NCETA
Australia's National Research Centre on AOD Workforce Development

Flinders UNIVERSITY

The development of Australia's alcohol and other drug workforce development strategy:

A discussion paper

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FOREWORD

A national Alcohol and other Drugs (AOD) Workforce Development Strategy (WFDS) is being developed at the request of the Intergovernmental Committee on Drugs. The project is being managed by the Northern Territory Department of Health and undertaken by the National Centre for Education and Training on Addiction (NCETA) at Flinders University.

This discussion paper provides a brief overview of issues relevant to the development of Australia's AOD WFDS. For a more comprehensive coverage of these issues, readers are invited to examine the full literature review available at www.nceta.flinders.edu.au.

The discussion paper outlines the background and context for the initiation of a WFDS, relevant Australian and international research and data, and potential areas for action to be addressed through the Strategy. It was informed by the preceding literature review. This paper is not intended to provide a definitive coverage of issues; rather, it is intended to be thought provoking, stimulating and in some respects challenging.

The scope of the AOD WFDS includes a wide range of human service providers from within and beyond the AOD field. It includes workers from health, welfare, law enforcement and corrections sectors and extends across policy, prevention, intervention and treatment roles. This is in recognition of the wide variety of personnel who play a role in reducing AOD harm. While much of this document focusses on the specialist AOD field it is important to be mindful of the broader scope of the Strategy development process.

The document will be used as the basis to inform and guide a national consultation process. The consultation process will provide an opportunity to address whether the discussion paper and the associated literature review:

- Contain significant gaps (for example issues, research, information, resources and examples of good practice)
- Accurately reflect the current state of play
- Reflect stakeholders' interests and concerns
- Contain potential responses that are consistent with stakeholders' perspectives.

Throughout this paper key questions are posed which are intended to stimulate discussion in relation to AOD workforce development. These questions appear in boxes.

The timeframe for consultation for the development of the Strategy is as follows:

- Discussion paper released September 2013
- Written submissions will be called for in early September
- A national consultation process will occur between September and November
- Development of the draft Strategy will occur early in 2014
- A final Strategy is due in June 2014.

Written submissions to the development process are welcome. These can be made via the NCETA website at www.nceta.flinders.edu.au or by phoning 08 8201 7535.

CONTENTS

LIST OF DISCUSSION QUESTIONS

1 WHY A WORKFORCE DEVELOPMENT STRATEGY?

The National Drug Strategy 2010-2015 (NDS) provides a national framework for action to minimise the harms to individuals, families and communities from alcohol and other drugs (AOD). Three 'pillars' form the overarching basis of this approach: demand reduction, supply reduction and harm reduction. These three pillars are underpinned by the need for a skilled and qualified workforce. A national workforce development strategy will assist jurisdictions in implementing best practice models for preventing and responding to AOD-related harms.

The AOD field, as with any area of endeavour, needs to continuously evolve and improve its practice in response to changes in societal needs and advances in knowledge. The AOD sector has experienced substantial change over recent decades. Shifts have occurred in patterns of consumption and the types of substances consumed, and advances in knowledge have led to changes in clinical practice and prevention strategies. These include:

- Shifting patterns of use, particularly towards poly-drug use
- New synthetic drugs
- An expanded range of pharmacotherapies and other treatment options
- Greater awareness of co-existing mental health disorders and multiple morbidities (particularly in the context of an ageing population)
- Greater awareness of foetal alcohol spectrum disorder, child protection and family inclusive practice issues
- Problematic use across a widened age spectrum
- Greater emphasis on cost efficiency, professional practice efficacy, improved outcomes and intersectoral collaboration
- A better understanding of effective preventive measures
- Greater recognition of the wide variety of workers involved in reducing AOD-related harm.

Factors such as these increase the demand to prevent and respond to AOD problems. As a result, there is growing recognition of the need for a workforce development approach in order to develop the capacity of the workforce to effectively respond to current and emerging AOD issues.

A WFD strategy can also help to:

- Identify the workforce implications of the current strategic and operational environment
- Balance current needs and prepare for the future
- Raise the profile of strategic workforce planning within organisations and influence change from the top down
- Integrate workforce planning with future directions for the organisation and sector
- Assess the current state of the workforce
- Create, drive and implement workforce planning.

One of the aims of the Strategy development process is to get broad general agreement about the extent and nature of WFD in the AOD field so that this can shape practice in this area and be built into service tendering processes and funding agreements.

A number of jurisdictions in Australia have considered and/or developed AOD Workforce Development Strategies. There is not, however, a nationally consistent approach to addressing the challenges facing the AOD workforce.

Q1. Has the lack of a nationally consistent approach to AOD workforce development impacted progress in responses to AOD-related harm in Australia? If so how?

2 THE SCOPE OF THE STRATEGY

The Australian workforce involved in the prevention and minimisation of harmful AOD use is highly varied, spanning a diverse range of employment sectors, industries and communities. Exposure to people with AOD problems varies across this workforce. Australia's National Drug Strategy (2010-15)

identified a range of groups in the AOD workforce, each of which has unique and specific needs that require comprehensive and systematic development. These groups included:

- Workers in treatment, prevention, health promotion and community services including AOD specialists, needle and syringe program workers and peer workers
- Police, emergency medical services, paramedics and correctional officers
- The mental health workforce
- The broader health and medical workforce, including general practitioners and other primary health care workers and hospital workers
- Indigenous health and law enforcement workers
- Culturally and linguistically diverse health and community service workers and child protection and disability workers
- Peer educators
- Pharmacists and the pharmacy workforce
- The education sector
- Community and support services, including workers from the welfare, homelessness, unemployment, income support and youth sectors (Ministerial Council on Drug Strategy, 2011).

All workers within these diverse groups are included within the scope of the Strategy.

Q2. In what way should the Strategy development address the diversity of workers within the scope of the Strategy?

3 WORKFORCE DEVELOPMENT - AN OVERVIEW

3.1 What is workforce development?

Workforce development in the AOD field aims to build the capacity of organisations and individuals to prevent and respond to AOD-related problems and to promote evidence-based practice. It goes beyond the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development and worker wellbeing. As such, WFD can be defined as:

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

This broad definition of WFD mandates a focus on a wide range of individual, organisational, structural and systematic factors that impact on the ability of the workforce to effectively prevent and respond to AOD issues. Without addressing these underpinning and contextual factors, the ultimate aim of increasing the workforce's effectiveness is unlikely to be achieved (Roche & Pidd, 2010).

It is possible to delineate four evolutionary phases of WFD in the AOD field.

3.1.1 Phase 1: Individual workers

The first phase involved a focus on individual workers. The key strategies in this phase were education and training programs and resources to enhance individual workers' knowledge and skills. However, by the early 2000s, the limitations of this approach were becoming apparent (Roche, 2002b). Emphasising the needs of individual workers failed to take into consideration the influence of the systems in which they worked. While education and training can enhance the skills and knowledge of individual workers, this does not always translate into sustainable work practice change. Quality service delivery is dependent on a range of organisational, structural, and systemic factors largely beyond the control of individual workers (Roche, Pidd, & Freeman, 2009; Roche, Watt, & Fischer, 2001).

3.1.2 Phase 2: The AOD internal systems approach

The next phase involved WFD strategies which focussed on the internal systems in which AOD workers were employed. It sought to facilitate and sustain the AOD workforce by targeting organisational and structural factors, as well as individual factors (Baker & Roche, 2002). The internal systems perspective included a diverse range of issues including:

- Recruitment and retention
- Information management
- Leadership, mentoring and supervision
- Knowledge transfer & research dissemination
- Workplace support
- Evidence based practice
- Professional and career development
- Workforce wellbeing
- Clarification of staff roles & functions
- Policy
- Clinical supervision
- Effective teamwork
- Evaluating AOD programs & projects
- Goal setting
- Organisational change
- Legislation
- Scholarships

(Roche & Pidd, 2010)

The incorporation of a systems focus into the definition of WFD signalled an important conceptual shift. Work Force development was no longer viewed as just comprising education and training initiatives. Instead, education and training initiatives were increasingly viewed as a subset of WFD activities which, in the absence of broader approaches, were likely to have limited effect (Roche, 2001). This is shown in Figure 1, which demonstrates that infrastructure, systems and organisational issues are essential to compliment and facilitate training. Figure 2 demonstrates how education and training programs influence individual factors which, in turn, articulate with a range of system factors.

