Alcohol and Other Drugs
Workforce Development
Issues and Imperatives:

Setting the Scene

National Centre for Education and Training on Addiction (NCETA)

Ann M Roche
Ken Pidd

NCETA
Australia's National Research Centre
on AOD Workforce Development

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NCETA'S WORKFORCE DEVELOPMENT SERIES

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.

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:
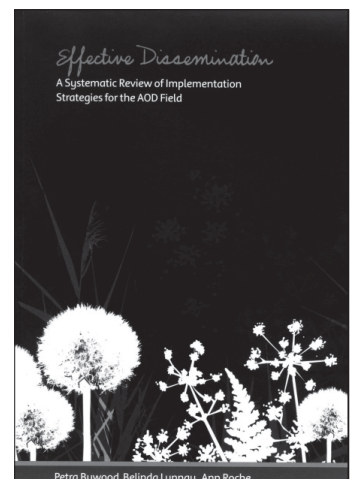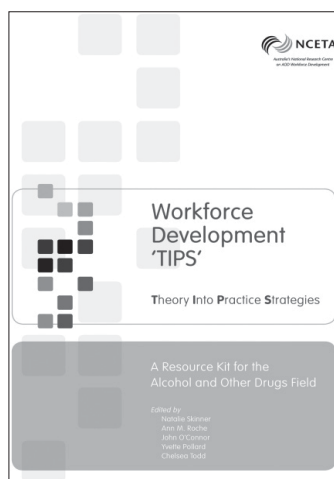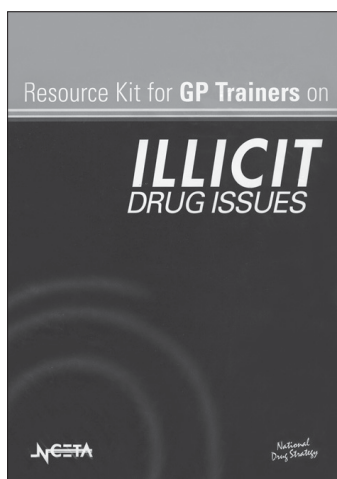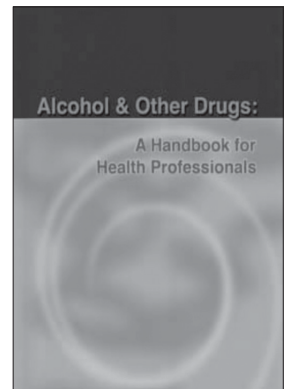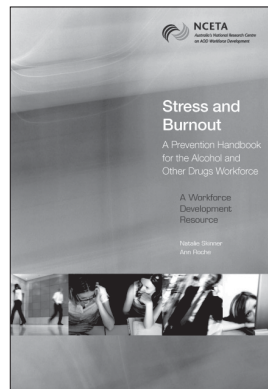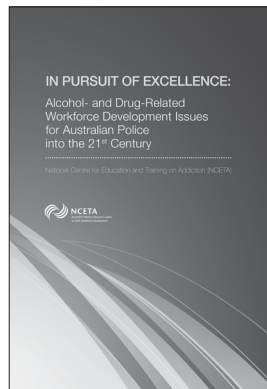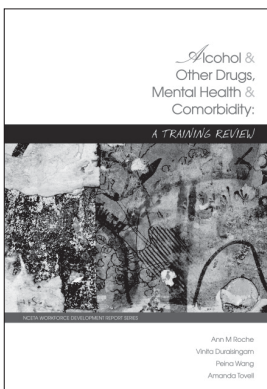
Acknowledgements

Glossary

The following terms and acronyms have been used:

AOD	Alcohol and Other Drugs
AOD field	agencies, organisations and individuals providing AOD-specific or AOD-related services and/or programs
AOD workforce	refers to both AOD specialist workers and mainstream generic workers who are employed in the health, welfare, law enforcement, criminal justice, and education sectors
IGCD	the Intergovernmental Committee on Drugs
MQS	Minimum Qualification Strategy
NADA	NSW Network of Alcohol and Drug Agencies
NGO	Non-Government Organisation
RTO	Registered Training Organisation
VAADA	Victorian Association of Alcohol and Drug Agencies
WANADA	Western Australian Network of Alcohol and Drug Agencies

Preface

This document builds on the body of work undertaken by NCETA in relation to AOD workforce development over the past decade. This report has been prepared to inform the development of a National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy. It describes the background, context and issues currently facing the AOD workforce and outlines steps for the development of a national strategy. The present document provides substantially broader data than previously available and incorporates new conceptual models of workforce development.

This document is set out in two main parts – Part A and Part B, preceded by an executive summary that outlines recommendations for a national workforce development strategy. Part A also contains five chapters that address key elements of relevance to the development of national workforce development strategies. Each chapter ends with a summary and an outline of implications for a national workforce development strategy. The five chapters contained in **Part A** cover the following issues.

Chapter 1: Workforce development an overview
Provides an overview of why AOD workforce development is a priority. It details encouraging developments that have occurred to-date but also notes that a comprehensive and strategic approach executed at the national level has been missing to this point in time and is now pressingly required.

Chapter 2: The wider context
Highlights the importance of considering the wider workforce and service delivery system within which the AOD field operates and the relevance of this wider context to the development of a national workforce development strategy. It also outlines the need for a national strategy to be able to accommodate emerging trends and the adoption of evidence based practice.

Chapter 3: Broadening the definition of workforce development
Details a broad definition of workforce development that incorporates a systems approach to individual and organisational change is presented. This section also examines different models of workforce development and implications of these models for a national workforce development strategy.

Chapter 4: The Structure of the Australian AOD workforce
Provides an overview of available data concerning the AOD workforce, identifies gaps in this data and underscores the importance of on-going workforce mapping and workforce planning for a national workforce development strategy.

Chapter 5: Contemporary workforce development issues
Describes current workforce development challenges facing the AOD field. These include issues such as recruitment and retention, education and training, professional development, accreditation and minimum qualifications, salaries and awards, leadership and management, workplace support and worker wellbeing.

Part B contains five chapters which provide more detailed data from the 13 surveys undertaken to date that profile the AOD specialist and generalist workforces.

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Executive Summary

A new National Drug Strategy will be developed in 2010. A new National Drug Strategy provides opportunity to spotlight the crucial, but often overlooked, area of workforce development. This co-occurs with related initiatives with a strong workforce development focus, such as the development of a National Workforce Agency as part of the COAG Health Workforce Reform package, and the National Health and Hospitals Reform Commission report, the National Preventative Health Strategy and the draft National Primary Health Care Strategy. As in the 2006 productivity commission report the efficiency and effectiveness of the health workforce is inextricably linked to the broader health care system (Productivity Commission, 2005).

This document outlines key issues of relevance to the production of a nationally co-ordinated AOD workforce development strategy, including a model of workforce development, and presents an overview of available data to create a profile of the AOD workforce.

The evaluation of the 2004-2009 National Drug Strategy (NDS) noted that:

> *"Australia is an international leader in AOD workforce development research, primarily through the work of NCETA, and that this is one of the positive outcomes of the current phase of the NDS.*
>
> *This leadership has not yet been translated into a national workforce development strategy and implementation plan." (Siggins Miller, 2009, p64)*

Despite this, considerable progress has been made in Australia over the past 5-6 years in regard to workforce development, particularly at the jurisdictional level. However, efforts to-date have been piecemeal and unco-ordinated and a nationally co-ordinated approach has been lacking. Program implementation has also been hampered by limited staff numbers and turnover, and skills gaps in the AOD treatment and prevention sectors as well as the broader health and human services system.

A national strategic approach is pressingly needed. It would allow for:

- a more analytical, proactive approach rather than an ad-hoc, reactive approach
- reduced duplication across sectors and jurisdictions
- more efficient use of resources
- development of a national pool of competence
- a risk mitigation strategy
- effective application of evidence based best practice
- duty of care for funding decisions.

Implementation of such an approach would also result in better outcomes for both clients of services and the community at large.

Workforce Development Defined

In a submission to the Intergovernmental Committee on Drugs (IGCD)[1] in November 2002, NCETA defined workforce development 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."*

Effective workforce development goes beyond just the provision of education and training to include issues such as recruitment and retention, workforce planning, professional and career development, and worker wellbeing. This broader approach to workforce development involves a wide range of individual, organisational, structural and systemic factors that can impact on the ability of the workforce to effectively and efficiently respond to AOD issues.

The central goals of workforce development include building the capacities of organisations and individuals to respond to alcohol or drug related problems, and to promote evidence based practice in the AOD field (Bywood, Lunnay, & Roche, 2008). Without addressing underpinning and contextual factors, the impact of change at the individual level alone will remain limited, transient and ultimately ineffective.

While ever workforce development is construed as synonymous with education and training it will inevitably be delegated to the remit of the jurisdictions, thereby obviating the role or responsibility for national involvement and co-ordination. The position taken here posits workforce development as extending well beyond education and training, and thus locating it within the remit of both national and jurisdictional bodies.

A Workforce Development Model

An overarching model of workforce development is proposed which is comprised of five levels:

1. Systems
2. Organisations
3. Workplaces
4. Teams
5. Individuals.

A national workforce development strategy needs to address each of these levels and facilitate evidence based practice initiatives that target organisations through to individuals. At the organisational system levels, initiatives are required to facilitate the integration of new knowledge and accommodate changes in work practices. While at the individual level, initiatives that improve access to information and build skills to translate this information into work practice are required. In addition, initiatives are also required that develop effective partnerships between research and service delivery agencies.

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1. The IGCD endorsed this definition and it was subsequently adopted in several state-based AOD workforce development strategies.

AOD Training and Education

Australia has witnessed a substantial increase in the provision of AOD-relevant training over the past decade. During this time, AOD education and training moved from being nearly absent from all major professional training programs in the early 1990's (Roche, 1998) to more widely available opportunities at undergraduate and postgraduate levels in the higher education and VET sectors by the early 2000's (Roche & Kennedy, 2003).

More recently, in a review of AOD, mental health (MH) and co-morbidity (CM) training, Roche et al. (2009) identified the increased availability of training options at both accredited and non-accredited levels and provided details of over 158 AOD accredited courses, plus an additional 11 AOD and mental health co-morbidity courses. Of the 158 AOD courses, most (48%) were offered at the TAFE Certificate level compared to the majority (55%) of mental courses which were offered at the postgraduate level.

Number of AOD, MH and AOD/MH Co-morbidity Courses by Award Level

Award level	AOD	CM	MH	Total	%
SoA*	16	4	9	29	7%
Certificate	79	3	80	162	42%
Undergraduate	33	2	7	42	11%
Postgraduate	27	2	118	147	38%
Other**	3	0	4	7	2%
Total	158	11	218	387	100%

SoA = Statement of Attainment
*** Other = university certificate/associate certificate courses*

While provision of AOD training opportunities has increased exponentially over the past decade and is now readily available at all levels, it is nonetheless expensive, especially at the accredited level, and requires substantial time and resource commitments from the worker and often their organisation as well.

Who Are the Workforce?

The AOD workforce comprised of multiple occupations engaged in a wide range of roles. The AOD workforce comprises two distinct groups:

1. frontline AOD specialist workers (who may work in AOD specialist organisations agencies or in AOD programs within non-AOD specialist organisations)

2. generalist workers (who work in the mainstream workforce, and have extensive contact with the wider community and are thereby well placed to implement AOD prevention and intervention strategies).

A wide range of professions come into contact with individuals with alcohol and drug problems as part of their work, including specialist and generalist health professionals, and other professions such as police, teachers, corrections, welfare, counsellors, youth

workers and bar staff. AOD specialist workers can provide intensive treatment for individuals with AOD problems, while generalist workers such as GPs are well positioned to screen individuals for alcohol and drug problems and provide brief interventions. Others play important prevention and policy roles.

The workforce is also employed across a diverse range of organisations that straddle the government, not-for-profit (non-government or as it is sometimes known, the third sector) and, to a lesser extent, the private sector. Moreover, the systems and structures within which the AOD workforces operate vary across sectors, jurisdictions, and individual agencies. This diversity presents important challenges for the development of a national strategic response.

There are also large jurisdictional variations in regard to the proportion of government and non-government specialist treatment agencies (and workers within such agencies). These large variations make it difficult to generalise about the AOD workforce from one jurisdiction to another and make a nationally co-ordinated workforce development plan particularly important.

Profiling the AOD Specialist Workforce

While Australia has excellent data collection systems in place in relation to tracking current and emerging drug trends, little work has been undertaken to use these data to estimate future workforce needs. Moreover, no nationally co-ordinated framework to workforce map and plan for the AOD sector has been developed.

This report presents a comprehensive compilation of available data on the Australian AOD specialist workforce.[2] Derived from 13 AOD workforce development surveys (5 national and 8 jurisdictional) undertaken over the past decade are presented.[3] No similar compilation or synthesis is available elsewhere.

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2. Some information on the AOD sector is available via data collected as part of the National Minimum Data Sets (NMDS) and the Clients of Treatment Service Agencies (COTSA) national census. Very few data are collected about agency characteristics and no data are regularly or systematically collected about staff demographics or their workforce development needs. Data are not collected from agencies that primarily provide AOD education, prevention and/or brief counselling/referral, nor is data from AOD specialist workers involved in AOD programs embedded within other (non-AOD specialist) social organisations. Similarly, little data has been collected on mainstream workers who are involved in AOD work.

3. See Part B of this report for details extracted from each of the 13 AOD workforce surveys undertaken to-date.

AOD Specialist Workforce Surveys 2001-2009

National Surveys		
2001	National NGO survey (43 respondents)	Pitts (2001)
2002	An NCETA national survey of 234 specialist treatment agency managers	Wolinski, O'Neill, Roche, Freeman, & Donald (2003)
2003	An NCETA national survey of 1,024 mainstream workers engaged in AOD work	Freeman, Skinner, Roche, Addy, & Pidd (2004)
2005	An NCETA national survey of 1,345 specialist AOD workers	Duraisingam, Pidd, Roche, & O'Connor (2006)
2005	An NCETA national survey of 280 specialist treatment agency managers	Duraisingam, Roche, Pidd, Zoontjens, & Pollard (2007)
Jurisdictional Surveys		
2002	A survey of 745 Victorian AOD workers employed in agencies funded by the Victorian Department of Human Services	Victorian Department of Human Services (DHS) (2005)
2005	A survey of 136 Northern Territory AOD workers employed in 18 AOD specialist treatment agencies and AOD intervention programs	NT Department of Health and Community Services (2005)
2006	A survey of 134 ACT specialist AOD workers	McDonald (2006)
2007	An NCETA survey of 167 South Australian AOD workers employed in 18 non-government AOD specialist agencies and 26 non-government mainstream agencies with AOD programs	Tovell, Roche & Trifonoff (2009)
2008	WA survey of 207 AOD workers from 35 NGO services – part of the 2007 Sector Remuneration Survey	WAAMH et al. (2008)
2008	A NSW Network of Drug and Alcohol Agencies (NADA) survey of 111 NSW non-government specialist workers and 85 managers of NSW non-government specialist treatment agencies	Gethin (2008)
2008	A survey of 492 workers employed in Victorian AOD agencies	Conolly (2008)
2009	A survey of 132 ACT workers from 9 AOD agencies	ACT AOD Sector Project (2009)

Key demographic workforce features extracted from eight of these surveys are shown in the summary table below. This table provides the most comprehensive overview of the AOD workforce currently available.

Differences in key AOD specialist workforce demographics across jurisdictions

Survey	Female	Av age (yrs)	NGO workers	Generic AOD workers	Nurses[1]	Part-time	Median years in AOD field	Tertiary quals[4]	No AOD specific quals[2]	AOD quals ≥ Cert IV[3]
National 2002 (managers)	57%	46	50%	**	**	**	11-15 (23%)	47%		**
National 2005 (managers)	61%	47	40%	22%	36%	6%	9	77%	25%	53%
National 2005 (all workers)	66%	43	42%	40% (61% ngo; 24% gov)	31% (9% ngo; 47% gov)	30%	5	65%	26%	48%
ACT (2009)	69%	41	78%	52%	9%	37%	5.6	65%	26%	34%
NSW (2008)*	61%	44	100%	49%	8%	54%	**	40%	**	33%
Vic (2008)*	65%	59% >40	**	44%	8%	37%	2-5	62%	16%	56%[†]
SA (2007)*	67%	59% >40	100%	36%	2%	39%	6	57%	35%	27%
NT (2005)	**	**	**	**	**	**	**	52%	**	**

[1] the proportion of nurses varies greatly as some surveys only included the NGO sector.
[2] No accredited AOD specific qualifications
[3] AOD-specific qualifications at Cert IV level of higher
[4] undergraduate or post graduate qualifications
* data only available for non-government workers
** data not available
[†] 73% meet Victorian MQS standards for accreditation as an AOD worker

Jurisdictional variations notwithstanding, national surveys indicate that the majority of AOD specialist workers:

- are female (66%)

- aged 45 years or older

- approximately one third (30%) are employed part-time

- median length of AOD service is 5 years for AOD workers

- largest occupational groups are generalist AOD workers (40% of the specialist NGO workforce) and nurses (31% of the specialist government workforce).

This profile highlights several important workforce development issues including:

AOD qualifications	A substantial proportion has no formal AOD specific qualifications
Gender	The majority of AOD workers are female and this has particular implications for workforce development strategies
Age	The majority of AOD workers are over 40 years of age. This may result in future workforce shortages (as older workers reach retirement age) and may impact strategies to up-skill the workforce
Part-time workers	A substantial proportion of AOD workers are employed part-time. These workers may have particular difficulty accessing training and other professional development opportunities
NGO vs Public sector workers	A large proportion of AOD workers are employed in the NGO sector. Differences between the NGO sector and the public sector in terms of workforce profiles, funding, infrastructure, remuneration and career development opportunities present challenges for a national workforce development strategy.

Although numerous workforce surveys have been conducted over the past decade they lack coordination and consistency, use different methods and measures, and therefore pose difficulties in synthesising and generalising from their findings. Nonetheless, Australia has a better overall picture of the AOD workforce today than it did even five years ago, and is therefore better placed to develop more appropriate and refined workforce development strategies.

This report also identifies a range of additional issues that are relevant to the development and implementation of a national workforce development strategy. These include:

- recruitment and retention
- awards, remuneration and career paths
- professional development
- accreditation and minimum qualifications
- clinical supervision and mentoring
- leadership and management
- workforce support
- worker wellbeing.

The production and implementation of an effective national workforce development strategy for the AOD field requires strong coordination, leadership, and collaboration across jurisdictions, government departments, sectors, and individual agencies. A comprehensive strategy will clearly define actions to be undertaken, provide timelines, and allocate responsibility for implementation. To achieve this, high level support will be required to inform the development of a strategy, provide funding for the production and implementation of the strategy, and assist with intersectoral collaboration. This can be best

achieved by a nationally co-ordinated approach involving the Intergovernmental Committee on Drugs (IGCD) and the Australian Government.

Recommendations

In light of the findings identified in this report, the following recommendations are made:

A Mechanism for National Coordination

1. A national AOD workforce development Advisory Committee should be established, facilitated by NCETA, with representatives from key relevant national and jurisdictional bodies to deliberate on all major workforce development issues, develop nationally agreed and consistent positions, and advise on workforce development strategies. This committee should assign responsibility for the production of a workforce development strategy to an appropriate individual or organisation and oversight of the production process.

2. Consultation forums need to be conducted to allow relevant stakeholders to provide input into the strategy. These consultations forums should be structured in such a way as to ensure input from the broad range of stakeholders outlined above. Submissions from the wider community and clients of service providers should be encouraged.

3. A national clearinghouse of workforce development initiatives, including programs, policies and research, should be established with reports and regular updates made widely available to the field.

4. A bi-annual workforce development conference should be held to enable key players to share developments, report on progress, discuss challenges and monitor developments and emerging trends relevant to AOD workforce development.

5. Each state Department of Health should nominate a designated senior officer as their workforce development liaison officer and contact point.

6. Workforce development should comprise a regular standing item on IGCD meetings, with updates against specific strategic goals from the Commonwealth and state representatives.

Workforce Mapping and Monitoring

There is a paucity of reliable and valid data concerning workforce development strategies, especially in the AOD field. While efforts to address workforce issues are increasing, it is rare for the outcomes of these efforts to be evaluated. As it is essential for workforce development initiatives to be based on best practice, there also needs to be a concomitant increase in development of the evidence base for workforce development.

1. Regular national reviews (e.g., 3-yearly) of the AOD workforce should be undertaken to continue to monitor and map the demographic features of the workforce and assess workforce flows (including recruitment and retention). NCETA is the appropriately positioned body to undertake these surveys and to act as a central repository of data on the AOD workforce.

2. Jurisdictional workforce surveys are also encouraged, but they should be undertaken with guidance from NCETA to ensure consistency and compatibility of the data collected. This will maximise the usefulness of available data and will add considerable efficiencies to the limited resources allocated in this area.

Recruitment and Retention

It is widely agreed that recruitment and retention are priority workforce development issues. It is recommended that a set of comprehensive strategies be put in place at national and jurisdictional levels to address the older age profile of the AOD workforce, to increase retention and improve recruitment of both AOD specialist workers as well as groups such as prescribers. Such strategies would include:

1. initiating/expanding programs to attract younger workers, such as traineeships or recruitment drives in higher education or VET settings

2. establishing programs to attract and re-train redundant workers from shrinking industries such as manufacturing

3. implementing programs to attract mature aged workers wanting a career change or wanting to re-enter the workforce.

Minimum Qualifications

The issue of minimum qualifications need to be addressed nationally. Important lessons have been learned from the Victorian initiative in this regard. It is recommended that the newly established Advisory Committee (see above) reviews the findings from Victoria and other studies currently underway to examine the question of minimum qualifications and implement national policies and guidelines in this regard.

Organisational Accreditation

The question of whether AOD organisations should be subject to independent review and accreditation is an important workforce development issue with quality assurance implications. The Advisory Committee should examine this issue and identify options available and determine a recommended course of action.

Awards, Salaries and Conditions and Career Paths

Several studies have been undertaken examining these issues. A critical review is needed to address the shrinking salary base of NGO workers and its implications. Correspondingly, the recent award of medical specialist status to addiction medicine clinicians has an enormous economic impact on the services supporting these staff. A review is also required to model the impact that these new awards will have on the ability of services to maintain their existing staff levels.

Fostering Integration, Co-ordination and Partnerships

Comprehensive, inter-sectoral and long term workforce development planning processes are required to ensure an adequate AOD workforce for the future. Workforce development initiatives that are implemented across sectors, systems and agencies are the most efficient way to build workforce capacity. This requires strategies to optimise and strengthen integration and co-ordination between health, law enforcement and human services sectors (including welfare, housing, Indigenous and youth), especially in light of the emphasis on the social detriments of AOD problems and renewed interest in social inclusion.

Workforce Development Review and Research Agenda

Finally, a comprehensive review of existing information on the AOD workforce and workforce development issues facing the field is needed. This review would need to identify priority areas and workforce development models of best practice, and identify any research needed to inform future workforce development policy or programs.

In conjunction with the Advisory Committee proposed above, a national workforce development research agenda should be established. To-date, there is a growing body of AOD-related workforce development research that has been undertaken; however, it lacks any co-ordinated framework. Establishing a research agenda with priority areas indicated will provide a useful guide to researchers and funders alike.

Strategy development principles which underlie the steps outlined above include:

- Building on existing efforts and initiatives that have been demonstrated to be effective and successful

- Broad consultation with relevant key players and potential partners

- Drawing on available research

- Consideration of identified trends and issues in AOD use, service delivery, IT, social developments and economic and workforce/workplace issues

- Identifying responses that can be realistically implemented in a timely manner.

Part A:
Towards a National AOD
Workforce Development Strategy

CHAPTER 1: WORKFORCE DEVELOPMENT AN OVERVIEW

There have been substantial changes in the alcohol and other drugs (AOD) field in recent decades that have major implications for the development of a responsive, effective, and sustainable AOD workforce. These changes include the increased complexity of AOD issues and growth in demand for AOD services, together with issues facing the wider Australian workforce such as advances in technology, an ageing workforce, and a tight labour market.

These complex and diverse changes have led to increased recognition that a co-ordinated strategic national approach is needed to develop the capacity of the AOD workforce to effectively respond to current and emerging AOD issues. However, to-date no comprehensive national framework has been developed and implemented.[4]

The recent evaluation of the National Drug Strategy (NDS) (Siggins Miller, 2009, p53) stated that:

> *"An appropriately sized, skilled and qualified workforce is critical in sustaining effective delivery of interventions. Capacity to implement programs has been limited by staff shortages and turnover, and skill gaps in the alcohol and other drug (AOD) sector specifically and in the Australian workforce generally. The NDS contribution to training programs and resources is highly valued, as is the work of NCETA in developing a concept of workforce development far broader than education and training. More attention is needed to building the capacity and profile of professionally-trained, specialist AOD workers. Attention is needed to competitive pay and conditions, incentives and benefits.*

> *A new national AOD workforce development strategy, as proposed by NCETA and recently discussed by IGCD, will be an important initiative."*

This document is intended to assist the development of a national workforce development strategy for the AOD field. It provides a basis upon which such a strategy could be progressed.

AOD Workforce Development - A Priority

Workforce development is increasingly recognised as a priority area. It featured prominently in the 2004-2009 National Drug Strategy: Australia's Integrated Framework (MCDS, 2004), and it is anticipated that even greater emphasis will be placed on workforce development in future drug strategies. The 2004-2009 National Drug Strategy recognised that a multifaceted approach is required to develop the AOD workforce and called 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).*

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4. A report on the development of a national AOD workforce strategy was produced for the Inter-Governmental Committee on Alcohol and Other Drugs (IGCD) in 2004. That report provided a useful and informative tool at the time. However, no action plan was associated with the document, it was not progressed and subsequently languished. Considerable change has since taken place rendering that earlier report now substantially out of date and superseded by a range of other events and initiatives.

