populations

(Substance Abuse and Mental Health Services Administration (SAMHSA), 2007, p. 117).

There is evidence that effectively trained staff will fail to use newly acquired skills if he or she returns to a work environment where the new skills are not understood and actively supported. Building skills and changing practice involves a combination of training and environment change. Without attention to the work environment, training efforts will be undermined.

THREE DOMAINS OF WORKFORCE DEVELOPMENT

A workforce development approach requires at least three levels of action (see Table 3) to ensure effective responses. The following three domains are identified as a useful schema for mapping out the multiple levels which a comprehensive workforce development strategy needs to address. They are:

1. Systems wide actions
2. Capacity building
3. Professional development.

Table 3 offers suggested strategies that could be implemented at each level to enable effective work practice changes that build the capacity of health and human service professionals to respond to the alcohol and other drug issues of their patients/clients.

While neither exhaustive nor definitive, these three domains provide an indication of the types of broad areas that are appropriately captured under the umbrella of an overarching workforce development schema and highlight that a workforce development approach extends well beyond merely addressing issues related to training alone. The latter is an extremely limited option if applied in isolation from other essential workforce development strategies. Moreover, training strategies if implemented as a principal practice change strategy run the risk of not only being of limited effectiveness but also of wasting the few police resources traditionally available for these endeavours. Squandering limited resources can be ill-afforded by any sector.

> *"there is a propensity to do what is affordable, not what is effective"*
> *(Substance Abuse and Mental Health Services Administration (SAMHSA), 2007).*

Table 3: Indicative AOD-relevant system wide, capacity building, and professional development levels strategies for police

Level 1. System-wide Actions	Level 2. Capacity Building	Level 3. Professional Development
1.1 Foster formal and informal linkages with relevant sectors to increase access to appropriate services	2.1 Develop and implement professional AOD support programs	3.1 Critique all current police professional AOD training
1.2 Appoint professional AOD support specialists	2.2 Provide resources and funds for professional AOD support programs	3.2 Establish a process to identify basic/essential AOD competencies for police
1.3 Develop AOD intervention policies and guidelines	2.3 Provide AOD training at various levels from basic through to more advanced for police	3.3 Ensure basic/essential AOD competency courses exist for all police
1.4 Update job descriptions to include AOD tasks, activities, skills and knowledge	2.4 Develop relevant undergraduate programs and content	3.4 Develop on-line AOD courses for police
1.5 Examine/preview current AOD guidelines	2.5 Develop resources to measure attitudes	3.5 Review existing face-to-face training courses for on-line development suitability
1.6 Develop AOD resources for managers	2.6 Develop and/or modify resources to conduct attitude change training	3.6 Develop advanced AOD training courses/workshops for police
1.7 Provide rewards and recognition for intervening in AOD issues	2.7 Provide relevant AOD-related supervision and mentoring	3.7 Develop workplace-based learning materials/packages on managing AOD issues
1.8 Foster role legitimacy by ensuring the imprimatur of senior officers	2.8 Acknowledge and address issues of stress and burnout and implement appropriate programs	3.8 Disseminate more broadly existing workplace-based learning materials that are applicable and relevant
	2.9 Develop strategies to address retention	3.9 Provide postgraduate study and professional development grant funding
	2.10 Develop a recruitment strategy	3.10 Ensure provision of training in relation to research, evaluation and prevention

Part A of this report has outlined a range of workforce development-related issues of relevance to police that may be considered in future initiatives. It has highlighted the lack of workforce development attention directed to AOD matters for police in comparison with comparable professional groups who also spend a large proportion of their time and resources dealing with AOD problems.

It is clear that a closer examination of the roles played by police in this area is needed. Such a comprehensive examination would allow an objective assessment to be made of the needs of police in this area, and it would provide an indication of the areas in which action may be required to enhance police activity in relation to AOD matters.

Until such an objective and comprehensive assessment is made caution should be applied in the allocation of resources on the basis of assumed need.

Part B that follows, provides data from three separate research activities that sheds light on some aspects of police-relevant workforce development issues. These studies provide a small but important contribution to a complex picture. Further work along these lines, and that outlined above, is required to establish a better evidence base of the workforce development needs of police in relation to AOD problems.

Part B

This part of the report presents data of relevance to the assessment of police workforce development needs. It is presented in three sections.

1. *The first section provides findings from a survey of WA Police conducted by NCETA, in collaboration with WA Police, in 2008. The survey specifically addressed issues associated with police officers' roles and training needs related to AOD matters.*

2. *The second section presents details of a survey undertaken by NCETA in 2004 of 11 different professional groups including police. It examined a range of factors related to their roles as workers dealing with AOD issues including their views about their needs.*

3. *The final section of this part of the report contains details of AOD training courses relevant to police.*

NCETA 2008 SURVEY OF WA POLICE

To review police views about relevant workforce development issues, a survey of police officers was undertaken in collaboration with WA Police in 2008. The survey was supported by a cost shared funding arrangement with the MCDS. The findings from that survey are presented below.

Participants

Participants were police officers working in Western Australia (employed by WAPOL). Police officers throughout Western Australia were contacted and informed about the survey through their internal electronic communication system. A link was provided to the survey where it could be accessed and completed online. Data collection was conducted over 16 weeks and reminders were sent to maximise response rates.

Measures

An online, purpose-specific questionnaire was developed to assess police officers' workforce development needs (see Appendix 1). The survey contained 30 questions and took approximately 10-15 minutes to complete. It included questions on the following issues:

- demographic characteristics including age, gender, ethnicity, education, type of work, rank, length of service, type of past and current training / education undertaken
- frequency and degree of challenge in responding to AOD-related incidents
- perceived importance of AOD issues within their role as police officers
- perceived level of supervisor / co-worker support for undertaking AOD training
- perceived organisational role legitimacy (i.e., the extent to which an organisation's culture, policies and practices supported, guided and encouraged police to undertake AOD training)
- work practices in dealing with people who are affected by AOD-related problems
- level of interest in AOD issues and training / education
- past and current training / education on AOD-related courses and perceived effectiveness
- preference for type of training and mode of delivery
- perceived need for and importance of additional AOD training / education
- perceived barriers to training / education in this area.

Ethics

The survey tool was designed in close collaboration with police and underwent several iterations before finalisation and piloting. Ethics approval was obtained from Flinders University Social and Behavioural Research Ethics Committee. The survey was also approved by the Police Commissioner of WA Police and was reviewed and approved by the WA Police Indigenous Community and Corporate Research Team.

Procedures

The study was advertised in local police newsletters and their internal communication system, inviting interested police officers to participate in the survey. Respondents had the option of completing the survey online or hard copies, together with self-addressed reply paid envelopes, were available if preferred. Potential respondents were assured of anonymity and confidentiality.

Findings

Participant demographics

A total of 135 surveys[21] were completed at the cut-off date (1 December 2008).[22] Slightly more than one third of the respondents were aged between 26 to 35 years, 79% were males (n=104), and one respondent was Indigenous. Gender and Aboriginality of respondents were representative of the WA Police population[23] (Western Australia Police, 2008). The highest formal qualifications obtained were either secondary school certificates (n=48; 37%) or TAFE qualifications (n=48; 37%).

Almost a third of respondents (n=43) worked in the Specialist Crime Section. Approximately half the respondents (n=64) were located in the north and central metropolitan surrounds and 22% (n=30) in regional WA. On average, respondents had been working for WA Police for 11.5 years, and 37% of respondents (n=40) had been working for WA Police for five years or less (see Figure 2). The majority were constables (30%; n=40), senior constables (29%; n=39) or sergeants (20%; n=27).

The sample is therefore representative of the demographics of the WA Police service overall, as indicated in the most recent WA Police Annual Report, but not at the level of specific functions.

Table 4 presents the detailed breakdown of demographics.

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21 Numbers of respondents reported vary due to non-responses for some survey items.
22 A total of 6,770 police staff (sworn and unsworn) were employed at WAPOL at the time.
23 Comparison of demographics conducted based on figures in the WAPOL Annual Report 2008.

Table 4: Demographic details of respondents

	Frequency	%	N
Age Range			
18-25 years	15	11	
26-35 years	49	37	
36-45 years	40	31	
46-55 years	21	16	
56+ years	6	5	131
Gender			
Male	104	79	
Female	27	21	131
Aboriginality			
Non-indigenous	129	99	
Indigenous	1	1	130
Highest Educational Level			
Secondary school (less than Year 12)	10	8	
Secondary school (completed Year 12)	48	37	
TAFE (Certificate / Diploma)	48	37	
Undergraduate / Honours degree	12	9	
Postgraduate degree / diploma	12	9	130
Length of Service			
Mean = 11.5 years			
Range = 0.3 – 39.8 years			109
Rank			
Senior executive	1	1	
Commissioned officer	6	4	
Senior sergeant	1	1	
Sergeant	27	20	
Senior constable	39	29	
First class constable	4	3	
Constable	40	30	
Probationary constable	6	4	
Special constable	1	1	
Cadet	5	4	
Other	4	3	134
Section			
Specialist crime	43	32	
Traffic and operations	21	16	
Counter-terrorism and state protection	20	15	
Corruption prevention and investigation	14	10	
Metropolitan regional support	13	10	
Other	23	17	134
Region[24]			
North metropolitan	64	48	
South metropolitan	13	10	
Regional WA	30	22	
Other	27	20	134

