

International Symposium on Continuing Education In the Dependence Field

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Country report: Australia

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A skilled workforce is critical to the implementation of effective alcohol and other drug (AOD) strategies and interventions to reduce drug related harm. Traditionally, the approach taken to achieving a skilled workforce has pivoted around the provision of education and training. Such training is provided at a pre-service or in-service level and in a variety of different delivery modes pitched at highly variable levels of expertise.

While education and training is an important part of developing any given workforce, it is insufficient of itself and a wider array of WFD strategies are needed for an optimal result. The need for a broader workforce development model is addressed later in this report.

Aspects Questions

Section 1. System / structure

1.1 Is there systematic provision of continuing training in the substance-dependence field? If so, what does the system consist of (players, providers, offerings) and what are its interrelationships and limits (interfaces)?

In Australia, as in many other countries, there is no systematic approach to continuing training in the substance-dependence field. There is however a reasonable degree of consistency across all eight states and territories in terms of the options available for continuing training in substance-dependence matters.

Most training providers are state based but some training is also provided through national bodies (for example the Royal Australasian College of Physicians provides specialty training for medical practitioners in the alcohol and other drugs (AOD) field). The state based nature of most training makes it difficult to establish and co-ordinate a national training agenda with consistent priorities, content and strategies.

The uptake of any AOD training is largely subject to the personal inclination of the individual; although increasing preference is given to the employment of workers who have undertaken some form of formal AOD training. One exception to this is in relation to medical practitioners who are prescribers of pharmacotherapies (eg methadone, buprenorphine). In the latter case, a medical practitioner must receive training by an approved trainer and be deemed competent to become a pharmacotherapy prescriber and is then authorized to do

so by the State Department of Health. Because the laws relating to pharmacotherapy vary slightly from state to state, each jurisdiction sets up and runs its own training and has its own authorization process. Training to become an approved pharmacotherapy prescriber is offered in both face to face formats and also in distance education modes via electronic delivery.

Generic AOD training courses are offered by universities in all states in Australia. These are mostly at the graduate level and can be undertaken at the level of Graduate Certificate, Diploma or Masters degrees. Most of these courses are offered in distance education modes which allow them to be accessed by workers in rural and remote areas of the country. As Australia is a large country with a small and widely dispersed population this is an important factor. Moreover, epidemiological data indicate higher levels of substance use problems among rural populations (particularly in relation to alcohol).

University courses have increased in number since the early 1990's when accredited courses first commenced. University fees have also increased significantly over the past 5 to 8 years; thus limiting their accessibility by large segments of the AOD workforce. In general, workers in the AOD field do not earn large salaries.

Because of the growing recognition of the importance of evidence-based practice and the need to produce more technically skilled workers, there is greater acceptance on the part of funders and AOD organizations of the importance of continuing education and training and in some instances employers provide scholarships or help to subsidise training.

Greater emphasis has been placed on the training and upskilling of some professional groups compared to others. Two groups who have received considerable attention are nurses and medical practitioners. Australia has established a specific graduate level AOD course for nurses. This can be undertaken as a distance education course and therefore caters for nurses across the country. It has been extremely well received. In addition efforts are directed at including AOD content in the undergraduate training of nurses.

Greater attention is required (at both the undergraduate and postgraduate levels) to professional groups such as psychologists and social workers. They receive comparative little input on AOD matters during the course of their basic training.

Counsellors: there is no nationally approved certification program for generic AOD counsellors in Australia. From time to time this is raised as an issue and there have been suggestions that a unified certification system be introduced (along the lines of that offered in the United States of America for example). However, there has not been wide spread support for this notion.

There are five main deliverers of training:

1. University level
2. Technical and Further Education (TAFE) sector
3. Registered Training Organisations (RTO's)
4. Professional bodies
5. Experts providing occasional and ad hoc non-accredited courses

The training providers attempt to cater for the needs of a very diverse AOD workforce (as indicated below).