The need for a national AOD workforce development strategy was also highlighted by Dr Neal Blewett (2006) who has 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.***
>
> *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".*

A Decade of Growing Recognition

While there is a pressing need to introduce a nationally co-ordinated approach to workforce development, there have nonetheless been some encouraging, albeit gradual, developments at both national and jurisdictional levels over the past decade. Examples of the growing prominence given to workforce development include the following:

Box 1: Examples of the growing recognition of workforce development

1997	Evaluation of the National Drug Strategy (NDS) 1993-1997 makes no reference to workforce development
1998	National Drug Strategic Framework 1998-2002/03 makes passing reference to workforce development
2003	NDS evaluation refers to workforce development 17 times
2004	NDS makes only one reference to workforce development but it is an entire paragraph devoted to discussion of the issue
2005	Intergovernmental Committee on Drugs (IGCD) Annual Report to the Ministerial Council on Drug Strategy (MCDS) mentions workforce development 10 times
2009	The NDS Evaluation undertaken by Siggins Miller highlights the extent to which workforce development had been largely overlooked in any systematic and planned efforts at the national level.

Major government bodies have also acknowledged the importance of workforce development as central to their core business in recent years. NSW Health, for instance, identified workforce development as one of its top priority action areas in their Co-morbidity Framework for Action to respond to co-morbidity issues in health settings (NSW Health, 2008). This action area notes the importance of establishing management guidelines, building capacity, increasing staff numbers, partnering with peak organisations, developing new resources and up-skilling the workforce. Other areas for action included improving

infrastructure and systems development, improving responses in priority settings for priority clients, and improved promotion, prevention and early intervention strategies. Anticipated outcomes from that Framework are to:

- promote professional practice and thus improve quality of care
- increase work satisfaction and prevent worker burnout
- increase multidisciplinary and inter-agency/sector collaboration
- improve dissemination and implementation of research findings.

The Victorian Department of Human Services introduced a workforce development strategy for 2004-2005 (Victorian Government Department of Human Services, 2005). The underpinning feature of that strategy was the introduction of a minimum qualification standard for AOD work. Five strategic directions were identified, including:

- specialist AOD workforce skill development
- AOD workforce recruitment and retention
- Koori AOD workforce development initiatives
- generalist health and welfare worker AOD skill development
- quality standards for AOD treatment services.

Workforce development also features prominently in the goals and priorities of professional groups such the Australasian Professional Society on Alcohol and Other Drugs (APSAD) and the Drug and Alcohol Nurses Association of Australia (DANA), and among the peak bodies representing the NGO sector such as the Alcohol and Other Drugs Council of Australia (ADCA) and the New South Wales Network of Drug and Alcohol Agencies (NADA).

In preparing this report close consideration and acknowledgement is given to the progress that has been achieved to-date in this area. There have been a number of workforce development reviews, audits, and workforce surveys[5] and an array of important jurisdictional initiatives undertaken. Non-exhaustive examples of workforce development reviews and audits are provided in Box 2, and examples of the implementation of workforce development strategies in specific jurisdictions are illustrated in Box 3.

A range of other workforce development initiatives have also been introduced at national, jurisdictional, and sectoral levels (e.g., clinical guidelines, training directories, resource kits, targeted training programs). What is presented here is not comprehensive or exhaustive; rather, these examples are merely illustrations of recent workforce development initiatives.

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5. Details of Australian AOD workforce surveys are summarised in Chapter 4 and presented in detail in Part B of this report.

Reviews of the education and training needs of the national AOD specialist workforce	Allsop et al. (1998) Roche (1998)
National workforce development symposia	National Centre for Education and Training on Addiction (2001 & 2002)
Recognition of the organisational and systemic barriers to the development of the Australian AOD workforce	Allsop & Helfgott (2002) Roche, Hotham, & Richmond (2002)
Workforce Development Issues in the AOD Field: An IGCD briefing paper	Roche (2002)
A review of key workforce development issues for the non-government AOD sector	Skinner, Freeman, Shoobridge, & Roche (2004)
A report on the development of a national AOD workforce strategy	Intergovernmental Committee on Drugs (IGCD) (2004)
An audit of the workforce development needs of the South Australian AOD workforce	National Centre for Education and Training on Addiction (2006)
Profiling and identifying the training needs of the NSW non-government AOD workforce	Deakin & Gethin (2007)
Workforce in Crisis. A report on remuneration, retention and recruitment in the AOD, mental health, family and domestic violence and women's health sectors.	WAAMH et al. (2008)
NSW Alcohol and Other Drug Non-Government Sector: Workforce Profile and Issues 2008	Gethin (2008)
Achieving Professional Practice Change: From Training to Workforce Development	Roche, Pidd, Freeman (2009)
Alcohol and other drugs, mental health & co-morbidity: A training review.	Roche, Duraisingam, Wang, & Tovell (2009)
In pursuit of excellence: Alcohol and drug related workforce development issues for Australian Police into the 21st century.	Roche, Duraisingam, Trifonoff, & Nicholas (2009)

Box 3: Examples of workforce development initiatives by jurisdiction
(examples and illustrations provided are not exhaustive)

The introduction of an AOD workforce development strategy in Victoria	Victorian alcohol and other drugs workforce development strategy 2004-2006
The introduction of minimum qualifications in Victoria	Victorian alcohol and other drugs workforce development strategy : Minimum Qualification Strategy (2006)
The adoption of a framework for AOD workforce development in New South Wales	NSW Health drug and alcohol plan 2006-2010: A plan for the NSW Health Drug and Alcohol Program
The establishment of the NSW Drug and Alcohol Workforce Development Council	Drug and alcohol issues: An agenda for workforce development in NSW (2005)
Models of Workforce Development. A brief overview document	NCOSS (2007)
The introduction of minimum qualifications in the ACT	ACT AOD minimum qualification strategy (2008)

While developments such as those illustrated in Box 2 and Box 3 form important contributions, many have only focused on education and training and/or the development of individual workers' skills and they have not tackled wider organisational or systemic factors. It has only been relatively recently that strategies have been introduced to address factors that pertain to a wider and more comprehensive approach to workforce development.

This shift to a more comprehensive approach to workforce development was acknowledged in the recent evaluation of the NDS which stated that:

> *"There has been a stronger emphasis on workforce development in recent years. NCETA's focus has changed over the years from developing and delivering AOD training programs (it filled a problematic gap in this area in its early days) to research on workforce development issues. This research has provided much of the evidence for workforce development policies and action plans.*
>
> *Our informants have pointed out that Australia is an international leader in AOD workforce development research, primarily through the work of NCETA, and that this is one of the positive outcomes of the current phase of the NDS. This leadership has not yet been translated into a national workforce development strategy and implementation plan." (Siggins Miller, 2009, p64)*

The NDS evaluation noted in particular the need for investment in the recruitment of new workers, the retention of the existing workforce and modelling to estimate future needs and identify strategies to ensure a future supply of an appropriately skilled and qualified workforce.

Recommendation six (of a total of eight) from the NDS evaluation related to workforce development was as follows:

> *"Recommendation 6: Develop a strategic approach to AOD workforce development to meet by current and future needs, for example by:*
>
> 1. *addressing structural issues of national concern such as more competitive employment conditions in the AOD sector, better clinical supervision and mentoring, and incentives, continuity of entitlements across government, non-government and private providers, and funding for medical, nursing and allied health specialist training in AOD-related conditions*
> 2. *identifying strategies to ensure a supply of appropriately skilled and qualified workers (such as enhancing their scope of practice, and providing MBS items for allied health professionals engaged in the AOD sector)*
> 3. *identifying strategies to ensure a supply of appropriately skilled and qualified Aboriginal and Torres Strait Islander and CALD AOD workforces*
> 4. *using NCETA's central role to focus on strategic workforce development and modeling to estimate future needs, in collaboration with other bodies, including some of the State AOD peaks and State and Territory AOD agencies" (Siggins Miller, 2009, p60).*

Summary and Implications for a National Workforce Development Strategy

Overall, workforce development efforts to-date have been increasing. They nonetheless remain piecemeal and unco-ordinated. Clearly there has also been a steady growth in the recognition and understanding of the importance of workforce development and its implications for the long term development of the AOD field. What is needed at this point in time is a nationally co-ordinated approach to progress strategies that are ripe for implementation.

A nationally co-ordinated strategic approach to workforce development would allow for:

1. a more strategic and planned approach

2. a more proactive approach rather than ad-hoc, reactive responses

3. consistency across sectors and jurisdictions

4. more efficient use of resources

5. higher quality workforce development initiatives

6. better outcomes for both clients of services and the community at large.

Before examining a strategic workforce development approach for the AOD field in more detail, it is important to first consider the wider context and broader issues of relevance. Key contextual issues are examined in the next chapter.

CHAPTER 2: THE WIDER CONTEXT

The AOD workforce is part of the community/human services and health industry sector which is Australia's third largest employer, employing more than 1.1 million Australians and comprising more than 10% of the workforce (Community Services and Health Industry Skills Council, 2009). Over the past 10 years there has been a 38.7% growth in employment in this sector and this trend is expected to continue.

It has been estimated that the community services and health sector will contribute 24% of all workforce growth to 2012, growing at a rate of 3% (170,000 new jobs) per year (Community Services and Health Industry Skills Council, 2008a). That is, one in four of all new jobs created over the next five years will be in the health and community services sector. While this growth will provide an important contribution to the future health and welfare of Australians and Australia's future economy, it also presents a substantial workforce development challenge.

The health and community services sector is also the largest employer of women, and as highlighted in later sections of this report the AOD workforce is comprised of approximately 66% female workers. There are important but often overlooked implications of the predominance of female workers in the AOD workforce.

The AOD field not only sits within the wider health and community/human services sector, it also forms part of the education and law enforcement/criminal justice sectors. It is thereby impacted by a wide range of contextual factors of relevance to these sectors that are central to the development of a national workforce development strategy.

Key issues relevant to this wider context include:

- the availability of a skilled and effective generic workforce, appropriately distributed across the population
- the implementation of long term planning processes and cooperation between all jurisdictions to achieve workforce goals
- the impact on Australia of worldwide shortages of particular groups of workers; such shortages particularly impact rural and remote areas.

To meet the future AOD needs of the Australian population in an environment of worldwide health and other workforce shortages may require initiatives that include:

- changing the types and mix of workers
- changing professional roles, and
- providing existing workers with new skills and knowledge.

A number of generic trends also impact on service delivery both within the AOD field and wider health and community/human services workforce. These include:

- increases in consumer demand and expectations
- new developments in technology

- changing models of care

- an increase in knowledge of genetic factors impacting upon disease

- a trend towards more targeted therapies

- increasing demand for services.[6]

Compounding the increased demand for health and community/human services in general are substantial difficulties in recruiting and retaining qualified staff, particularly in rural and remote areas. This is an on-going issue in the AOD sector (Pitts, 2001; Wolinski et al., 2003; Duraisingam et al., 2006).

Australian governments have introduced a range of targeted policies to address workforce shortages (e.g., overseas trained doctor programs, additional nursing places, subsidies for rural doctors, etc). However, these strategies alone may not be sufficient to meet the challenges facing Australia's health and community/services workforces at large and the AOD workforce in particular.

Lawrance (2009), for example, has highlighted the anticipated shortage of addiction medicine specialists in NSW in the coming years as a substantial proportion of the current AOD specialists are approaching retirement and there are few new graduates entering the field. To address this challenge NSW has instituted a suite of capacity building initiatives including funding the Australasian Chapter of Addiction Medicine to establish specialist training programs in Addiction Medicine including:

- online topics

- the development of training to enhance GPs' ability to manage difficult patients and those with co-morbidity

- the development of common learning objectives for undergraduate medical training,

- provision of additional medical specialists in rural areas.

Any workforce development initiatives need to be cognisant of the broader health and human service systems within which AOD services operate. AOD-related problems are often complex and multi-faceted and thereby require interventions by multiple service deliverers. There is also growing recognition that AOD problems do not exist in isolation and that they are usually accompanied by an array of complex factors. As a result there is greater emphasis placed on social inclusion strategies.

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- new developments in technology

- changing models of care

- an increase in knowledge of genetic factors impacting upon disease

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6. An Australian Community Sector Survey of service provision in 2007-08 found demand for services across the board increased 19% from the previous year. In addition the percentage of people eligible for services who were turned away increased by 17.3% (ACOSS, 2009).

- a trend towards more targeted therapies

- increasing demand for services.

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A range of sectors must inevitably be involved when developing a national AOD workforce strategy. These sectors include:

- health

- human service

- law enforcement/criminal justice

- housing

- employment

- mental health

- disability services

- education

- child care and child safety protection.

Other National Initiatives Relevant to Workforce Development

Given this wider context, the development of a national strategy may be assisted by reference to other recent national initiatives that address workforce issues and strategies in the health and human services sectors, such as those indicated below. In many cases, health and human service workforces face similar challenges to those encountered by the AOD workforce.

The Health Sector

In recent times there has been a great deal of attention focused on health system reform in Australia and workforce issues have featured large in these dialogues (see below). Before the current wave of proposed reform initiatives the National Health Workforce Strategic Framework[7] was adopted in 2004. The overall goal of that Framework was to ensure Australia had a sustainable health workforce that was knowledgeable, skilled and adaptable. That goal was underpinned by seven guiding principles and a range of related strategic directions. The seven guiding principles and related strategies were constructed to be applied at the national, jurisdictional and regional/local level. These guiding principles were:

1. Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market

2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need

3. All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration

4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes

5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs

6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence

7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:

   • cohesion among stakeholders including governments, consumers, carers,

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7. Australian Health Ministers' Conference (AHMC), National Strategic Health Workforce Framework, May 2004, Sydney.

public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors

- stakeholder commitment to the vision, principles and strategies outlined in this framework

- a nationally consistent approach

- best use of resources to respond to the strategies proposed in this framework

- a monitoring, evaluation and reporting process.

Importantly, the National Health Workforce Strategic Framework was linked to an action plan[8] and responsibility for developing strategies to meet the Framework was assigned to the National Health Workforce Taskforce.

More latterly there has been a flurry of reform activity in the health sector and workforce issues and workforce development have been central to discussions at various levels. For example. the Australian National University in late 2009 held a National Health Reform Series that addressed the topic of 'Can we fix the health system without reforming the workforce'. They embarked on this series to improve dialogue between academic endeavours and public policy and to (as the Prime Minister has alluded) make more porous the thick walls between academia, the bureaucracy and the community in general. The Workforce was chosen as the first topic in this series because it was argued that without tackling some of the key workforce issues little could be done in terms of health system reform. As a recent Productivity Commission report states "the efficiency and the effectiveness of the health workforce is inextricably linked to the broader health care system, and if you are going to play with one of those inextricably linked elements, of course, you're going to have effects on the other."

The National Health and Hospitals Reform Commission have argued that to achieve a strong and integrated health care system we need an adequate, sustainable and effective workforce and currently Australia's primary health care workforce (as one case in point) is facing challenges in numbers, distribution, demands and changes in role delineation. In terms of primary care workforce numbers, Australia has significant shortages in all types of primary health care workforces. They are more acute in remote, rural and outer metropolitan areas, but they also exist in urban areas.

It is increasingly recognised that the health care workforce is the fundamental structure on which a health care system is built. The health care workforce comprises the personnel, knowledge, skills and experience of individual practitioners. How health care knowledge, skills and experience are applied, delivered and sustained is then determined by the support systems and infrastructure that are developed.

Challenges in health care demands are reflected in the ageing of the population, the dramatically increasing prevalence of chronic diseases, requiring complex treatment, and the rapidly rising rates of lifestyle risk factors: so too is the workforce changing. The future primary health care workforce will be increasingly female. Generation X and Y have greater

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8. National Health Workforce Action Plan, July 2004.

expectations of career flexibility and they will view multiple careers in their lifetimes as the norm rather than the exception. Among the medical workforce many of them will have more than one degree or formal qualification. All of these developments and trends have important implications for the AOD field and the AOD workforce.

The Aged Care Sector

The aged care workforce also faces workforce issues that are similar to the AOD field and the wider health and human services sector (Martin & King, 2008). The National Aged Care Workforce Strategy[9] contains seven broad objectives that are underpinned by a range of strategies that cover issues such as workforce supply, education and training, recruitment and retention, and ensuring the desirability of the aged care sector as a place to work. The aim of the strategy is to provide a people management and development framework to ensure a sustainable and viable aged care sector. Implementation of the strategy and the development of associated action plans is the responsibility of the Aged Care Workforce Committee.

Both the Health and Aged care workforce strategies recognise that effective workforce development involves collaboration and cooperation with a range of stakeholders including governments, peak bodies, training and education providers, individual organisations and other workforce sectors. Both strategies are based on an understanding of existing workforce profiles and recognise the need for workforce development models to be based on best practice evidence. Both strategies are linked to action plans and assign responsibility for strategy implementation and monitoring. Finally, both strategies recognise the need for long-term structural reform and the need for on-going evaluation and revision of strategies in order to build on best practice and adapt to changing conditions

Emerging Trends

While there are numerous workforce development related challenges facing the AOD field, two wider contextual issues of particular importance are:

1. new and emerging trends in health/community service responses and

2. the increased emphasis on evidence based practice and the related challenge of research transfer/dissemination.

Over the past 20 years, the AOD field (and the wider health/community services sector) has experienced unprecedented changes that have major implications for the development of a responsive and sustainable AOD workforce. Provision of quality and timely AOD responses has been substantially impacted by:

- changing patterns of substance use (including earlier onset and extended duration of use)

- increased prevalence of polydrug use[10]

- unprecedented increasing in use of pharmaceutical susbtances

- a growing recognition of mental health/drug use co-morbidity

- an expanding knowledge base

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9. National Aged Care Workforce Strategy, March 2005.

10. Australia has extensive and detailed data on patterns and prevalence of AOD use (e.g., NDSHS, ASSAD) together with excellent sentinel systems (e.g., IDRS, EDRS) to inform policies, programs and interventions.

- advances in treatment protocols and

- an emphasis on evidence based practice.

AOD use and related problems cut across society and impact on a wide range of health, education, human service, police, and criminal justice workers and there is also a growing demand for services, policies and programs from specialist AOD agencies, as well as from generalist workers.

The diversity of the AOD workforce also presents particular challenges when responding to emerging trends that have implications for service delivery. Not only is the AOD workforce comprised of multiple occupations engaged in a wide range of roles, the workforce is also employed across a diverse range of organisations that straddle the government, not-for-profit sector (non-government or as it is sometimes known, the third sector) and, to a lesser extent, the private sector. Moreover, the systems and structures within which the AOD workforce operate vary across sectors, jurisdictions, and individual agencies.

A recent example of such challenges is provided by the growing recognition of various forms of com-morbidity in the community. In the AOD field the co-morbidity's most commonly identified is the co-occurance of an AOD problem and a mental health problem[11] (see Box 4). But increasingly it is recognised that there are many other forms of co-morbidity that can be equally debilitating for the person/s involved.

For example, there is increasing concern about the effects that AOD use has on the family and especially children (Dawe, Atkinson, Frye et al., 2007). A substantial proportion of proportion of Australian children have a parent attending alcohol and drug treatment (Odyssey House, 2004). Moreover, parental alcohol and/or drug use is an important contributory factor to notifications of child abuse or neglect. Thus, the AOD treatment workforce has the potential to play an important role in ensuring the safety and welfare of these children. In addition, treatment regimes that acknowledge and work with families may be more effective than those that focus on the individual alcohol or drug user in isolation (Dawe et al., 2007; Dodd & Saggers, 2006; Forrester & Harwin, 2004). However, while there has been some effort in this area,[12] there remains much that needs to be done at the level of front line workers, policy and protocol development, service delivery modification and cross sectoral collaboration.

There is also evidence indicating that the level of prescription pharmaceutical opioids, stimulants and benzodiazepines has increased dramatically in Australia over the past decade (Nicholas, 2002; Parliament of Victoria Drugs and Crime Prevention Committee, 2007). The reasons for this are complex and not all relate to the misuse of these drugs.

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11. For a more detailed review of co-morbidity as an AOD workforce development issue the reader is referred to Roche, Duraisingam, Wang, & Tovell (2008). Alcohol and other drugs, mental health & co-morbidity: A training review. National Centre for Education and Training on Addiction (NCETA), Adelaide.

12. For example the Australian Government's 'Kids in Focus-Family Drug Support' program and the previous 'Strengthening Families Program'.

Box 4: An example of a key workforce development issue - Co-morbidity
(in this instance AOD and mental health co-morbidity)

One important workforce development issue facing the AOD field is co-morbidity. It is estimated that between 50 and 75% of people with a lifetime prevalence of drug problems or dependence also have an ongoing mental health disorder. The literature also suggests that the proportion of clients with co-existing mental health and drug problems in either an AOD or mental health treatment setting is high, however the proportion of staff who are trained to treat both disorders are relatively low. Co-morbidity-related problems also impact on the criminal justice system including police.

People with AOD-related problems often have other health, welfare and social issues that may need to be addressed. Maintenance of gains made through treatment is often enhanced through co-ordinated collaborations between AOD and other health and welfare services. Moreover, these collaborations allow for the sharing of workforce development resources and build on the skills and knowledge base of individual workers and allow for cross-sectoral career paths.

The high rate of co-morbidity of alcohol or drug problems and mental illness raises concerns for the training of AOD specialists. It does not seem possible to provide AOD workers with enough training in mental health to provide adequate holistic treatment for the client with alcohol or drug problems and a mental illness (Saunders & Robinson, 2002). Mental health is a complex speciality that usually requires two to five years additional training for doctors, nurses or psychologists, and it may not be possible to develop brief training programs suitable for AOD workers (Saunders & Robinson, 2002).

At a strategic level, the need for cross disciplinary training and improved system integration has been recognised in recent years. Advances have been made with the allocation of substantial funding to address this issue, however, much more progress is required to maximise the effectiveness of quality treatment interventions. A national workforce development strategy needs to consider joint workforce development initiatives with key sectors such as mental health. Intersectoral collaboration will be more effective in supporting systems to respond to people with co-existing mental health and AOD problems compared to each sector operating in isolation.

The Australian Government responded to the issue of comorbidity with the National Comorbidity Initiative (NCI). The NCI aims to improve coordination across mental health services and AOD treatment services, develop best practice guidelines for service delivery, and increase professional education and training, thereby increasing the capacity of clinicians and services to better meet the needs of people with AOD and mental health comorbidity.

Other important factors include the ageing of the population and more aggressive pain management practices. Nevertheless, there is little doubt that as these drugs have become more widely prescribed they become more widely misused and this has a number of implications for workforce development in the alcohol and other drugs sector. Dealing with this issue will also require not only building the skill level of AOD workers, but also policy and protocol development, service delivery modification and cross sectoral collaboration.

More complex AOD issues and increased demands on the AOD workforce are not restricted to the Australian context. Similar issues have also been identified in the Canadian and U.S. AOD workforces (DHHS, 2005; Gallon, Gabriel, & Knudsen, 2003; Ogborne & Graves, 2005).

In many respects, the workforce development issues facing the AOD field are not dissimilar to challenges confronting other Australian workforces. These challenges include:

- an ageing workforce
- skill shortages
- an increasing trend towards shorter working hours[13]
- a competitive employment market
- new technologies, and
- changes in work practices
- increased demand on services
- increased focus on OHS issues as a result of higher levels of reported assaults against workers by clients and others.

While the ageing of the Australian workforce is an issue for the national workforce in general, it is particularly important for the AOD sector and the wider community services and health industry. In 2008, 46% of workers in the community services and health industries were over the age of 45, which is 9% above the all industry average (Community Services and Health Industry Skills Council, 2008a). Data concerning the Victorian AOD workforce indicate the proportion of workers over the age of 40 years increased from 48% in 2002 to 59% in 2006 (Connolly, 2008).

Evidence Based Practice and Research Dissemination

A growing emphasis on evidence based practice and the way in which research, knowledge and skills are translated into practice are major challenges for the AOD workforce (Roche, 2001). Evidence based practice is the use of current best evidence to make decisions about work practices and it is one of the major drivers of workforce change. Evidence based practice requires the translation of research into practical strategies for workers. However, given the large amount of AOD research being generated, a passive translation process alone is insufficient to achieve work practice change (Bywood et al., 2008; Roche, 2001).

A number of key barriers to evidence based practice have been identified. These barriers include:

- lack of high quality research, in particular randomised controlled clinical trials (although the evidence base is growing rapidly in the AOD field)
- research evidence that cannot be applied beyond specific settings
- the complexity of AOD problems (Allsop & Helfgott, 2002; Evans, 2001)
- limited expertise within the non-government sector to access, research and present new evidence
- limited funding, time, and expertise within the non-government sector to conduct treatment evaluations (Gethin, 2008).

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13. Although it is noted that the hours worked by Australian workers are still among the highest in developed countries in the world (Dollard, 2007).

While there have been some advances in the AOD field concerning evidence based practice, more needs to be done to develop effective partnerships between researchers and practitioners in order to facilitate the translation of research into practice. The literature on the translation of evidence into practice highlights the importance of using theoretical models of change to understand the behaviour of professionals and the development of strategies required to change behaviour (Bero, Grilli, Grimshaw et al., 1998; Davies & Nutley, 2002).

Summary and Implications for a National Workforce Development Strategy

A national AOD workforce development strategy needs to operate in a much wider workforce and service delivery context and as such needs to be linked with relevant existing workforce development strategies, policies and plans (e.g., the National Health Workforce Strategy, the Indigenous Health Workforce Strategy[14]).

In addition, a national workforce development strategy needs to be flexible to emerging trends and facilitate and support evidence based practice initiatives that target both individuals and organisations. At the individual level, initiatives that improve access to information and build skills to translate this information into work practice are required. At the organisational level, initiatives are required to facilitate the integration of workers' new knowledge and accommodate changes in work practices accordingly. A national strategy also needs to contain initiatives that target the co-morbidity skills of AOD specialist workers and workers in the mental health sector. In addition, initiatives are also required that develop effective partnerships between research and service delivery agencies.