Note. N = number of respondents

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24 North metropolitan included central metropolitan, west metropolitan and northwest metropolitan regions of Perth. South metropolitan included southeast metropolitan and east metropolitan areas. Regional WA encompassed Goldfields-Esperance, Great Southern, Kimberley, Mid-west Gascoyne, Peel, Pilbara, Southwest, and Wheatbelt regions. Respondents who specified 'other' were those who operated statewide.
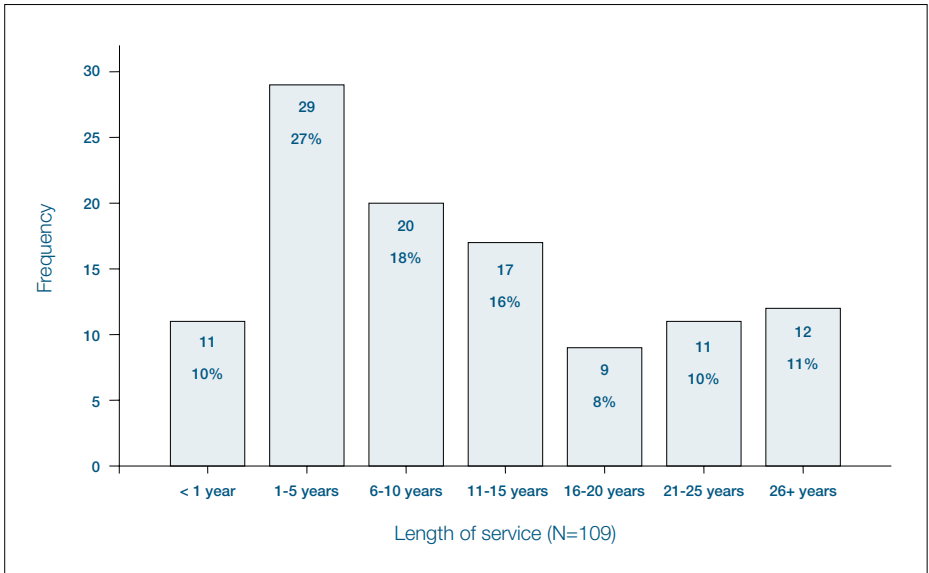
Figure 2: Years of WA Police Service

Alcohol and Drug-related Incidents

On average, respondents spent approximately 49% of their usual working week responding to alcohol-related incidents, and 22% of their time responding to other drug-related incidents. As can be seen in Figure 3, more than a quarter of respondents (n=24) spent over 70% of their usual working week responding to incidents where alcohol use was a factor. Almost half the respondents (n=43) spent up to 50% of their work time responding to alcohol-related incidents whereas only eight respondents stated that they did not spend any time at all responding to such incidents.

In relation to incidents where drug use other than alcohol was a factor, 40% of respondents (n=32) spent 10% or less of their usual working week dealing with such incidents. The majority of respondents spent less than a third of their weekly time responding to these incidents, with only 4% of respondents stating that they usually spent more than half their working week on other drug-related incidents.
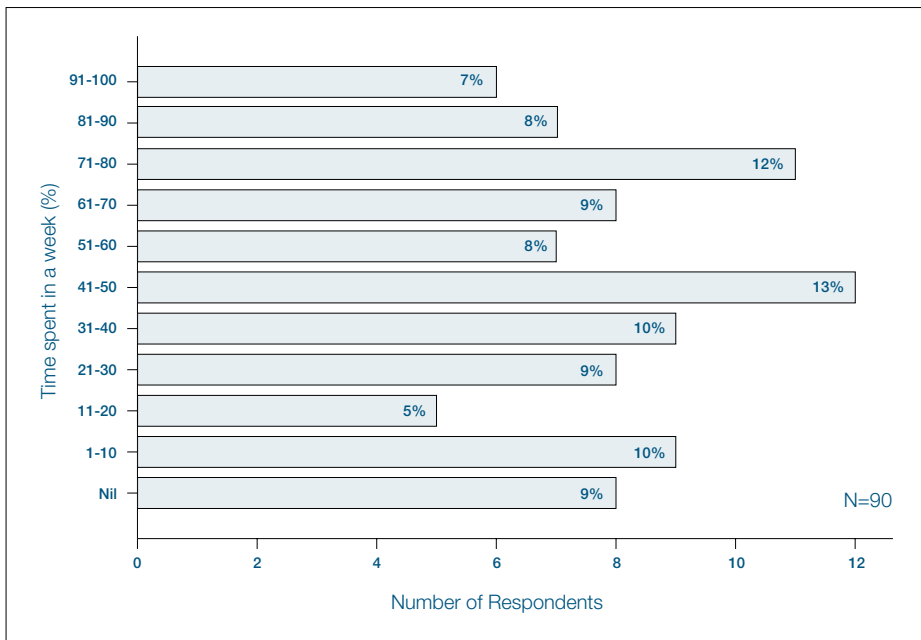
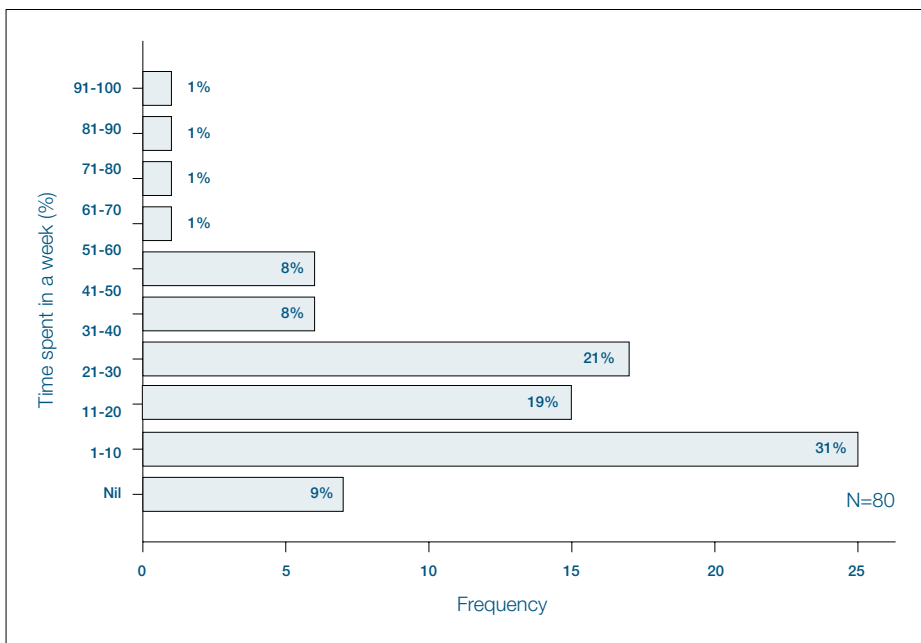Figure 3: Proportion of work time spent responding to alcohol-related incidences

Figure 4: Proportion of work time spent responding to drug-related incidences

Demanding Incidents

The most demanding incidents were those that involved ice/methamphetamines, alcohol and other amphetamines. Fifty five percent of respondents (n=58) perceived incidents involving ice/methamphetamine to be very demanding and almost half the respondents (n=52) perceived incidents involving alcohol to be very demanding (see Table 5). In addition, 43% of respondents (n=46) found dealing with incidents involving other amphetamines to be very demanding. Incidents involving cannabis and over-the-counter drugs were perceived to be the least demanding overall.

Table 5: Perceived level of demand in dealing with AOD-related incidents

Incidents Involving	Very demanding	Somewhat demanding	A little demanding	Not demanding	N/A	Total (N)
Alcohol	52 (48%)	39 (36%)	13 (12%)	2 (2%)	2 (2%)	108
Cannabis	5 (5%)	38 (36%)	47 (44%)	13 (12%)	3 (3%)	106
Ice/Meth	58 (55%)	30 (28%)	9 (8%)	3 (3%)	6 (6%)	106
Other amphetamines	46 (43%)	33 (31%)	15 (14%)	3 (3%)	9 (9%)	106
Heroin	11 (11%)	33 (31%)	21 (20%)	19 (18%)	21 (20%)	105
Other opioids	10 (10%)	28 (27%)	25 (24%)	15 (14%)	26 (25%)	104
Cocaine	12 (11%)	23 (22%)	24 (23%)	18 (17%)	28 (27%)	105
Ecstasy & other related drugs	25 (24%)	38 (36%)	25 (24%)	7 (7%)	9 (9%)	104
LSD	21 (20%)	15 (14%)	22 (21%)	18 (17%)	28 (27%)	104
Hallucinogens	24 (23%)	19 (18%)	26 (25%)	15 (14%)	21 (20%)	105
Over-the-counter drugs	3 (3%)	29 (28%)	42 (40%)	17 (16%)	13 (13%)	104

Common Alcohol-related Incidents

Antisocial behaviour, violent crime, and drink driving incidents were the most common alcohol-related issues that police 'always' or 'often' had to deal with when policing. Antisocial behaviour included noise, disturbances, public drunkenness, and damage offences; violent crime; and drink driving incidents (see Table 6). Nearly half the respondents (48%; n=52) stated that they always encountered antisocial behaviour fuelled by alcohol. About a quarter of respondents reported always having to deal with drink driving (28%; n=30) and violent crime, assault and family violence (25%; n=27) where alcohol was a factor.