Figure 1: The different levels and components of workforce development. Source: Roche & Pidd, 2010

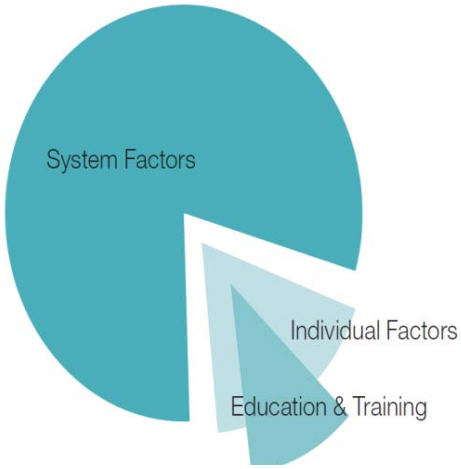

Figure 2: Education and training as one element of workforce development. Source: Roche & Pidd, 2010

It is important not to underestimate the challenges associated with implementing internal systems measures in some environments. In particular, rural and remote AOD services can have great difficulties providing adequate mentoring, supervision and support to their workers and ensuring their wellbeing. The environmental scan undertaken in 2013 by the Community Services and Health Industry Skill Council (CSHISC) highlighted the significant shortage of community services and health workers in rural and remote Australia. The CSHISC called for the implementation and rigorous evaluation of evidence-based measures, within a broader workforce development paradigm, to improve recruitment and retention in these environments. Citing the World Health Organization (2012), the CSHIC called for:

- The exposure of students to working in these environments
- Regulatory enhancements to support rural/remote workers

- Bonded education entitlements
- Financial incentives (Community Services & Health Industry Skills Council, 2013).

3.1.3 Phase 3: A human services systems approach

While the AOD internal systems approach represents an improvement over an individual worker approach, it is unlikely to fully meet the needs of the sector into the future. There is a growing appreciation of the need to prevent and address problematic AOD use in conjunction with other mental, physical, and social problems (Roche, 2013). There is also a growing awareness that no one group alone can meet the needs and expectations of clients, nor can these groups continue to work in silos. This is because they are reliant on the complementary skills of their colleagues to provide optimal care. Consequently, different governance arrangements are required. There is also growing client and community expectation of greater partnership and inclusion in the health care process (Nisbet, 2010).

It is therefore important that measures are put in place to ensure greater integration of the AOD sector with other sectors to deliver joined up service provision in prevention and treatment. To this end, it will be necessary to establish more formalised relationships and governance structures with the community/human services, health, law enforcement and education sectors (Roche & Pidd, 2010).

From this perspective, the future of the specialist AOD sector is likely to increasingly lie in more structured relationships with other sectors to prevent harms and address the needs of clients with multiple morbidities. This will involve working more closely with preventionists from different areas, community general practitioners and allied health workers, particularly those funded under mental health initiatives. It may also involve staff exchanges and outplacements between different organisations. At the same time, this should not occur at the risk of diminishing the unique skills and knowledge which are at the core of specialised AOD practice.

It is also critically important for the AOD WFD Strategy to focus not only on the needs of frontline AOD specialist workers, but also on the needs of other workers who, while not working in AOD specific organisations or programs, are well placed to implement AOD prevention and strategies. To focus on the needs of other workers will require adapting to varying systems, structures, and work practices across different sectors, organisations, and individual agencies. A human services systems approach will allow these diverse factors to be encapsulated and addressed within the Strategy.

3.1.4 Phase 4: Into the future

Implementing a human services systems approach will enhance the capability of the AOD workforce to respond to existing challenges. The AOD workforce of the future will need to develop the capacity to change and evolve to meet future challenges. The extent and nature of these challenges are unclear, but the development of the AOD WFD Strategy provides an opportunity to address emerging directions and broader strategic priorities. That is, the roles and functions of the AOD workforce should reflect bigger picture strategic directions and be shaped and informed by them.

Q3. At which evolutionary phase of WFD is the AOD sector?

3.1.5 What are the implications of a human services systems perspective for the Strategy?

A human services systems perspective of workforce development has important implications for developing and implementing a national AOD sector WFD strategy. It is helpful to think about three areas of focus for WFD activities (system wide issues, capacity building and professional development), all of which must be targeted in order for initiatives to be effective. These are outlined in Table 1.

Table 1. Suggested focus areas at the system wide, capacity building and professional development levels.

System wide issues	Capacity building	Professional development
Foster formal and informal linkages with health and human service professionals and AOD services to increase access to appropriate services, particularly those required by patients/clients with complex and high severity problems Appoint professional AOD support specialists for relevant health / human service professions Develop client/patient AOD intervention policies and guidelines for human service professionals Update job descriptions to include AOD tasks, activities, skills and knowledge Examine/produce current AOD guidelines for relevant health professions Develop AOD resources for managers Provide financial incentives for health professionals to intervene in AOD issues	Develop and implement professional AOD support programs for relevant health/human service professions Provide resources and funds to support professional AOD support programs Provide training for professional AOD support workers Develop undergraduate student programs Develop resources to measure attitudes Develop and/or modify resources to conduct attitude change training Provide clinical supervision	Critique current health/human service professional AOD training Establish a process to identify basic/ essential AOD competencies for health/human service professionals Ensure basic/essential AOD competency courses exist for all health/human service professionals Develop on-line AOD courses for health/human service professionals Review existing face-to-face training courses for on-line development suitability Develop advanced AOD training courses/workshops for health/ human service professionals Develop and disseminate workplace-based learning Materials/packages on managing clients/patients with AOD issues Provide postgraduate study and professional development grant funding Provide backfill funding for workers to attend training

Source: (Roche, Pidd, et al., 2009)

Q4. Are there currently any gaps in (or beyond) systems approaches, capacity building and professional development?

4 THE ALCOHOL AND OTHER DRUGS WORKFORCE

4.1 What is the profile of the AOD workforce?

Little work has been undertaken that provides an insight into the profile of the AOD workforce involved in policy and prevention activities. More work has been undertaken in profiling the workforce providing clinical services as described below.

In order to simplify and clarify understanding of the clinical AOD workforce, it is commonly broken down into specialists and generalists. That is, there are many professions whose workers may come into contact with individuals who have AOD problems. They can be classified into two distinct groups:

1. AOD specialist workers; and
2. Generalist workers.

Specialist AOD workers are those whose core role is assisting people with AOD problems. This includes AOD workers, nurses, peer workers, addiction medicine specialists and specialist psychologists and psychiatrists. Specialist workers may be employed in AOD specialist organisations or in AOD programs within non-AOD specialist organisations. They provide intensive treatment for clients with AOD-related issues (Roche & Pidd, 2010). These workers may have specialised degrees

or little or no formal training (Libretto, Weil, Nemes, Copeland Linder, & Johansson, 2004). The knowledge and skills required by these workers covers many diverse areas, including an understanding of relevant social, legal and medical issues (Berends et al., 2010). They are also employed in a diverse range of organisations, and can be found in the government, not-for-profit (non-government) and private sectors. Furthermore, the proportion of government and non-government specialist treatment agencies (and workers within such agencies) varies widely between jurisdictions. The systems and structures within which the workforce operates also differ across sectors, jurisdictions, and individual agencies (Roche & Pidd, 2010).

Generalist workers are employed in the mainstream workforce and have non-AOD-related core roles, but nonetheless come into contact with individuals who have AOD issues. Examples include police officers, teachers, social workers, nurses, child protection workers, culturally and linguistically diverse workers, counsellors and GPs. Generalist workers can play an important role in implementing AOD prevention and intervention strategies.

It is difficult to ascertain the extent and nature of the specialist and generalist AOD workforce within Australia. The most comprehensive overview of the AOD workforce currently available is a compilation of 13 AOD workforce development surveys conducted by NCETA (Roche & Pidd, 2010). This data demonstrates that, jurisdictional differences notwithstanding:

- The majority of specialist workers are female
- The majority of specialist workers are aged 45 years or older
- Approximately one third of specialist workers are employed part time
- Median length of AOD service is five years
- The largest occupational groups are AOD workers and nurses
- A substantial number of workers have no formal AOD-specific qualifications (Roche & Pidd, 2010).

An issue that is closely related to the diversity of the AOD workforce concerns the potential to better match the skills and experience of AOD workers to the level of complexity of the range of tasks involved in AOD prevention and treatment. In this way, more highly qualified workers would undertake more complex roles (such as family therapy and cognitive behavioural therapy), while those with no formal qualifications, or vocational qualifications, would be limited to undertaking tasks of lesser complexity.

The diversity of the AOD workforce, in conjunction with variations between and within jurisdictions, can make it difficult to generalise about the AOD workforce from one jurisdiction to another. This also presents important challenges for the development of a national strategic response. The National WFD Strategy will need to present a coordinated and comprehensive approach which is nonetheless appropriate and relevant for a wide variety of workers and work settings. These very challenges highlight the need for, and importance of, a nationally coordinated workforce development plan.