The next chapter discusses in greater detail what a contemporary picture of workforce development encapsulates and identifies the key underpinning conceptual framework.

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14. Australian Government. (2007). National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013. Canberra: Australian Government.

CHAPTER 3: BROADENING THE DEFINITION OF WORKFORCE DEVELOPMENT

To identify appropriate workforce development strategies that might be applied in the AOD field it is first important to be clear about what "workforce development" itself comprises and to identify the component parts that fall under this broad, and at times elusive, umbrella term. These definitional and conceptual issues are pivotal and are addressed in this section.

In a submission to the Intergovernmental Committee on Drugs (IGCD)[15] in November 2002, NCETA defined workforce development 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."*

This definition of workforce development signals an important conceptual shift that has occurred in recent years. Workforce development is no longer viewed as merely comprising education and training initiatives. There is an increasing awareness that a focus on education and training alone is a limited approach to workforce development (Roche, 2001).

However, it is little more than a decade ago that education and training were identified as the key area of concern in the alcohol and drug field (Roche, 1998). This concern was accompanied by pressure to standardise education, training and qualifications for specialist workers. Throughout the 1990's various reports consistently emphasised the need to provide structured education and training to specialist workers to ensure consistent quality and to cover gaps in knowledge and skills, as many previous education and training efforts were found to be highly variable in nature, content and quality, and often unstructured and ad hoc (National Centre for Education and Training on Addiction, 1998).

More recently, however, this narrow and exclusive emphasis on education and training and skills development has been revised and broadened. Traditional, bottom-up approaches that focused solely on addressing the skill levels of workers have been increasingly recognised as inevitably doomed to fall short if they were applied in isolation from other workforce development strategies.

It has also been highlighted that education and training is only one of many factors that affect workers' performance (Roche, Watt, & Fischer, 2001). While education and training can build the skills and knowledge of individual workers, whether such increases in skills and knowledge transfer into sustainable work practice change and quality service delivery depends on a range of organisational, structural, and systemic factors largely beyond the control of individual workers.

The need to approach education and training in the context of larger, systemic factors prompted a shift in focus to 'workforce development' (Roche et al., 2001). The central goals of workforce development include building the capacities of both organisations

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15. The IGCD subsequently endorsed this definition and it has been adopted in several state-based AOD workforce development strategies.

and individuals to respond to alcohol or drug related problems, and to promote evidence based practice in the AOD field (Roche et al., 2001). Importantly, workforce development incorporates organisational and systemic initiatives to increase the knowledge and skills of both specialist and generalist workers, and includes strategies such as supervision and partnerships. Contemporary approaches to workforce development require corresponding top down approaches that incorporate all major factors that drive change and impact on the workforce that also complement bottom up approaches (such as training).

The expanded definition of workforce development applied here highlights the importance of infrastructure, systems and organisational issues as the foundation for training and skills development (see Figure 1). Without addressing underpinning and contextual changes illustrated here, the impact of change at the individual level alone will also remain limited, transient and ultimately ineffective.

Figure 1: The different levels and components of workforce development

The primary aim of workforce development is to facilitate and sustain the AOD workforce by targeting organisational and structural factors as well as individual factors (Baker &

Roche, 2002). While not an exhaustive list, examples of individual versus organisational and structural factors include the following:

Box 5: Individual, organisational and structural factors affecting WFD

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

(Allsop & Helfgott, 2002; Roche, 2001)

This broader approach to workforce development recognises that education and training are only one aspect of a range of systems and individual factors that can influence the ability of the workforce to respond to AOD issues (Figure 2). Moreover, without the prerequisite planks in place that underpin training, it will ultimately be an ineffective and limited strategy.
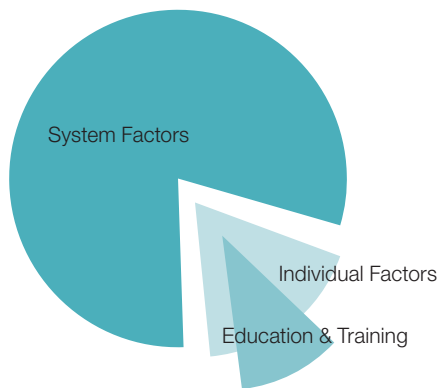
Figure 2: Education and training as one element of workforce development

Training, Training Transfer and Work Practice Change in a Workforce Development Context

The multi-faceted approach to workforce development as presented here does not negate the importance of training; rather, it places training in a different context and locates it as part of a broader, more complex array of factors that must also be simultaneously addressed.

There is a body of work that has focused not only on the importance of training but also on training transfer. This body of work is based on the premise that for training to result in changes in work practices, knowledge and skills gained in the training environment need to transfer to the workplace. There are numerous factors, both internal and external to the training environment that can prevent training transfer. Factors that needed to be considered as part of the training transfer process were examined by NCETA and a model of factors that could influence work practice and training transfer was developed (Pidd, Freeman, Skinner et al., 2004).

The multi-level approach to training evaluation is illustrated in NCETA's 4-level model as shown in Figure 3. The 4-level model comprises:

1. the individual

2. the team

3. the workplace

4. the organisation.

As Figure 3 shows, each of these four levels involves inherently different issues.

Work Practice Factors			
Individual	Team	Organisation	Workplace

Previous experience
Role Legitimacy
Role adequacy
Willingness
Personal views
Career motivation
Personal satisfaction
	Collective efficacy
	Group norms
	Informal support
	Formal support
	Situational constraints
	Team morale
		Organisational role
		  legitimacy
		Systems influence
		Opportunity for input
		Openness to change
		Professional
		  development
			Job conditions
			Teamwork
			Workload
			Supervisor support

Figure 3: Factors that influence work practice and training transfer

A Systems Approach

Central to the definition of workforce development proposed here 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 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 health practices which are sustainable" (Crisp, Swerissen, & Duckett, 2000, p99).

A systems approach to workforce development has two important implications for the development and implementation of national AOD workforce development initiatives. 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.

Both of these elements extend well beyond a narrow training approach. The first incorporates issues related to areas such as recruitment and retention, worker wellbeing, and salaries and awards; while the second relates to areas such as training transfer, research dissemination, clinical supervision and mentoring and the like.

Clearly, a wide and diverse range of issues are captured in a workforce development strategy that extend well beyond a focus on education and training alone, and includes factors such as:

- 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 the broader issues captured under the umbrella of workforce development the reader is referred to NCETA's workforce development Theory Into Practice (TIPS) resource,[16] which addresses issues such as:

- Clinical supervision
- Effective teamwork
- Evaluating AOD programs and projects
- Goal setting
- Mentoring
- Organisational change
- Recruitment and retention
- Professional development
- Workforce wellbeing
- Workplace support.

To assist individual AOD agencies identify workforce development deficits and implement workforce development initiatives, NCETA has produce a brief workforce development checklist (Roche & Pidd, 2009) (see Box 6).

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16. Skinner, Roche, O'Connor, Pollard, & Todd (Eds) (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/.

Workforce Development Issue	Yes	No
Do you regularly undertake training needs analyses?		
Do you evaluate the impact of worker training on work practice?		
Do you have a strategy for staff recruitment?		
Do you have employee retention strategies in place?		
Do you provide supervisors and managers with supervision/management training?		
Do you conduct regular staff performance appraisals?		
Have you implemented strategies to ensure effective teamwork?		
Do you have a clinical supervision program in place?		
Do you have a staff mentoring program in place?		
Do you have a strategy in place to ensure staff are aware of, and meet, client/program orientated goals?		
Are client/program outcomes regularly evaluated?		
Do you have strategies in place to monitor and evaluate changes in work practices (e.g., the introduction of new clinical guidelines or new evidence based practices)?		
Do you have a staff professional development plan in place?		
Do you have strategies in place to monitor staff work loads and stress levels?		
Do you have strategies in place to support staff wellbeing?		
Do you have strategies in place to monitor and improve staff performance?		

Models of Workforce Development

To-date, no definitive overarching model of workforce development has emerged for the AOD field. This deficit largely reflects the lack of serious attention directed to this issue. It is also a reflection of the difficulties encountered in moving the field on from old paradigms and conceptual frames where workforce development was really only 'training' under the guise of new terminology – the all too common 'old wine in new bottles' phenomenon.

One model of workforce development has conceptualised it as a four-stage process (see Figure 4). According to De Geyndt's framework, the four most important components of workforce development comprise planning the workforce, providing adequate training for the workforce, managing the workforce in a manner which maximises the workforce's performance, and evaluating feedback from outcomes (Hornblow, 2002).
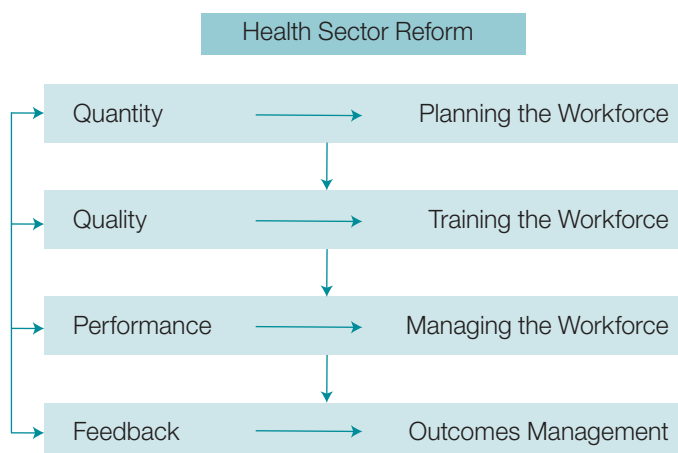
Figure 4: De Geyndt's Framework of workforce development for health workforce (from Hornblow, 2002)

While De Geyndt's model is an important advance over simplistic training solutions, and has proved to be useful in terms of health workforce reform (at least in New Zealand), it nonetheless fails to fully capture some of the more complex and diverse issues and challenges confronting the contemporary AOD field.

As noted, no clear and comprehensive model of workforce development has been available to-date. To fill that void, we present here a conceptual model of workforce development that may be useful as an organising framework to achieve a shared understanding of workforce development amongst policy makers, researchers and practitioners.

An inter-related multi-level model

Roche (2004) developed an integrated model of workforce development that comprises three distinct but inter-related levels; as shown in Box 7 on the next page.

An integrated approach is recommended that incorporates the three levels of 1. a systems perspective, 2. organisational capacity building, and 3. development of a skilled workforce (see Box 7). NCETA's workforce development program of work addresses various issues across these three levels and provides illustrations of how these areas may be operationalised.

Box 7: A multi-level approach to workforce development

1. A Systems Perspective	• Design and Implementation of Workforce Development Policies • Managing Organisational Change • Resources and Partnerships • Workforce Mapping • Workforce Planning
2. Organisational Capacity Building	• Workforce Sustainability (Recruitment, Motivation, Stress and Burnout, Job satisfaction, Career paths, Turnover, Job Redesign) • Management & Supervision (Clinical supervision, Mentoring)
3. Development of a Skilled AOD Workforce	• Information Management (Evidence based practice, Accessing information effectively) • Development of Knowledge, Skills and Abilities • Transfer of Training to Work Practice

This model of workforce development pivots on the notion that a multi-faceted approach is essential to address the range of factors that impact on the ability of the alcohol and other drugs (AOD) workforce to function with maximum effectiveness. There are five levels on which any workforce development initiative needs to operate. These are:

1.   Systems

2.   Organisations

3.   Workplaces

4.   Teams

5.   Individuals.

This approach builds upon previous work on workforce development by NCETA (Baker & Roche, 2002; Pidd et al., 2004; Roche, 2001; Roche et al., 2002) and others (Allsop & Helfgott, 2002; Health Workforce Advisory Committee, 2002; Kavanagh, Spence, Wilson, & Crow, 2002; Network of Alcohol and Other Drug Agencies, 2003). It also draws on literature related to capacity building, organisational psychology and organisational change. In taking this multi-faceted, systematic approach to workforce development emphasis is placed on building the capacity and sustainability of the AOD workforce. This approach to workforce development offers a comprehensive way of thinking about and responding to the complex interplay of issues that affect the AOD workforce. The foundation of workforce development rests on the recognition that a range of interactive factors have an impact on effective AOD work. These key components include knowledge, skills and experience; organisational structures, systems and culture; government policies and strategies; and work conditions and opportunities.

A skills growth – skills atrophy model
A useful model for analysing factors that support either skill growth or skill atrophy across the diverse range of industries (including the AOD field) that make up the community services and health sector has been developed by the Community Services and Health Industry Skills Council (2008b). This model contains seven factors (or preconditions) necessary for skills growth (see Figure 5) and can be utilised to measure potential for skills

growth within an industry sector or individual industry. Each of the factors within the model operates on a continuum and has the potential to contribute to either skills growth or skills atrophy. For example, a low investment funding model contributes to skills atrophy, while optimal investment funding contributes to skills growth. The seven factors contained within the model and their relevance to the AOD field is briefly described below.

1. Funding model
The funding model refers to the level of funding available. Funding models lie along a continuum that falls between two extremes - a low investment approach where cost minimisation is the primary concern and an optimal investment approach where adequate funding to build sustainable capacity is an important objective. Four themes associated with low cost models, relevant to the health and community services sector, were identified in the Community Services and Health Industry Skills Council report (2008):

   a. the increased emphasis on a low cost high efficiency funding model that has either introduced or intensified the degree of competition felt within the sector

   b. the scope for collaboration between service and care providers narrows or closes

   c. in an operational sense, low cost funding models undermine organisational ability to centrally monitor training options

   d. funding pressures mean 'down-time' is no longer available to devote to on-the -job learning.

These low cost funding model themes are evident within the AOD field. A large proportion of available AOD funding operates within a wider government policy context, which varies according to federal and jurisdictional levels. Variations and complexities in funding environments make it difficult to formulate training strategies that are responsive to both employer and client need.

2. Ownership profile
The employer ownership profile in the health and community services sector (including the AOD field) is difficult to discern. In general, not-for-profit and public sector organisations, while constrained by income, are not guided by the profit considerations of for-profit organisations and as such view training differently. The size of the organisation also affects capacity to train (with larger organisations having more scope) and both size and sector (public, private, not-for-profit) interact in their impact on training.

Within the AOD field, government and non-government not-for-profit organisations predominate with only a small proportion of private for-profit organisations. However, the proportion of government compared to non-government not-for-profit organisations varies across jurisdictions. This results in diversity in the form and size of organisations within the AOD field, which in turn impacts on the availability of, and access to, training. Management practices, the organisation and scheduling of work, work loads, and training practices are all shaped by the organisational profile (Community Services and Health Industry Skills Council, 2008b).

3. Employment structures
Training regimes have traditionally been built around full-time employment. Employees who are part-time, casual, or agency workers are likely to find it more difficult to access employer supported training. Data concerning the AOD workforce indicate a substantial proportion

of workers are employed on a part-time and/or casual basis. Moreover, many part-time and full-time positions are based on short-term funding grants. These conditions are likely to limit access to training and professional development opportunities.

4. Job design and perceptions
Because they have traditionally been perceived as being outside the productive economy, 'caring' roles in the health and community services sector have been under-valued. However, these industries have emerged from an old economy model of domestic care to professional industries and this must be reflected through skill sets and career pathways. In addition, AOD work is a highly stigmatised area. Not only are clients stigmatised but so too are their families and the frontline workers who are involved with AOD work. Stigma associated with AOD work also influences the willingness of both specialist and mainstream workers to intervene and deal with AOD issues.

5. Employee receptiveness to training
Employees will be prepared to undertake training when they have the time and energy to devote to training and the additional skills gained are valued by the workplace. However, it can be argued that limited funding and poor working conditions within health and community services sector (including the AOD field) create disincentives to train. Within the wider health and community services sector and the AOD field, excessive workloads, cost cutting and changed management structures have made it more difficult for employees to undertake training. Moreover, as funding is often fixed or restricted, there is little opportunity to promote, reclassify, or financially reward employees who increase their skills as a result of undertaking training.

6. Organisation of professional groups
Professional groups organise members of an occupation around a common set of skills and job roles as well as shared ethics. These groups have long given professions such as law and medicine and other traditional trades the power to influence the work performed by their members and how their members interact with other occupations in the same field. The presence of a professional group is a persuasive signifier that the occupation has skills worth preserving and upgrading. Examples in the AOD field include the Australasian Professional Society on Alcohol and Other Drugs (APSAD), the Chapter of Addiction Medicine and the Drug and Alcohol Nurses Association (DANA).

7. Perceptions of customer need
Moves to redirect community services to a client-centred model have profound implications for training. Internationally (e.g., the US) there have been moves to adopt radical models where funding is directed to the individual client, who is able to spend the funds as they wish. This creates disincentives to invest in developing the skills of employees and denies employees opportunity to voice their skill needs. To-date there appears no indication that such models are being considered for the Australian AOD sector.

1. Funding Model	Low investment	←→	Optical investment
2. Employer ownership profile	+ Diverse, difficult to characterise	←→	+ Fewer types, more homogeneity
3. Employment structures	+ Fragmented	←→	+ More stable across sector
4. Job design and preception	+ High intransignet to change	←→	+ High, but scope for technological reshaping of labour process
5. Employee receptiveness to training	+ Low	←→	+ High
6. Organisation of professional groups	+ Inactive, not well mobilised	←→	+ Mobilised and active
7. Perceptions of customer needs	+ Splintered	←→	+ Uniformly accepted
	↓ Potential for atrophy		↓ Potential for growth

Figure 5: A model of training skills formation and skills growth (source: Community Services and Health Industry Skills Council, 2008)

Summary and Implications for a National Workforce Development Strategy

While training and skills development are likely to be important components of any workforce development strategy, a national strategy for the AOD workforce needs to adopt a broad systems approach that also includes elements that ensure the sustainability of the AOD workforce and facilitate and support frontline workers to effectively apply their knowledge and skill to work practice. To achieve these aims, a national strategy needs to build on previous AOD workforce development efforts and recognise that the AOD workforce operates in an environment that includes other community/human services, health, law enforcement and education workforces.

In particular, initiatives that promote intersectoral collaboration and partnerships should be encouraged. This collaboration should also include sectors that deal with the range of health and welfare issues experienced by clients of AOD services, including police and criminal justice. The importance of partnerships and collaborations in the AOD field is outline in Box 8.

Partnerships between AOD organisations may also facilitate improvement in the treatment in alcohol-related problems (Wilkinson, Browne, & Dwyer, 2002). Partnerships foster cooperation between AOD organisations and the transfer of skills and knowledge among workers (Wilkinson et al., 2002). Through partnerships, organisations can also collaborate on strategies to increase and improve the provision of services to individuals with alcohol or drug related problems. However, Wilkinson, Browne and Dwyer (2002) note that one barrier to the implementation of effective partnerships is that such collaboration can require time, effort and resources beyond an organisation's capacities, especially for the initial development of partnerships. Wilkinson, Browne and Dwyer (2002) identified several factors that could facilitate the development of a successful partnership. These include:

- open lines of communication between the organisations
- an assessment of shared goals of the organisations
- thorough planning of the collaboration
- including evaluating resource needs
- measurable outcome goals of the partnership so that the results of the partnership can be evaluated.

CHAPTER 4: THE STRUCTURE OF THE AUSTRALIAN AOD WORKFORCE

To ensure that effective service delivery occurs into the future healthcare policies and strategies need take into account future workforce requirements, the distribution and work contexts of the existing workforce, training needs, workforce roles and scope of practice (Keane, Smith, Lincoln, Wagner, & Lowe, 2008). Good workforce data is essential for this to occur. However, surprisingly little is known about the Australian AOD workforce and to-date workforce planning largely occurs on an ad-hoc basis at the level of individual treatment agencies.

Workforce Planning

An initial step in the effective development of current and future workforces involves workforce planning. Planning for future workforce needs is particularly important in a rapidly evolving and continually changing field such as the AOD sector. While Australia has excellent data collection systems in place in relation to tracking current and emerging drug trends, little work has been undertaken to use these data to estimate future workforce needs. Moreover, no nationally co-ordinated framework for workforce mapping and planning for the AOD sector has been developed. Workforce planning that has been undertaken has occurred almost exclusively at an organisational level.

Workforce planning, however, is essentially a strategic exercise. It enables organisations to identify their workforce needs and then put in place strategies to develop and sustain that workforce. However, it is imperative that such planning operates at levels that extend beyond the agency or organisation to encapsulate the broader systems within which they function. Implicit goals within workforce planning include meeting service delivery needs while simultaneously ensuring the health and wellbeing of the workforce itself.

An effective workforce plan sets out the goals, strategies and objectives for the future development of the workforce and, in doing so, enables the right number of appropriately skilled workers to be in the right place at the right time. In part, workforce planning in the AOD field involves the analysis of data on drug trends in order to anticipate the number of future workers and skill sets required. The planning process should also provide strategies to ensure sufficient workers with the right skill sets are available where needed. Workforce planning directs resources to specific workforce issues, anticipates emerging workforce and service demand trends and future needs, and allows for timely workforce development responses to change.

Workforce Mapping

Before any workforce planning can be undertaken, a workforce mapping strategy is necessary to profile and quantify the existing workforce.

> "…without a clear understanding of who forms the workforce it is not possible to ensure appropriate strategies are in place to support their ongoing development" (Roche, 2001, p9).

However, only limited data are available in relation to the Australian AOD workforce. Lack of data concerning the AOD workforce is a major impediment to appropriate workforce planning and workforce development strategies. This limitation is not restricted to Australia. It is also evident in the wider international context (Hoge, Morris, Daniels et al., 2007; Kaplan, 2003; Ogborne & Graves, 2005).

Some information on the Australian AOD sector is available via data collected as part of the National Minimum Data Sets (NMDS) and the Clients of Treatment Service Agencies (COTSA) national census. However, these data mainly concern treatment and client characteristics. Very few data are collected about agency characteristics and no data are regularly collected about agency staff demographics or their workforce development needs. In addition, data from both of these sources is restricted to specialist treatment agencies. Data from agencies that primarily provide AOD education, prevention and/or brief counselling/referral are not collected, nor is data from AOD specialist workers involved in AOD programs embedded within other (non-AOD specialist) social organisations. Similarly, little data has been collected on mainstream workers who engage in AOD work.

Many state governments are aware of the profile of government agencies and many state based non-government peak agencies collect workforce data from their AOD treatment agency members. However, to-date no co-ordinated initiatives have been undertaken at a national level to collate and analyse these data. Due to the breadth and diversity of the occupations and work roles that comprise AOD work, data on mainstream generic workers are more difficult to collect and collate.

Outlined below is an overview of the Australian AOD workforce based on the best data currently available.

Specialist vs Generalist Workers

The AOD workforce is not restricted to AOD specialist workers employed in AOD specialist organisations. The AOD workforce comprises two distinct groups:

1. frontline AOD specialist workers (who may work in AOD specialist organisations agencies or in AOD programs within non-AOD specialist organisations), and

2. generalist workers (who work in the mainstream workforce, not the AOD sector, but have extensive contact with the wider community and are thereby well placed to implement AOD prevention and intervention strategies).

Professions involved in responding to alcohol or drug related problems can be classified as specialists or generalists. Specialist workers are usually located within an AOD-specific service (for example, psychologists, social workers, or counsellors who work in alcohol or drug treatment services). In contrast, a generalist worker may be required to respond to AOD-related problems, but may not work in a specific AOD setting (for example, nurses and general practitioners). Hence, specialist and generalist workers' roles in the treatment of alcohol-related problems can be very different, but there is often a high degree of overlap.

An increasingly important role is played by generalist workers in the mainstream workforce. These workers may be employed in sectors such as health, welfare and community services, law enforcement, police and education.

There has been debate regarding the roles of specialist and generalist professionals in intervening in AOD problems (Roche, 1998; Thom, 2001). For some time the role of generalist workers in the treatment of AOD-related problems has been debated (Durand, 1994; Farmer & Greenwood, 2001; Roche & Richard, 1991). The move towards inclusion of generalist workers is in part due to the movement away from the traditional conception of dependence of a disease (Thom, 2001). According to the disease model, dependence was a disease that was best treated by a specialised physician (Thom, 2001). More recent theories conceptualise dependence as one end of a continuum of AOD patterns (Thom, 2001). Hazardous, or high-risk levels of consumption have been emphasised as a more widespread health issue (Roche, 1999). This has broadened the focus of care to include the prevention of AOD-related problems and the minimisation of acute harm resulting from risky patterns of drinking or drug use, which may be better suited to generalist health workers (Thom, 2001).

Increasingly it has become apparent that specialist workers can not be the only workers who respond to alcohol and other drug problems. However, specialist workers may be more able to treat dependent individuals as the greatest advantage of specialist treatment over generalist treatment is the longer period of time available to the specialist workers to engage, counsel and treat the client's alcohol or drug related problems. Also, more recent interventions for AOD problems, such as the growing array of new pharmacotherapies, require specialised, technical knowledge, and thus are more suited to specialist intervention.

Unfortunately, while there is substantial research on responses to AOD-related problems, little information is available on the specialist alcohol and drug workforce in Australia, including information about qualifications (Hornblow, 2002; National Centre for Education and Training on Addiction, 1998). Until relatively recently, estimates of the proportion of AOD workers who held AOD specific qualifications were based on key stakeholder opinions (National Centre for Education and Training on Addiction, 1998). A more recent survey of AOD workers indicated nearly half the AOD specialist workforce held no AOD specific qualifications (Duraisingam et al., 2006). In a comparable Canadian study (Ogborne, Braun, & Schmidt, 2001), researchers found that among specialist drug and alcohol counsellors or other staff, 25% had a certificate or diploma in addiction studies, or were studying to obtain one, and only 12% were certified as alcohol or drug treatment counsellors. The United States has a formal accreditation system for addiction specialists, allowing assessment of the number of addiction specialists in different health professions. From this data, 4% of primary care professionals, 4% of psychiatrists, 2% of nurses and 10% of social workers have specialised in addiction (Keller & Dermatis, 1999). As no formal accreditation process exists in Australia, there are no comparable statistics (Roche et al., 2001).