Table 6: Perceived level of frequency in dealing with alcohol-related incidents

Alcohol-related Incidents	Always	Often	Sometimes	Rarely	Never	N/A	Total (N)
Antisocial behaviour including noise, disturbances, public drunkenness, and damage offences	52 (48%)	33 (31%)	11 (10%)	6 (6%)	2 (2%)	3 (3%)	107
Property crime	19 (18%)	42 (40%)	31 (29%)	10 (9%)	2 (2%)	2 (2%)	106
Violent crime, assault, family violence	27 (25%)	45 (42%)	22 (21%)	7 (6%)	2 (2%)	4 (4%)	107
Sexual assault	4 (4%)	10 (9%)	28 (26%)	47 (44%)	7 (7%)	11 (10%)	107
Child abuse/neglect	5 (5%)	16 (15%)	31 (29%)	35 (33%)	8 (7%)	12 (11%)	107
Drink driving	30 (28%)	42 (39%)	20 (19%)	6 (5%)	5 (5%)	4 (4%)	107
Sly grog (unlawful supply of alcohol)	2 (2%)	14 (13%)	26 (24%)	42 (40%)	13 (12%)	9 (9%)	106

Table 7: Perceived level of frequency in dealing with drug-related incidents

Incidents involving	Always	Often	Sometimes	Rarely	Never	N/A	Total (N)
Antisocial behaviour[25]	9 (8%)	38 (36%)	41 (38%)	11 (10%)	2 (2%)	6 (6%)	107
Property crime	11 (10%)	30 (28%)	48 (45%)	11 (10%)	2 (2%)	5 (5%)	107
Violent crime, assault, family violence	6 (6%)	31 (29%)	41 (39%)	18 (17%)	3 (3%)	7 (6%)	106
Sexual assault	1 (1%)	8 (8%)	31 (29%)	39 (36%)	15 (14%)	13 (12%)	107
Child abuse/neglect	1 (1%)	16 (15%)	30 (28%)	39 (36%)	11 (10%)	10 (10%)	107
Fatal overdose	-	3 (3%)	27 (25%)	46 (43%)	18 (17%)	13 (12%)	107
Non-fatal overdose	-	6 (6%)	36 (34%)	38 (36%)	16 (15%)	10 (9%)	106
Drug driving	5 (5%)	22 (22%)	31 (30%)	25 (24%)	9 (9%)	10 (10%)	102
Possession, trafficking, cultivation and manufacture	9 (8%)	36 (34%)	40 (37%)	11 (10%)	3 (3%)	8 (8%)	107
Clandestine labs	2 (2%)	9 (9%)	19 (18%)	46 (43%)	17 (16%)	13 (12%)	106

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25 Includes noise, disturbances, public intoxication, damage offences, loitering to buy drugs, discarded drug use equipment in public places.

Common Drug-related Incidents

Antisocial behaviour followed by possession / trafficking / cultivation / manufacture were the two most commonly reported drug-related incidents reported by police (see Table 7). Forty-four percent of the respondents (n=47) stated that they 'always' or 'often' encountered drug-related antisocial behaviour on the job. The drug-related antisocial behaviours reported included noise, disturbances, public intoxication, damage offences, loitering to buy drugs, discarded drug use equipment in public places, drug possession, trafficking, cultivation and manufacture; property crime; and violent crime, assault and family violence. Forty-two percent of respondents (n=45) stated that they 'always' or 'often' came across activities involving drug possession, trafficking, cultivation and manufacture in their work role. Other drug-fuelled incidents frequently encountered included violent crime, assault and family violence, and property crime committed by drug users.

Work Role

With respect to work role and AOD-related incidents, more than 90% of respondents agreed/tended to agree that there were definite advantages to improving their expertise in AOD-related areas (94%, n=88) (see Table 8). Most officers reported that they were able to deal with AOD-related incidents as competently as responding to other incidents (93%, n=87); and that they were confident of their abilities to respond to AOD-related incidents (93%, n=86). Four out of five respondents agreed that they had the necessary experience and knowledge to respond to AOD-related incidents (86%, n=81) and people with AOD-related issues (87%, n=81). Fewer than 30% (n=27) agreed that they did not have the necessary skills to respond to AOD-related incidents.

Three out of four respondents also agreed / tended to agree that most people with AOD problems were not interested in dealing with these problems (75%, n=70) and that they generally brought their difficulties upon themselves (74%, n=69).

Table 8: Level of agreement in relation to responding to AOD-related incidents

Issues	Agree (%)	Disagree (%)	N/A (%)	Total (N)
Able to deal with AOD-related incidents as competently as responding to other types of incidents	87 (93%)	5 (5%)	2 (2%)	94
Definite advantages in improving expertise in AOD-related areas	88 (94%)	4 (4%)	2 (2%)	94
Have necessary experience to respond to AOD-related incidents	81 (86%)	11 (12%)	2 (2%)	94
Confident in ability to respond to AOD-related incidents	86 (93%)	5 (5%)	2 (2%)	93
Have necessary knowledge to respond to people with AOD-related issues	81 (87%)	10 (11%)	2 (2%)	93
Do not have many of the skills necessary to respond to AOD-related incidents	27 (29%)	65 (69%)	2 (2%)	94
Most people with AOD problems are not interested in dealing with these problems	70 (75%)	22 (23%)	2 (2%)	94
People with AOD problems generally bring their difficulties on themselves	69 (74%)	22 (23%)	3 (3%)	94

Table 9 presents the proportion of respondents who agreed or disagreed with statements concerning their organisation's role in relation to AOD-related incidents. Three out of five respondents agreed that their organisation strongly supported responses to AOD-related incidents (75%, n=68) and that organisational responses to AOD-related incidents were consistent with responses to other crime / social problems (72%, n=67).

Organisational Support

Sixty nine percent (n=64) agreed that their organisation had clearly stated goals and objectives in its involvement with AOD-related incidents. Nearly 60% (n=54) of respondents agreed that their organisation consistently strived to improve responses to AOD-related incidents. However, more than half the respondents disagreed that staff roles and responsibilities in responding to drug and alcohol related incidents were clearly laid out in their job descriptions (53%, n=49).

Table 9: Level of agreement on the organisation's role in relation to AOD-related incidents

Issues	Agree (%)	Disagree (%)	N/A (%)	N
Clear AOD-related responsibilities in job descriptions	39 (43%)	49 (53%)	4 (4%)	92
Responses to AOD-related incidents consistent with responses to other crime / social problems	67 (72%)	23 (25%)	3 (3%)	93
Clearly stated goals / objectives in involvement with AOD-related incidents	64 (69%)	26 (28%)	3 (3%)	93
Consistently strives to improve responses to AOD-related incidents	54 (58%)	36 (39%)	3 (3%)	93
Strongly supports responses to AOD-related incidents	68 (75%)	19 (21%)	4 (4%)	91

The issue of clear job descriptions is a central workforce development concern, and one of particular relevance in the current context. The reader is referred to the NCETA workforce development Theory Into Practice Strategies (TIPS) Kit (see Skinner et al., 2005) for more detail on this issue.

AOD Education and Training

Eighty-five percent of respondents (n=87) had previously undertaken AOD-related training, which mainly comprised on-the-job and non-accredited training (see Figure 5).[26]

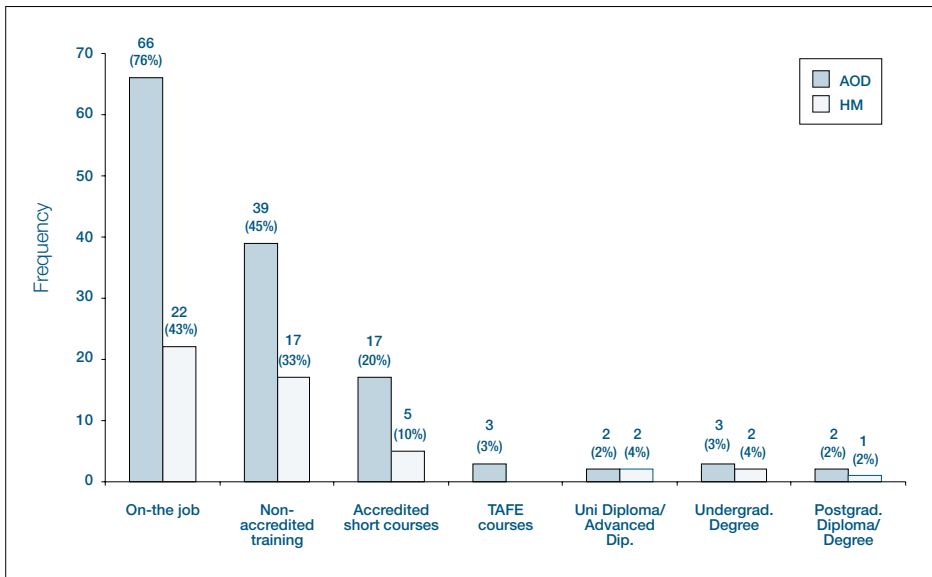26 Respondents could select more than one option.

Figure 5: Previous AOD education and training received

Half the respondents (49%; n=51) had received training that was specifically related to drug harm minimisation. The training received mainly comprised on-the-job and non-accredited training (see Figure 5).

None of the respondents perceived the training to be very useful in terms of dealing with AOD-related incidents (see Table 10). Seventy percent of respondents (n=67) thought that the training they had received was 'a little' (45%) to 'somewhat useful' (25%) in responding to alcohol-related incidents. Approximately half the respondents perceived that there was a little to some value of the training in relation to dealing with incidents that involved cannabis, ice/methamphetamines, or other amphetamines. Around 19-29% stated that they had not received any training in relation to drugs other than alcohol. On average, approximately a third of respondents perceived that the training received was not relevant to their current role (see Table 10).

Table 10: Perceived value of training in dealing with incidents related to specific drugs

Drug-related incidents	Very useful	Somewhat useful	A little useful	No training	Not relevant to role	Total (N)
Alcohol	0	24 (25%)	43 (45%)	13 (13%)	16 (17%)	96
Cannabis	0	13 (14%)	39 (42%)	24 (25%)	18 (19%)	94
Ice / Methamphetamines	0	15 (16%)	32 (35%)	18 (19%)	28 (30%)	93
Other amphetamines	0	12 (13%)	31 (34%)	20 (22%)	29 (31%)	92
Heroin	0	10 (11%)	27 (29%)	21 (22%)	35 (38%)	93
Other opioids	0	7 (8%)	26 (29%)	19 (21%)	38 (42%)	90
Cocaine	0	10 (11%)	25 (27%)	21 (22%)	38 (40%)	94
Ecstasy & other related drugs	0	10 (11%)	30 (31%)	27 (29%)	27 (29%)	94
LSD	0	8 (9%)	26 (28%)	23 (24%)	37 (39%)	94
Hallucinogens	0	8 (9%)	27 (29%)	21 (23%)	36 (39%)	92
Over-the-counter drugs	0	8 (9%)	28 (30%)	17 (19%)	39 (42%)	92

Alcohol-related training was perceived to be more useful than the training received for other drugs, while approximately a third of respondents perceived that the training received overall was not relevant to the role of police. Training received in relation to drink driving, licensed premises and clandestine labs (see Table 11) was assessed as the most useful of the training received.