Q5. What are the major WFD issues facing specialist AOD workers?

Q6. What are the major WFD issues facing generalist workers performing AOD-related roles, such as general practitioners, social workers, counsellors, child protection workers and CALD workers?

Q7. In what way should factors such as the age, gender and working arrangements of the AOD workforce be addressed in the WFD Strategy?

5 INFLUENCES ON THE DEVELOPMENT OF A WFD STRATEGY

5.1 Health-related influences

5.1.1 Australian Safety and Quality Framework for Health Care

In 2010 Australian Health Ministers endorsed the Australian Safety and Quality Framework for Health Care. The Framework describes a vision for safe and high-quality care for all Australians and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and

high-quality care. These are that care is consumer centred, driven by information, and organised for safety.

Consumer centred care involves:

- Providing care that is easy for patients to get when they need it
- Making sure that health care staff respect and respond to patient choices, needs and values
- Forming partnerships between patients, their family, carers and health care providers

Being driven by information involves:

- Using up-to-date knowledge and evidence to guide decisions about care
- Collecting safety and quality data, analysing it and feeding it back for improvement
- Taking action to improve patients' experiences.

Being organised for safety means:

- Making safety a central feature of how health care facilities are run, how staff work and how funding is organised.

These are central principles that should inform the development of the AOD WFD Strategy.

5.1.2 The broader policy environment

There are a number of national policies which significantly impact the future direction of the AOD workforce, and therefore have a range of implications for the WFD Strategy. These are listed below.

- *The National Drug Strategy (NDS)*
- *The National Alcohol Strategy (NAS)*
- *The National Mental Health Strategy (NMHS)*
- *Directions in Australia and New Zealand Policing 2012-15*
- *The National Preventive Health Strategy*
- *Australian and New Zealand Policing Advisory Agency Drug and Alcohol Strategy 2012-15*
- *The National Health Reform Agenda*
- *The National E-Health Strategy (NE-HS)*
- *The National Pain Strategy (NPS)*
- *National Integrated Strategy for Closing the Gap in Indigenous Disadvantage*
- *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*
- *The National Rural and Remote Health Workforce Innovation and Reform Strategy*
- *The Sixth National HIV Strategy 2010–2013*
- *The First National Hepatitis B Strategy 2010–2013*
- *The Third National Hepatitis C Virus Strategy 2010–2013*
- *The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*
- *National Framework for Protecting Australia's Children 2009–2020*
- *Investing in the Early Years—A National Early Childhood Development Strategy*

At present a new National Aboriginal and Torres Strait Islander Peoples Drug Strategy is under development.

Q8. What will be the major influences of the broader policy environment on the development of the WFD Strategy?

5.1.3 Health workforce reform

The Australian health care system is being placed under increasing pressure, due in part to the growing burden of chronic disease, an ageing population, workforce pressures and inequalities in health outcomes (Department of Health and Ageing, 2010). As it currently stands, the health workforce does not have capacity to meet future health service demand.

It is increasingly recognised that, in order to deliver high quality health care into the future, the Australian health workforce will require significant reform (Health Workforce Australia, 2011). This reform began in 2011 with the release of the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015, and will have significant and on-going implications for the development of an AOD WFD Strategy.

Analysis of key international, national and jurisdictional strategies and workforce planning documents led to the development of five domains for action within the reform (Health Workforce Australia, 2011). The domains and associated objectives are summarised in Table 2.

Table 2. National Health Workforce Reform Domains for Action

Domain	Objectives
Health workforce reform for more effective, efficient and accessible service delivery	Reform health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address population health needs.
Health workforce capacity and skills development	Develop an adaptable health workforce equipped with the requisite competencies and support that provides team-based and collaborative models of care.
Leadership for the sustainability of the health system	Develop leadership capacity to support and lead health workforce innovation and reform.
Health workforce planning	Enhance workforce planning capacity, both nationally and jurisdictionally, taking account of emerging health workforce configuration, technology and competencies.
Health workforce policy, funding and regulation	Develop policy, regulation, funding and employment arrangements that are supportive of health workforce reform.

Source: Health Workforce Australia (2011)

The reform framework is guided by the following principles:

- Work from a community, individual and carer needs perspective
- Involve the community, consumers and carers
- Align with the intent and actions of Closing the Gap
- Ensure the quality and safety of care is improved
- Facilitate collaboration with governments and professional bodies, education providers, and the private, not-for-profit and community sectors.
- Recognise Australia's diversity, and promote equity of access and outcomes
- Recognise and support members of the community (e.g. volunteers and carers)
- Build health services research and evaluation into all redesign initiatives
- Build and disseminate the evidence base for successful workforce reform
- Ensure mechanisms for accountability and evaluation are undertaken
- Recognise the importance of informed personal choice and self-management reform (Health Workforce Australia, 2011).

A key theme in the literature regarding health sector reform concerns the problems of the siloing of services. In commenting on the current organisation of the community services sector in Victoria, Shergold (2012) pointed out:

> *At present, services are often designed and organised in bureaucratic silos, more for the sake of administrative convenience than outcome effectiveness. Programs tend to focus on solving problems after they occur, rather than intervening early to prevent them from developing. It is widely accepted that it costs more to focus on treatment, rather than prevention. In future, the system must aim to have broader focus along the spectrum of support including early intervention. It should help people to build the*

long-term capabilities they need to take on a greater role in managing their own life. (p. 6-7)

Alcohol and other drug service provision in Australia is likely to be profoundly affected by these reforms, which warrant careful consideration in the development of the AOD WFD Strategy. The reforms will impact in terms of patterns of service provision (resulting in a greater emphasis on the better integration of services to meet the needs of clients with multiple morbidities) and an increased emphasis on prevention.

Enhancing the emphasis on prevention and linked up service provision will require specialist and generalist practitioners with somewhat different skill sets. The Western Australia Drug and Alcohol Office (DAO) has developed a framework of skills and knowledge required of staff responsible for the development, implementation and evaluation of evidence-based, effective AOD prevention activity. The framework requires that staff have relevant knowledge and competencies in: undertaking needs assessments; program planning, implementation and evaluation; coalition building; and advocacy. It also requires them to have specified values and ethics (DAO, n.d).

Q9. Specialist AOD services, like much of the Australian health and welfare sector, will not have the capacity to meet future demand without major structural reforms. What shape should these reforms take and what are the implications of these reforms for WFD Strategy development?

5.1.4 Health inequalities

Access to health services and health outcomes are unevenly distributed across Australian society, and it is essential that this be taken into account within the AOD WFD Strategy. Individuals are likely to have poorer health and experience earlier mortality if they:

- Have a lower socio-economic status
- Have lower levels of education
- Have insecure working conditions
- Live in rural or remote areas
- Are of Aboriginal or Torres Strait Islander descent (Australian Government Preventative Task Force, 2009)

Internationally, alcohol and drug dependence are more common in countries with greater income inequality and Australia is one such country (Wilkinson & Picket, 2010).

Aboriginal and Torres Strait Islanders, especially those living in rural or remote areas, are particularly disadvantaged in terms of health outcomes (Australian Government Preventative Task Force, 2009).

While governments are seeking to address health inequalities through a number of programs (Closing the Gap, Building Australia's Future Workforce, etc.) ongoing inequality is a likely driver of poor health outcomes for a proportion of Australia's population. Australia's National Preventative Health Strategy states that Australia's primary health care system should, at a minimum, be able to:

- Systematically identify people at risk and effectively assess the level of risk and readiness for change
- Deliver appropriate interventions on-site or refer to external services
- Have in place referral processes that allow ready access to appropriate, quality-assured lifestyle modification providers and programs
- Monitor and assess outcomes and sustain improvements over time (Australian Government Preventative Task Force, 2009).

To achieve this, the health sector requires:

- A multidisciplinary workforce with relevant skills and expertise
- Appropriate tools and resources
- Information systems that provide risk data on the practice population

- Effective linkages to wider community services (Australian Government Preventative Task Force, 2009).

Q10. How can the AOD workforce adapt to meet the challenges associated with current and emerging health inequalities and what are the implications of this for the WFD Strategy?

5.1.5 The ageing population and health workforce

Demographic changes have seen an unprecedented increase in the average age of the population in both developed and developing countries, and in projected future increases of older people within these populations (Tinker, 2002; World Health Organization, 2002). Health professionals and workforces (including the AOD sector) need to be better equipped to deal with a dramatic increase in the incidence of non-communicable diseases (World Health Organization, 2011), along with ageing, fertility and mortality trends.