Roche (1998) provided a classification of professions who respond to alcohol and other drug (AOD) related problems based on different roles. An overview of this classification is given in Table 1. It highlights the training and other needs of specialist, generalist professionals and other workers. Generalist health professionals are categorised as A1, while groups A2 and B1 are the specialist alcohol and other drug workers. Groups C1 and C2 comprise of the other professions that come into contact with individuals with alcohol-related problems in the course of their work. The specialist, unqualified workforce (Group B1) have the most difficult education and training needs to meet, while accredited short courses could meet the needs of groups A1 and C1.

The classification of the AOD workforce shown below indicates the different education and training needs of different professions in the workforce. There has been significant pressure

to extend basic AOD training to the generalist workforce (those identified as A1, C1 or C2 professionals), in order to include professions such as GPs, nurses, pharmacists, teachers and probation officers (Roche, 1998). Such training would ensure generalist workers have the skills to identify and initially respond to alcohol-related problems, and refer the individual on to a more specialised service (Roche, 1998). Education and training could be provided to generalist workers at different levels: during basic training, by incorporating AOD education in undergraduate topics, post basic training, by offering accredited tertiary courses, and through the provision of short courses that allow on-going education for health professionals (Roche, 1998). The priority afforded to education and training is highlighted in the literature on what should be included in training, how to deliver training, and how to evaluate the effectiveness of the training (cf. Ask, Ashenden, Allsop et al., 1998; O'Donovan & Dawe, 2002; Roche, 1998).

Table 1: Classification of frontline professionals

Title	Description
Group A	
A1. Non-AOD health professionals	Non-AOD health professionals, e.g. doctors, nurses, social workers, psychologists and so on with no particular training or background in AOD.
A2. AOD-specialist health professionals	Specialist professionals such as psychologists, counsellors, psychiatrists, public health physicians and so on who have a particular interest in the alcohol and drug field.
Group B	
B1. Alcohol and drug workers	These are the alcohol and drug workers who do not usually have a particular professional qualification, and may not have a high level of basic education (which can thus make the acquisition of further education and training difficult by not being able to fulfil entry requirements for tertiary level courses), but who may have substantial personal experience with alcohol and/or drugs.
Group C	
C1. Non-health professionals	Non-health professionals may come from very varied professional backgrounds (e.g., police, teachers, probation officers) with varying levels of professional education and training within their basic profession.
C2. Non-health AOD specialists	These might include teachers, criminal justice system personnel, economists with a specialist interest in alcohol and other drugs.
Group D	
D1. Volunteers	Volunteers are increasingly engaged within the alcohol and drug field and have varied backgrounds with varying levels of education and training and work experience. Volunteers play an important part in the delivery of alcohol and drug services and have special education and training needs.

AOD Workforce Data

The AOD specialist workforce
Data on the AOD specialist workforce is relatively easy to collect and collate. However, efforts to-date have been sporadic and unco-ordinated.

One of the few sources of data that provides information on the national AOD specialist workforce is the series of surveys undertaken by NCETA (see Table 2) (Duraisingam et al., 2007; Freeman et al., 2004; Wolinski et al., 2003). In addition, data on the AOD specialist workforce has also been obtained from a number of surveys conducted on a jurisdictional basis (e.g., Gethin, 2008; McDonald, 2006).

In total, 13 AOD workforce surveys (5 national and 8 jurisdictional) have been undertaken to-date and their details are presented in chronological order in Table 2.[17] While differences between surveys in terms of survey methods and questions asked limit the degree to which the results of each survey can be compared, when viewed collectively, these studies do allow for a composite profile of the AOD workforce to be developed.

Table 2: AOD specialist workforce surveys 2001-2009

National survey		
2001	National NGO survey (43 respondents)	Pitts (2001)
2002	An NCETA national survey of 234 specialist treatment agency managers	Wolinski, O'Neill, Roche, Freeman, & Donald (2003)
2003	An NCETA national survey of 1,024 mainstream workers engaged in AOD work	Freeman, Skinner, Roche, Addy, & Pidd (2004)
2005	An NCETA national survey of 1,345 specialist AOD workers	Duraisingam, Pidd, Roche, & O'Connor (2006)
2005	An NCETA national survey of 280 specialist treatment agency managers	Duraisingam, Roche, Pidd, Zoontjens, & Pollard (2007)
Jurisdictional survey		
2002	A survey of 745 Victorian AOD workers employed in agencies funded by the Victorian Department of Human Services	Victorian Department of Human Services (DHS) (2005)
2005	A survey of 136 Northern Territory AOD workers employed in 18 AOD specialist treatment agencies and AOD intervention programs	NT Department of Health and Community Services (2005)
2006	A survey of 134 ACT specialist AOD workers	McDonald (2006)
2007	An NCETA survey of 167 South Australian AOD workers employed in 18 non-government AOD specialist agencies and 26 non-government mainstream agencies with AOD programs	Tovell et al. (2009)
2008	WA survey of 207 AOD workers from 35 NGO services – part of the 2007 Sector Remuneration Survey	WAAMH et al. (2008)
2008	A NSW Network of Drug and Alcohol Agencies (NADA) survey of 111 NSW non-government specialist workers and 85 managers of NSW non-government specialist treatment agencies	Gethin (2008)
2008	A survey of 492 workers employed in Victorian AOD agencies	Conolly (2008)
2009	A survey of 132 ACT workers from 9 AOD agencies	ACT AOD Sector Project (2009)

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17. Further detail on each of these surveys is provided in Part B (Chapters 6, 7 & 8) of this report.

Relevant key data from these surveys are presented in Table 3. More detailed data from these surveys is provided in Part B of this report.

Table 3: Differences in key AOD specialist workforce demographics across jurisdictions

Survey	Female	Av age (yrs)	NGO workers	Generic AOD workers	Nurses[1]	Part-time	Median years in AOD field	Tertiary quals[4]	No AOD specific quals[2]	AOD quals ≥ Cert IV[3]
National 2002 (managers)	57%	46	50%	**	**	**	11-15 (23%)	47%		**
National 2005 (managers)	61%	47	40%	22%	36%	6%	9	77%	24.5%	52.5%
National 2005 (all workers)	66%	43	42%	40% (61% ngo; 24% gov)	31% (9%ngo; 47%gov)	30%	5	65%	26%	34%
ACT (2009)	69%	41	78%	52%	9%	37%	5.6	65%	26%	*34%*
NSW (2008)*	61%	44	100%	49%	8%	54%	**	40%	**	33%
Vic (2008)	65%	59% >40	**	44%	7.7%	37%	2-5	61.5%	16.1%	56%[†]
SA (2007)*	67%	59% >40	100%	36%	2%	39%	6	57%	35.4%	27%
NT (2005)	**	**	**	**	**	**	**	52%	**	**

[1] the proportion of nurses varies greatly as some surveys only included the NGO sector.
[2] No accredited AOD specific qualifications
[3] AOD-specific qualifications at Cert IV level of higher
[4] undergraduate or post graduate qualifications
* data only available for non-government workers
** data not available
[†] 73% meet Victorian MQS standards for accreditation as an AOD worker

Available data indicate the Australian frontline AOD specialist workforce consists of more than 10,000 workers from a diverse range of occupations (Wolinski et al., 2003). Specialist AOD agency staff undertake a range of activities (e.g., counselling, treatment, prevention, education) in a variety of organisations (government, non-government, and private).

The proportion of non-government specialist treatment agencies (or workers within such agencies) varied substantially across jurisdictions from 40% to 78% (Table 3). There are large jurisdictional variations in this regard. There is also a current (and ongoing) change in the distinction between government and NGO services. In Victoria, for example, this distinction has become increasingly blurred. Overall, the proportion of government to NGO agencies appears to be approximately 50:50.

Key features of the AOD workforce include the following:

- the majority of AOD specialist workers are female
- nearly half are aged 45 years or older

- between 30% and 54% of workers are employed part-time

- average duration of working in the AOD field is approximately 5 years.

The largest occupational groups were generalist AOD workers (40% of the specialist workforce) and nurses (31% of the specialist workforce) (Duraisingam et al., 2006). However the proportions of generalist AOD workers and nurses varied substantially between public sector and non-government organisations. National data indicate that in the public sector a substantial proportion (up to 47%) of the workforce were nurses, while a smaller proportion (as low as 24%) were generic AOD workers. In contrast, only a small minority of the non-government workforce were nurses (as low as 8%), while up to 62% were generic AOD workers. This difference between government and non-government workforces may reflect differences in service delivery models.

The majority of AOD workers held formal qualifications at the certificate, undergraduate, or post-graduate level, however, a substantial proportion have no formal qualifications. The most common forms of AOD-specific education and training received by workers are accredited or non-accredited short courses. While there are variations across jurisdictions, in general, less than half the AOD specialist workforce hold formal AOD-specific qualifications at the certificate, undergraduate or post-graduate level.

The mainstream generalist AOD workforce[18]

To-date few data are available on the mainstream generalist AOD workforce. However, a 2003 NCETA survey (Freeman et al., 2004) provides some insight into the profile of and workforce development issues facing mainstream workers who respond to AOD issues.

Freeman et al. (2004) identified that a substantial proportion of mainstream workers spend a significant amount of their work time responding to AOD issues. These workers come from a diverse range of occupational backgrounds and undertake a range of AOD work roles. Despite this, high proportions of workers across all occupational groups reported receiving no AOD-related education and training. This was especially apparent in occupational groups where AOD roles undertaken were not part of their main occupational role (e.g., teachers, pharmacists and community development workers). Lack of any AOD–related training was also reported by 12% of AOD specialists and by a significant proportion of workers from occupational groups where AOD roles were consistent with their main occupational role (e.g., nurses, mental health workers, and medical staff). This training deficit may impact on the quality of the AOD services provided by a wide range of occupational groups.

Across particular occupations low levels of role adequacy, role legitimacy, informal and formal support, and organisational role legitimacy were also evident. This is of particular concern as these factors are significant predictors of mainstream workers' motivation to respond to AOD issues and the amount of time they spend in responding to AOD issues (Freeman et al., 2004).

The importance of the mainstream generic workforce cannot be over emphasised. Mainstream workers often have extensive contact with the wider community and can be well placed to implement AOD prevention and intervention strategies. However, only a small proportion of mainstream workers have the necessary skills and knowledge to adequately respond to AOD issues.

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18. Further data on the mainstream generalist AOD workforce is provided in Chapter 9, Part B of this report.

Priority Workforce Groups

A number of AOD workforce groups have been identified as having specific workforce development issues that need to be addressed as a priority within any national strategy. These groups include:

- Nurses
- Indigenous workers
- Rural/remote workers
- Police
- GP prescribers.[19]

Each of these groups is discussed in turn below.

Nurses

Nurses are one of the largest professional group within the AOD specialist workforce (Duraisingam et al., 2006; Wolinski et al., 2003). Nurses provide crucial expertise in the clinical management of AOD clients and the provision of services such as pharmacotherapy and detoxification. Retention of existing AOD nurses and the recruitment of new AOD nurses is of particular concern given that nurses are in short supply in the Australian health care system in general (CDNM, 2005).

However, AOD specialist nurses face particular workforce development challenges, including:

- higher levels of stress associated with violent/aggressive clients compared to other AOD workers
- less job satisfaction than other AOD workers
- less access to clinical supervision than other AOD workers (Duraisingam et al., 2006)
- more likely to quit if they perceive lower levels of workplace support and become cynical about their work.

As AOD use contributes to a substantial proportion of hospital separations (Ridolfo & Stevenson, 2001) and Emergency Department presentations (Watt, Purdie, Roche, & McClure, 2004) generalist nurses are also well placed to respond to AOD issues. However, research indicates that mainstream nurses tend to hold more negative attitudes towards AOD users than other professionals, resulting in them being less likely to engage in AOD work (Howard & Chung, 2000). More recent research has shown that this can be overcome by providing tailored training to increase nurses' skill levels and confidence in responding to AOD issues (King, Kalucy, de Crespigny, Stuhmiller, & Thomas, 2004), particularly if training is provided in conjunction with strategies that provide adequate role support (Ford, Bammer, & Becker, 2008).

While some support for nurses that specialise in AOD work is provided by organisations such as Drug and Alcohol Nurses Australasia (DANA), substantially expanded resources are required to engage and support both mainstream and AOD specialist nurses.

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19. GP prescribers are discussed in more detail in Chapter 10, Part B of this report.

The 2003 NCETA survey (Freeman et al., 2004) indicated that nurses undertook more AOD work roles than most other occupational groups within the mainstream workforce. The most common roles identified were referral, counselling and detection/screening/ motivational interviewing. The majority of nurses surveyed had received AOD-related education or training. However, the most common form of AOD education or training received was accredited or non-accredited short courses. Relatively few mainstream nurses held AOD-specific graduate or post-graduate qualifications. This is of some concern given graduate or post-graduate university studies were perceived by nurses to have a greater impact on the quality of work practice than non-accredited training courses (Freeman et al., 2004). The amount of time mainstream nurses spent responding to AOD issues was largely determined by role adequacy, role legitimacy, and individual motivation to respond. An effective workforce development strategy would need to target these factors. To achieve this, a national co-ordinated approach is required that:

Increases AOD role support for both AOD specialist and generalist nurses

- Ensures that appropriate AOD content is included in nursing curriculum at the pre-service and in-service levels

- Ensures policies, guidelines are strategies are in place that raise awareness of AOD issues and the need to respond to these issues throughout the wider health system.

Moreover, due to competition for nurses in the wider health system, a review of the role nurse play in AOD specialist treatment services may be warranted. This may result in the establishment of multidisciplinary service models where workers perform functions and roles beyond traditional occupational boundaries. For example, some of the work roles of nurses in AOD specialist treatment agencies may be able to be undertaken by generic AOD workers who have undergone specific training and up-skilling.

Indigenous workers

Indigenous AOD workers are an especially important segment of the AOD workforce and they carry a particularly heavy load. They are often not highly trained or well supported but nonetheless are required to carry out a wide range of demanding roles. In addition, they are often 'on call' 24/7 and as a result many experience high levels of stress and burnout.[20] In addition, there are comparatively few Indigenous people employed in the health and human services fields. Indigenous health professionals comprised only 1% of the total health workforce in 2001 (Pink & Allbon, 2008). This contrasts with the proportion of the Australian population who are Indigenous, which is 2.5% (Australian Bureau of Statistics, 2007) (Australian Bureau of Statistics, 2007).

The Indigenous AOD workforce has complex and pressing needs. These needs are largely due to due to:

- rural/remote issues such as recruitment retention, limited access to clinical supervision and training, limited funding and managerial support

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20. At the time of writing, NCETA was undertaking a national study examining factors that contribute to Indigenous workers' wellbeing, stress and burnout and ameliorative factors.

- Indigenous client base issues such as the need for community acceptance, literacy and language issues, and the stress arising from dealing with often complex and emotional presentations

- workforce development issues facing the wider indigenous health workforce such as lack of career paths, wage disparity, gender imbalance, and high levels of work demand.

The development of the Indigenous workforce is a priority of the current National Drug Strategy (MCDS, 2004) and the National Drug Strategy Aboriginal and Torres Straight Islander Peoples Complementary Action Plan 2003-2009.[21] Central to the actions outlined by these documents is the need to:

- take a whole of government and community approach in implementing action plans

- increase the size of the Indigenous workforce

- enhance the capacity of mainstream services to respond to Indigenous AOD issues.

There have been a number of initiatives introduced at a national and jurisdictional level to develop the Indigenous AOD workforce including:

- the Indigenous National Alcohol and other Drugs Workforce Development Program

- Strong Spirit Strong Mind: WA Aboriginal Alcohol and Other Drugs Plan 2005-2009

- induction and foundation programs for NSW Aboriginal alcohol and other drug workers

- Koori training initiatives as part of the Victorian AOD workforce development strategy.

While these developments are acknowledged, a co-ordinated national approach is required that can address a wider range of issues. This approach should involve specific culturally appropriate workforce development strategies that:

- increase the numbers of Indigenous AOD workers and non-indigenous AOD workers who deal with Indigenous Australians

- engage and build the AOD skills and knowledge of other Indigenous health and human service agencies

- expand the role and capacity of Indigenous communities to effectively identify and address community AOD issues.

In particular, strategies are required that extend the focus beyond the training of existing Indigenous workers at the level of Certificate III and Certificate IV (as important as this is) to incorporate a broad and comprehensive recruitment and capacity building strategy. This could include the following strategies:

- recruit Indigenous high school students into tertiary education

- provide managerial training

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21. National Drug Strategy Aboriginal and Torres Straight Islander Peoples Complementary Action Plan 2003-2009.

- mentoring and support programs
- pro-active leadership identification and training programs
- advanced skill development at postgraduate level.

Rural/remote workers

Rural and remote AOD workers face unique workforce development challenges including recruitment difficulties, isolation, lack of resources and limited access to training opportunities. Some of these challenges relate to infrastructure support. For example, non-metropolitan workers are more likely to report inadequate funding (Roche, O'Neill, & Wolinski, 2004; Wolinski et al., 2003) and the inability to provide staff back-fill to allow workers to attend training (Duraisingam et al., 2006) compared to metropolitan workers.

Non-metropolitan agencies are also more likely to report difficulty in filling staff vacancies and lack of access to supervision compared to metropolitan agencies (Roche et al., 2004; Wolinski et al., 2003). Limited services in geographically remote areas also underscore the need for both rural AOD specialist and mainstream workers to have a wide range of skills necessary to meet the diverse demands placed upon them.

There have been some attempts to address the workforce development needs of the rural/remote AOD workforce. These include customised AOD short courses in rural and regional NSW TAFE colleges, provision of backfill and travel costs for professional development activities supported through DoHA's current co-morbidity Scholarships program. However, very little has been done on a nationally co-ordinated basis.

A co-ordinated national approach is required to:

- address funding and infrastructure issues
- improve access to training and professional development opportunities
- expand the capacity of local communities to effectively identify and address community AOD issues
- build the capacity of existing local services to respond to AOD issues
- facilitate innovative recruitment strategies such as recruiting and training local community residents.

Police

In many cases, police are the first of the frontline workers who are required to respond to AOD issues. This may involve them having to deal with AOD-affected individuals and their consequent or associated criminal behaviour. It also includes the policing of licensed premises, 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 as much, if not more, of their time in dealing with AOD related issues as workers who are actually employed in the AOD field.

Despite the important role of police in dealing with AOD related issues, to-date no systematic assessment has been made of the AOD workforce development needs of police. However, recently NCETA examined a broad range of workforce development issues pertaining to the AOD work roles of police (Roche, Duraisingam, Trifonoff et al., 2009).[22] This examination included a survey of 135 Western Australian (WAPOL) police. Roche et al. (2009) found a substantial proportion of police time was spent on AOD related incidents.

More than a quarter of police surveyed reported spending 70% of their time on AOD related incidents. Despite the amount of time police spent on AOD related incidents, more than half the police surveyed reported their roles and responsibilities in responding to such incidents were not clearly described in their job descriptions and while 85% had undertaken AOD related training, the majority of this training comprised on-the-job and non-accredited training. More than 90% of the survey respondents reported they would be interested in undertaking further AOD training specifically related to policing.

Police play a crucial role in supply reduction and can also play a significant role in demand and harm reduction. Some existing law enforcement activities are examples of successful demand and harm reduction strategies (e.g., roadside AOD testing, liquor licensing legislation compliance, drug diversion schemes, cautioning schemes etc). Significant political and organisational support for a harm minimisation approach has also been provided with the involvement of police ministers in the MCDS and the involvement of senior police in the IGCD.

There has been a range of AOD capacity building initiatives targeting police including the adoption of guidelines for managing people affected by AOD (e.g., psychostimulant guidelines[23]) and the provision of drug diversion training.

Most of these existing initiatives have been introduced at a jurisdictional level. As recommended by Roche et al. (2009) a comprehensive national strategy is necessary that caters for the unique, specific and jurisdictional AOD related needs of police. This strategy should extend beyond a national training package/program by involving a multi-tiered approach that address key issues across the domains of system-wide action, capacity building and professional development (Roche, Duraisingam, Trifonoff et al., 2009).

GP prescribers[24]

Although medical practitioners potentially have a wide range of roles to play in relation to AOD issues, one of the most important is the prescribing of pharmacotherapies. As the use of pharmacotherapies has become even more prominent over the past decade, the role of medical practitioners has increased correspondingly. However, a recent NCETA study (Hotham, Roche, Skinner, & Dollman, 2005) indicated limitations in the available data prevented a detailed assessment of the current GP prescriber workforce.

The limited data that was available indicated significant shortfalls in the number of prescribers available in each state to service opioid pharmacotherapy clients (state variations in private versus public service provision notwithstanding). It was consistently observed across states that a relatively small number of prescribers were providing services for the majority of opioid pharmacotherapy clients.

More recent research that examined the availability, accessibility and affordability of pharmacotherapy treatment (Ritter & Chalmers, 2009) indicated the lack of prescribers

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22. For a more detailed examination of the AOD workforce development issues facing police the reader is referred to the review by Roche et al. (2009) "In pursuit of excellence: Alcohol and drug related workforce development issues for Australian Police into the 21st century", available in hard copy or from the NCETA website.

23. Jenner, Baker, White & Carr. (2004) Psychostimulants – Management of acute behavioural disturbances: Guidelines for police services. Australian Government Department of Health and Ageing, Canberra.

24. GP prescribers are discussed in more detail in Chapter 10, Part B of this report.

remains a problem. Ritter and Chalmers (Ritter & Chalmers, 2009) found that the overall availability of pharmacotherapy programs was limited by the number of participating practitioners and concluded that encouraging greater participation was an important workforce issue.

Summary and Implications for a National Workforce Development Strategy

The diverse nature of the AOD workforce highlights the need for a national, co-ordinated approach to the on-going collection of AOD workforce data in order to allow for effective workforce planning. A nationally co-ordinated approach to the collection of workforce data is important as it would allow for consistency in data collection methodology and more effective identification of jurisdictional differences. Efforts undertaken to-date to map the AOD workforce have being sporadic and piecemeal, resulting in an inefficient use of very limited resources. Future efforts are clearly needed to consolidate AOD workforce mapping initiatives.

The on-going collection of data concerning the AOD workforce is important for workforce planning as it allows for the identification of gaps between skills supply and skills demand, but it also allows for the identification of other workforce development issues. While some limited data concerning the AOD specialist workforce are available, much less data are available on the AOD generalist workforce.

Data reviewed in this chapter highlights several important workforce development issues facing the AOD specialist workforce in particular. These issues are outlined below.

Minimum qualifications
A large proportion of AOD specialist workers have no accredited AOD specific qualifications. An important issue for a national workforce development strategy is the need to increase the quality of AOD services by reducing the number of workers with no AOD-specific qualifications. This could be achieved by up-skilling the existing workforce through the establishment of a minimum standard of AOD qualifications[25] and ensuring a qualified future workforce through an increase in new entrants with higher education and/or Vocational Education and Training (VET) qualifications. One advantage of a minimum qualification strategy is that it allows workers to receive recognition for prior work experience and learning training, minimising the time required for further training to reach the minimum qualification standard.

Particular needs of part-time workers
In order to up-skill the existing AOD workforce, specific strategies targeting part-time workers are an imperative as between 30% and 54% of the workforce work part-time. These part-time workers may have particular difficulty accessing training and other professional development opportunities.

NGO/Public sector issues
A large proportion of AOD workers are employed in the NGO sector. Variations in workforce profiles between government and non-government workforces and between jurisdictional

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25. This strategy has been implemented in two jurisdictions (Victoria and the ACT). In Victoria, where a minimum qualification strategy has been in place since 2006, 73% of the workforce have received minimum qualification accreditation.

workforces also present challenges for a national workforce development strategy. While 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.

In addition, infrastructure and funding support appears to be more of an issue for non-government specialist workers than government workers, which in turn also impacts workforce development (Duraisingam et al., 2006; NADA, 2003; Roche et al., 2004; VAADA, 2003; WANADA, 2003a, 2003b; Wolinski et al., 2003). Lack of infrastructure and funding support limit the ability of workers to access training and other professional development opportunities. Lack of funding and differences in salaries and awards for the NGO and public sector also mean that in may cases NGO workers are paid substantially less than public sector workers (see Chapter 5 for further details). This may result in a continual workforce drain from the NGO to public sector, with the NGO sector bearing most of the burden for training new entrants to the AOD workforce. Alternatively, it could result in a 'second class' AOD workforce which in turn may impact the quality of AOD service delivery.

Moreover, the proportions of generalist AOD workers and nurses varied substantially between public sector and non-government organisations. Nurses were more likely to be employed in the public sector. This may reflect differences in service delivery models. However, it may also present recruitment difficulties for the public sector (given that nurses are in short supply) and the low number of nurses employed in the NGO sector may limit the delivery of specialist treatment services in the NGO sector.

Workforce gender mix
The majority of AOD workers are female and this has particular implications for workforce development strategies. These issues include the heightened importance of family/work life balance, maternity leave, child care, carers' leave, flexible working hours, etc.

Age of the workforce
The mature age of the AOD specialist workforce warrants consideration in the development of any workforce development strategies. There are several implications of the older age profile of the AOD workforce. Some are positive, while other implications may be less positive. For instance, older workers may find it more difficult to learn new information and develop new skills, particularly if they lack a professional background to use as the foundation on which to build new knowledge. Some workers may also lack the fundamental education needed to further develop their professional skill base. New approaches may also conflict with previous training and experience and may therefore be met with a degree of resistance.

In addition, available data indicate that the workforce is continuing to age. This may result in substantial workforce shortages as older workers reach retirement age if not offset by high replacement levels (i.e., improved recruitment and/or retention). In addition the age of the workforce may impact strategies to up-skill the workforce. Older workers may find it more difficult to learn new information and develop new skills, particularly if they lack a professional background to use as the foundation on which to build new knowledge.