While none of the respondents perceived the AOD education / training they had received to be very useful in dealing with incidents where drugs and/or alcohol were a factor, 76% of respondents (n=72) perceived that the training was 'a little' (40%) to 'somewhat' (36%) useful in dealing with drink driving incidents (see Table 11). Approximately 30% of respondents thought that the training was somewhat useful in relation to patrolling licensed premises and dangers from clandestine labs. About a third of respondents felt that the training they had received was only a little useful in dealing with intoxicated people and AOD-related violent crime, assault and family violence. On average, 23% of respondents stated that they had not received training that dealt with the AOD-related incidents listed in Table 11.

Table 11: Perceived value of training in dealing with AOD-related incidents

Incidents	Very useful	Somewhat useful	A little useful	No Training	Not relevant to role	Total (N)
Dealing with intoxicated people	0	16 (17%)	34 (36%)	26 (27%)	19 (20%)	95
Patrolling & visiting licensed premises	0	29 (31%)	23 (24%)	19 (20%)	24 (25%)	95
Drink driving	0	34 (36%)	38 (40%)	12 (13%)	11 (11%)	95
Drug driving	0	18 (19%)	23 (24%)	17 (18%)	37 (39%)	95
Antisocial behaviour including noise, disturbances, damage offences, loitering to buy drugs, discarded drug use equipment in public places	0	21 (23%)	31 (34%)	16 (17%)	24 (26%)	92
Dangers from clandestine labs	0	27 (29%)	23 (24%)	19 (20%)	25 (27%)	94
Drug possession, trafficking, cultivation, manufacture	0	20 (22%)	33 (35%)	21 (23%)	19 (20%)	93
Property crime*	0	12 (13%)	26 (28%)	25 (26%)	31 (33%)	94
Unlawful supply of alcohol (sly grog)	0	9 (10%)	23 (24%)	22 (23%)	40 (43%)	94
Violent crime, assault, family violence*	0	13 (14%)	33 (35%)	24 (25.5%)	24 (25.5%)	94
Sexual assault*	0	6 (7%)	23 (24%)	23 (24%)	42 (45%)	94
Child abuse & neglect*	0	5 (5%)	23 (25%)	22 (23%)	44 (47%)	94
Fatal overdose	0	5 (5%)	21 (23%)	28 (30%)	39 (42%)	93
Non-fatal overdose	0	7 (8%)	19 (21%)	27 (29%)	38 (42%)	91

*AOD-related

Seventeen respondents provided additional comment regarding the quality and adequacy of AOD education / training received. The main comments were that apart from basic training at the Academy, no other formal AOD training had taken place and most knowledge was gained "on the job". A few stated that the training received was not enough.

"I have only ever learned from other officers on-the-job"

"Training I remember having received from police about drugs and alcohol has generally been to do with police procedures for prosecutions, diversion, etc. I did receive some informal training in regards to how to deal with people affected by ice/other amphetamines. Alcohol-related training provided by police was solely to do with the enforcement of the Liquor Control Act."

"Training supplied by academy was the effects of alcohol and drugs nothing specifically in dealing with people affected. This was learned on the job."

Future Training

More than three quarters of respondents felt that the most appropriate level of AOD training for their work role would be at university level in the form of undergraduate (n=50; 76%) or postgraduate degrees or diplomas (n=51; 76%). Almost all respondents (n=92; 97%) felt that on-the-job training was not an appropriate level for training in AOD (see Table 12).

Table 12: Appropriate level of AOD education / training

Level of AOD Training	Yes	No	Total (N)
On-the-job	3 (3%)	92 (97%)	95
Non-accredited training	16 (19%)	69 (81%)	85
Accredited short courses	11 (12%)	79 (88%)	90
TAFE courses	33 (45%)	41 (55%)	74
Uni diplomas	43 (63%)	25 (37%)	68
Undergraduate degrees	50 (76%)	16 (24%)	66
Postgraduate diplomas / degrees	51 (76%)	16 (24%)	67

More than 90% of respondents stated that they would be interested in undertaking further AOD training specifically related to policing (n=85).

In relation to the AOD training they would like to receive, the majority of respondents stated that they would prefer to receive training at the Academy or workplace (n=53; 61%) and in a classroom setting (n=62; 70%). Forty-four percent (n=40) preferred to train with both police and health professionals and 23% (n=20) said they would prefer to undertake training with police only (see Figure 6).
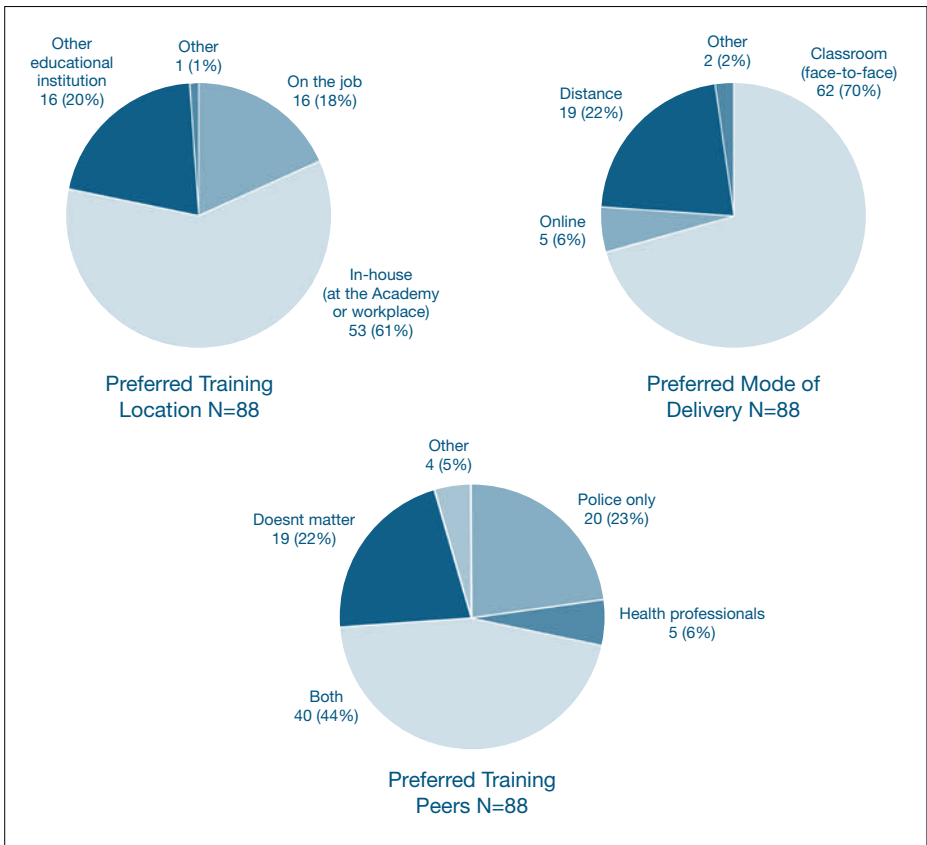
Figure 6: Preferred training location, mode of delivery, and training peers

The main reason given by those respondents who stated that they were not interested in undertaking further AOD training was that it would not enhance their career opportunities (see Table 13).

Table 13: Reasons for not requiring further AOD training / education

Reasons for not wanting further AOD training	Frequency
Further training would not enhance career opportunities	4
Have received sufficient training	3
AOD training would not increase effectiveness as a police officer	3
Not aware of available courses	2
Current courses irrelevant to work role	2
Current course times unsuitable	0
Lack of time	0
Lack of financial support	0
Lack of support from colleagues	0
Lack of support from supervisors	0
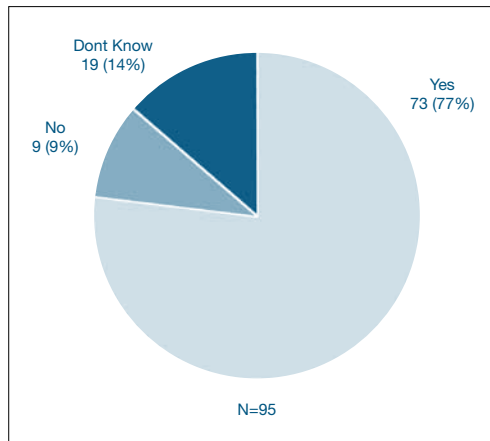
Figure 7: Useful to undertake AOD training earlier in career

Seventy seven percent (n=73) of respondents felt that it would have been useful to undertake training earlier in their career to help them deal with incidents related to drugs and alcohol. Ninety five percent (n=90) of respondents thought that education and training on policing licensed premises would be useful to their role (see Figure 8).
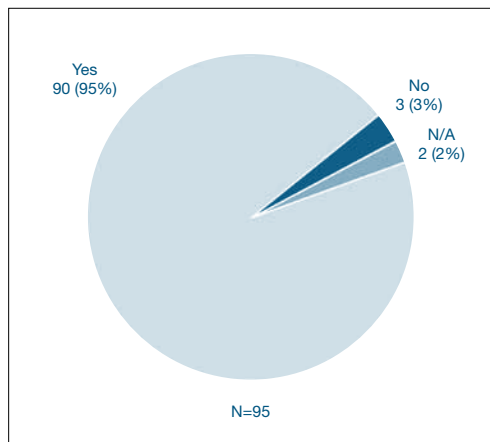

Figure 8: Useful to undertake training on policing licensed premises

Principles of drug harm minimisation

Three quarters (n=67) of respondents had a good understanding of the principles of drug harm minimisation, as reflected in their selection of all three statements that best described its principles (see Table 14). Additionally, 40% (n=37) of respondents stated that their organisation had operational policies or guidelines for police officers to apply drug harm minimisation principles to their job (see Figure 9). Forty three percent (n=39) did not know if such operational policies / guidelines existed in their organisation.