In particular, health occupations such as GPs and nurses have an ageing workforce, with half of workers aged over 45 years in 2003 (Australian Bureau of Statistics, 2003), and many health professionals working beyond the age of 65 (Department of Education Employment and Workplace Relations, 2005). As these workers begin to retire, the human services workforce is likely to be negatively impacted by a loss of highly skilled workers. This means that the AOD sector will continue to age and will have to compete with other sectors for staff in an increasingly difficult human resource environment.

The demand for workers in the health care and social assistance areas in Australia will outstrip all other sectors between 2011/12 and 2016/17 (see Figure 3). This will increase pressure on AOD services to attract and retain suitable staff.

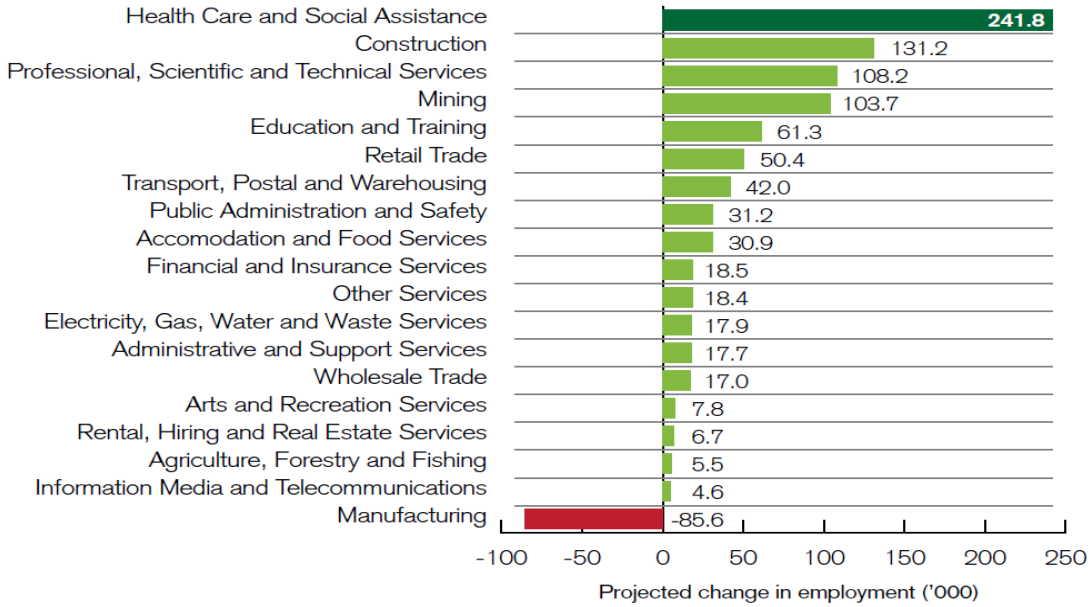

Figure 3: Projected employment growth to 2016/2017, all industries.
Source: Community Services & Health Industry Skills Council, (2013).

Q11. What are the implications of an ageing population in Australia for the AOD workforce and for the WFD Strategy?

Q12. As the market for skilled workers becomes more competitive with the ageing of the Australian workforce, what can the AOD sector in Australia do to ensure that it attracts and retains high quality staff? What are the implications for the WFD Strategy?

5.1.6 The needs of Indigenous Australians

Indigenous Australians have higher rates of tobacco and other drug use compared to the non-Indigenous population. Patterns of harmful AOD use by Indigenous people need to be understood in the context of a history of dispossession, denial of culture, and conflict. This alcohol and drug use by Indigenous people contributes to compromised physical and psychosocial health status, and ongoing socio-economic disadvantage (Gleadle et al., 2010). Indigenous AOD workers, who have responsibility for preventing and responding to AOD-related harm among Indigenous Australians therefore face particular challenges.

The size of the workforce involved in addressing AOD problems among Indigenous Australians is difficult to ascertain, but it is clear that such workers are usually employed in comparatively low status, lower paid positions such as Indigenous Health Workers or community workers (Gleadle et al., 2010). Against this background of disadvantage and complex AOD use, Indigenous AOD workers face unique stressors including:

- Heavy work demands reflecting the high community need and a shortfall of Indigenous AOD workers
- Dual forms of stigmatisation stemming from attitudes to AOD work and racism
- Lack of clearly defined roles and boundaries, particularly within an Indigenous community context
- Difficulties translating mainstream work practices to meet the specific needs of Indigenous clients
- Challenges of isolation when working in remote areas
- Dealing with clients with complex comorbidities and health and social issues
- Lack of cultural understanding and support from non-Indigenous health workers (Roche, Nicholas, Trifonoff, & Steenson, 2013).

These challenges mean that Indigenous AOD workers have particular workforce development needs, and that WFD strategies are required that can be implemented in a culturally safe manner.

Encouragingly, there are a growing number of AOD courses that address Indigenous AOD issues. In 2009 21% of accredited AOD courses in Australia were either specifically designed for Indigenous students or covered Indigenous issues in depth. See Figure 4.

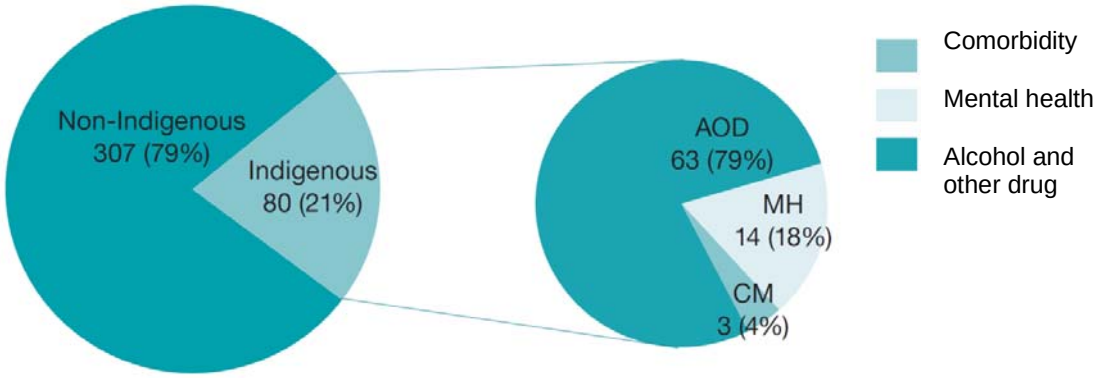

Figure 4: The proportion of accredited courses with Indigenous content. Source: Roche et al. (2008)

Q13. What are the key AOD workforce development issues for Indigenous AOD workers? In particular, what are the implications for Indigenous AOD workers of having culturally unsafe working environments?

5.1.7 Ageing and AOD use

It has been predicted that baby boomers will have greater rates of lifetime alcohol and drug use than previous generations, leading to more older people experiencing AOD harm in the future (Lynskey, Day, & Hall, 2003). This trend is already evident in Australian recipients of opioid pharmacotherapy

treatment. Between 2006 and 2012 the proportion of clients aged less than 30 halved (from 28% to 13%) and the proportion of clients aged 50 and over doubled (from 8% to 18%). The ageing of AOD clients is also evident in Europe (European Monitoring Centre for Drugs and Drug Addiction, 2010).

This trend requires a better understanding of the physiological and psychological impact of drug use in ageing populations (Colliver, Compton, Gfroerer, & Condon, 2006). Issues may include drugs being metabolised more slowly and organs being more sensitive to the effects of drugs during older age, affecting cognitive and motor function.

Older people presenting to AOD treatment services are more likely to be using alcohol and cannabis, rather than just alcohol alone (Colliver et al., 2006). Similarly, there is increasing potential for interactions between alcohol and prescription drugs in older people, with 18.7% of the older people using alcohol and prescription drugs in one study vulnerable to adverse interactions (Pringle, Ahern, Heller, Gold, & Brown, 2005). This highlights the need for screening for both alcohol and medication use susceptible to the effects of alcohol (Pringle et al., 2005). In addition, given the predicted increase in older people using cannabis, potential interactions between cannabis and prescription drugs are likely to impact on AOD service provision.

The ageing of the population also means that increased consideration should be given to programs which aim to prevent harmful AOD use among older Australians.

Q14. What are the key AOD WFD issues associated with working with older clients and what are the implications of this for the WFD Strategy?

5.1.8 Emerging issues

In recent years the AOD workforce has been confronted by many new and changing problems. Many of these issues are still emerging, and it is not always clear what their implications will be, or how they ought to be addressed. However, all will impact upon AOD prevention, treatment and policy measures into the future, and as such must be addressed within the WFD Strategy.