Workforce 'Churn'
Older workers by definition are more likely to be retiring from the paid workforce in the near future; thus compounding recruitment and retention issues. As the older and more

experienced workers leave, a void is created for younger and less experienced workers who remain in the system.

The impending retirement of a large proportion of the AOD workforce impacts in several ways. It creates a continual workforce 'churn' where a high level of recruitment is needed to maintain stasis; that is, recruitment is needed for replacement purposes as well as to address growth in service demand. This is an expensive and time consuming and therefore inefficient process that creates a drain that can be ill-afforded by the resource constrained AOD sector.

The exit of older workers from the system also impacts on the work roles and responsibilities of those workers who remain. When significant numbers of older workers exit the system, it makes the job of younger workers more difficult in many ways.

Older workers may also be less compatible therapeutic agents with younger clientele. The needs of young people have received increased attention of late and effort has been directed toward providing better matches between the needs of young people and their treatment staff. Conversely, as the Australian population ages and also continues to use both illicits and risky alcohol into older age brackets (with the associated negative consequences and impacts on the service delivery system) there will be an even greater role and place for the older worker.

Three complimentary recruitment and retention strategies could be utilised to address the older age profile of the AOD workforce:

1. initiate/expand programs to attract younger workers, such as traineeships or recruitment drives in higher education or VET settings

2. establish programs to attract and re-train redundant workers from shrinking industries such as manufacturing

3. implement programs to attract mature aged workers wanting a career change or wanting to re-enter the workforce.

The last two of these strategies accept the mature age of the AOD workforce as a positive rather than a negative. Given the ageing profile of the Australian workforce in general, tapping into an increasing supply of mature age workers may be an effective strategy not only for recruitment, but also to meet the treatment service needs of older drug users. However, for this strategy to be optimally effective, workforce development strategies also need to consider existing AOD worker retention rates. The most frequent length of service in the AOD field reported by the AOD specialist workforce was 5 years. Given the mature age of the workforce, the short duration of employment for a large proportion of the workforce may indicate workforce retention issues.

Mainstream generalist workers

An important objective of any national workforce development strategy will be to also respond to the AOD-related work issues facing mainstream generalist AOD workers. While the type of AOD work undertaken by mainstream workers and the amount of time they spent on AOD issues varied across occupational groups, all 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) (Freeman et al., 2004). 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 in responding to AOD issues. To-date, this has been a largely overlooked area and is one that requires greater attention.

Provision of high quality AOD services may be enhanced if workers were encouraged to undertake, and provided with more opportunities to complete, appropriate forms of AOD-related training. Nurses, medical staff and mental health professionals have been one of the major areas of focus of workforce development interventions to date. A need for greater emphasis on improving the AOD skills, confidence, available support and feelings of role legitimacy of other professional groups (e.g., emergency and first aid workers, pharmacists, teachers, welfare workers etc) is warranted.

The workforce development needs of the mainstream workforce are likely to differ from the needs of the specialist AOD workforce although here may be important areas of overlap. In addition, the structural and organisational barriers that prevent mainstream workers from engaging in AOD work are likely to differ from barriers experienced by AOD specialist workers. Thus, any national workforce development framework may need to include separate but complementary strategies for mainstream workers and the frontline AOD specialist workforce. Workforce development needs will vary according to occupations, organisations and work roles. Similarly, organisations will vary considerably across a range of characteristics. A national strategy needs to be sufficiently flexible enough to be applicable to all agencies that deal with AOD issues regardless of their location, size, or whether they are government, non-government or private organisations.

Priority workforce groups

Moreover, both the AOD specialist and mainstream (generalist) workforce includes a number of occupational groups, that have specific and, in some cases, unique workforce development needs. A national workforce development strategy may require separate, but inter-related initiatives that target these groups. To accommodate the diverse needs of different AOD workforce groups a co-ordinated, multifaceted and flexible workforce development strategy is needed that acknowledges other workforce development initiatives and strategies that also include these groups.

For example, general practitioner participation in the provision of opioid pharmacotherapies represents an important strategy by which to ensure that alcohol and other drug using clients can access quality, holistic health care. Hotham et al. (2005) identified an urgent need for workforce development strategies to improve the recruitment and retention of GP prescribers (particularly younger GPs and female GPs), and to encourage inactive registered prescribers to resume service provision. A national workforce development strategy is needed to facilitate the effective coordination, provision and uptake of training and to ensure professional practice change (i.e. enhanced levels of prescribing). The foundation of this strategy rests on accurate information concerning facilitators and barriers to service provision, rates of training uptake by GPs, and proportions of trainees subsequently providing prescribing services.

CHAPTER 5: CONTEMPORARY WORKFORCE DEVELOPMENT ISSUES

This chapter provides a brief overview of key workforce development issues and covers:

- Recruitment & Retention

- Awards, Salaries and Conditions and Career Paths

- Education and Training

- Accreditation and Minimum Qualifications & Core Competencies

- Professional and Career Development

- Professionalisation of the Workforce/Professional Groups

- Clinical Supervision and Mentoring

- Leadership and management

- Infrastructure Support

- Workforce support

- Information management

- Worker wellbeing.

Recruitment

AOD specialist workers

Surveys of AOD treatment agencies consistently indicate that the field faces considerable recruitment challenges. The majority of AOD treatment agency managers report difficulty in recruiting qualified and suitably skilled workers, particularly in rural and regional agencies (Pitts, 2001; Roche et al., 2004; Wolinski et al., 2003). This trend continues with a recent survey of non-government treatment agency managers indicating a decline in response to job advertisements (Gethin, 2008).

Relatively little is known about the nature or extent of AOD specialist staff shortages. It is unclear whether staff shortages are due to a lack of suitably qualified workers, or due to suitably skilled workers being reluctant to apply for vacancies under the wages and working conditions offered. In addition, few data are available concerning the length of time unfilled positions remain vacant, or the extent to which staff shortages negatively impact on AOD-related services. What is known, however, is that staff shortages substantially contribute to agency staff workloads and worker stress levels (Duraisingam et al., 2006; Duraisingam et al., 2007).

Recruitment challenges may be due to the growth in AOD services which has increased the demand for specialist workers. Moreover, the current tight employment market may also impact on the supply of workers. This may especially be the case for nurses, who make up more than 30% of the AOD specialist workforce (Duraisingam et al., 2006). Given that nurses are in short supply in the Australian health system (CDNM, 2005), treatment agencies

may be facing increased recruitment competition. The non-government sector in particular faces recruitment difficulties due to lower salaries offered compared to government agencies (Gethin, 2008) (see section on awards and salaries below).

Barriers to recruitment most commonly cited by AOD workers and agency managers include:

- low salary and poor benefits

- a perception that AOD clients are difficult to work with

- stigma and lack of respect associated with AOD work

- lack of opportunity for career progression

- lack of career paths and opportunities (Duraisingam et al., 2006; Gethin, 2008; Pitts, 2001).

While there have been some strategies developed to recruit AOD specialist workers at a jurisdictional level (e.g., the Victorian AOD Workforce Development Strategy; the NSW Workforce Development Council) and a sectoral level (e.g., NADA's promotion of AOD careers and traineeships), to-date no nationally co-ordinated response to AOD workforce recruitment difficulties has been devised.

Overcoming recruitment barriers is often left to individual AOD agencies and organisations. However, issues such as low salary and perceptions of difficult clients or stigmatised work are to a large degree out of the control of individual agencies and organisations. Overcoming low salaries requires strategies to review current funding arrangements and industrial awards and the promotion of flexible working practices (NADA, 2003). Similarly, attempts to overcome other barriers, such as the stigma attached to AOD work and low levels of awareness of the nature of AOD work, are unlikely to be effective if they are based on organisational responses alone. Broad, systemic strategies are required to effectively address these issues.

Mainstream generalist workers

Barriers to the recruitment of mainstream generalist workers to AOD work are complex and likely to involve a range of individual, professional and structural factors (Allsop et al., 1998; Baker & Roche, 2002). Little attention has been paid to identifying the recruitment barriers experienced by mainstream workers. Some of the barriers facing specialist AOD workers may not be relevant to mainstream workers (e.g., low salary) while other factors are relevant to both (e.g., stigma associated with AOD work). Three recruitment barriers relevant to both workforce groups, and particularly relevant to the mainstream workforce, include:

- role desirability (attitudes toward AOD work) role support (funding and infrastructure),

- role competency (skills and knowledge), and

- role legitimacy (work practice policies, work relevance, organisational support).

These factors are discussed further in Chapter 9.

Retention

The AOD field also faces considerable workforce retention challenges with 44% of agency managers reporting difficulty retaining staff (Pitts, 2001). Workplace conditions also impact on workforce retention. Around a third of frontline workers report excessive workloads

and 23% report high levels of work stress (Duraisingam et al., 2006), while 54% of AOD treatment agency managers report high workloads and 30% report high levels of stress (Duraisingam et al., 2007). The most common reason for high workloads cited by both managers and frontline workers was staff shortages (Duraisingam et al., 2006; Duraisingam et al., 2007).

NCETA's research also indicated 31% of agency staff intended to look for a new job in the next 12 months and 19% intended to leave the AOD field (Duraisingam et al., 2006). Retention issues were also evident among agency managers with 29% planning to look for a new job in the next 12 months, and 20% intending to look outside the AOD field (Duraisingam et al., 2007). However, due to the lack of available data concerning actual AOD workforce turnover rates, the degree to which these turnover intentions reflect staff resignations is unclear.

There are numerous reasons why the AOD field is facing workforce retention difficulties and many of these reasons also relate to recruitment difficulties. The most common reasons cited include:

- Poor salary, terms and conditions
- Lack of professional and career development opportunities
- High workloads and work stress
- Complexity of roles
- Poor public profile (stigma of work)
- Difficult work environments
- Uncertainty of tenure due to short-term funding
- Limited clinical supervision and managerial support
- Limited recognition for effort (Duraisingam et al., 2006; NADA, 2003; VAADA, 2003; WANADA, 2003a, 2003b).

In some cases, both recruitment and retention difficulties appear related to funding arrangements. Many AOD agencies operate on short-term funding which can negatively impact recruitment and retention by providing little job security. Moreover, many AOD agencies are funded to undertake a defined set of activities and the funding received is often insufficient to maintain or upgrade agency infrastructure or to ensure staff development (ADCA, 2008; NADA, 2003).

Funding issues appear more salient in the non-government sector compared to the government sector. Non-government AOD treatment agency managers are more likely to report inadequate funding compared to managers of government agencies (Wolinski et al., 2003), while government AOD specialist workers are more likely to be satisfied with their pay and conditions compared to non-government workers (Duraisingam et al., 2006). Any workforce development strategy therefore needs to not only consider funding arrangements, but also factors such as:

- employment conditions
- industrial awards
- the relationship between qualifications and remuneration, and
- career pathways.

Awards, Salaries and Conditions and Career Paths

Closely linked to recruitment and retention challenges is the issue of remuneration, awards and career paths. This is a particular problem for NGO agencies which make up more than half the AOD sector. Increasingly there is disparity between salaries and conditions offered by NGO AOD agencies and public sector agencies. This disparity is linked to funding and differences in awards. A recent review of the ACT AOD workforce revealed hourly rates paid to AOD workers employed by NGOs ranged from $18.53 to $24.61, while the public sector (ACT Health) paid AOD workers an average of $33.60 per hour (ACT Alcohol and Other Drug Sector Project, 2009). While this difference in hourly rates may reflect differences in the skill/qualification levels of AOD workers in the public sector compared to the NGO sector (e.g., more nurses are employed in the public sector), other data indicate that a disparity exists even when NGO workers have the same skill/qualification level and job role as their public sector counterparts.

A recent survey of NGO employees in Western Australia (WAAMH et al., 2008) revealed the wages for a significant proportion of NGO survey respondents had fallen progressively behind those of public sector employees (Table 4).

Table 4: Comparison of salary disparity between similar positions in the Public Service Sector and the Community Service Sector (WAAMH et al., 2008)

Community Drug Service Team Councellor						
Community Service Sector SACS Award				Public sectors WA Health-HSU Award 2006 & HSU- WA Health State Industrial Agreement		
Award	% Increase	Salary		Award	% Increase	Salary
2003 SACS Level 5.1	2% Safety Net Review Effective 20.06.03	$38,960		2003 HSOA Level 3/5.1*	2% Effective 06.08.03	$41,740
2004 SACS Level 5.2	2.47% Safety Net Review Effective 20.06.04	$41,039		2004 HSOA Level 3/5.2**	3.4% Effective 18.01.04	$43,232
2005 SACS Level 5.3	2.11% Safety Net Review Effective 20.06.05	$42,910		2005 HSOA Level 3/5.3***	3.5% Effective 01.01.05	$47,406
2006 SACS Level 5.3	2.4% Fair Pay Com. Effective 20.06.06	$43,926		2006 HSOA Level 4/6.4	1.65% Effective 01.01.06 4.5% Effective 01.07.06	$51,238 $56,585
2007 SACS Level 5.3	0.6% Fair Pay Com. Effective 20.06.07	$44,203		2007 HSOA Level 4/6.5	4% Effective 01.07.07	$63,679

*Due to the reclassification of health professionals in the public service in 2005, workers were back paid from 2003 to the equivalent of the new 4/6.1 health professional pay scale.
**Due to the reclassification of health professionals in the public service in 2005, workers were back paid from 2003 to the equivalent of the new 4/6.2 health professional pay scale.
***Due to the reclassification of health professionals in the public service in 2005, workers were back paid from 2003 to the equivalent of the new 4/6.3 health professional pay scale.

Table 4 demonstrates how over a period of 5 years, the salary gap between Public and Community Service Sectors has widened. For two AOD counsellors who began work in 2003 (one in an NGO agency and one in the Public sector) the Public sector employee had earned $38,930 more than the NGO employee by 2008. In 2008 their salaries differed by $19,476, despite both working the same number of hours per week, with similar responsibilities and using similar skills.

In addition, the public sector usually offers better options for advancement and promotion and portable long service leave entitlements.

Furthermore, across a number of professional groups there have been successful bids for substantial salary increases, limiting the ability of poorly 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 or other cash strapped services.

With the advent of the Chapter of Addiction Medicine, an important workforce development initiative in and of itself, there has been the appointment and/or reclassification of medical staff as addiction specialists. This resulted in existing AOD medical staff becoming eligible for special medical staff awards and in some cases this has equated to very substantial salary increases. Usually these salaries are drawn from fixed (if not shrinking) budgets, and will have the inevitable consequence of reducing the available funds for other staff positions.

While the move towards the establishment of the Chapter of Addiction Medicine was applauded, particularly the elevated status and enhanced perception of the AOD field that was anticipated would accompanying it, the financial impact and impost that it brings with it is only now being realised.

Future workforce planning and associated funding for the AOD field at both the national and jurisdictional levels will be required to accommodate this substantial increase in salary and benefits afforded to Addiction Medicine specialists in a way that has never occurred previously.

Education and Training

The broader definition of workforce development as outlined in earlier sections of this report notwithstanding, education, training and skills development are recognised as critically important to clinical staff. Increasingly it is recognised that policy makers, preventionists, researchers, and a range of other workers engaged in non-clinical roles also require up-skilling in relation to AOD matters.

Few AOD courses, for either AOD specialist or mainstream workers, were available until the mid 1990's. Over the past decade, however, there has been a substantial increase in the availability of both accredited and non-accredited courses. NCETA has undertaken a number of audits of available AOD training opportunities (e.g., Allsop et al., 1998; Roche & Kennedy, 2003) and has recently completed a national audit of accredited and non-accredited courses in the AOD and mental health areas (Roche, Duraisingam, Wang et al., 2009). Hence, a detailed data base exists to identify the courses available and assess their suitability and adequacy. Such an assessment will form an important part of a national

workforce development strategy, and the data required to undertake the assessment, as well as recent critical reviews, are currently available to assist this process.

In general, these reviews document the provision of AOD education and training as moving from piecemeal, sporadic and absent from nearly all major professional training programs (Roche, 1998) in the early 1990's to widely available AOD education and training opportunities at undergraduate and postgraduate levels in the higher education and VET sectors by the early 2000's (Roche & Kennedy, 2003). To maintain these advances, Roche and Kennedy (2003) identified the need to:

- improve coordination between education and training providers
- establish mechanisms for national oversighting and monitoring of training and education provision
- provide greater support to existing training providers
- provide more effective and efficient exchange of resources.

While most of these strategies for improved coordination and greater efficiency have not been adopted, there has nonetheless continued to be an expansion in both the quantity and quality of available AOD training opportunities.

NCETA's review of training (Roche, Duraisingam, Wang et al., 2009) found a total of 387 accredited courses located across 107 higher education and training institutions. The majority of accredited courses were specifically focused on mental health (56%, n=218), while 41% (n=158) were courses with an AOD focus and the remaining 3% (n=11) were AOD/MH co-morbidity courses (i.e. where a course was specifically designed to address AOD/MH co-morbidities).
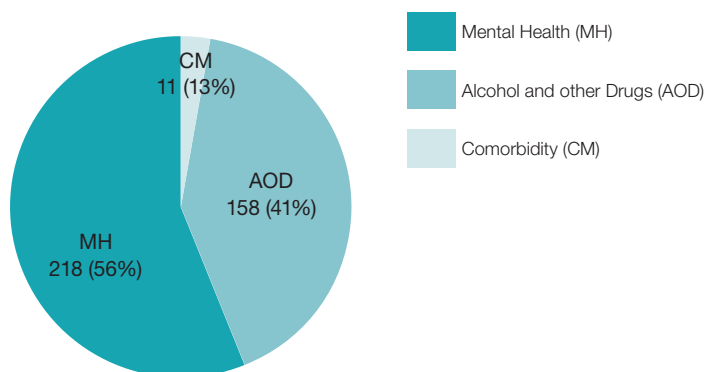

Figure 6: Proportion of Accredited AOD, MH and AOD/MH Co-morbidity Courses

AOD training tends to be predominately concentrated at the TAFE Certificate level with the majority (48%) of available AOD accredited courses offered at the Certificate level compared to the majority (55%) of mental courses which were offered at the post graduate level (Table 5).

Table 5: Number of AOD, MH and AOD/MH Co-morbidity courses by award Level

Award Level	AOD	CM	MH	Total	%
SoA*	16	4	9	29	7%
Certificate	79	3	80	162	42%
Undergraduate	33	2	7	42	11%
Postgraduate	27	2	118	147	38%
Other**	3	0	4	7	2%
Total	158	11	218	387	100%

* SoA = Statement of Attainment

** Other = university certificate / associate certificate courses

There is also a growing number of courses that address Indigenous issues as illustrated in Figure 7, where 21% of accredited courses are either specifically designed for Indigenous students or cover Indigenous issues in depth.
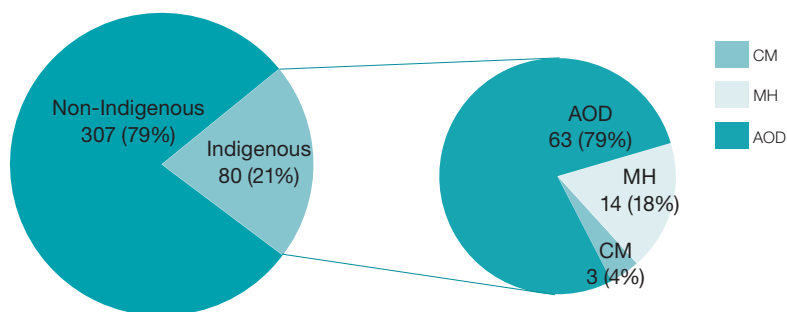
Figure 7: Proportion of Accredited Courses with Indigenous Content

Training and education also needs to be provided at multiple levels including pre-service, on-going in-service programs, with programs that also target structural factors at both the discipline and organisational level (Allsop et al., 1998).

Pre-service training

Pre-service training is an essential element in any workforce development strategy (Allsop et al., 1998; Roche, 1998). Pre-service training not only provides new entrants to the workforce with essential skills and knowledge, but when AOD content is included in relevant undergraduate courses it exposes a wide range of disciplines and professions to AOD work and increases role legitimacy.

Pre-service training delivered in the higher education and VET sectors is particularly important as it provides a pathway into AOD work and as such, can contribute to improved recruitment rates. However, reviews of AOD education and training have identified concerns with pre-service training that need to be addressed in any national workforce development strategy. First, rapid changes in the AOD field can make it difficult for teaching staff to keep up with advances unless they are linked to the AOD field (Roche & Kennedy, 2003). Second, training delivery and competency assessment within the VET sector requires work-based experience which in turn relies on linkages with AOD agencies. Surveys of the AOD field indicate concern in relation to consistency in the quality of competency assessments, with some AOD managers dissatisfied with VET training (Deakin & Gethin, 2007; Gethin, 2008; Wolinski et al., 2003).

In-service training

While pre-service training and education strategies are required to build the skills and knowledge of new entrants to the AOD field, on-going in-service training for the existing and future workforce is also required. The need for appropriate and relevant training is particularly important in the AOD specialist workforce where substantial numbers of workers have no formal AOD-specific qualifications (Duraisingam et al., 2006; Duraisingam et al., 2007; Wolinski et al., 2003). Until recently, most AOD-specific training that has been delivered to the current AOD workforce consists of non-accredited courses or accredited short courses (Duraisingam et al., 2006; Wolinski et al., 2003).

Despite the relatively low numbers of AOD workers with formal AOD qualifications (albeit the proportions appear to be increasing substantially), AOD work is a rapidly evolving and expanding field and as such, the provision of on-going in-service training is necessary for all workers, regardless of the qualifications they hold. Within the AOD field, a number of factors have been identified as influencing the need for on-going learning including:

- changing patterns of drug use
- an increasing evidence base
- improvements in treatment technologies
- increasing recognition of co-morbidity issues
- changes in work practices involving evidence based practice, and
- collaboration across agencies (ADCA, 2008).

The diversity of the AOD workforce also results in a need to tailor education and training to meet the specific professional and situational requirements of AOD specialists and mainstream workers (Roche, 1998). Roche (1998) outlined a hierarchy of education and training needs that ranged from the need for basic introductory level content for novices to advanced skill and knowledge development among qualified AOD specialist workers. Flexible and diverse training and education strategies are needed to meet these needs.

As many health and human services workers commonly encounter AOD problems as part of their usual work, it is increasingly argued that upskilling mental health and generic human services workers to ensure that they are at least conversant with the clinical literature and have basic AOD knowledge is essential. However, many professional and clinical training programs do not include coverage of AOD issues. In addition, there is often a communication gap between the research and practice communities, as noted earlier (see the sections on training transfer and evidence based practice), such that empirical findings are not effectively disseminated to generic health and human services workers.

Within the AOD specialist workforce, substantial barriers to in-service training and education have been identified including limited training options in some jurisdictions and access to training often constrained by distance, time, lack of flexibility in delivery, lack of backfill staff, and financial costs involved in attending training (Deakin & Gethin, 2007; NADA, 2003; VAADA, 2003; WANADA, 2003b). Access to training opportunities is a particular issue for remote and rural workers (Deakin & Gethin, 2007; Wolinski et al., 2003).

Accreditation and Minimum Qualifications

Currently there is no national professional accreditation in Australia for AOD specialist work. This situation prevents the establishment of formal minimum standards of competence for AOD workers and therefore the requirement of workers to meet minimum standards of competency. To some extent, this has been addressed in vocational education training (VET) with the development of the Community Services Training Package which includes a Certificate IV level of training in AOD work. This training is nationally recognised and accredited under the Australian Qualifications Framework. However, the use of this training to establish minimum standards for AOD-specific qualifications is largely informal. Only two jurisdictions to-date (Victoria and the ACT[26]) require AOD specialist workers to be accredited to at least the level of Certificate IV. Minimum qualification requirements came into effect in Victoria in 2006 and at the time of writing were undergoing implementation in the ACT.

A 2003 study of Victorian AOD workers found that only 8% of the qualifications of workers were AOD-specific (Victorian Government Department of Human Services, 2005). In response to this finding and recommendations by the Drug Policy Expert Committee (Drug Policy Expert Committee, 2000) the Victorian Department of Human Services (DHS) adopted a Minimum Qualifications Strategy (MQS) for the AOD workforce. The MQS formed part of the Victorian AOD Workforce Development Strategy 2004-2006 and came into effect on 1 July 2006.

The aim of the MQS was to ensure that the AOD workforce had a minimum level of knowledge and competency specifically in the AOD field and to ensure that this was consistently maintained. To achieve the MQS, AOD workers could either hold an AOD-specific qualification equivalent to (or above) CHC41702 Certificate IV in Alcohol and Other Drugs Work; or a tertiary qualification in health, social or behavioural science and complete, at a minimum, four AOD core competencies from the Community Services Training package CHC02.

In 2009, a review of the MQS was undertaken (Petroulias, 2009). It involved a survey of 250 Victorian workers, their managers and key industry groups to determine the relevance of the MQS to meet the skills and knowledge requirements of AOD service provision. This review found that 73% of surveyed AOD workers met the MQS while 14% were undertaking training to meet the MQS. In general, the majority of industry groups, agency managers and workers surveyed believed the MQS was an efficient and effective way of maintaining a consistently competent and knowledgeable AOD workforce and that the current set of four core units of competency within the MQS (at the Certificate IV level) were relevant to AOD work. However, AOD agency managers were more likely to believe that minimum qualifications should be at the Diploma level, compared to AOD workers. In addition, the review identified that an elective unit of competency, provided at the Diploma level (CHCAOD11A - Provide advanced interventions to meet the needs of client with AOD issues), was viewed by a majority of survey respondents to be also relevant to the needs of AOD workers engaged in direct clinical service provision. This would indicate that more advanced training at a higher Australian Qualification Framework (AQF) level may be required.

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26. The Victorian Department of Human Services and ACT Health have introduced a formal minimum standard of competence based on the Certificate IV in AOD work (Victorian Government Department of Human Services, 2005).