Table 14: Statements that best describe the principles of harm minimisation

Statements	Frequency (%)	Total (N)
Drug harm minimisation includes strategies designed to disrupt the supply and production of illicit drugs	9 (10%)	91
Drug harm minimisation includes strategies designed to prevent the uptake of harmful drug use, including abstinence-orientated strategies to reduce drug use	2 (2%)	
Drug harm minimisation includes strategies designed to reduce drug-related harm for individuals and communities	13 (14%)	
Drug harm minimisation includes all of the above	67 (74%)	
Drug harm minimisation includes none of the above	0 (0%)	
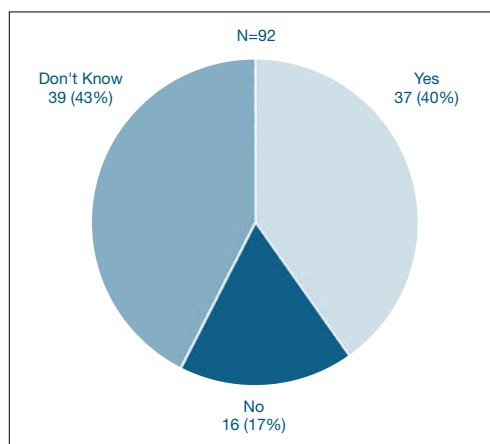
Figure 9: Operational policies / guidelines on harm minimisation in organisation

Additional Comments

Twelve respondents provided additional comment regarding some of the matters addressed in the survey. While a number of respondents thought learning on the job was sufficient, others felt that the importance of AOD-related education and training should be emphasised and "sold" to police personnel, particularly station and district level managers.

"Drug and alcohol issues often take a back seat on policing priorities at this level, especially when compared to crime statistics such as burglary. Therefore some sectors of police aren't concerned with improving their knowledge or response in the area. Having said that, upper levels within WA Police make districts responsible for those issues and are pushing the importance of AOD. Also police play a large role in dealing with drug and alcohol issues and for officers (at lower ranks who consistently deal with these issues) not to have an understanding of harm minimisation and AOD issues diminishes the WA Police's effectiveness and contribution in the area. I think further education in these areas would raise priority for dealing with these issues at district level and increased education at the lower rank levels would improve day to day responses to incidents."

"It is obvious from an Operational Officer's perspective that we do not get enough training. Although AOD is a specialist area, I consider it a necessity that all Officers work a seconded amount of time to improve their knowledge and confidence when dealing with alcohol /drug matters."

Summary

In summary, this survey of 135 WA Police officers found a significant proportion of the police workforce frequently dealt with incidents that involved alcohol or other drugs in a usual working week, some of which were perceived as highly demanding. Respondents generally perceived that they had sufficient knowledge, skills and competence to respond to people / incidents involving drugs and alcohol. While the majority of respondents had undertaken some form of AOD-related training, this training was mainly on-the-job or in the form of non-accredited courses. None of the training received was perceived to be very useful in dealing with AOD-related incidents. Most respondents expressed interest in undertaking further AOD training (i.e., mainly university courses) that was specifically related to policing.

Although respondents acknowledged organisational support towards harm minimisation principles and effective responses to AOD-related incidents, job descriptions and duty statements lacked clarity regarding the roles and responsibilities of police officers in relation to drugs and alcohol.

NCETA 2004 NATIONAL AOD WORKFORCE SURVEY

In 2004, NCETA undertook a large scale national survey of workers who encountered AOD matters as part of their day-to-day working lives.[27] The survey involved approximately 1,000 workers from the following professional groups; nurses, mental health specialists, AOD Specialists, medical staff, emergency and first aid, pharmacy, youth workers, community development workers, social workers, teachers and police.

- AOD specialists (N = 218)
- nurses (*N* = 241)
- medical staff (*N* = 51)
- emergency and first aid workers (*N* = 24)
- pharmacists (*N* = 28)
- mental health professionals (*N* = 104)
- youth workers (*N* = 34)
- community development workers (*N* = 45)
- social workers (*N* = 59)
- teachers (*N* = 48)
- police (*N* = 96).

The survey included 96 police officers from various states across Australia. Key results pertaining to police are presented below.

This study provides an opportunity to compare the findings from the WA 2008 Police survey with the data from the police component in the 2004 survey. It also provides an opportunity to compare the responses from police with 10 other professional groups.

The survey involved a questionnaire containing 148 items developed to measure a broad range of factors that impact on work performance and information related to individual workers, their workplaces and work teams, and the organisations within which they work.

Summary findings are presented below on factors such as workers' main roles in responding to AOD issues, workers' motivation to respond, and the amount and type of training received. Potential workforce development implications of the results are also highlighted.

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27 For the methods of the full survey of over 1000 workers contained in this study see the NCETA report Freeman T, Skinner N, Roche AM, Addy D, Pidd K. Workforce Development Issues in Australian Frontline Workers Responding to Alcohol and Other Drug-Related Problems: Preliminary Findings from a National Survey. National Centre for Education and Training on Addiction, Flinders University, 2004.

Table 15: Demographic characteristics of the different occupational groups

Occupational Group	N	Gender M	Gender F	Age Range	Age M	Age SD	Urban (pop. > 100,000)	Country (pop. < 100,000)	Small Country (< 1000)	Comb.
AOD Specialists	218	77	140	22-65	41.4	10.3	120	85	9	3
Nurses	241	47	194	23-65	42.8	8.9	126	91	22	1
Medical Staff	51	28	23	26-74	46.3	11.0	28	20	3	0
Emergency and First Aid Workers	24	16	8	24-60	37.8	9.5	15	8	1	0
Pharmacists	28	9	19	22-60	39.1	12.5	24	4	0	0
Mental Health Professionals	104	31	73	24-74	39.2	10.8	78	16	6	1
Youth Workers	34	12	22	22-48	33.3	8.0	18	14	0	0
Community Development Workers	45	16	29	21-65	39.6	10.4	28	16	0	1
Social Workers	59	17	42	23-70	41.2	11.1	39	16	4	0
Teachers	48	22	26	19-60	44.3	9.9	23	25	0	0
Police	96	72	23	20-54	34.0	7.1	34	57	5	0
Total	948	347 (37%)	599 (63%)	19-74	39.9	10.0	533	352	50	6

Of the 96 police officers in this survey, two thirds were male, the average age was 34 years and approximately two thirds were located in country areas.

Police reported less diverse AOD roles than professionals such as nurses, youth workers and community development workers who reported the widest variety of AOD roles. AOD-related activities engaged in by police included referral, safety and prevention and/or health promotion, in addition to policing AOD use.

Across all occupational groups workers viewed their main roles as being reactive (i.e., responding to an existing AOD problem) rather than proactive (i.e., acting to prevent potential future harm). This finding highlights the demand-driven nature of existing service response systems and the need for alternative, proactive models. Workforce development strategies may need to reinforce prevention as a major role of all occupational groups including police in responding to AOD issues. To date, this has been a largely overlooked area and is one that requires greater attention.

AOD Training

The uptake of AOD-related education and training is summarised in Table 16. The proportion of workers who had completed some form of AOD-related education varied between occupational groups from 40% to 82%. The most common forms of AOD-related education were non-accredited training courses and accredited short courses.

Tertiary AOD-related study was less common, although a substantial proportion of AOD specialists, youth workers and social workers reported that they had completed AOD-related tertiary study either at TAFE, undergraduate university, graduate university, or postgraduate university levels. Mental health professionals and medical staff were the groups most likely to have completed AOD-related education, and reported completion of AOD-related education more often than AOD specialists, nurses and other occupational groups.

The impact of training was uniformly reported to be high and did not differ according to the type of education or training.

Table 16: Uptake of AOD-related education and training amongst frontline workers

	None	Short courses	TAFE	University
AOD specialists	12%	40%	18%	19%[1]
Nurses	19%	56%	1%	14%
Medical staff	12%	63%	0%	10%
Emergency and first aid	38%	42%	4%	8%
Pharmacists	56%	28%	4%	8%
Mental health	13%	55%	8%	16%
Youth workers	20%	44%	12%	18%
Community development	35%	43%	9%	4%
Social workers	22%	37%	6%	28%
Teachers	29%	63%	0%	4%
Police	**23%**	**49%**	**0%**	**1%**

1 Rows may not add to 100% as some data were missing or coded as 'other'

Police were in the top five of the 11 professional groups surveyed reporting that they had received some AOD training. The majority of police obtained their training via short courses as opposed to undertaking TAFE or university level courses. Almost half (49%) of all police officers surveyed reported undertaking short AOD training courses.

Police were the least trained of any of the 11 professionals groups at the level of university training in relation to AOD matters. Excluding medical staff and teachers, police also received least training at the TAFE level. Tertiary study in the AOD field appears to be rare among police officers.

Responding to AOD Issues

The majority of police (56%) spent a substantial amount of time responding to AOD issues (44% spent more than 20% of their time on AOD issues). The main role reported was policing AOD use, but referral, safety and prevention and/or health promotion aspects were also noted as main roles.

Police reported moderately high levels of role adequacy and role legitimacy, but low work satisfaction and career motivation, and the lowest levels of motivation to respond to AOD issues. Police also reported the most negative attitudes towards responding to drug users (National Centre for Education and Training on Addiction (NCETA), 2006; Skinner, Feather, Freeman, & Roche, 2007).

For police, the most important predictors for responding to AOD issues were individual factors including role legitimacy, personal views and career motivation. Perceptions of formal support and systems influence were also related to police officers' motivation to respond to AOD issues. The impact of team factors such as team experience, informal and formal support was moderately low, while the impact of perceived organisational role legitimacy was moderate.