Different substances and patterns of use

The landscape of available psychoactive substances is rapidly changing. In Europe new synthetic psychoactive substances are reported to authorities a rate of approximately one per week (European Monitoring Centre for Drugs and Drug Addiction, 2012). These trends are highly likely to impact Australia because the Internet has increased the flow of information about these drugs. The Internet also provides a means through which they can be purchased (European Monitoring Centre for Drugs and Drug Addiction, 2012). This phenomenon is likely to present particular difficulties for treating those who experience acute and chronic harms stemming from the use of these drugs because the nature of the substance they have taken can be unclear to the client and to the treating clinician (Arnold, 2013).

Q15. How can the AOD workforce best adapt to meet the challenges posed by the rapid rate with which new substances are appearing?

Furthermore, over the past decade there have been significant changes in the profile of substances for which Australians are seeking treatment. Since 2001-02 among publically funded AOD treatment episodes in which the client was seeking help for their own problems:

- Alcohol problems increased by 10% to 47%
- Heroin problems halved from 18% to 9% (Australian Institute of Health and Welfare, 2012).

Moreover, in the past twenty years there has been a dramatic increase in the prescribing of pharmaceutical opioids in Australia and the country is experiencing increasing harms as a result (Royal Australasian College of Physicians, 2009). Harms include increased morbidity (Australian Institute of Health and Welfare, 2013) and mortality (Rintoul, Dobbin, Drummer, & Ozanne-Smith, 2011) and harms from injection of drugs intended for oral use (Degenhardt et al., 2006). Similar problems apply to benzodiazepines and other psychoactive prescription medicines, as well as some over-the-counter medicines (Drugs and Crime Prevention Committee: Parliament of Victoria, 2007).

A further prescription drug issue on the horizon concerns the use of smart drugs. Neuroscience research has raised the possibility that some prescription drugs, used to treat conditions such as attention deficit hyperactivity disorder, narcolepsy and Alzheimer's disease, may improve cognitive functions in healthy people such as executive function, alertness, concentration and memory (Partridge et al., 2011). While their use and benefits are unlikely to be as significant as media reports suggest (Partridge et al., 2011), nevertheless the harmful use of these powerful medicines could significantly impact on AOD treatment services in the future.

Finally, prescription drugs such as smart drugs, prescription opioids, antipsychotic medicines and sedative hypnotics have the potential to displace the demand for illicit drugs. This will require quite different responses from AOD treatment and prevention services and has important implications for the development of the AOD workforce (Roche, 2013).

Q16. How could these changes in the substances associated with harm in Australia impact on the AOD workforce? What are the implications of this for WFD Strategy development?

New paradigms and treatments

In the future, approaches to preventing and responding to AOD problems are likely to arise from a much broader base than is currently the case. Dealing with the end results of problematic substance use will always be important and there will always be a role for specialist treatment services (Ash et al., 2006; Gowing, Proudfoot, Henry-Edwards, & Teesson, 2001; Marsh, Dale, & Willis, 2007). Future responses will be shaped by drivers that extend this orientation, including increased emphasis on the prevention and treatment implications of:

- Social determinations of health (e.g. early life experiences, work, unemployment, social exclusion) which will feature more prominently in our understanding of causal factors as well as response strategies to ameliorate problems
- Integrated models of care (mental health, aged care, child and family, Indigenous, prisoners, non-English speaking) will become more prominent as pressure and expectations grow for more coordinated and holistic care
- Complex health and comprehensive community services models; no longer will narrow and simplistic models be adequate (Roche, 2013).

As the AOD sector moves towards a broader base, technology-based approaches are likely to become more prominent. Developments in e-health technologies mean that these are already playing an important role in some countries, and they may play a more important role in the future. These technologies can have several advantages over traditional preventive and intervention methods including:

- Increasing the number of people who have access to evidence-based prevention strategies and interventions
- Increasing utilisation by segments of the general population who do not currently access treatment or are not exposed to preventive programs
- Their cost effectiveness (Cunningham, Kypri, & McCambridge, 2011).

These technologies include computer-assisted screening and therapy (such as a range of web-based interventions), text messaging, internet interventions supplemented with telephone calls, computer-generated advice letters based on phone interviews, email interventions, counselling via telephone, computer programs in the clinic or classroom, therapist administered virtual reality programs and computer-assisted counselling programs (Cunningham et al., 2011; Newman, Szkodny, Llera, & Przeworski, 2011). In order to use these technologies the AOD workforce will need to acquire more information technology skills and enhance their awareness of the technological environment of their stakeholder groups. Tracking of prescriptions and treatments through e-health systems may also generate significant data that may be used to better plan health service delivery, including AOD prevention and treatment. In addition, new pharmacotherapies are also likely to be developed to treat AOD problems.

All of these changes will impact the ways in which AOD services are provided in Australia, and a flexible and knowledgeable workforce will be required to respond to them. In addition, Australia will require better shaped, integrated and appropriately developed service systems within which workers operate.

Q17. What are the implications of: broadening the base of AOD prevention and treatment (to have more of a focus on social determinants of health and more integrated interventions); and increased use of technology for the WFD Strategy?

Multiple morbidities

Clients of AOD services are at risk of a range of comorbid conditions including infectious diseases and non-communicable diseases (Australian Government Preventative Task Force, 2009). Mental illnesses are also a particularly prevalent comorbidity among AOD clients.

The appropriate management of long-term multi-morbid disorders is a key challenge for health systems internationally. It is increasingly apparent that multi-morbidities are the norm for people with chronic health problems, particularly among the most socio-economically disadvantaged. The prevalence of mental health disorders in an individual increases with the number of physical disorders present, however existing health systems are dominated by single-morbidity approaches that are increasingly inappropriate. Use of many services to manage individual diseases can become duplicative and inefficient, and is burdensome and unsafe for patients because of poor coordination and integration (Barnett et al., 2012).

Co- and multiple morbidities have important implications for the training and structure of the AOD workforce. Strategies such as co-location, multi-disciplinary health professionals and teams, inter-professional education and cross sectoral workforce development will increasingly be required. This issue will become a growing challenge for AOD service provision in the future. AOD services will need to develop ways of meeting the multi-morbidity needs of their clients through a combination of enhanced generalist in-house service provision and enhanced linkages with other service providers.

Q18. How does AOD service provision need to adapt to meet the challenges posed by multiple morbidities?

Q19. What are the implications of this for the AOD Strategy?

National Drug and Alcohol Clinical Care & Prevention (DA-CCP) Project

The findings of the DA-CCP project (due to be released later in 2013) are likely to have a significant impact on AOD service provision in Australia. The DA-CCP project aims to:

- Build the first national population-based model for AOD service planning by estimating the need and demand for services
- Use clinical evidence and expert consensus to specify the care packages required by individuals and groups
- Calculate the resources needed to provide these care packages
- Provide a AOD service planning tool for jurisdictions.

The DA-CCP model concerns the situation as “it should be”, not what is currently available. It will provide information on:

- The estimated number of people ‘needing’ treatment (by drug type and age range)
- Nationally shared descriptions of units of service (care packages)
- The number of staff required (medical, allied health/nursing, AOD workers) to deliver those services
- The number of beds and treatment places required
- The amount of other care required (e.g. doses of medicines, medical investigations, etc.)

Increased emphasis on service outcomes

In the future, the outcomes of service provision, rather than the inputs or outputs, will be increasingly important. As Shergold (2012) pointed out:

> *Today's system has a greater emphasis on inputs and outputs rather than outcomes.* ***Inputs*** *direct attention to processes, not results.* ***Outputs*** *are easier to measure but they only tell us the product of an intervention, such as the number of services provided.* ***Outcomes*** *capture the extent to which a service has achieved its intended results, by improving the lives of individuals, families or the community. They are critical. Unfortunately they can be difficult to measure.*
>
> *In future, it will be important to shift to a longer-term outcome focus. This will require considerable effort. In particular, the system will need to develop new and innovative models of funding and service provision so that it is possible to measure and recognise when good results are achieved. It must provide incentives to ensure that the best outcomes can be delivered across the system. (p. 7 emphasis in original text)*

From this perspective, future service funding is likely to be increasingly linked to the ability of agencies to deliver demonstrable outcomes for the community. Work on outcome based funding is emergent. The definition of outcomes in relation to prevention, treatment and recovery is as yet undefined. However there are indications that outcome measurement will become a critical part of service design and delivery. Other funding models such as client directed funding, consortia based funding and area based funding may also have an impact.

The implications of a movement towards outcomes-based funding extend beyond changes in service provision. Such a movement will also mean that the AOD sector will need to be more familiar with the collection, interpretation and presentation of data in order to ensure continued funding.

Q20. As funders of AOD services increasingly move towards outcomes-based funding arrangements, how will this impact on the ways that services measure their impact?

Q21. How should this be reflected in the WFD Strategy?