Professional accreditation based on a minimum qualification standard can be a useful workforce development strategy as it:

- provides workers with relevant base level knowledge and skills

- raises the professional profile of the workforce

- provides consistency in the assessment of standards of practice

- can be used as practice benchmarks in quality improvement processes

- contributes to the development of formal career paths

- allows for transportability of skills between jurisdictions and organisations.

However, while minimum qualification standards based on certificate level qualifications obtained through the VET sector may be an appropriate strategy for workers with few or no relevant qualifications or skills, it may not be appropriate for AOD specialist workers who have relevant (but not AOD-specific) graduate and post-graduate qualifications. In addition, some AOD agency managers have expressed dissatisfaction with Certificate IV level training (Deakin & Gethin, 2007; Gethin, 2008; Wolinski et al., 2003). This dissatisfaction concerns AOD knowledge and procedural deficits and overall variation in the quality of VET teaching (Deakin & Gethin, 2007; Gethin, 2008). Despite these concerns, there is a significant level of support for the introduction Certificate IV level (or higher) minimum AOD qualifications (Deakin & Gethin, 2007; McDonald, 2006).

Core Competencies

In recent years there has been growing consensus regarding what constitutes the basic knowledge and skill sets that should be held by specialist AOD workers. In Australia, current minimum qualification strategies require AOD workers to either hold an AOD-specific qualification equivalent to (or above) CHC41702 Certificate IV in Alcohol and Other Drugs Work; or a tertiary qualification in health, social or behavioural science and complete at a minimum four AOD core competencies from the Certificate IV in Alcohol and Other Drugs Work. The Certificate IV in Alcohol and Other Drugs Work consists of 14 units of competency, 11 of which were compulsory, two could be chosen from a compulsory list of 8 topics, while one topic could be chosen from a list of 11 electives. From the Certificate IV in Alcohol and Other Drugs Work compulsory unit topics, four were selected as core competencies for the Victorian and ACT minimum qualification strategies.

These four core competencies were:

- CHCAOD2C Orientation to the AOD sector (AQF level 4)

- CHCAOD6B Work with clients who are intoxicated (AQF level 4)

- CHCAOD8C Assess the needs of clients who have AOD issues (AQF level 4) and,

- CHCAOD10A Work with clients who have AOD issues (AQF level 4).

Despite agreement on the basic knowledge and skill sets that should be held by AOD workers, recent surveys have identified skills and knowledge gaps among Certificate IV in AOD Work graduates (Deakin & Gethin, 2007). The current Certificate IV in AOD work consists of the Community Services Training package CHC02. As of July 2010, it will be replaced by package CHC08. To-date, it is unknown to what extent new core competencies from this training package will fill these skill and knowledge gaps.

For AOD generalist workers, 'alcohol education inventories' have also been established that form the basic knowledge expected of health professionals or mental health professionals in regard to alcohol (Brown University Center for Alcohol and Addiction Studies Postdoctoral Fellows, 2009). Such inventories comprise relatively short (e.g., 50 item) self assessment tests that are updated on a regular basis. Surveys conducted in the USA suggest that alcohol-related knowledge of mental health professionals in general training is less than adequate. Further work on the determination of basic skill sets and competencies of mainstream workers, in relation to AOD issues, is required.

Professional and Career Development

Through the provision of professional and career development opportunities, which involves a range of activities including:

- clinical supervision

- mentoring

- on-the-job learning

- job rotation

- cross-organisational staff exchanges

- conference/workshop attendance

- access to education and training.

Professional and career development not only improves AOD workers' knowledge, skills and competencies, but can also improve service delivery and positively impact other workforce development issues such as retention, worker wellbeing and organisational change (Pollard, 2005). However, despite the importance of this workforce development strategy, AOD workforce surveys consistently indicate that a substantial proportion of the workforce has limited or no access to adequate professional development opportunities (Duraisingam et al., 2006; VAADA, 2003; Wolinski et al., 2003). Lack of access to professional development opportunities is a particular issue for rural/remote workers.

The AOD workforce requires a range of strategies that can provide opportunities for workers to enhance their skill level and professional development. Central to these strategies is a lifelong learning approach that supports the development and enhancement of knowledge, skills and competencies to assist with emerging issues. However, effective lifelong learning in the workforce depends on multilevel strategies that target structural and system factors that act as barriers.

Professionalisation of the Workforce/Professional Groups

One strategy for building the capacity of the AOD workforce to provide effective and efficient responses to AOD issues is the professionalisation of the workforce. While the introduction of a minimum qualification level for AOD workers (as outlined above) goes someway toward professionalisation of the workforce, however, a minimum qualification level only provides a consistency in minimum levels of knowledge and competence. Many AOD professionals hold qualifications above these minimum levels (e.g., medical practitioners, nurses, psychologists etc).

An important method for professionalising AOD workforce groups with higher level qualifications is the establishment of professional groups that represent these different

professions. Such groups not only work toward increasing the skill levels of the professions they represent, but can be useful strategies to recruit AOD workers with specialised skills. Examples of existing professional groups include Drug and Alcohol Nurses of Australasia (DANA) and the Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine (ACoAM). Such groups could be expanded to other professions in the AOD field such as psychologists and social workers. The establishment of such groups would not only lead to the improvement of AOD related skills and knowledge among these professions, but also provide a vehicle for co-ordinated and comprehensive internship and clinical placement programs within AOD agencies.

A recent example of such an approach is the establishment of the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA). This Association was established to work for the interests of Aboriginal Health Workers by supporting career and professional development, networking, professional accreditation, and representation at peak forums.

Clinical Supervision and Mentoring

Clinical supervision is a particularly effective strategy (Kavanagh et al., 2002; Roche, Todd, & O'Connor, 2007) for developing and maintaining clinical skills and effective practice. Kavanagh, Spence, Wilson and Crow (2002) argue that the seldom-used practice of supervision in the AOD field may provide benefits to the alcohol workforce. Over the past decade, there has been growing interest in and support for clinical supervision in the AOD field in Australia with numerous important initiatives undertaken. Kavanagh et al. (2002) defined supervision as primarily an alliance between members of the workforce to enhance clinical practice, fulfil the goals of the organisation and to meet the standards of the organisation and profession. Research suggests that effective supervision can help the transference of complex, clinical skills to members of the workforce, and increase workers' job satisfaction and morale (Kavanagh et al., 2002). Since workers' lack of confidence in their skills to treat individuals with alcohol-related problems has been identified as a barrier to effective treatment (Shaw, Cartwright, Spratley, & Harwin, 1978), increasing these skills and increasing job satisfaction would increase the quality of treatment provided to individuals with alcohol-related problems, and also workers' willingness to treat these individuals.

Workforce development needs vary according to different work roles. For example, there is a demonstrated need for clinical supervision among workers who directly treat or counsel clients, while managers of agencies report the need for managerial support, training and mentoring.

Two of the most useful activities for professional development in the AOD field are clinical supervision and mentoring. Clinical supervision involves developing the clinical skills of less experienced AOD workers via the provision of support and guidance from a more experienced clinician. Mentoring involves a partnership between relatively in-experienced and experienced AOD workers in order to provide leadership and professional development to the less experienced worker.

The provision of clinical supervision also has additional benefits. It can:

- improve specialist staff retention
- increase workers' job satisfaction

- improve communication between workers
- promote standardised practice competencies (Todd & O'Connor, 2005).

Mentoring is also an effective broad based workforce development strategy in that it can:

- increase and maintain skills and knowledge
- facilitate work practice change
- support and motivate work performance,
- improve recruitment and retention rates (Todd, 2005).

However, recent initiatives not withstanding, research indicates a substantial proportion of the AOD specialist workforce has limited or no access to clinical supervision and mentoring opportunities (Duraisingam et al., 2006; Kavanagh et al., 2002; Wolinski et al., 2003).

A national workforce development strategy needs to consider clinical supervision and mentoring as a priority. Comprehensive resources to assist with clinical supervision and mentoring have been produced by NCETA and some jurisdictions (e.g., NSW and Victoria) have developed clinical supervision policies and protocols. Strategies need to go beyond the development and provision of resources and guidelines. As there is an acknowledged lack of skilled AOD specialist workers, strategies are also needed that increase the pool of, and improve access to, potential clinical supervisors and mentors.

Leadership and Management

Professional and career development opportunities need to offer more than just AOD-specific opportunities. In particular, there is a demonstrated need for the development of leadership and management skills among the AOD workforce (Duraisingam et al., 2007; NADA, 2003; WANADA, 2003a, 2003b; Wolinski et al., 2003). Within the AOD field many workers move from clinical roles to management roles (Wolinski et al., 2003) without any formal management training or experience and hence a substantial proportion of agency managers report that they do not have the necessary management skills to carry out their work role effectively (Duraisingam et al., 2007). This is particularly the case in the NGO sector (Spooner & Dadich, 2008).

Strategies designed to enhance the managerial competency of AOD agency managers need to not only focus on issues such as governance, financial management and effective human resource management, but also on an understanding of workforce development and effective workforce development strategies.

In addition, a national workforce development strategy needs to consider the issue of leadership in the AOD field. There is ample evidence to indicate that good leadership plays an important role in the development of an effective and efficient workforce. However, with an ageing workforce, the AOD field faces substantial leadership loss in the next 10-15 years.

Strategies to develop leadership programs are important, not only for AOD treatment agency managers, but for a wide range of AOD-related organisations. Moreover, these leadership development initiatives should target a broad range of roles requiring leadership skills such as team leaders, supervisors, managers, program directors, and senior executives.

Infrastructure Support

A key issue that has emerged from reviews of AOD workforce development issues and surveys of the AOD workforce is infrastructure support. While funding levels are generally more of a concern in the non-government sector compared to the government sector, system level funding issues impact the AOD sector in general (NADA, 2003; Pitts, 2001; VAADA, 2003; Wolinski et al., 2003).

These issues affect workforce development in three ways. First, non-government agencies in particular report insufficient funds to maintain or upgrade infrastructure, which impacts on knowledge management and the work environment (ADCA, 2008). Second, limited provision of funding to cover the costs of staff backfill to attend training and for travel and accommodation costs (particularly in the case of remote and rural workers) curtails staff development (NADA, 2003; Pitts, 2001; VAADA, 2003; Wolinski et al., 2003). Finally, little funding is available for the evaluation of AOD programs and projects, thereby hampering progress through limited knowledge of effective verses ineffective programs.

Workforce Support

There is a substantial body of evidence to indicate that support provided by co-workers, supervisors and organisations can have a positive influence on worker effectiveness and wellbeing (e.g., Rhoades & Eisenberger, 2002). In the AOD workforce, support is particularly important. Work in the AOD field is often demanding, with high workloads, complex work issues, high levels of stress and high levels of turnover.

The 2005 NCETA surveys (Duraisingam et al., 2006; Duraisingam et al., 2007) identified that the majority of AOD workers reported high levels of co-worker and supervisor support (71% and 80% respectively). However, there are differences between non-government and government workers. For example, 15% of workers employed in government agencies disagreed that their supervisor was concerned about staff welfare, compared to 9% of workers employed in non-government agencies (Duraisingam et al., 2006). Of more concern were the 20% of agency managers who reported that their organisation did not provide them with sufficient support for their role as a manager (Duraisingam et al., 2007).

The provision of workplace support is a particularly important workforce development issue as significant positive correlations have been identified between workplace support and both length of service as an AOD agency manager ($p < .01$) and length of service in the AOD field ($p < .05$) (Duraisingam et al., 2007).

A range of factors can be utilised to provide workplace support including:

- fair and equitable treatment at work
- provision of recognition and other valued rewards
- supportive management/supervision
- adequate job conditions
- effective management of work stress
- ensuring sufficient work-related resources (Skinner, 2005).

Information Management

Another workforce support issue relevant to the AOD workforce concerns the provision of work-related resources. Due to the rapidly expanding AOD-relevant knowledge base, timely access to accurate and relevant information is an important workforce development issue.

Strategies are needed that improve access to contemporary, accurate and relevant information by improving the relationship between research organisations and AOD agencies in order to facilitate information dissemination. Similarly, teaching AOD specialist workers how to access, assess, and translate current research and other evidence into work practice is an essential workforce development strategy (Allsop & Helfgott, 2002; Baker & Roche, 2002; Bywood, 2006; Bywood et al., 2008). The issue of information management is particularly salient given the growing emphasis placed on evidence based practice.

NCETA recently conducted a comprehensive review of research concerning the effectiveness of various strategies for dissemination and implementation of research into practice and found that while all strategies reviewed were to some extent effective, some strategies were more effective than others in changing behaviour (Bywood et al., 2008). The findings of this review emphasise the need for careful selection of strategies to ensure the best match with content area and target audience or behaviour to be changed.

One strategy of critical importance is computer based information technology and information management systems. The recent survey of managers of NSW NADA member agencies indicated that for non-government agencies at least, information technology (IT) and information management systems were a workforce development issue. Of the 101 member agencies surveyed, only just over half (57%) rated their IT systems as good or excellent (Deakin & Gethin, 2007). In addition 89% of those surveyed reported their staff would require training in information technology over the next year (Deakin & Gethin, 2007).

Worker Wellbeing

The 2005 NCETA workforce surveys also provide some important statistics concerning worker wellbeing. Of the 1,345 AOD specialists surveyed by Duraisingam et al. (2006), nearly one in five (19%) reported high stress levels. Statistically, high workloads were the most significant predictor of work stress. More than one in three workers (35%) reported that they had "too much work to do everything well" and nearly half (41%) believed that they did not have "enough time to get everything done" (Duraisingam et al., 2006). Other factors reported that contributed to work stress were staff shortages (which in turn increased work loads), dealing with difficult clients, and complex client presentations.

A similar trend was evident among agency managers. More than one in five (21%) reported high levels of burnout and nearly half (48%) reported they felt emotionally drained at the end of most working days (Duraisingam et al., 2007). Over half (54%) the managers surveyed felt that they had too much work to do everything well and the majority (67%) also felt that there was not enough time to get everything done. The factors managers most frequently reported as causing work pressure for them were staff shortages, too little time to meet work expectations, and conflict between clinical and managerial roles (Duraisingam et al., 2007).

High workloads and high levels of work stress among AOD workers are important considerations in any workforce development strategy as they are associated with a range

of negative outcomes including low job satisfaction and performance, and increased absenteeism and turnover.

Summary and Implications for a National Workforce Development Strategy

1. *Recruitment and retention*
    The AOD field faces on-going recruitment and retention challenges. Barriers to recruitment of specialist AOD workers include, low salary and poor benefits, stigma and negative attitudes associated with AOD work and lack of career paths. Barriers to the recruitment of mainstream workers include role desirability, role competency and role legitimacy. These recruitment barriers are also likely to negatively impact retention rates. In the non-government sector in particular, many of these recruitment and retention issues are linked to inadequate funding.

    The recruitment and retention of AOD specialist workers and mainstream AOD workers requires a co-ordinated national approach to raise the profile of the AOD field and improve recognition of the quality and value of the work undertaken by AOD workers. While low levels of remuneration is an issue across the board, particular effort is required to address the salary and award disparity between the NGO and Public sector workers. Other recruitment strategies could involve the funding and promotion of AOD content in undergraduate courses and ensure relevance of any AOD content is taught (NADA, 2003). Awareness of AOD work and the image associated with this work could be improved by encouraging greater participation of the AOD workforce in government consultations, the use of media campaigns, and by further supporting professional bodies that represent the AOD field (NADA, 2003). Strategies are also required that address stigma and negative attitudes associated with AOD work.

    As a priority, a national strategy should also include recruitment and retention programs to address the lack of AOD specialist workers in rural and remote areas and the lack of Indigenous workers that has been recognised in previous alcohol and illicit drug action plans. In addition, initiatives are needed that improve partnerships and linkages between government and non-government AOD agencies and between the AOD field and the wider health and welfare sector in order to improve/create career paths and allow for innovative strategies such as cross sectoral staff exchanges or placements.

    Career pathways could also be expanded through articulation of courses and qualifications between VET and higher education. It should be noted that in NSW progress has been made on establishing articulation arrangements between NSW TAFE and university. Most of these arrangements involve a one year exemption from degree course if a TAFE diploma in AOD work has been completed. A national strategy should consider strategies to implement this type of articulation on a coordinated national basis.

2. *Training, education and professional development*

   Over the past decade there has been substantial growth in the number of accredited AOD course provided at the VET, undergraduate and post-graduate levels. Despite this growth, the AOD field continues to face challenges concerning the delivery and up-take of AOD training and education. With regard to pre-service training there remains concern regarding the degree to which training content and curricula has kept pace with rapid knowledge and technological change in the AOD field, together with concerns over the consistency and quality of competency assessments. The issue of adequate minimum competency standards is particularly important as there is currently no national professional accreditation in Australia for AOD specialist work.

   As AOD work is a rapidly evolving and expanding field, the provision of on-going in-service training is also necessary for all workers, however, substantial barriers to in-service training have been identified including limited training options in some jurisdictions and access to training often constrained by distance, time, lack of flexibility in delivery, lack of backfill staff, and financial costs involved in attending training. Access to training opportunities is a particular issue for remote and rural workers.

   The professional development of the AOD workforce needs to go beyond the mere provision of pre-service and in-service training. AOD organisations need assistance with the identification of training needs and strategies to ensure effective training transfer. The on-going development of AOD workers' knowledge and skills can also be enhanced through the provision of professional and career development opportunities, which involves a range of activities including clinical supervision, mentoring, on-the-job learning and conference/workshop attendance. Moreover, professional and career development opportunities need to offer more than just AOD-specific opportunities. In particular, there is a demonstrated need for the development of leadership and management skills among the AOD workforce.

   A national strategy needs to incorporate initiatives that improve linkages between the AOD field and AOD education and training providers to ensure the relevance and appropriateness of curricula content. The strategy also needs to include mechanisms for national oversighting and monitoring of training and education provision to ensure consistency and quality and to ensure skill development occurs at all levels in the AOD field, not just entry level. In addition, the national strategy needs to target structural barriers to the provision of tertiary AOD training and education at the discipline and organisational level. Moreover, a national strategy needs to incorporate initiatives to assist individual workplaces with the conduct of training needs assessments and the implementation of initiatives to ensure effective training transfer. A key priority for the strategy should be access to training and education for rural/remote workers and part-time and/or casual workers.

   A national workforce development strategy needs to contain initiatives to overcome barriers to professional and career development. The strategy needs to recognise that while there are a range of activities that can

contribute to professional and career development, clinical supervision and mentoring are a priority. In addition, the strategy needs to also include initiatives to enhance managerial competence and leadership skills. A co-ordinated, comprehensive and multilevel approach to professional and career development is required. The development of a national AOD workforce strategy also needs to consider the issue of accreditation as a central workforce development strategy and to explore a range of possible options tailored to suit the needs of different jurisdictions.

3. *Workforce support & worker wellbeing*
    The support of co-workers, supervisors and the work organisation can positively influence worker wellbeing and worker effectiveness. Workforce support is crucial in a work environment such as the AOD field within which high workloads and high levels of work stress are evident. Two important areas for supporting the AOD are effective information management and the provision of adequate infrastructure.

    A national strategy needs to contain initiatives that provide overall support to the workforce and assist individual organisations to support their workers. These initiatives need to focus, in particular, on worker wellbeing among the AOD specialist workforce. A national workforce development strategy also needs to outline processes that address the issue of information management for the AOD field. It should also address resource development and distribution, the development of practice guidelines and evidence based research transfer strategies. Also of critical importance is the inclusion of initiatives that review funding arrangements for infrastructure support and strategies to ensure the wellbeing of existing and future workers.

Part B: Profiling the AOD Workforce

This section contains summary details of all 13 AOD workforce surveys undertaken to-date. They comprise four national workforce surveys and one study of methadone prescribers undertaken by NCETA and eight jurisdictional workforce surveys undertaken by NCETA and AOD Peak organisations. These studies are presented as follows:

Chapter 6: AOD specialist managers (NCETA national survey 2002)

Chapter 7: AOD specialist frontline workers and managers (NCETA national surveys 2005)

Chapter 8: AOD specialist frontline workers (jurisdictional surveys)

    a. Australian Capital Territory (2006 and 2009)

    b. New South Wales (2008)

    c. Victoria (2002 and 2008)

    d. South Australia (2007)

    e. Northern Territory (2005)

    f. Western Australia (2007)

Chapter 9: Mainstream generalist workers (NCETA national survey 2003)

Chapter 10: Methadone prescribers (NCETA study 2005)

CHAPTER 6: AOD TREATMENT AGENCY MANAGERS (NCETA NATIONAL SURVEY 2002)

In 2002, NCETA surveyed managers of the 549 AOD specialist treatment agencies listed in the 2001 Clients of Treatment Service Agencies (COTSA) database (Roche et al., 2004; Wolinski et al., 2003). The purpose of the survey was to determine the nature and size of the specialist workforce and identify workforce development issues. A total of 234 managers (representing 318 agencies – a 65% response rate) of specialist treatment organisations responded to the survey.

Overall, managers of AOD services:

- were predominantly female (57%)

- 46 years of age on average (range 23-69 years)

- nearly half had been in their current managerial position for less than two years

- possessed varying levels of managerial and AOD education, training and experience

- identified management training as a high priority.

Slightly more than half the managers were from organisations in the non-government sector and located in metropolitan areas (Table 6).

Table 6: AOD treatment organisation by type and location (2002)

Agency type	Metropolitain		Non-metro		Total	
	N	(%)	N	(%)	N	(%)
Government	52	(53)	46	(47)	98	(42)
Non-government	70	(60)	47	(40)	117	(50)
Private	16	(84)	3	(16)	19	(8)
Total	138	(59)	96	(41)	234	(100)

The most common service provided by AOD specialist treatment organisations in 2002 was outpatient rehabilitation (Table 7).

Table 7: Types of services provided by AOD specialist treatment organisations (2002)

Type of Service	N	(%)
Outpatient rehabilitation	149	(64)
Outpatient withdrawal	78	(33)
Inpatient rehabilitation	64	(27)
Inpatient withdrawal	65	(28)
Therapeutic community	37	(15)
Other	7	(3)

The major treatment services offered are detailed in Table 8. Just over half the AOD specialist treatment organisations surveyed in 2002 (51%, n = 119) offered only one type of treatment service, the remainder offered two or more treatment services.

Table 8: Major treatment services provided by specialist treatment organisation (2002)

Major service provided	N	(%)
Counselling	222	(95)
Referral	217	(93)
Assessment	206	(88)
Education	198	(85)
Group work/counselling	162	(69)
Follow up service	157	(67)
Crisis management	148	(63)
Rehabilitation	145	(62)
Withdrawal management	134	(57)
Medication management	118	(50)
Self-help program	109	(47)
Accommodation	108	(46)
Other pharmacotherapies	85	(36)
Methadone maintenance	74	(31)
Alcoholics Anonymous	69	(29)
Work program	58	(25)

Managers were asked to report the number and type of staff they employed. Based on survey response rates and the number of treatment agencies listed on the COTSA data base, it was estimated that the AOD specialist treatment workforce consisted of 10,190 workers in 2002 (Table 9). It is probable that this estimated workforce number has now increased in the intervening period.

Table 9: Actual reported and extrapolated AOD specialist staff numbers (2002)

Type of staff	Reported		Estimated
	N	(%)	N
Therapeutic	4,690	(70)	7,167
Other	1,811	(27)	2,768
Alcohol specific	167	(3)	255
Total	6,668	(100)	10,190

Numbers of AOD specialist workers (therapeutic staff) by occupation and the percentage of the AOD workforce these occupations represent are listed in Table 10.

Table 10: Reported (and estimated) staff working in 318 (and 486) specialist treatment agencies (2002)

Occupation	Reported		Estimated
	N	(%)	N
Nurses	1,206	(26)	1,843
Generic AOD workers	873	(19)	1,334
Psychologists	400	(9)	611
Counsellors	272	(6)	415
Social workers	265	(6)	405
Administration	234	(5)	358
Youth workers	209	(4)	319
Doctors	175	(4)	267
Peer workers	154	(3)	235
Volunteers	94	(2)	144
Allied health	70	(1)	107
Psychiatrists	60	(1)	92
Ancillary staff	60	(1)	92
Teachers/trainers	58	(1)	89
Managers	49	(1)	75
Health/Edu staff	33	(0.7)	50
Graduates*	26	(0.5)	40
Indigenous workers	17	(0.4)	26
Project officers	9	(0.2)	14
Pharmacists	7	(0.1)	11
Other staff	419	(9)	640
Total	4,690	(100)	7,167

* Graduates were defined as employees with an undergraduate degree in the area of social science

Differences between government and non-government AOD workforces

Managers employed in government AOD specialist organisations were approximately evenly distributed across metropolitan and non-metropolitan locations (Table 11). Non-government (not-for-profit) and private (for profit) organisations were more predominate in metropolitan locations.

Table 11: Distribution of government and non-government AOD specialist treatment agencies across metropolitan and non-metropolitan locations (2002)

Organisation type	Metropolitan		Non-metropolitan	
	N	(%)	N	(%)
Government	52	(53)	46	(47)
Non- Government	70	(60)	47	(40)
Private	16	(84)	3	(16)
Total	138	(59)	96	(41)

Treatment approaches varied according to organisation type, with a larger proportion of government agencies (90%) reporting a harm minimisation approach compared to non-government (71%) and private (53%) organisations. Exclusively abstinence approaches were more common in non-government (20%) and private (32%) organisations compared to government organisations (6%).

CHAPTER 7: AOD TREATMENT AGENCY MANAGERS AND AOD SPECIALIST WORKERS (NCETA NATIONAL SURVEYS 2005)

In 2005, NCETA conducted two further specialist workforce surveys. The first comprised a survey sample of 1,345 frontline workers (Duraisingam et al., 2006) and the second comprised 280 agency managers (Duraisingam et al., 2007) employed at AOD specialist treatment organisations listed in the 2001 COTSA database. The main aim of the frontline workers survey was to examine factors that may influence worker recruitment and retention, while the main aim of the managers' survey was to examine managers' occupational wellbeing.

In both surveys a range of demographic data was collected. Key characteristics of AOD frontline workers and agency managers are shown in Table 12.