Table 17: Time responding to AOD issues by occupation: Number (%) of workers

Occupation	Percentage of time spent responding				
	1-20%	21-40%	41-60%	61-80%	81-100%
AOD Specialists	7 (3%)	9 (4%)	20 (9%)	29 (14%)	153 (70%)
Nurses	78 (32%)	33 (14%)	18 (8%)	13 (5%)	98 (41%)
Medical Staff	15 (31%)	8 (16%)	7 (14%)	6 (12%)	13 (27%)
Emergency and First Aid	14 (59%)	6 (25%)	2 (8%)	0	2 (8%)
Pharmacists	23 (82%)	2 (7%)	0	0	3 (11%)
Mental Health	36 (35%)	11 (11%)	4 (4%)	13 (12%)	40 (38%)
Youth Workers	10 (29%)	7 (21%)	3 (9%)	1 (3%)	13 (38%)
Community Development	12 (27%)	4 (9%)	2 (4%)	8 (18%)	19 (42%)
Social Workers	19 (33%)	8 (14%)	6 (10%)	6 (10%)	19 (33%)
Teachers	44 (92%)	2 (4%)	0	1 (2%)	1 (2%)
Police	**43 (44%)**	**22 (23%)**	**12 (13%)**	**12 (13%)**	**7 (7%)**

Police reported spending a similar amount of time on AOD issues as a number of other professional groups. But, few police officers received TAFE or University level training in AOD issues.

Table 18: Main roles nominated by occupational group

	AOD spec.	Nurses	Medical	Emer-gency	Phar-macy	Mental H.	Youth W.	Com. Dev.	Social W.	Teachers	Police
Assessment/ intake/triage	20%	13%	12%	-	-	14%	-	-	12%	-	-
Case management	6%	6%	-	-	-	-	9%	-	-	-	-
Counselling	61%	30%	32%	-	25%	78%	32%	23%	54%	27%	-
Crisis management	13%	25%	20%	25%	-	10%	9%	7%	14%	8%	-
Screening/mot. interviewing	6%	26%	34%	13%	14%	11%	12%	11%	19%	17%	-
Education	8%	6%	-	-	-	-	9%	16%	5%	25%	-
Information/ advice	-	-	-	-	18%	-	9%	9%	7%	-	-
Prevention/ health prom.	14%	14%	14%	-	11%	8%	21%	36%	14%	25%	7%
Referral	21%	33%	16%	-	14%	21%	50%	43%	41%	42%	8%
Safety	-	11%	-	-	21%	-	6%	-	9%	6%	8%
Treatment/ intervention	9%	14%	10%	8%	-	9%	12%	-	-	-	-

Note. AOD spec = AOD specialists, Mental H. = Mental health professionals, Youth W. = Youth workers, Com. Dev. = Community development workers, Social W. = Social workers, health prom. = health promotion, mot. interviewing = motivational interviewing. A dash indicates that less than 5% of the occupational group nominated this role as a main role.

AOD Training and its Impact on Work Practice

A wide range of training options are available to frontline workers including accredited and non-accredited short courses, TAFE certificates, university diplomas and degrees and postgraduate studies (see Appendix 2 for details of the Australian Qualifications Framework). Little is known, however, about the perceived impact of various types of training on work practice. Frontline workers' AOD education and training and their perceptions of the extent to which education and training improved their capacity to undertake appropriate and effective responses to AOD issues was examined in this survey.

Perceived impact of training on work practice was assessed on a 4 item scale addressing the extent to which training related directly to work practice, enhanced knowledge and skills, and improved response effectiveness. Responses were assessed on a scale that ranged from 1 (indicating that training did not impact on work practice) to 4 (indicating that training did impact on work practice).

In general, the perceived impact of training on work practice was uniformly high across educational categories. For AOD specialists and nurses, graduate or post-graduate education was reported to have the most impact on work practice. Trends in other occupational groups supported this finding.

Just over half of police reported receiving AOD-related education, largely from non-accredited training courses (32%) or accredited short courses (17%). Perceived impact of training on work practice was uniformly high and did not differ significantly across educational categories.

Table 19: Highest level of police education / training achieved and perceived impact of training on work practice

AOD-related education/training	Number (%)	Perceived impact Mean (SD)
Non-accredited training courses	31 (32%)	2.90 (.46)
Accredited short courses	16 (17%)	3.14 (.41)
Undergraduate university	1 (1%)	2.50 (N/A) [1]
Other	7 (7%)	3.13 (.61)
Total with AOD-related education	55 (57%)	2.99 (.47)
No AOD-related education	22 (23%)	
Missing	19 (20%)	

1 Standard deviations (SD) cannot be calculated with samples of one, as there is no variation.

This study also examined the role of individual, team and organisational factors on work practices. The individual, team and organisational/systems factors assessed were:

- individual variables: role adequacy, role legitimacy, motivation to respond to AOD issues, work satisfaction, personal views on responding to AOD issues and career motivation

- team variables: team experience, informal support and formal support

- organisational/systems factors: organisational role legitimacy and systems influence.

These factors are summarised in Box 1 and the areas of most relevance to police are highlighted in bold.

Box 1: Summary of individual, team and organisational factors

	Individual factors
Role adequacy	Generally good. Highest among AOD specialists, emergency and first aid workers, medical staff and mental health, and lowest among pharmacists and teachers.
Role legitimacy	Similar pattern to role adequacy. Highest among AOD specialists, medical staff and mental health, and lowest among pharmacists, teachers and community development workers.
Motivation to respond	Overall levels were high, and there was comparably little variability. **Police**, emergency and first aid workers and pharmacists reported the lowest levels.
Work satisfaction	Highest among AOD specialists and lowest among teachers, emergency and first aid workers, and **police**.
Personal views	Generally tolerant across all groups. **Police**, emergency and first aid workers, pharmacists, medical staff and teachers reported the least positive attitudes towards responding to AOD issues.
Career motivation	Highest among AOD specialists, mental health, community development, youth and social workers, and lowest among emergency and first aid workers and **police**.
	Team factors
Team experience	Highest among AOD specialists and youth workers, and lowest among emergency and first aid workers and pharmacists.
Informal support	Highest among AOD specialists and youth workers, and lowest among emergency and first aid workers, pharmacists and **police**.
Formal support	Highest among AOD specialists, youth workers, mental health, nurses and community development workers and lowest among emergency and first aid workers.
	Organisational factors
Organisational role legitimacy	Highest among AOD specialists, and lowest among emergency and first aid workers and pharmacists.
Systems influence	Similar pattern to organisational role legitimacy. Highest among AOD specialists, and lowest among emergency and first aid workers, pharmacists, teachers and **police**.

TRAINING COURSES FOR POLICE

Training Options for Police

To assess the training options currently available for police, a review of a recently established database of 1,192 courses (Roche, et al., 2008) was undertaken. The database included accredited and non-accredited courses offered at levels ranging from the Certificate II-IV levels through to university graduate and postgraduate courses. The courses included offerings in the field of alcohol and other drugs, comorbidity, mental health and psychology. Not examined were short courses that would be offered by the police academies or other forms of in-house police-specific training. A three stage search process was undertaken to identify relevant courses.

Stage 1: Search for Accredited AOD Courses

All known training bodies (including universities, TAFEs, RTOs and other training providers) were canvassed to identify all relevant accredited courses in Australia.

Information regarding accredited courses was obtained via:

- Internet searches
- Published course directories (online and hard copy)
- Requests for information on AOD and MH listserves
- Telephone or email where clarification and/or additional information was required.

A search for AOD accredited courses was conducted between August 2007 and February 2008. Online course directories were also examined for information about AOD-related courses.

Keywords used to search for AOD-related courses included *"addiction", "drug", "alcohol", "AOD", "substance abuse", "substance use", "community services", "epidemiology", "counselling", "harm reduction", "harm minimisation", "public health"* and *"youth".*

Stage 2: Search for Non-Accredited AOD Courses

To compile details of non-accredited courses, information was sought from specialist AOD training providers on the availability and nature of short non-accredited training courses in Australia run between July 2007 and June 2008. Calls for input were widely circulated and draft lists of courses were posted on the NCETA website to allow for identification of errors or omissions. In addition, information was gathered via Internet searches, AOD electronic list servers, training websites, etc., using similar keyword searches used to locate accredited courses.

While every effort was made to try and locate all existing relevant accredited and non-accredited courses, it is acknowledged that the final database may not be exhaustive and some courses may have unintentionally been omitted or may no longer be offered. There are several reasons for this; outdated course information may still be on a website, some

courses may be new, and/or not highly publicised at the time the search process was conducted. There were also some difficulties experienced in navigating websites when attempting to locate relevant courses and course information. Such potential barriers highlight the need for AOD courses to be well marketed, easily accessible and regularly updated.

Stage 3: Identification of AOD Courses Relevant to Police / Law Enforcement

From the compiled list of accredited and non-accredited AOD courses, a secondary search was undertaken to identify those that were or could potentially be relevant to law enforcement officers.

The following keywords and phrases were used to guide this search process: *"police", "policing", "legislation", "law enforcement", "legislation", "crime", "criminal justice", "criminology", "justice", "public safety", "court"* and *"legal".* These keywords / phrases were used to search course titles and descriptions.

After a comprehensive search was conducted, a closer examination was undertaken to ensure that each course identified was available, suitable and of relevance to police officers.

Courses identified as part of this process are relevant to the AOD sector broadly. They do not include any training courses/subjects/modules that may be provided internally by police jurisdictions throughout Australia. An analysis of the AOD training that is provided by individual police jurisdictions for their own members was outside the scope of the current project.

The course search resulted in the identification of six courses relevant to police from a total of 1,192. A total of five accredited courses and one non-accredited[28] AOD course relevant for police were located across Australia (see Table 20). Three universities and two TAFEs in South Australia, Western Australia and Victoria offered accredited courses. The non-accredited course was provided by a training body in New South Wales.

The courses that were identified as part of this project are relevant to the AOD sector broadly and are external to any training that may be provided at a local level by individual police organisations throughout Australia.

Accredited and non-accredited courses

Five accredited courses were found to be relevant for police officers, two of which were offered in higher education institutions in Western Australia. The other accredited courses were offered at universities in South Australia and Victoria. Two courses were offered at the Certificate IV level, two at the Graduate Certificate level and one at the Graduate Diploma level. Only one relevant non-accredited course was located within the database of AOD non-accredited courses. It was a 2-day workshop offered by a training centre in New South Wales.