Consumer input into service provision and client led care environments

Having consumer input into service provision is an important part of providing person-centred care. The Victorian Department of Health's New Directions for Alcohol and Drug Treatment Services calls for people to have:

- Improved knowledge and confidence to make choices about their treatment and awareness of how to self-manage after formal treatment
- High levels of active involvement in their treatment including planning, setting goals and decision making
- A comprehensive assessment and care plan that is oriented towards their goals and designed with them according to their choices, preferences and changing needs (Department of Health Victoria, 2012).

A related factor impacting the broader community services and health sector is that of client-led care environments in which clients have a greater say in how resources allocated to their care are expended. This is currently having a significant impact in the aged care and disability sectors as increasing numbers of workers physically work outside of centralised services and are based within the community. While this trend increases service accessibility, it also creates challenges in the provision of supervisory support, quality of care regulation and occupational health and safety. It also increases the need for skills, such as goal-based planning, case management, client capacity building and financial management and requires a commitment to client empowerment and self-determination (Community Services & Health Industry Skills Council, 2013).

Q22. What are the implications for the AOD WFD Strategy of the need to enhance consumer input into service provision and client led care environments?

Future structuring of AOD organisations

Many Australian AOD service providers have undergone substantial restructuring in recent years. The integration of AOD and mental health service agencies is occurring in several jurisdictions, for example.

Currently the human services system delivers hundreds of distinct programs. This has led to the development of a range of specialist occupations including AOD work. This specialisation has delivered many gains that the system cannot afford to lose. From a government perspective however, this has also been associated with a focus on programs rather than people and on particular needs rather than the inter-relationship of multiple disadvantage. It has also resulted in a duplication of administrative effort for both governments and providers (Shergold, 2012). For these reasons the integration of programs is likely to increase in the future.

On the one hand, the integration of AOD and mental health services may aid service provision to clients as a result of the frequent co-occurrence of co-morbid AOD and mental health conditions (Burnam, Burnam, & Watkins, 2006; Butler et al., 2008). On the other hand, this may lead to a dilution of the specialist AOD skill base as service provision becomes more generic. There are also issues of clients who do not have co-occurring AOD and mental health issues but may have AOD issues and other morbidities (homelessness, poverty, family violence, child protection issues etc.) This is an issue that warrants careful consideration in the development of the AOD WFD Strategy.

Q23. How should the WFD Strategy reflect the need to balance possible integration of AOD and mental health services (to provide more comprehensive approaches to prevent and treat multiple morbidities) with the need to maintain the specialist skills required to prevent and treat AOD problems?

Family inclusive policy and practice

The AOD family and child welfare sectors have increasingly recognised the relationship between AOD problems, childhood and adolescent development and child wellbeing and protection. However, relatively few programs consider the needs and development of children and adolescents, or provide for the care of children, whilst parent/s are in counselling or treatment programs. Family inclusive policy and practice involves raising awareness of the impact of substance abuse upon families, addressing the needs of families (Addaction, 2009) and seeing the family - rather than an individual adult or child - as the unit of intervention. It involves identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of prevention, treatment and intervention processes, in order to ensure that as parents they are supported and child wellbeing and safety is maintained (Battams & Roche, 2011).

Family inclusive policy and practice does not rely on one particular practice model in service delivery, and can be built into existing practices. Family inclusive policy and practice goes well beyond understanding and meeting the needs of families and children/adolescents, as it entails seeing families as partners in the client-worker relationship and working with their strengths. A strengths-based approach recognises and builds on the strengths, resilience, assets and resources of individuals, families, organisations and communities (Battams & Roche, 2010).

Q24. What are the implications of family inclusive policy and practice for the WFD Strategy?

5.2 Work-related influences

5.2.1 The globalisation of the human services workforce

As the human services workforce becomes increasingly globalised, AOD agencies will be required to compete for staff with not only other Australian agencies, but also with other countries. A further issue related to globalisation is the “brain drain” of human service professionals from developing to industrialised countries. Australia’s targeted skilled migration programs play an important role in providing workers with relevant skills. This skilled migration can be highly detrimental to developing countries because it is very asymmetrical. Developing countries lose not only much-needed human resources, but considerable investments in education and fiscal income (Simoens, Villeneuve, & Hurst, 2005).

Therefore, the AOD workforce not only has to contend with the increasing likelihood of the overseas movement of workers, but also needs to consider the ethical dilemma of drawing human resources from developing countries.

Q25. What measures could the AOD sector implement to attract and retain staff?

5.2.2 Differences between government and non-government sectors

Approximately half of all AOD workers in Australia are employed in government agencies and half in non-government agencies (NGOs), although large jurisdictional variations exist. There are significant differences in workforce profiles between government, NGO, and jurisdictional workforces (Roche & Pidd, 2010). While staffing differences between government and non-government AOD specialist treatment organisations may be largely due to differences in service delivery models, these differences impact on workforce development needs. Infrastructure and funding support issues may be different for the NGO workforces than for government workforces which, in turn, has workforce development implications (Duraisingam, Pidd, Roche, & O'Connor, 2006; Roche, O'Neill, & Wolinski, 2004; VAADA, 2003; WANADA, 2003).

There is also a significant disparity between salaries and conditions offered by NGO agencies and public sector agencies. Staff employed by NGO agencies are generally paid considerably less due to funding arrangements and differences in awards (Roche & Pidd, 2010). While these salary differences may reflect differences in the skill and qualification levels of AOD workers in the public sector (e.g., more nurses are employed in the public sector), a disparity exists even when NGO workers have the same skill/qualification level and job role as their public sector counterparts. This can lead to a workforce drain from the NGO to the public sector, with the NGO sector bearing a significant burden for recruiting and training new entrants to the AOD workforce. Alternatively, it can result in a 'second tier' AOD workforce which in turn may impact on the quality of AOD service delivery (Roche & Pidd, 2010).

Furthermore, across a number of professional groups there have been successful bids for substantial salary increases, limiting the ability less of well-funded NGOs to recruit specialist professionals. For example, salaries for nurses are now commensurate with similarly trained and qualified professionals. This often makes them unaffordable within the NGO sector (Roche & Pidd, 2010).

There are also issues relating to the impact on salaries of workers acquiring or being required to have qualifications. There is a cost to both individuals and organisations in achieving qualifications. Often this is not recognised in NGO industrial awards or agreements. However it is more likely to be recognised in government roles, creating an incentive for NGO staff who have acquired qualifications to move into the government sector.

The range of differences between the government and the NGO sectors presents challenges for a national workforce development strategy.

Q26. How do workforce development needs differ between workers employed in government and NGO services?

5.2.3 Service practice standards

One option that warrants consideration in the development of the AOD WFD Strategy is the potential for the development of National AOD practice standards. In 2002 the National Mental Health Education and Training Advisory Group (NMHETAG) developed National Practice Standards for the Mental Health Workforce (NMHETAG, 2002). The Standards apply to mental health nurses, occupational therapists, psychiatrists, psychologists and social workers and address attitudes, knowledge and skills. Other staff, such as primary health care workers, general practitioners, Indigenous mental health workers, rehabilitation counsellors and other therapists, are free to adopt all, or part, of the standards. There are twelve standards which address a range of issues including prevention, early detection, client rights, treatment and evaluation and research. The standards can also be used by education providers as the basis for curriculum development.

Q27. Should practice standards be developed for the AOD Sector to address prevention and treatment services?

5.2.4 The needs of law enforcement agencies

Law enforcement agencies in Australia play a pivotal role in preventing, reducing and responding to AOD-related harms. While it is recognised that law enforcement activities are carried out by a range of agencies, the National AOD WFD Strategy will focus predominantly on policing and correctional services.

Policing

Police often have to respond to the manifestations of AOD-related harm, including street and domestic violence, anti-social behaviour, serious crime and road trauma. Policing recognises that enforcement is only part of the solution and needs to be supported by a range of strategies and initiatives to address these problems (Australian and New Zealand Policing Advisory Agency, 2012). Policing, as with other sectors, faces a range of challenges such as changing community needs and expectations, an ageing, growing and diverse population, rapid technological change, a tightening labour market, increasing natural disasters, national security and adaptive, organisational and transnational crime (The Standing Council on Police and Emergency Management, 2012). There are also parallels with the directions being taken by police and by other public sector organisations, such as an increased emphasis on problem prevention, seeking new approaches to increasingly complex problems and the formation of partnerships with other agencies.

The key strategic document for Australasian Policing (Directions in Australia New Zealand Policing 2012-15) (The Standing Council on Police and Emergency Management, 2012) calls for policing organisations to reduce the impact of AOD-related harm by:

- Continuously improving education, awareness and enforcement strategies
- Developing innovative approaches with 'at risk' groups
- Continuing to work with communities and partners on harm reduction
- Supporting new ways of using science and technology in alcohol and drug detection.