Table 12: Key demographic characteristics of frontline AOD workers and agency managers (2005)

Sample characteristics		Frontline Workers (n=1,345)	Agency Managers (n=280)
Age (years)	Mean	42.9	46.6
	SD	10.23	8.32
	Range	20-73	27-67
Gender	Female	66%	61%
Organisational sector	Government	50%	53%
	Non-government (not-for-profit)	42%	40%
	Private (for profit)	7%	7%
Location	Urban	62%	52%
	Regional	17%	22%
	Rural and remote	18%	26%
Working arrangement	Permanent	77%	87%
	Contract	19%	12%
	Casual	4%	1%
Work status	Full time	70%	94%
	Part time	30%	6%

These surveys indicated that around half the AOD workforce (50% of frontline workers and 53% of managers) were employed in government organisations. The majority were female (66% of frontline workers and 61% of managers). Just over three-quarters (77%) of frontline workers considered themselves to be in permanent employment, and 70% were in full-time work. In contrast, 87% of managers considered themselves to be in permanent employment, and 94% were in full-time work.

The mean age of frontline workers was 43 years, while the mean age of managers was 47 years. Nearly half (48%) the frontline workforce and nearly two-thirds of agency managers (63%) were aged 45 years and over. Figure 8 shows the age breakdown of respondents in the sample. There were no significant age differences for organisational type (government, non-government, private) or employment location (metropolitan vs rural).
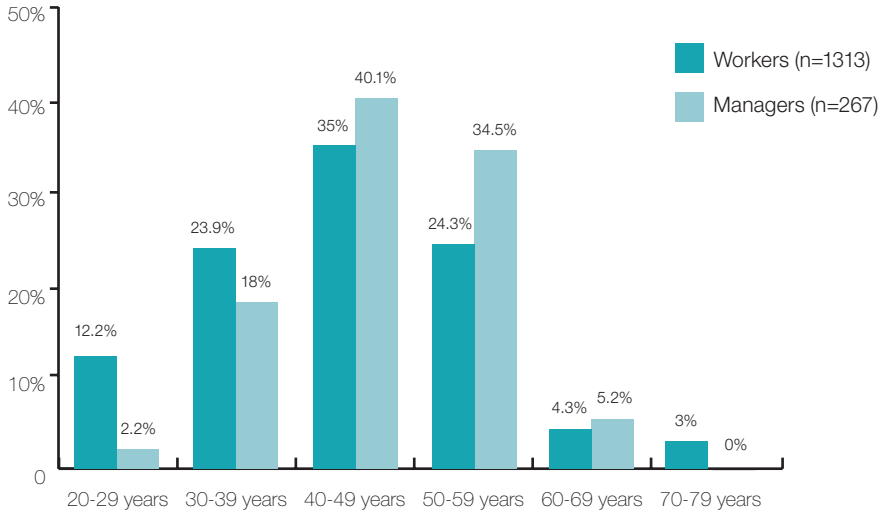

Figure 8: Proportion of frontline AOD workers and agency managers by age group (2005)

The majority of frontline workers (71%) were either AOD generalist workers (n=517) or nurses (n=419) (Figure 9). Most generalist AOD workers (e.g., welfare workers, support workers, and youth workers) did not have any specific professional qualifications. Nearly 80% of nurses were female. The majority of psychologists (74%), social workers (71%), and counsellors (68%) were female. In contrast, the majority of doctors (64%) were male.
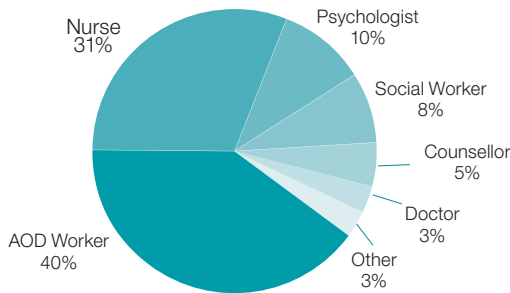

Figure 9: Proportions of frontline AOD workers by occupation (2005)

While the occupational background of agency managers was similar to that of frontline workers, the largest proportion of managers had a nursing background (Figure 10).
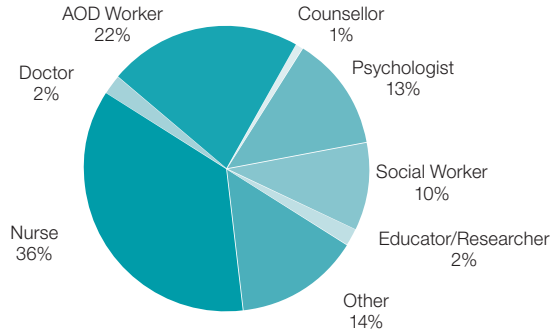
Figure 10: Proportions of AOD agency managers by occupation (2005)

For frontline workers, the median[27] length of service in the AOD field was 5 years (range <1-40 years). The median length of service in frontline workers' current organisation was 3.5 years (range <1-40 years). More than half (56%) had been working in the AOD field for 5 years or less, and nearly three-quarters (73%) had been working in their current organisation for the same amount of time that they had been in the AOD field (Figure 11).

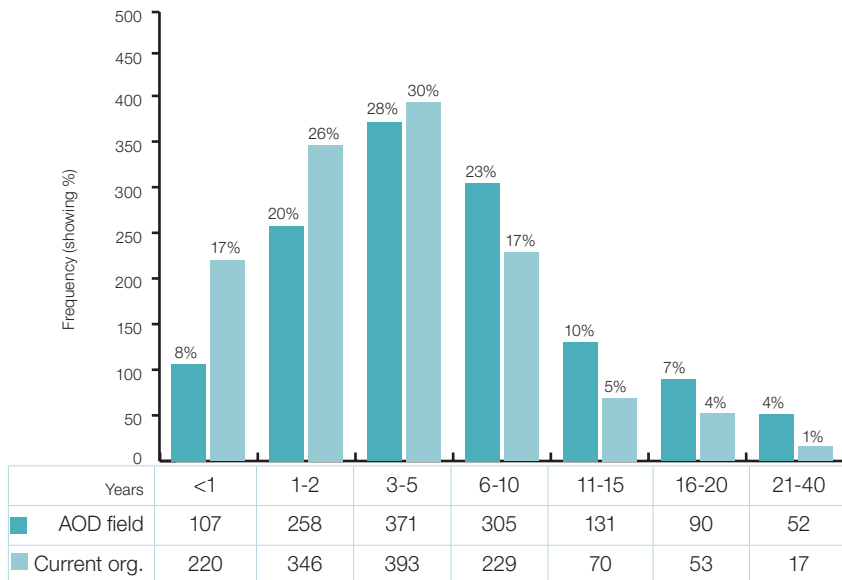| Years	<1	1-2	3-5	6-10	11-15	16-20	21-40
AOD field	107	258	371	305	131	90	52
Current org.	220	346	393	229	70	53	17

Figure 11: Proportion of frontline AOD workers by length of service in the AOD field and current work organisation (2005)

27. Due to wide variability in scores, the median was used as the most appropriate measure of central tendency for length of service.

For agency managers, the median length of service in their current organisation was 5.5 years (range <1- 44 years), while the median length of service in the AOD field was 9 years (range <1-35 years). On average,[28] respondents had 4 years of experience as an AOD manager (range <1-35 years) (Figure 12).

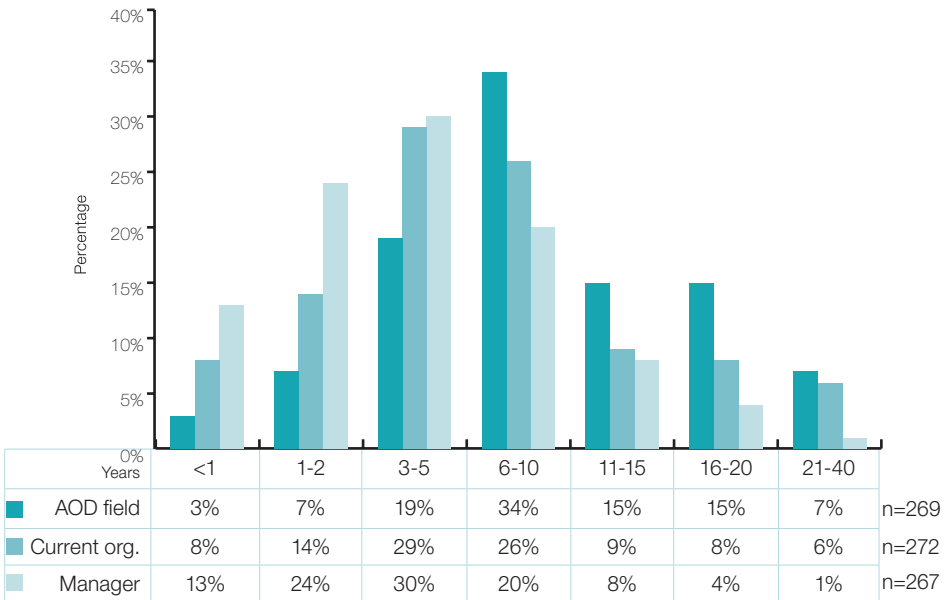| Years	<1	1-2	3-5	6-10	11-15	16-20	21-40	
AOD field	3%	7%	19%	34%	15%	15%	7%	n=269
Current org.	8%	14%	29%	26%	9%	8%	6%	n=272
Manager	13%	24%	30%	20%	8%	4%	1%	n=267

Figure 12: Proportion of AOD agency managers by length of service in the AOD field, current work organisation, and as an agency manager (2005)

Nearly two-thirds of frontline workers (65%) and more than three-quarters (77%) of agency managers held undergraduate or post graduate qualifications (Figure 13).
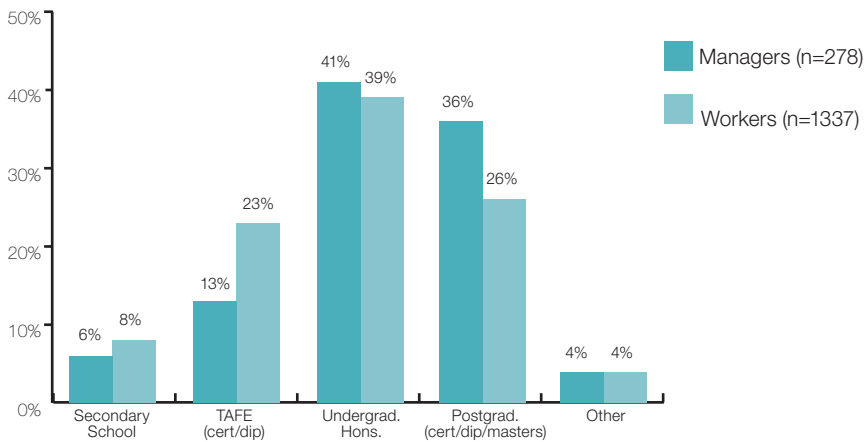
Figure 13: Highest general education level of frontline workers and agency managers (2005)

28. The median is reported as average length of service.

The types of AOD-related training courses that were most frequently undertaken by managers and frontline workers were non-accredited (including in-service training) and accredited short courses. In terms of the highest AOD-related qualification attained, a third of managers (n=92) had obtained a university qualification and 47% (n=639) of frontline workers had completed a TAFE or university qualification (Figure 14).
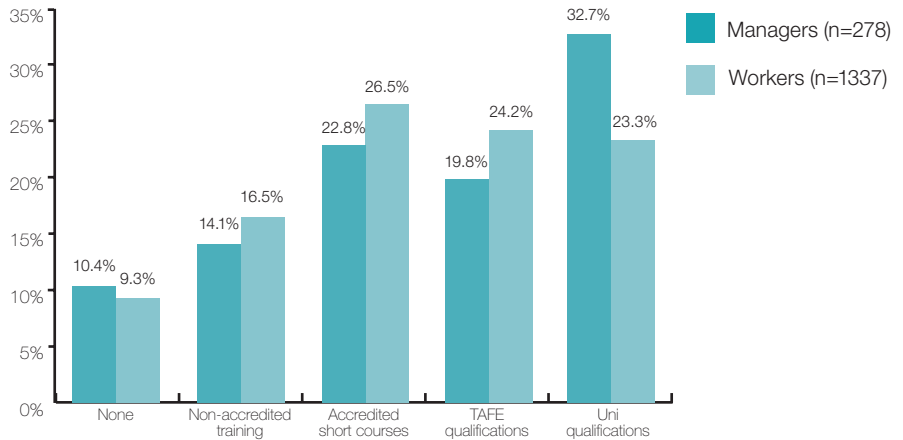

Figure 14: Proportions of frontline AOD workers and agency managers by highest AOD-specific qualifications (2005)

Differences between government and non-government AOD workforces

Similar to the 2002 NCETA survey (Wolinski et al., 2003), the 2005 NCETA surveys (Duraisingam et al., 2006; 2007) also indicated that government and non-government sector managers were evenly split between metropolitan and non-metropolitan areas. The majority of AOD managers (72%; n=13) and workers (74%; n=64) from private treatment services were located in urban areas, with less than a fifth of the private AOD workforce situated in regional and rural areas (Figure 15).
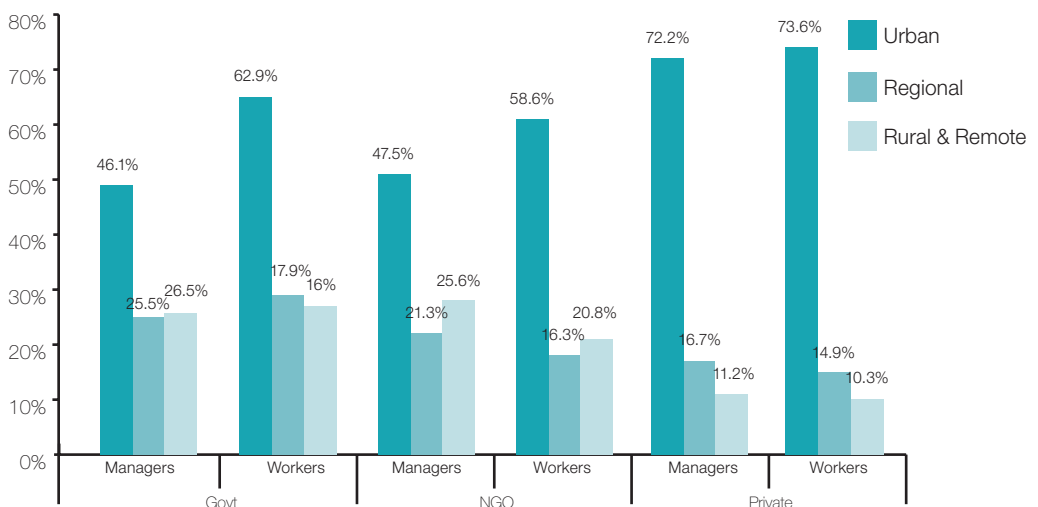

Figure 15: Distribution of government and non-government AOD specialist treatment agencies across urban, regional, and rural or remote locations (2005)

In addition, the proportion of frontline workers in each occupational category varied across organisational sectors, particularly between government and non-government agencies (Figure 16). For government services, nurses were the most common occupational category comprising 47% of the government services workforce.

For non-government agencies, the majority of workers were generalist AOD workers (62%). Compared to government and private agencies, a much smaller proportion of nurses worked in non-government agencies. Similarly, less than 0.5% of doctors (n=2) worked in non-government agencies. The proportion of social workers and counsellors/therapists working in non-government agencies was slightly larger than the proportion working in government and private agencies.
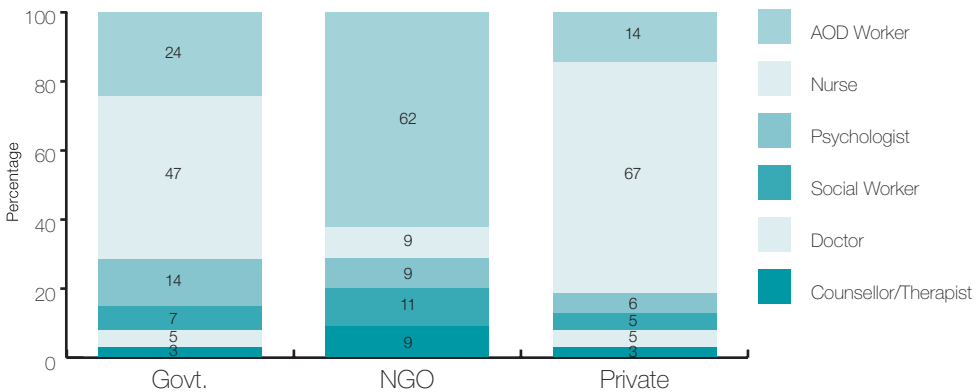
Figure 16: Proportions of the AOD workforce by occupation and sector (2005)

Other differences identified in the 2005 NCETA survey included a longer mean length of service for government (5.6 years) and private workers (5.8 years) compared to non-government workers (4.0 years) and higher proportions of non-government workers had undertaken AOD-specific training compared to government and non-government workers. A larger proportion of generic AOD workers (61%) were employed in non-government, compared to government (24%) and private (14%) organisations, while a larger proportion of nurses (47%) were employed in government and private (67%), compared to non-government (9%) organisations (Duraisingam et al., 2006).

CHAPTER 8: AOD SPECIALIST WORKERS (JURISDICTIONAL SURVEYS)

While much of what is known about the national AOD workforce comes from NCETA surveys, several workforce profile surveys have also been conducted on a jurisdictional basis (ACT Alcohol and Other Drug Sector Project, 2009; Connolly, 2008; Gethin, 2008; McDonald, 2006; Northern Territory Department of Health and Community Services, 2005; Tovell et al., 2009). Although limited in number and scope, these surveys identify jurisdictional differences in workforce profiles that have potential workforce development implications. Details are presented below.

The following section provides details of the AOD workforces derived from specific state-based surveys undertaken in:

1. ACT
2. New South Wales
3. Victoria
4. South Australia
5. Northern Territory
6. Western Australia.

While these surveys provide unique data concerning jurisdictional workforces, cross jurisdictional comparisons are made difficult by different survey methods, tools and questions. There is no consistency in the types of questions asked or issues addressed. As a result, it is difficult to get a precise picture of the AOD workforce from available data sources. Caution needs to be applied when generalising from these findings due to their different sampling frames and methodologies.

Australian Capital Territory

In 2006, a survey of 134 workers employed in AOD specialist treatment agencies was conducted in the ACT (McDonald, 2006). The majority of workers surveyed (82%) were employed in non-government organisations. Nearly two-thirds (65.5%) were female and 35.6% were aged 40-49 years. Over half (59.1%) were aged 40 years or over.

The majority (79.5%) of those surveyed reported that they were permanent employees and 75% were in full-time employment. Nearly half those surveyed (44%) were generic AOD workers, 29% were employed in management or administration roles, 7.8% were nurses, 7.2% were social workers and 3.6% were psychologists.

The number of years spent working in the AOD field ranged from 1 to 25 years. The median number of years was 5.

Nearly a half (43%) held undergraduate or post graduate qualifications, while 18% held no formal qualifications (Figure 17).
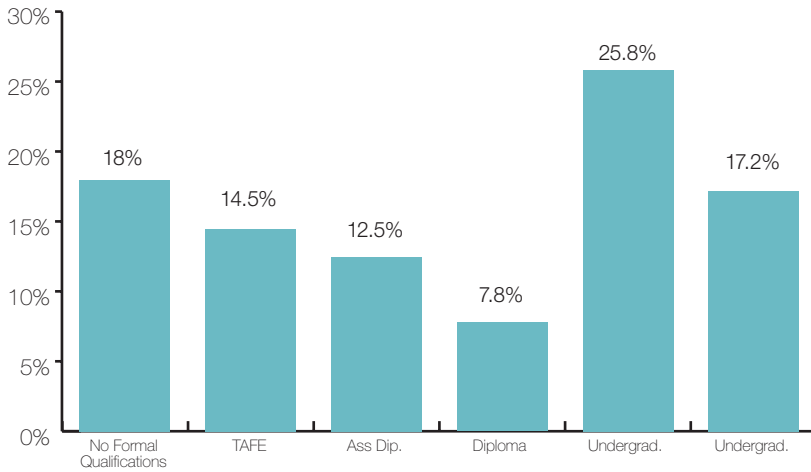
Figure 17: Education/qualification level of ACT AOD specialist workers (2006)

A substantial proportion of the ACT workforce (28.6%) held no formal AOD-specific qualifications, more than a third (36.5%) held certificate level or higher AOD-specific qualifications, and just under a third (29.4%) had only undertaken non-accredited or accredited short courses (Figure 18).
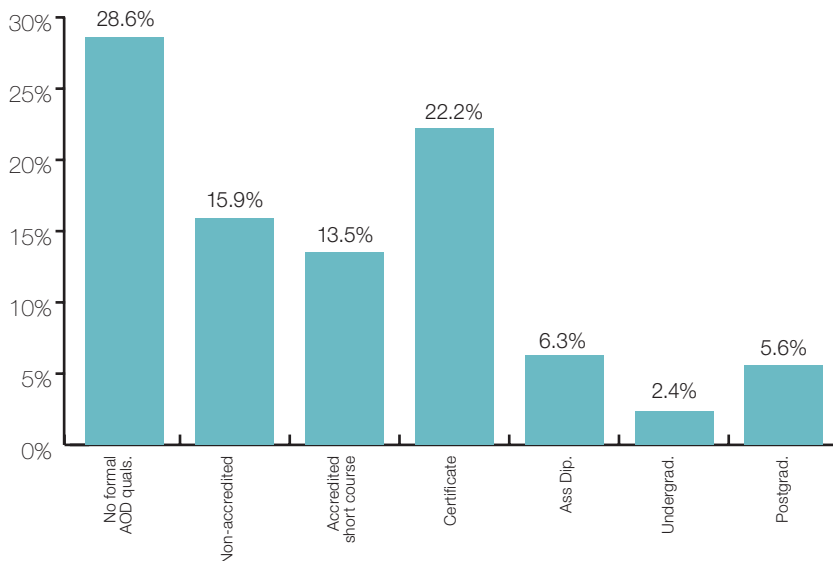
Figure 18: Highest level of AOD-specific qualification held by ACT workers (2006)

A more recent survey of the ACT workforce conducted in 2009 indicated that while the demographic profile of the workforce had changed little in three years, a slightly larger proportion of workers held AOD specific qualifications and some working conditions had changed (ACT Alcohol and Other Drug Sector Project, 2009). Of the 132 AOD workers who responded to the 2009 survey, 78% worked in the NGO sector, 69% were female, the average age was 41 years and the median length of service in the AOD field was 5.7

years. Over half (52%) were AOD workers, 9% were nurses, 2% were psychologists and 29% were employed in management or administration. The number of workers employed full time had reduced to 63%, 14% held no formal qualifications and 26% held no formal AOD qualifications.

The profile of the ACT AOD workforce was similar to the national AOD workforce in terms of gender mix, age, and employment status. However, substantial differences were also apparent. A larger proportion of ACT workers were employed in the non-government sector, a substantially smaller proportion of nurses were employed in the ACT workforce, and a smaller proportion of ACT workers held undergraduate or post graduate qualifications.

New South Wales (NGO Workers)

In 2008 the Network of Alcohol and Drug Agencies (NADA) conducted a member agency survey of 111 workers and approximately 85 agency managers employed in the NSW non-government (NGO) AOD sector (Gethin, 2008). This survey was restricted to NADA member sites of which 77 (72%) were AOD specialist organisations and 30 (28%) were social service organisations with an AOD program or AOD specialist workers.

The majority of NSW workers were female (61%) and 48% of all workers were aged 45 years or older. Nearly half (48%) were generalist AOD workers, 23% were employed in management or administration roles, 8% were nurses, 2% were psychologists, and 1% were social workers. More than one in three (38%) were employed part-time and 37% were employed on a casual basis. Nearly 40% held undergraduate or post-graduate qualifications and 24% held Certificate IV in AOD work (Figure 19). Approximately one third held AOD specific qualifications (Gethin, 2008).
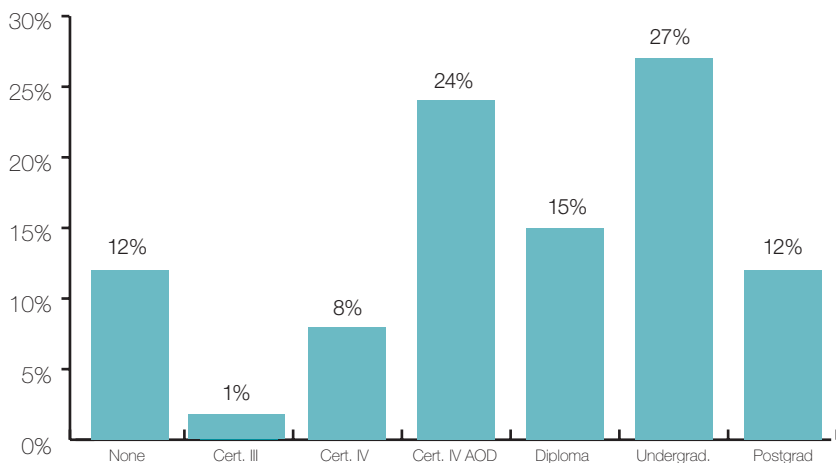
Figure 19: Qualification/education level of the NSW non-government AOD workforce (2008)

In general, the profile of the NSW NGO AOD workforce is similar to that of the national NGO AOD workforce. However, there are some differences. Fewer psychologists and social workers appear to work in NSW NGOs, and a substantially smaller proportion of NSW NGO workers held undergraduate or postgraduate qualifications compared to national data. Due to differences in measures used in the NCETA and other jurisdictional surveys (Duraisingam et al., 2006; Wolinski et al., 2003) compared to the NADA survey (Gethin, 2008) it is difficult

to compare levels of AOD-specific qualifications. The NADA survey provided no details regarding length of service.