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28 Non-accredited courses were defined here as courses that do not have documented accreditation processes and standards associated with tertiary institutions (that have vested in them the right to accredit courses) and professional standard bodies that have government imprimatur for this purpose. These processes and principles are laid down in the Australian Qualifications Framework 2007 ("Standards for State and Territory Course Accrediting Bodies" and the "Standards for Accredited Courses"). The process of accreditation involves demonstrating a community need for the course and content that is consistent with current evidence and leading industry standards.

Table 20: Accredited and non-accredited AOD courses relevant to police (as at 2008)

Institution	State	Course Title	Level
Adelaide University	SA	Alcohol & Drug Studies	Graduate Diploma
Adelaide University	SA	Alcohol & Drug Studies	Graduate Certificate
Edith Cowan University[29]	WA	Drug and Alcohol Harm Minimisation	Graduate Certificate
RMIT University	VIC	Alcohol & Other Drugs / Dual Award in Criminal Justice	Certificate IV
Central TAFE	WA	Alcohol and Other Drugs Work	Certificate IV
Centre for Community Welfare Training	NSW	Working with Coerced Clients	Non-accredited

Despite the importance of AOD issues to policing, the majority of tertiary AOD courses currently available primarily targets public health or drug treatment professionals and hence are seen as less relevant for police (Kennedy & Roche, 2003). Adelaide University offers a Graduate Certificate in Alcohol and Other Drug Studies which includes a subject on law, policy and prevention that deals with drugs, crime and national policies for alcohol and illicit drugs. The program also includes two other subjects which have a focus on treatment and pharmacotherapies. While the former subject would be applicable for police, the latter subject is likely to be less relevant to them.

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29 See Appendix 3 for further detail.

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Appendices

2008 NCETA WA POLICE SURVEY

Welcome to the Survey

This is a survey about the drug and alcohol education / training needs of police officers in Western Australia. Information collected from this survey will help assess the demand for additional drug and alcohol training for police.

If you are interested in participating, please complete this brief survey. It should only take approximately 10 minutes of your time. Be assured that any information you provide will be treated in the strictest confidence and neither you nor the area you work for will be individually identifiable in the resulting report and other publications. You are free to discontinue your participation at any time or to decline to answer particular questions. While details you provide will be held in the strictest confidence, the Internet is not necessarily a secure medium.

This project is a joint collaboration with Western Australia Police, the Drug & Alcohol Office, Department of Health, Western Australia, and the National Centre for Education and Training on Addiction (NCETA), Flinders University. The survey has been submitted and approved by the Commissioner of Police in WA, Karl J O'Callaghan APM.

The survey has also been approved by Flinders University Social and Behavioural Research Ethics Committee. The Secretary for this Committee can be contacted on 08-8201 5962, fax 08-8201 2035 or email sandy.huxtable@flinders.edu.au.

The final report summarising results from the survey will be made available later in the year.

Please feel free to contact me if you have any queries about this project. If you require a hard copy of the survey, please contact Vinita Duraisingam via email at vinita.duraisingam@flinders.edu.au.

Thank you for your attention and assistance.

Yours sincerely,

Professor Ann Roche
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National Centre for Education and Training on Addiction (NCETA)
Flinders University
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Email: ann.roche@flinders.edu.au

A. Demographics

This information is for statistical purposes only. Please tick your answers to the following questions.

A1. What region of the WA Police do you work in?

○ Central Metropolitan   ○ Great Southern

○ North West Metropolitan   ○ Kimberley

○ West Metropolitan   ○ Mid-West Gascoyne

○ East Metropolitan   ○ Peel

○ South East Metropolitan   ○ Pilbara

○ South Metropolitan   ○ South West

○ Goldfields-Esperance   ○ Wheatbelt

○ Other (please specify)

[   ]

A2. Which section of the WA Police do you work in?

○ Specialist Crime

○ Traffic and Operations

○ Counter-Terrorism and State Protection

○ Corruption Prevention and Investigation

○ Metropolitan Regional Support

○ Other (please specify)

[   ]

A3. Please specify your rank.

○ Senior Executive

○ Commissioned Officer

○ Sergeant

○ Senior Constable

○ Constable

○ Probationary Constable

○ Recruit / Direct Entry and Accelerated Training Program (DEAT) in training

○ Aboriginal Police Liaison Officer

○ Special Constable

○ Other (please specify)

[   ]

A4. How long have you been employed by the WA Police?

Years [   ]

Months [   ]

Demographics (cont'd)

A5. Please select your age range.

- ○ 18-25 years
- ○ 26-35 years
- ○ 36-45 years
- ○ 46-55 years
- ○ 56 years or over

A6. What is your gender?

- ○ Male
- ○ Female

A7. Are you Aboriginal or Torres Strait Islander?

- ○ No
- ○ Yes, I am Aboriginal
- ○ Yes, I am Torres Strait Islander
- ○ Yes, I am Aboriginal and Torres Strait Islander

A8. Please indicate the HIGHEST formal qualification you have COMPLETED.

- ○ Secondary school - less than Year 12
- ○ Secondary school - completed Year 12
- ○ TAFE (Certificate / Diploma)
- ○ Undergraduate or Honours Degree
- ○ Postgraduate Degree or Diploma (e.g. Postgraduate Diploma, Masters)
- ○ Other (please specify)

B. Drug and Alcohol Related Incidents

B1. In a usual working week, approximately what percentage of your time do you spend responding to incidents where:

ALCOHOL USE is a factor (%)

OTHER DRUG USE is a factor (%)

B2. Please tick the response which best describes how demanding it is to respond to incidents involving the following types of drugs.

	Not demanding	A little demanding	Somewhat demanding	Very demanding	N/A
Alcohol	○	○	○	○	○
Cannabis	○	○	○	○	○
Ice / Methamphetamines	○	○	○	○	○
Other amphetamines	○	○	○	○	○
Heroin	○	○	○	○	○
Other opioids	○	○	○	○	○
Cocaine	○	○	○	○	○
Ecstasy & other related drugs	○	○	○	○	○
LSD	○	○	○	○	○
Hallucinogens	○	○	○	○	○
Over-the-counter drugs	○	○	○	○	○

B3. In your work role, how often do you come across the following ALCOHOL related incidents?

	Never	Rarely	Sometimes	Often	Always	N/A
Anti-social behaviour including noise, disturbances, public drunkenness and damage offences	○	○	○	○	○	○
Property crime (as a result of alcohol use)	○	○	○	○	○	○
Violent crime, assault, family violence (as a result of alcohol use)	○	○	○	○	○	○
Sexual assault (as a result of alcohol use)	○	○	○	○	○	○
Child abuse and neglect (as a result of alcohol use)	○	○	○	○	○	○
Drink driving	○	○	○	○	○	○
Unlawful supply of alcohol (sly grog)	○	○	○	○	○	○

Other (please specify incident & frequency)

B4. In your work role, how often do you come across the following DRUG (not including alcohol) related incidents?

	Never	Rarely	Sometimes	Often	Always	N/A
Anti-social behaviour including noise, disturbances, public intoxication, damage offences, loitering to buy drugs, discarded drug use equipment in public places	○	○	○	○	○	○
Property crime committed by drug users	○	○	○	○	○	○
Violent crime, assault, family violence (as a result of drug use)	○	○	○	○	○	○
Sexual assault (as a result of drug use)	○	○	○	○	○	○
Child abuse and neglect (as a result of drug use)	○	○	○	○	○	○
Fatal overdose	○	○	○	○	○	○
Non-fatal overdose	○	○	○	○	○	○
Drug driving	○	○	○	○	○	○
Drug possession, trafficking, cultivation, manufacture	○	○	○	○	○	○
Dangers from clandestine labs	○	○	○	○	○	○

Other (please specify incident & frequency)

C. Drug and Alcohol Related Education / Training

C1. Have you ever received education / training related to drugs and alcohol?

○ Yes

○ No

C2. If yes, what kind of drug and alcohol education / training did you receive? (please tick all that apply)

☐ On-the-job

☐ Non-accredited training courses

☐ Accredited short courses

☐ TAFE Certificate / Diploma / Advanced Diploma

☐ University Diploma / Advanced Diploma

☐ Undergraduate Degree (e.g. Bachelors / Honours)

☐ Postgraduate Degree / Diploma (e.g. Postgraduate Diploma, Masters)

☐ Other (please specify)

C3. Have you ever received any education / training relating specifically to drug harm minimisation?

○ Yes

○ No

C4. If yes, what kind of drug harm minimisation education / training have you received? (please tick all that apply)

- ○ On-the-job
- ○ Non-accredited training courses
- ○ Accredited short courses
- ○ TAFE Certificate / Diploma / Advanced Diploma
- ○ University Diploma / Advanced Diploma
- ○ Undergraduate Degree (e.g. Bachelors / Honours)
- ○ Postgraduate Degree (e.g. Postgraduate Diploma, Masters)
- ○ Other (please specify)

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Adequacy of training received

The following questions examine the adequacy of drug and alcohol related training you have received in terms of your work role.

C5. Please tick the responses which best describe how useful the drug and alcohol education / training you have received was in responding to incidents involving the following types of drugs.

	Did not receive any training	Training was a little useful	Training was somewhat useful	Training was very useful	Not relevant to current role
Alcohol	○	○	○	○	○
Cannabis	○	○	○	○	○
Ice / Methamphetamines	○	○	○	○	○
Other amphetamines	○	○	○	○	○
Heroin	○	○	○	○	○
Other opioids	○	○	○	○	○
Cocaine	○	○	○	○	○
Ecstasy & other related drugs	○	○	○	○	○
LSD	○	○	○	○	○
Hallucinogens	○	○	○	○	○
Over-the-counter drugs	○	○	○	○	○

C6. Please tick the responses which best describe how useful the drug and alcohol education / training you have received was in dealing with the following incidents.