In recognition of the extent to which AOD issues impact policing, the Australian and New Zealand Policing Advisory Agency's Drug and Alcohol Strategy 2012-15 (Australian and New Zealand Policing Advisory Agency, 2012) calls for:

- The promotion of knowledge and information sharing to inform policing responses to harmful AOD use
- Increased police awareness of the impacts of AOD-related harm on the community
- The strengthening of partnerships with police, stakeholders and the community.

An examination of the workforce development needs of police in Australia (Roche, Duraisingam, Trifonoff, & Nicholas, 2009) revealed ten top priority WFD areas:

- Alcohol
- Psychostimulants
- Violence and antisocial behaviour
- Comorbidities
- Child protection and youth
- Diversion
- Night time economy and public space
- Indigenous communities
- Rural and remote policing
- Research, evaluation and prevention.

Overall, Roche and Duraisingam et al. (2009) found that the high AOD-related workloads of police, involving increasingly complex issues, stood in contrast to the dearth of systematic workforce development attention directed to this area. They found that top priority was for increased emphasis on managing alcohol-related problems, particularly in relation to licensed premises. AOD-related tertiary study was found to be rare among police officers and few opportunities existed for police to undertake training that was relevant or tailored to their needs.

Roche and Duraisingam et al. (2009), as one small component of a broader workforce development initiative, called 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.

Q28.What are the key AOD workforce development issues for police?

Corrections

Alcohol and other drug use by offenders is a substantial challenge facing Australia's criminal justice system. Between 37% and 52% of offenders in Australia report that their offending is attributable to their drug problem. Comorbid substance use disorders and mental illnesses are common among offenders (National Corrections Drug Strategy 2006–2009 [NCDS, 2008]).

Correctional facilities are environments that contain a subset of the population who are experiencing higher than normal levels of impairment in multiple domains, including AOD problems. In addition, the nature of confinement, loss of liberty, boredom and despair means that some offenders are inclined to keep using drugs. The high risk of transmission of blood-borne viruses in correctional and community-based facilities and services poses a significant health risk to the wider community and recently released offenders are at heightened risk of both fatal and non-fatal heroin overdose (NCDS, 2008).

Despite these challenges, the contact between offenders and the correctional system presents a unique opportunity to address the range of problems facing this population which does not adequately access health care in the community. The provision of services to offenders in correctional and community-based facilities requires collaboration between health and justice jurisdictions. Effective partnerships with community service providers will deliver effective through-care and ease transition from highly structured custodial environments to the community (NCDS, 2008).

Q29. What are the key AOD workforce development issues for correctional services workers?

5.3 Education-related influences

Notwithstanding the need to adopt a systems view of AOD workforce development issues, education, training and skills development are critically important to clinical staff, policy makers, preventionists, researchers and a range of other workers engaged in non-clinical roles. These current and evolving issues will need to be suitably addressed in the development of the Strategy.

5.3.1 The AOD education and training landscape in Australia

Today AOD-related training is widely available in the higher education and Vocational Education and Training (VET) sectors, at both undergraduate and postgraduate levels. In 2009 there were 387 accredited AOD courses located across 107 higher education and training institutions in Australia (Roche & Pidd, 2010). However, despite this increase in availability, training and professional development continue to entail considerable time and resource outlay on the part of workers and organisations (Roche & Pidd, 2010). Higher education institutions largely cater for medical practitioners, nurses, psychologists and social workers. Other education programs are offered by the Drug and Alcohol Nurses of Australasia, the Australasian Professional Society on Alcohol & other Drugs and the Chapter of Addiction Medicine of the Australasian College of Physicians.

The VET sector largely caters for the needs of other AOD workers. Competency based training (CBT), is now the recognised method for vocational training in the AOD field. There is significant dissatisfaction among AOD managers with the VET sector's provision of AOD courses. Reasons for dissatisfaction include:

- Poor-quality training and assessment
- Lack of correspondence between what was learned through training and skills required on the job

- Training content being out of date or out of touch with industry developments
- Lack of practical experience/work placements
- Perceived variability in the quality of VET training
- Limitations in its ability to adequately equip workers with the necessary skills to meet the increasingly complex needs of AOD clients (Pidd et al., 2010).

A number of respondents in the Roche et al. (2012) study had significant reservations about the recently revised Training Package (CHC08), which provides a framework for all VET sector AOD qualifications. Sources of dissatisfaction included:

- A perception that the new Training Package represented a change from an AOD-specific to a generic qualification, as it contained many general units of competency that did not focus on AOD issues
- A lack of specific guidance or detail on the elements of competency, range statements and essential skills and knowledge required by students in relation to specific drugs
- A lack of consistency in training content, delivery and assessment criteria which potentially compromised the quality and standard of AOD courses offered
- A lack of guidance concerning the way in which a training provider should determine the focus of the training (e.g., by prevalence, risk of harm, student interest, employer need).

Respondents signalled a need to restructure the Training Package to make it more coherent, explicit and responsive to students and their workplace AOD requirements.

The changes in CHC08 towards a more generic package are reflective of tensions between governments and employers concerning the future directions of VET. Employers have a preference for a workforce with skills that are specific to the needs of their enterprise, whereas governments have a preference for a workforce with more generic skills that can facilitate redeployment as workforce needs change.

Other significant challenges to up-skilling the AOD specialist workforce also exist. For example, some jurisdictions have difficulty providing training options. This may be due to low student numbers, lack of trained educators, limited capacity to develop quality resources and competing funding priorities. Workers may also be constrained by distance, time, lack of flexibility in delivery, lack of backfill staff, and financial costs (Deakin & Gethin, 2007; NADA, 2003; VAADA, 2003; WANADA, 2003). These issues can be compounded for rural and remote workers (Deakin & Gethin, 2007; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003).

Q30. To what extent does existing AOD-related education and training meet the needs of the AOD workforce and how could this be improved?

5.3.2 Non-specialist higher education programs

Given that a wide range of human service providers have the capacity to prevent and reduce AOD-related harm, it is highly desirable that these issues are incorporated into undergraduate and postgraduate curricula in fields such as medicine, nursing, social work, psychology and policing. It is difficult to gain a clear understanding of the extent to which these issues are currently addressed. Given the degree to which these curricula are already “crowded” this is likely to be patchy. Nevertheless, enhancing the capacity of these professionals to reduce AOD related harm is critically important if the AOD field is to enhance its sphere of influence in reducing harm.

Q31. To what extent are AOD issues currently addressed in non-specialist AOD higher education programs in your jurisdiction and how might this be enhanced?

5.3.3 Accreditation and minimum qualifications

Until recently there was no national professional accreditation in Australia for AOD specialist work apart from Addiction Medicine Specialists, through the Royal Australasian College of Physicians. In August 2013, the Drug and Alcohol Nurses of Australasia (DANA), launched its Pathways to Credentialing Program. Although no nurses have yet been credentialed as AOD nurses, it is anticipated that this will occur in the near future. In addition there is a small number of AOD nurses

who have qualified as AOD Nurse Practitioners (Personal Communication Colleen Blums - President - Drug and Alcohol Nurses of Australasia, 2013).[1]

The lack of a widely implemented system of accreditation is an obstacle to the establishment of formal minimum standards of competence for AOD workers. It also risks the sector appearing as non-professional, both in the eyes of the community and the sector itself. This may impact on the ability of the sector to attract and retain high quality staff (Alcohol Tobacco and other Drugs Council Tasmania Inc., 2012).

Only two jurisdictions to-date (Victoria and the ACT) require AOD specialist workers to be accredited to at least the level of Certificate IV (Roche & Pidd, 2010). Victoria and the ACT have broadly similar requirements however the ACT requires workers to have a first aid qualification and requires that training includes a focus on working effectively with clients experiencing comorbid alcohol, tobacco and other drugs and mental health problems (Alcohol Tobacco and other Drugs Council Tasmania Inc., 2012). Victoria and the ACT implemented this requirement in 2006 and 2007 respectively. In these jurisdictions specialist workers without tertiary qualifications need to be accredited to at least Certificate IV level, while workers with relevant undergraduate or post graduate qualifications need to obtain four core units of competency at Certificate IV level (Pidd et al., 2010).

An evaluation of the introduction of the Victorian minimum qualification strategy (Health Management Advisors, 2010) found that it was effective in increasing the number of professionals with specialist AOD qualifications. The evaluation found that the workforce development initiatives were implemented effectively and participants expressed a high level of satisfaction with the programs they had participated in.