Victoria

In 2002, the Victorian Department of Human Services obtained data from 745 government funded AOD workers which were used to provide a profile of the Victorian AOD specialist workforce (Victorian Government Department of Human Services, 2005). These data indicate that 68% of the workforce was female and the largest proportion of workers (32%) was aged 41-50 years (48% were aged more than 40 years) and 60% were employed full-time. Nearly half (42%) were generic AOD workers (alcohol and drug counsellors = 24%, alcohol and drug worker = 9%, alcohol and drug clinician = 9%) and 16% were nurses. An undergraduate degree was held by 44% of the workforce (Figure 20), however, around 16% held no qualifications relevant to AOD work.

The largest proportion of Victorian workers (34%) had worked in the AOD field for 2-5 years. Twenty one percent had worked in the AOD field for 5-10 years, 14% for more than 10 years, while 14% had worked in the AOD field for 1-2 years and 17% for less than one year. The largest proportion (35%) had worked in their current organisation for 2-5 years, 13% for 5-10 years and 3% for more than 10 years. Twenty three percent had worked in their current organisation for 1-2 years, while 27% had worked in their organisation for less than 1 year. Approximately 8% of the workforce held formal AOD specific qualifications
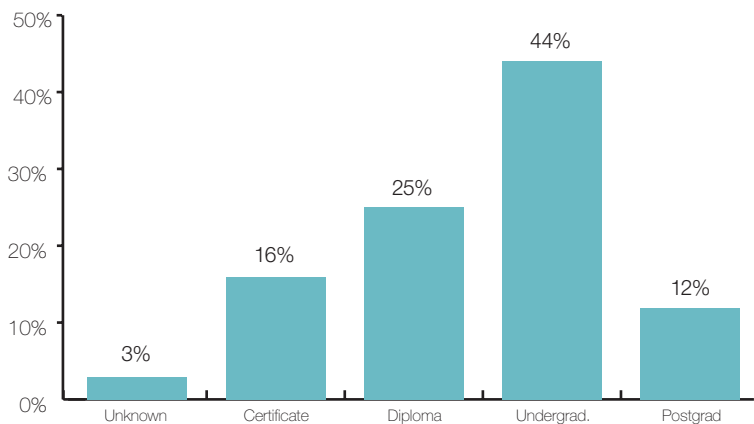
Figure 20: Qualifications held by the Victorian AOD specialist workforce (2002)

A more recent survey of 492 Victorian AOD workers conducted in 2008 indicated the workforce had aged substantially in the six years since the 2002 survey (Connolly, 2008). In 2002, 48% of respondents indicated they were over the age of 40 years, compared to 59% in 2008. In 2008, 65% of the workforce were female, 44% were AOD workers, while the proportion of nurses had dropped to just under 8%. Nearly two thirds (61.4%) were employed full time and the largest proportion of workers (36%) had worked in the AOD field for 5-10 years. In addition 62% held undergraduate or post-graduate qualifications, while the proportion of workers with AOD qualifications at the certificate IV or diploma level had grown to 56%.

Much of the Victorian data are limited to AOD specialist workers funded by the Victorian

Department of Human Services. As such, it is difficult to determine the proportion of the workforce that are employed by government and non-government agencies (in Victoria this distinction is not as clear as it is in other states).

South Australia (NGO Workers)

In 2007, NCETA conducted a survey of 44 South Australian NGOs with AOD programs, of which 18 organisations were AOD-specific (Tovell et al., 2009). Of the 167 workers surveyed, 59% were 40 or more years old and 67% were female. Just over half (58%) were employed full time and 63% considered themselves to be in permanent employment. Nearly one in three (31%) were generalist AOD workers, 14.5% were managers, 14% were social workers, 5.7% were administrators, 1.3% were nurses. More than half of those surveyed (59%) were engaged in a direct client service (51%) or clinical (8%) role. Of those undertaking a clinical or direct client service role, only a minority (35%) received clinical supervision.

Mean length of service in the AOD field was six years and mean length of service with their current work organisation was 3.6 years. More than half (55%) the non-government workforce held undergraduate or post graduate qualifications (Figure 21).
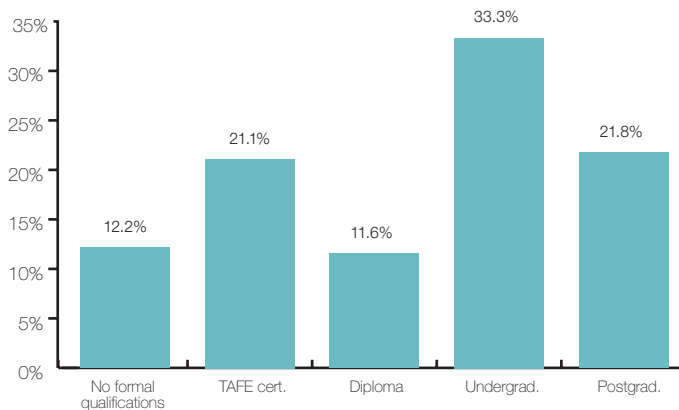

Figure 21: Highest education level of the South Australian non-government specialist AOD workforce (2007)

The most common form of AOD-specific training or education undertaken by those surveyed was non-accredited or accredited short courses (Figure 22).
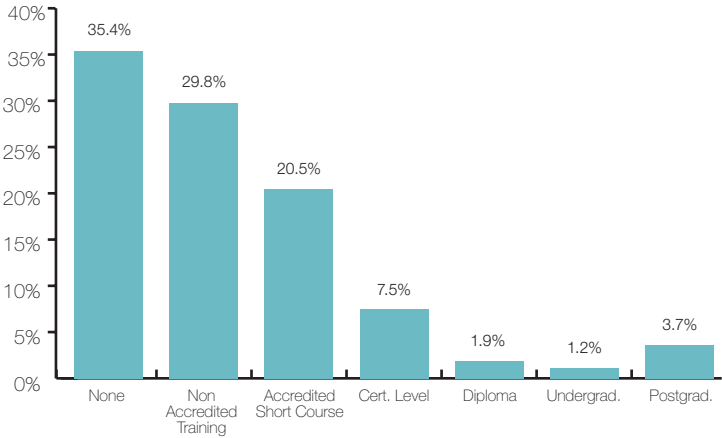

Figure 22: AOD-specific training or education undertaken by SA non-government AOD specialist workers (2007)

Consistent with national and jurisdictional data, the majority of the SA non-government AOD workforce held undergraduate or post graduate qualifications. However, a much smaller proportion had AOD-specific undergraduate or postgraduate qualifications.

Northern Territory

In 2005, the Northern Territory Alcohol and other Drugs Program conducted a review of AOD treatment services and interventions (Northern Territory Department of Health and Community Services, 2005). While the focus of this review was on the delivery of treatment services and the extent of treatment demand, some details on the NT AOD workforce were also collected. A total of 40 agencies were surveyed of whom 18 (45%) responded. These agencies employed a total of 136 workers of whom 20 were employed in an administrative role, 62 were employed in a clinical role, and 54 were employed in other (AOD support worker) roles. Of those employed in a clinical role, 17 (27%) held no tertiary qualifications and of those employed in AOD support worker roles, 49 (90%) held no tertiary qualifications. However, of the 17 clinicians with no tertiary qualifications, 13 (77%) had completed Certificate IV in AOD work as had 32 of the clinicians who held a tertiary qualification. A larger proportion of clinicians employed in government agencies (95%) held tertiary qualifications compared to clinicians employed in non-government agencies (61%).

Due to the limited nature of the data concerning the NT AOD workforce few comparisons can be made with national or other jurisdictional surveys.

Western Australia

A survey of AOD workers was conducted in 2007 as part of the 2007 NGO Sector Remuneration Survey (WAAMH et al., 2008). The AOD component of the survey comprised 207 AOD workers from 35 NGO services. The 207 AOD workers represented 40% of the total survey population of 521. No data were collected on AOD government workers.

Because the AOD workforce were embedded within a survey of a larger pool of workers it is difficult to distinguish between the AOD workers and the survey sample characteristics overall. Nonetheless, in general the survey found:

- only 4% earned above the average weekly earnings of all workers
- 44.7% held undergraduate or post graduate qualifications
- 35% expected to leave the sector within two years
- 123 NGO workers had resigned due to stress
- 253 had left the sector for better pay or conditions
- nearly half the managers surveyed experienced recruitment difficulties.

CHAPTER 9: THE MAINSTREAM GENERALIST WORKFORCE (NCETA NATIONAL SURVEY 2003)

The AOD workforce also consists of mainstream workers whose primary work role is not AOD-specific but which nonetheless involves AOD-related issues. Typically, these workers are employed in health and human service organisations and include similar occupations as those employed in the AOD specialist workforce. Examples of mainstream AOD workers include:

- Police
- Ambulance officers
- Community health workers
- Occupational health & safety professionals
- Teachers
- Correctional services workers
- Social workers
- Pharmacists
- Paramedics
- Nurses
- Medical practitioners
- Psychologists
- Mental health workers
- Youth workers

To-date, data concerning the mainstream workforce has been extremely limited. In practice there is not always a clear divide in the workplace between the roles of specialist and mainstream workers. Both specialist and mainstream workers may provide tailored services to specific client groups such as young people, Indigenous Australians, migrants and women. Little is known regarding the size of this workforce or the extent of their AOD work roles. However, a 2003 NCETA survey (Freeman et al., 2004) provides some insight into the profile of and workforce development issues facing mainstream workers who respond to AOD issues. Details from this study are outlined below.

The 2003 survey comprised 948[29] frontline mainstream workers from a wide range of occupational groups who spent at least some of their work time responding to AOD-related issues. The sample included:

- AOD specialists (N = 218)
- nurses (N = 241)

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29. The full data set included 1,024 frontline workers. The balance comprised frontline workers who were members of occupational groups that were not adequately represented in the survey.

- 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 inclusion of AOD specialists in the survey sample provided a unique opportunity to compare AOD specialists with mainstream generic workers.

Sixty three percent of the sample was female, and the average age was 39.9 years (range: 19-74 years). Fifty seven percent (533) worked in large urban areas (i.e., locations with a population of greater than 100,000).

Time Spent Responding to AOD Issues

The percentage of time spent responding to AOD issues was significantly different across occupational groups (Table 13). As expected, AOD specialists reported the greatest amount of time with 70% of workers spending 81-100% of their time responding to AOD issues. Approximately 40% of nurses, mental health professionals, youth workers, community development workers and social workers also indicated that 80-100% of their time was spent responding to AOD issues. Emergency and first aid workers, pharmacists and teachers reported the least time spent responding to AOD issues.

Table 13: Time responding to AOD issues by occupation (number and percentage of workers)

| Occupation | Percentage of time spent responding | | | | | | | | | |
| | 1-20% | | 21-40% | | 41-60% | | 61-80% | | 81-100% | |
	n	%	n	%	n	%	n	%	n	%
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	0%	2	8%
Pharmacists	23	82%	2	7%	0	0%	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	0%	1	2%	1	2%
Police	43	44%	22	23%	12	13%	12	13%	7	7%

Main AOD Roles

Mainstream frontline AOD workers can assume a wide range of roles in responding to AOD issues. The main roles nominated by occupational groups are summarised in Table 14.

Overall, the main roles in responding to AOD issues were consistent with the types of activities identified as common to each occupational group. For example, counselling and referral were identified as primary roles for mental health professionals, social workers, youth workers and AOD specialists. However, some occupational groups nominated roles that might traditionally lie outside their job descriptions. For example, pharmacists and teachers reported counselling as one of their main AOD roles.

Nine of the eleven occupational groups indicated referral or counselling to be their most frequently nominated AOD-related activity. Across all occupational groups, workers were more likely to nominate reactive (i.e. responding to an existing problem) rather than proactive roles (i.e. acting to prevent potential future harm), reflected in the higher ratings for roles such as assessment /intake/triage and crisis management, and lower ratings for roles such as prevention /health promotion/harm minimisation and detection, screening and motivational interviewing.

Table 14: Summary of main AOD roles by occupational group

AOD Role	AOD	Nurses	Medical	Emergency	Pharmacy	MH	YW	CD	SW	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/motivational 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 promotion	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 = AOD specialists, MH = Mental health workers, YW = Youth workers, CD = Community development workers, SW = Social workers. A dash (-) indicates that less than 5% of the occupational group nominated this role as a main role.

AOD Training and Education Levels Among Mainstream Workers

The proportion of mainstream workers who had completed some form of AOD-related education varied between occupational groups (Table 15). The most common form of AOD-related education undertaken was non-accredited and accredited short courses. Tertiary AOD-related study was less common, although a substantial proportion of AOD specialists, youth workers and social workers reported completion of AOD-related tertiary study at either TAFE or university.

Mental health professionals and medical staff were most likely to have completed AOD-related education, reporting the completion of AOD-related education more often than AOD specialists, nurses and other occupational groups. Pharmacists were the least likely to have completed AOD-related education.

Table 15: AOD-related education and training levels of mainstream workers by occupational group

Occupation	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 workers	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'

Role Adequacy and Role Legitimacy

Two important issues for mainstream workers who respond to AOD issues are role adequacy and role legitimacy. Role adequacy concerns a worker's confidence and perceptions of ability to respond to AOD issues (Shaw et al., 1978). Individuals with high role adequacy perceive themselves as capable of responding to AOD issues in the course of their work. Role legitimacy refers to the perceived appropriateness of responding to AOD issues (Shaw et al., 1978). Individuals with high role legitimacy believe that responding to AOD issues is a valid and appropriate part of their work and they have a right to do so.

Table 16: Mainstream workers' mean levels of role adequacy by occupational group

Occupation	Mean (SD)	95% Confidence Interval
AOD specialists	3.62 (.48)	3.55 – 3.68
Nurses	3.21 (.70)	3.11 – 3.30
Medical staff	3.53 (.38)	3.42 – 3.64
Emergency and first aid	3.54 (.40)	3.37 – 3.72
Pharmacy	2.52 (.75)	2.23 – 2.82
Mental health workers	3.50 (.55)	3.39 – 3.60
Youth workers	3.16 (.61)	2.95 – 3.37
Community development	3.15 (.67)	2.95 – 3.36
Social workers	3.24 (.66)	3.07 – 3.41
Teachers	2.77 (.52)	2.61 – 2.92
Police	3.30 (.51)	3.19 – 3.40

Role legitimacy among mainstream workers appears similar to that of role adequacy (Table 17). AOD specialists, medical staff and mental health professionals reported high role legitimacy, whereas pharmacists, teachers and community development workers indicated relatively low levels of role legitimacy. Police, youth workers, social workers, emergency and first aid workers and nurses reported higher role legitimacy than pharmacists, teachers and community developments workers, but lower role legitimacy than AOD specialists and medical staff.

Table 17: Mainstream workers' mean levels of role legitimacy by occupational group

Occupation	Mean (SD)	95% Confidence Interval
AOD specialists	3.67 (.41)	3.62 – 3.73
Nurses	3.46 (.51)	3.39 – 3.53
Medical staff	3.77 (.27)	3.69 – 3.85
Emergency and first aid	3.46 (.50)	3.25 – 3.68
Pharmacy	2.95 (.65)	2.69 – 3.20
Mental health workers	3.53 (.42)	3.45 – 3.61
Youth workers	3.44 (.43)	3.28 – 3.59
Community development	3.19 (.52)	3.03 – 3.34
Social workers	3.44 (.53)	3.30 – 3.58
Teachers	3.15 (.44)	3.02 – 3.28
Police	3.37 (.48)	3.27 – 3.47

Informal Support, Formal Support and Organisational Role Legitimacy

Other important factors that can influence the degree to which mainstream workers respond to AOD issues concerns the extent of formal and informal support and organisational role legitimacy evident in their workplaces. Informal support refers to the extent to which advice, encouragement and guidance in responding to AOD issues is available from colleagues and peers. Formal support concerns the availability of guidance and encouragement for responding to AOD issues provided in the form of formal supervision and organisational policies and procedures. Organisational role legitimacy refers to the degree to which responding to AOD issues is perceived to be a legitimate and appropriate role for the work organisation as a whole.

Apart from AOD specialists, youth workers, mental health workers and medical staff reported the highest levels of informal support, whereas emergency and first aid workers, pharmacists and police reported lower levels of informal support (Table 18).

Table 18: Mainstream workers' mean levels of informal support by occupational group

Occupation	Mean (SD)	95% Confidence Interval
AOD specialists	3.29 (.63)	3.20 – 3.37
Nurses	3.01 (.70)	2.92 – 3.10
Medical staff	3.15 (.65)	2.96 – 3.34
Emergency and first aid	2.36 (.64)	2.08 – 2.63
Pharmacy	2.50 (.76)	2.19 – 2.80
Mental health workers	3.18 (.68)	3.05 – 3.32
Youth workers	3.24 (.54)	3.05 – 3.42
Community development	3.00 (.74)	2.78 – 3.23
Social workers	3.09 (.73)	2.90 – 3.28
Teachers	2.97 (.50)	2.81 – 3.12
Police	2.60 (.65)	2.47 – 2.73

Apart from AOD specialists, youth workers and mental health workers reported the highest levels of formal support in responding to AOD issues, whereas emergency and first aid workers reported the lowest levels of formal support (Table 19).

Table 19: Mainstream workers' mean levels of formal support by occupational group

Occupation	Mean (SD)	95% Confidence Interval
AOD specialists	3.28 (.63)	3.19 – 3.36
Nurses	2.93 (.72)	2.83 – 3.02
Medical staff	2.84 (.72)	2.63 – 3.05
Emergency and first aid	2.16 (.73)	1.84 – 2.47
Pharmacy	2.49 (.72)	2.21 – 2.78
Mental health workers	3.06 (.75)	2.92 – 3.21
Youth workers	3.14 (.65)	2.91 – 3.37
Community development	2.90 (.78)	2.67 – 3.13
Social workers	2.79 (.77)	2.59 – 3.00
Teachers	2.76 (.50)	2.60 – 2.91
Police	2.66 (.64)	2.53 – 2.79

Apart from AOD specialists, youth workers, medical staff, community development workers, and mental health workers reported the highest levels of organisational role legitimacy, while emergency and first aid workers and pharmacists reported the lowest levels (Table 20).

Table 20: Mainstream workers' mean levels of organisational role legitimacy by occupational group

Occupation	Mean (SD)	95% Confidence Interval
AOD specialists	3.54 (.50)	3.47 – 3.61
Nurses	3.15 (.65)	3.06 – 3.23
Medical staff	3.22 (.67)	3.02 – 3.41
Emergency and first aid	2.59 (.78)	2.25 – 2.93
Pharmacy	2.74 (.74)	2.44 – 3.03
Mental health workers	3.23 (.73)	3.08 – 3.37
Youth workers	3.32 (.73)	3.07 – 3.58
Community development	3.27 (.68)	3.07 – 3.48
Social workers	3.11 (.70)	2.93 – 3.30
Teachers	3.07 (.54)	2.91 – 3.23
Police	3.04 (.52)	2.93 – 3.14

CHAPTER 10: METHADONE (AND OTHER PHARMACOTHERAPY) PRESCRIBERS[30]

Another important AOD-related workforce are medical practitioners. Although medical practitioners potentially have a wide range of roles to play in relation to AOD issues, one of the most important is the prescribing of pharmacotherapies. This section of the report examines available data on medical practitioners (usually GPs) who prescribe methadone or other pharmacotherapies. As the use of pharmacotherapies has become more prominent over the past decade, the role of medical practitioners has increased correspondingly. To examine the current and projected availability of GP prescribers, NCETA undertook a study specifically to examine this issue .

The three central aims of this project were to establish:

        a.   the extent of GP training in relation to opioid pharmacotherapies,

        b.   the extent of prescribing practice after training, and

        c.   the degree to which the GP prescriber workforce is sufficient to service the client population.

Data were examined from four states: New South Wales, Queensland, Victoria and South Australia. A significant lack of detailed, systematic and precise information to address these issues was found.

Training

Quantifying the outcomes of training in the four selected states proved to be difficult. In the two most populous states, New South Wales and Victoria, the relevant training consortia had changed in recent years and longer-term records were inaccessible. In South Australia and Queensland, records are only kept for periods ranging from three to five years. High attrition rates between GP training and subsequent prescribing were evident in South Australia and Queensland, but less so in Victoria.

Significant variation was observed across states in the style and delivery of training (e.g., use of clinical placements). There is a clear need for a comprehensive evidence base concerning the most effective style and delivery of training to maximise prescribing uptake and quality service provision (e.g., rapport with clients, relationship with dispensing pharmacist). Similarly, client quota systems differ significantly across states. The impact on the quality of service delivery, and the retention of GPs in prescribing programs, is not known. Anecdotal evidence, however, suggests that large client loads are associated with increased GP stress and dissatisfaction which in turn may lead to a withdrawal from provision of prescription services.

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30. This chapter is based on a study by Hotham, Roche, Skinner & Dollman (2005). The general practitioner pharmacotherapy prescribing workforce: examining sustainability from a systems perspective. Drug & Alcohol Review, 24(5), 393-400.

Table 21: GP methadone (pharmacotherapy) training in South Australia 1999-2001

	Number commencing theory training	Number (%) completing theory training	Number prescribing (after authorisation following clinical placement)	Proportion of trainees prescribing
1999	45	22[1] (49%)	12	27%
2000	26	15[1] (58%)	8	31%
2001	15	15 (100%)	6 + 1[2]	40% (47%[3])

[1] Incomplete data
[2] Willing to prescribe but no clients as yet
[3] Includes prescriber willing to prescribe as noted (2)

Table 22: GP methadone (pharmacotherapy) training in Queensland 1999-2001

	Number completing theory training	Number prescribing (after authorisation following clinical placement)	Percentage of trainees prescribing
1999	26	21	81%
2000	17	7	41% (53%[1])
2001	20	7	35%

[1]Includes 2 GPs working as methadone prescribers in government facilities

Table 23: GP methadone (pharmacotherapy) training in Victoria 1999-2001

	Number completing theory training(no clinical placement)	Number prescribing (after authorisation)	Proportion of trainees prescribing after completion of theory training
1999	Not available	Not available	Not available
2000	38	27	71%
2001	82	58	71%

For NSW and Victoria, changes in the organisations responsible for the provision of training have made training records inaccessible for the years 1999-2001 on a state-wide basis.

Mapping the GP Prescriber Workforce

Details of the prescribing activity of general practitioners related to methadone and other pharmacotherapies were sought from state health departments in Queensland, Victoria, New South Wales and South Australia.

Limitations in the available data prevented a detailed assessment of the current GP prescriber workforce. The limited data available indicated significant shortfalls in the number of prescribers available in each state to service opioid pharmacotherapy clients (state variations in private versus public service provision notwithstanding). It was consistently observed across states that a relatively small number of prescribers were providing services for the majority of opioid pharmacotherapy clients.

Very little demographic data was available on the current GP prescriber workforce. Data from South Australia illustrate the value of this type of information, where the GP prescriber workforce is characterised by a preponderance of male prescribers aged 45 years or older. This data indicates that workforce development strategies focused on the recruitment (and retention) of a younger cohort of GP prescribers, and female prescribers, is essential for the long term sustainability of effective and accessible methadone programs in South Australia.

In the absence of comparable demographic data in other states, it is unclear whether this pattern, with its implications for retention and recruitment, also occurs in other jurisdictions. The capacity to distinguish between active and inactive registered prescribers also has major implications for the development of effective workforce development and planning strategies. In South Australia and New South Wales one third of registered prescribers were not providing prescription services. These data suggest that a key strategy to address the shortfall of prescribers in these states would be to address barriers to service provision experienced by inactive prescribers, rather than focus exclusively on the recruitment of new prescribers. In the absence of relevant data, the extent to which this strategy is also appropriate for other jurisdictions cannot be established.

Three main factors impeded access to data:

1. different documentation and data collection procedures across jurisdictions

2. failure to retain past records beyond one or two years, and

3. responsibility for data collection shared between organisations across time (i.e. the organisation responsible for data collection changes over a number of years) and issues (e.g., one organisation collects data on training and another collects data on prescribing). The findings from this study clearly indicate the need for a centralised data collection system to be developed in each jurisdiction. In order to facilitate continuity and standardisation of data collection this role would be best filled by state departments of health.

The following list provides examples of the types of information required for effective workforce development and planning initiatives, and for accurate comparison of GPs' opioid pharmacotherapy prescribing between states:

- Number of GP prescribers (total, and proportion of entire GP workforce)

- Number of GPs undergoing prescriber training (total, and proportion of entire GP workforce)

- Proportion of GPs undertaking prescribing following training

- Number of clients per GP prescriber

- Number of prescribers per client load category

- Type of opioid pharmacotherapy prescribed (e.g., methadone, buprenorphine)

- Demographics of GP trainees and prescribers (e.g., age, gender, years qualified, years authorised as prescriber, location of practice)

- Number of active versus inactive authorised GP prescribers.

The following recommendations are designed to enhance provision of methadone and other pharmacotherapies to opioid dependent people.

RECOMMENDATIONS

1. There is a pressing need for the establishment of ongoing accurate quantification of the demand for, and suspected shortfalls in, pharmacotherapy provision in each jurisdiction.

2. Given the substantial investment made in training general practitioners to prescribe pharmacotherapies, it is important that the outcome of training be fully evaluated. Each jurisdiction should implement appropriate and comprehensive training records to enable outcomes to be accurately assessed. A formal notification process should be established between the state regulatory authority and the training organisation.

3. Prescribing data related to pharmacotherapies is collated differently in the various jurisdictions, making evaluation of prescribing patterns across Australia difficult. Jurisdictional personnel should be encouraged to liaise on the development of consistent methods of data collection. Such data would allow valuable interstate comparisons to be undertaken.

4. Of the four states reviewed, consistent information at the time of data collection about GP prescribing of opioid pharmacotherapies was not available in either New South Wales or Victoria. In those states, medical practitioner registration records do not indicate whether or not the practitioner is in general practice. Given that the majority of Australia's heroin use occurs in these two states, establishing accurate information regarding GP involvement in treatment is a high priority.

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