	Did not receive any training	Training was a little useful	Training was somewhat useful	Training was very useful	Not relevant to current role
Dealing with intoxicated individuals	○	○	○	○	○
Patrolling and visiting licensed premises	○	○	○	○	○
Drink driving	○	○	○	○	○
Drug driving	○	○	○	○	○
Anti-social behaviour including noise, disturbances, damage offences, loitering to buy drugs, discarded drug use equipment in public places	○	○	○	○	○
Dangers from clandestine labs	○	○	○	○	○
Drug posession, trafficking, cultivation, manufacture	○	○	○	○	○
Property crime committed by drug users	○	○	○	○	○
Unlawful supply of alcohol (sly grog)	○	○	○	○	○
Violent crime, assault, family violence (as a result of drug OR alcohol use)	○	○	○	○	○
Sexual assault (as a result of drug OR alcohol use)	○	○	○	○	○
Child abuse and neglect (as a result of drug OR alcohol use)	○	○	○	○	○
Fatal overdose	○	○	○	○	○
Non-fatal overdose	○	○	○	○	○

C7. Please feel free to provide additional comments on the adequacy and quality of training received.

Appropriate level of training

C8. Do you consider any of the following levels of drug and alcohol education / training to be appropriate to your role?

	Yes	No
On-the-job	○	○
Non-accredited training courses	○	○
Accredited short courses	○	○
TAFE Certificate / Diploma / Advanced Diploma	○	○
University Diploma / Advanced Diploma	○	○
Undergraduate Degree (e.g. Bachelors / Honours)	○	○
Postgraduate Degree (e.g. Postgraduate Diploma, Masters)	○	○

C9. Would you be interested in undertaking further drug and alcohol education / training that specifically relates to policing?

○ Yes

○ No

About the training you would like to receive

C10. Where would you most like to undertake education / training?

○ On-the-job

○ In house (at the Academy or workplace)

○ At another educational institution

○ Other (please specify)

[ ]

C11. What mode of education / training delivery would you prefer?

○ Online

○ Distance

○ Classroom (face-to-face)

○ Other (please specify)

[ ]

C12. Who would you prefer to be trained with?

○ Police only

○ Health professionals

○ Both

○ Doesn't matter

○ Other (please specify - e.g. legal professionals)

[ ]

Reasons for not wishing to receive training

C13a. Please specify your reasons for not wishing to undertake further education / training on drug and alcohol issues related to policing? (please tick all that apply)

☐ I have already received sufficient drug and alcohol education / training

☐ Drug and alcohol education / training would not increase my effectiveness as a police officer

☐ I am not aware of courses currently offered

☐ Current courses are not relevant to my role

☐ Undertaking further drug and alcohol education / training would not enhance my career opportunities

☐ Current course times are unsuitable

☐ Lack of financial support

☐ Lack of time

☐ Lack of support from colleagues

☐ Lack of support from supervisors

☐ Other (please specify)

[_____]

C13b. Please feel free to provide additional comments on this matter.

[   ]

Training needs in retrospect

C14. In retrospect, would it have been useful if you had received any, OR further, education / training in responding to drug and alcohol related incidents earlier in your career?

○ Yes

○ No

○ Don't know

C15. Do you think education / training on policing licensed premises is useful to your role?

○ Yes

○ No

○ Don't know

○ Not applicable

D. Work Role in relation to Drug and Alcohol Related Incidents

D1. These questions are about your work role in relation to drug and alcohol related incidents.

Please tick the response which best describes your level of agreement / disagreement with each statement.

	Disagree	Tend to disagree	Tend to agree	Agree	N/A
I am able to deal with drug and alcohol related incidents as competently as I respond to other types of incidents	○	○	○	○	○
In career terms, there are definite advantages in improving my expertise in drug and alcohol related areas	○	○	○	○	○
I have the necessary experience to respond to drug and alcohol related incidents	○	○	○	○	○
I am confident about my ability to respond to drug and alcohol related incidents	○	○	○	○	○
I have the necessary knowledge to respond to people with drug and alcohol related incidents	○	○	○	○	○
I do not have many of the skills necessary to respond to drug and alcohol related incidents	○	○	○	○	○
Most people with drug and alcohol related problems are not interested in dealing with these problems	○	○	○	○	○
I generally think people with drug and alcohol problems bring their difficulties on themselves	○	○	○	○	○

D2. These questions are about your organisation's role in relation to drug and alcohol related incidents.

Please tick the response which best describes your level of agreement / disagreement with each statement.

	Disagree	Tend to disagree	Tend to agree	Agree	N/A
Staff roles and responsibilities in responding to drug and alcohol related incidents are clearly laid out in their job descriptions	○	○	○	○	○
Responses to drug and alcohol related problems are consistent with this organisation's responses to other crime and / or social problems	○	○	○	○	○
This organisation has clearly stated goals / objectives about its involvement in drug and alcohol related incidents	○	○	○	○	○
This organisation consistently strives to improve the drug and alcohol related services it provides	○	○	○	○	○
This organisation strongly supports responses to drug and alcohol related incidents	○	○	○	○	○

E. Your Understanding of the Principles of Drug Harm Minimisation

E1. In your opinion, which statement best describes the principles of drug harm minimisation?
(Select ONE only)

○ Drug harm minimisation includes strategies designed to disrupt the supply and production of illicit drugs

○ Drug harm minimisation includes strategies designed to prevent the updake of harmful drug use, including abstinence-orientated strategies to reduce drug use

○ Drug harm minimisation includes strategies designed to reduce drug related harm for individuals and communities

○ Drug harm minimisation includes all of the above

○ Drug harm minimisation includes none of the above

E2. Does your organisation have operational policies / guidelines for police officers on applying drug harm minimisation in your job?

○ Yes

○ No

○ Don't know

F. Additional Comments

Thank you for completing the survey. Please feel free to comment on any matters addressed in this survey.

AUSTRALIAN QUALIFICATIONS FRAMEWORK

In reviewing currently available AOD courses it was important to be cognisant of the training frameworks within which such courses were offered, particularly the Australian Qualifications Framework (AQF).

The AQF provides a comprehensive national framework for all qualifications offered through Secondary Schools, the Vocational Education and Training Sector (e.g. Registered Training Organisations (RTO) and Colleges of Technical and Further Education (TAFE) and the Higher Education Institutions (e.g. Universities) (Ministerial Council on Education, 2007). It was introduced Australia-wide on 1 January 1995 and at the time of writing was in its fourth adaptation, having been last updated in 2007. Within the AQF there are specified learning outcomes and competencies for 15 levels of qualifications ranging from the Senior Secondary Certificate of Education to a Doctoral Degree, as outlined in Table 21. These qualifications may also be gained through alternative study pathways including apprenticeships, traineeships and work / school / organisationally-based training.

Table 21: AQF Qualifications by Accreditation Sector

Schools Sector	Vocational Education and Training Sector [30]	Higher Education Sector
Senior Secondary Certificate of Education		
	Certificate I	
	Certificate II	
	Certificate III	
	Certificate IV	
	Diploma	Diploma
	Advanced Diploma	Associate Degree
		Advanced Diploma
		Bachelor Degree
	Vocational Graduate Certificate	Graduate Certificate
	Vocational Graduate Diploma	Graduate Diploma
		Masters Degree
		Doctoral Degree

30 Certificates I to IV aim to recognise skills and knowledge that meet nationally endorsed industry/enterprise competency standards as agreed for those qualifications by the relevant industry, enterprise, community or professional group; and includes preparatory access and participation skills and knowledge such as:
- literacy and numeracy
- communication skills
- working in teams
- workplace technology and
- industry specific competencies, of increasing complexity and personal accountability at each level of the Certificate qualification (Queensland Government, 2007).

COURSE IN FOCUS: EDITH COWAN'S GRADUATE CERTIFICATE IN DRUG & ALCOHOL HARM MINIMISATION

The Graduate Certificate in Drug & Alcohol Harm Minimisation conducted at Western Australia's Edith Cowan University was selected for closer appraisal since it was the only course identified that was specifically targeted towards law enforcement and drug harm minimisation. This course is a new program that commenced in 2008. The course was offered off campus and could be completed within six months full-time or part-time equivalent. It offered four subjects / units:

i. Understanding Addictive Behaviour

ii. Addiction Studies: The Policy & Practice of Prevention

iii. Drug & Alcohol Prevention and Harm Minimisation: The Role of Police

iv. Essential Communication Skills for Justice Practice, or

v. Communication for Law Enforcement and Compliance.

According to the course description, it is designed for professionals who investigate and manage illicit AOD-related problems and provides an understanding of the nature of addictive behaviours and AOD harm minimisation policies and programs. In addition, the course also specifically examines the role of police in preventing illicit drug use and minimising harm.

One police officer who had completed the course provided feedback regarding its benefits. He stated that it provided in-depth knowledge and understanding of AOD use and government policies and strategies on AOD use and harm, and it identified initiatives and strategies that police can implement to address AOD-related issues within their work role. The course also helped him to understand how the role of law enforcement fits into various governmental frameworks, the roles and responsibilities of police within these policies and strategies, and what police can do to achieve effective results. This officer stated that the course:

> *"…was very orientated towards police, our roles and practical implementation of harm minimisation strategies."*
>
> *"Provided a theoretical understanding of models of drug and alcohol use and related harm. By understanding AOD use and harm the course identified the variety of areas where our efforts can be directed to achieve the best results."*
>
> *"Identified that intervening in drug and alcohol problems is a complex issue and the need for a variety of evidence based initiatives and strategies. The course gives examples of a broad range of strategies and how they fit into the principle of harm minimisation."*
>
> *"The course stimulated thought on how police can implement effective strategies to reduce AOD-related harm, or improve the effectiveness of existing strategies."*
>
> *Senior Constable*

He further noted that the course explained the principles of harm minimisation and the resultant benefits for both the police and the community when such an approach is adopted. The course also provided examples of how police currently assist in harm minimisation and identified solutions for further improvement.