The issue of minimum qualification requirements to work in the AOD field is a contentious one. It is particularly pertinent in relation to the employment of AOD workers with lived experience of AOD problems. There are concerns that the implementation of a minimum qualification requirement may add another layer of bureaucracy in the AOD field. It could also create a disincentive to base-level entry into the AOD sector if the achievement of the minimum qualification is seen as too onerous. Similarly, it could represent a barrier to attracting professionals such as psychologists, social workers and medical staff. Further, if the minimum qualification results in over-qualification of workers, these workers may not be required to perform duties commensurate with their skills (Alcohol Tobacco and other Drugs Council Tasmania Inc., 2012). There are also likely to be financial costs associated with staff receiving required training (including backfill costs) and having a more qualified workforce could lead to pressures to increase wages (Pidd et al., 2010). Likewise, having a requirement for minimum qualifications in the absence of commensurate wages could lead to recruitment difficulties as applicants seek employment in arenas in which their study is better rewarded. If minimum qualifications are to be introduced it will also be important to establish who will meet the associated costs.

A related issue concerns whether to have *minimum* qualifications or *essential* qualifications. Having minimum qualifications (for example set at Certificate IV level) means that all workers must have *at least* this level of qualification. Having a requirement for essential qualifications means that all workers must have the specified qualifications, regardless of which (potentially higher-level) qualifications they may have. If a requirement for essential qualifications is adopted (such as a requirement for four core units of competency at Certificate IV level) this may have unintended consequences. In Victoria, the requirement for a Certificate IV (AOD) as an essential qualification has had the effect that highly qualified and experienced counsellors and clinicians without the Certificate IV cannot be employed in AOD services. This may be despite having graduate or post graduate qualifications in AOD and related areas of practice. These staff are required to obtain these qualifications either by undertaking appropriate VET training or via recognition of prior learning. Either way, this is a significant cost to the individual or their organisation and can lead to an increased demand for subsidised training. If implemented without careful consideration, minimum qualifications can become a substantial impediment to them seeking employment in AOD work.

[1] A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practise. Nurse practitioners provide innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise (Australian Nursing and Midwifery Council, 2011).

If minimum qualifications are to be implemented, this gives rise to consideration of the appropriate level of these qualifications. The extent to which certificate level training meets the requirements of the sector is unclear. A survey of managers of drug treatment services (Pidd et al., 2010) found that the majority (86%) preferred specialist workers to have either higher education qualifications with explicit AOD content, or relevant higher education qualifications with additional accredited or non-accredited AOD training. While VET qualifications were seen as 'sufficient' for a minimum qualification, just over half of all managers indicated that the qualification level should be higher than Certificate IV, with more than one in three supporting a minimum qualification at the undergraduate or postgraduate level (Pidd et al., 2010).

There are also concerns about the extent to which current certificate level VET training meets the specific needs of the AOD Sector. The Certificate IV in Alcohol and other Drugs Work (CHC08) package replaced the CHC02 package in 2008. Concerns have been expressed by AOD managers (Pidd et al., 2010) and VET trainers (Roche et al., 2012) that the move to the CHC08 package led to the introduction of generic topics into the curriculum at the expense of alcohol and drug-specific topics and content. This may not provide students with the skills required to support clients with complex needs. Consideration could be given to the use of minimum qualifications at different levels of practice. This could involve a framework of minimum qualifications ranging from Certificate IV, to diploma, advanced diploma, vocational degrees and higher education qualifications linked to specific levels of practice.

The introduction of minimum qualifications may contribute to the on-going professionalisation of the AOD workforce. However, further action in this regard is needed, for example establishing professional groups which represent specific professions (e.g. social workers) as has occurred for the Drug and Alcohol Nurses of Australasia, the Chapter of Addiction Medicine in the Royal Australasian College of Physicians and the Alcohol and other Drugs Special Interest group of the Australian Psychological Society. Such groups not only lead to improvement in AOD-related skills, but also provide a mechanism for coordinated and comprehensive internship and placement programs (Roche & Pidd, 2010).

Q32. Should there be minimum educational standards that apply for specialist workers in the AOD field? If so what level should they be set at?

Q33. If minimum qualifications for employment in the AOD field were to be introduced: should there be recognition that professional qualifications, such as psychology, nursing, social work and medicine do not also require VET sector AOD qualifications or competencies; should experienced AOD workers be required to obtain the minimum AOD competencies; and what measures should be introduced to support peer and ex-peer workers to obtain these qualifications?

Q34. If national minimum qualifications were introduced, who should meet the costs associated with their implementation?

5.3.4 Increasing trend towards inter-professional education and practice

In response to the increasing requirement for effective team work between different health professionals and agencies, the future health workforce will need to work as effective members of inter-professional teams. This approach aims to resolve real world or complex problems, to provide different perspectives on problems, to create comprehensive research questions, to develop consensus on clinical definitions and guidelines and to provide comprehensive health services (Choi & Pak, 2006).

Inter-professional education:

- Focuses on the needs of, and actively involves, service users and carers
- Encourages professions to learn with, from and about each other
- Respects the distinctive contributions of each profession
- Seeks to enhance practice, and increase satisfaction, within professions (Australasian Interprofessional Practice and Education Network, 2013).

There is strong support in higher education, health and government for embedding and developing inter-professional education as a central part of the curriculum of all health professions (Nisbet, Lee, Kumar, Thistlethwaite, & Dunston, 2011). The Productivity Commission noted that there has been considerable change and innovation in Australia's health workforce including improvements in workplace efficiency and the growing use of inter-disciplinary and multidisciplinary approaches to patient care. However, the Commission also indicated there is evidence that opportunities for grater workforce innovation and collaboration have not been progressed (Productivity Commission, 2005; Royal College of Nursing, 2006).

This trend towards inter-professional education is likely to significantly impact future WFD in the AOD field.

Q35. How could education and training approaches for the AOD workforce be adapted to be more inter-professional?

5.4 Translation of research into practice

It is critically important that prevention, early intervention and treatment practices in the AOD field are based on the best available research evidence. For this reason the intersection between researchers and practitioners is increasingly important. The implementation of change in the AOD field should be based on the best available evidence concerning factors which influence the behaviour of clinicians. A recent systematic review (Bywood, Lunnay, & Roche, 2008) found that the four most effective strategies to encourage uptake of new policies or procedures were:

1. Interactive educational meetings (educational activities aiming to increase knowledge or skills regarding the new policy or procedure)
2. Educational outreach visits (enlisting a change agent to visit practitioners and deliver information about a new strategy or policy)
3. Prompts and reminders (regular reminders to practitioners to undertake a new task)
4. Audit and feedback (providing summaries of a practitioners' work over a period of time, compared to a benchmark standard).

The review found that these strategies were more likely to be effective if they:

- Had a clear and succinct message
- Came from a reliable and credible source
- Had an interactive format
- Contained information tailored to the local setting which was relevant to the practitioner
- Had clear identification of roles and activities
- Were accessible and easy to use systems or procedures
- Focused on barriers to change
- Addressed change at multiple levels (individual, organisational, policy)
- Required practitioners to take action
- Were sustainable (Bywood et al., 2008).

Another study also highlighted that changing the structures within which people work is important for evidence based practice, rather than simply encouraging a few to use new ways of working in spite of the system (Allsop & Stevens, 2009). This study found that factors which can impede effective practice in responding to drug-related problems include:

- Professional factors (lack of incentives, inadequate knowledge and skills, lack of instruction/supervision)
- Personal factors (attitudinal barriers towards drug and alcohol problems)
- Organisational factors (staff recruitment and retention methods, attention given to cross-sectoral collaboration, funding contracts, performance indicators and management priorities) (Allsop & Stevens, 2009).

In addition, existing educational support and professional development initiatives currently available to the AOD sector will continue to play an important role. These include AOD libraries and information services, newsletters and magazines, informal workshops, conferences and seminars.

Q36. How could research translation occur more effectively in the AOD field?

CONCLUSION

The reduction of AOD harm in Australia is dependent on having a skilled, effective and adaptable workforce. This Discussion Paper has described a range of factors impacting on the development of Australia's first AOD WFD Strategy. It has also provided the evidence base to support the development of the Strategy.

The Strategy development process is occurring amid a range of changes and pressures to the community service provision in Australia occurring as a result of structural reform, fiscal restraint and increased expectations from funders.

The key challenge for the future will be to extend the thinking of the AOD sector about what constitutes WFD. It will be essential to make the transition from a paradigm which focusses on the learning needs of individual workers; to one which focusses on the ways in which internal organisational environments of employing agencies impact on the effectiveness of workers; and ultimately to one which focusses on the ability of workers to operate more effectively across sectors.

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