The AOD Workforce

The Australian workforce involved in the prevention and minimisation of drug and alcohol problems is highly varied, spanning diverse employment sectors, industries, communities and cultures. There is a mix of specialist and other (non-specialist) workers, employed in a range of levels, contexts and combinations as indicated in the box below.

Roles vary from clinical treatment to policy, education, research and advocacy. Specialists include nurses, doctors, psychologists and social workers with expertise in drug and alcohol work. Many workers, while not drug and alcohol specialists, may be required to deal with drug and alcohol problems in varying situations. They are likely to be involved in 'frontline' activities such as providing brief interventions, initial assessment and referral to specialist help. The provision of AOD training therefore needs to cater for all these groups of workers with their myriad of roles.

Generic health and medicine	nurses, general practitioners, medical specialists, pharmacists, ambulance officers and emergency medicine staff
Mental health workers	mental health workers, counsellors, psychiatrists, psychologists and psychiatric nurses
Human services and community workers	community nurses, case workers, youth workers, family support workers, child care workers, health workers, social workers, community development officers, Aboriginal health workers, migrant workers and accommodation officers
Police, corrections and criminal justice system workers:	judiciary, staff in court diversion, probation and parole, prisons and corrections, police and juvenile justice
Others	teaching and school support, security, hospitality, drug and alcohol regulation and compliance, sport and recreation, occupational health and safety and other therapies.

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1.2 Is the system directed in any way? If so, by whom (government, administration, NGOs, professional associations) and how (national or international coordination, financial support, setting of standards, educational policy goals, recognition and certification of qualifications acquired)?

In general the provision of continuing education in the AOD field is not directed by any national body or set of guidelines. Courses are primarily developed in two ways: The first is through the educators themselves (ie within the university system) who identify the need for new knowledge and training and go about establishing new sets of courses that reflect this. The second is through the professional bodies who determine what skills and competencies in particular areas are required by their workers.

The training provided by the vocational sector, Technical And Further Education (TAFE), usually to those with limited educational achievement and who are not eligible for university entrance, have a national training program of courses that are developed around sets of specified 'competencies'.

Some training is demand driven in that workers in the field are insistent that training be made available in new areas of interest or concern. For example, in recent years there has been pressure to provide training in the area of co-morbidities, or party drugs.

1.3 What is the status of continuing training in the professional substance-dependence field and to what extent does it enhance the professionalism of the field?

The status of training varies considerably and is largely dependent on the training provider. University based courses are held in high regard and are assessed against objective criteria that apply to all university level courses. TAFE courses are not necessarily held in such high regard and this is not necessarily a reflection of their quality or rigour. The status of courses offered by and to specific disciplines is generally well regarded.

Other forms of training, particularly the short courses of one to two days duration, vary from a high standard with exacting scientific requirements through to those which are of doubtful credibility, accuracy and relevance (although the latter are increasingly less common).

The AOD field has been increasingly professionalized over the past one to two decades. The high standard and sophistication of training has in part contributed to this increased professionalism. The field is increasingly served by workers who are well trained in a specific discipline and therefore come to the AOD field as a well qualified graduate. The era of largely unqualified workers who enter the field with little more than a personal experiential background of alcohol or drugs is coming to an end (although there is still a proportion of the AOD workforce in Australia who fit this description).

1.4 Where financial support is provided:

- Is such support oriented entirely or predominantly to the offering or also to demand, e.g. in the form of educational vouchers?**
- Are structures and/or programmes supported?**

Financial support varies greatly across courses, jurisdictions and providers. Some universities have been subsidized by their local state department of health to provide graduate AOD level courses. Similarly, some departments of health also provide scholarships to workers to attend these courses.

There have been growing numbers of scholarships available in recent years for higher level studies eg at the Doctoral level indicating a recognition of the importance of ensuring the ongoing development of skills at this level too.

Nonetheless, the provision of financial support to trainers/educators is continually under threat. Across the country the most common concern is obtaining and retaining on-going financial support for courses. In the increasingly competitive and commercially oriented university sector unless courses have large number of students and can demonstrated financial viability and independence they are under treat of termination.

Section 2. Form

2.1 In what form is continuing training provided?

- off the job: seminars, courses, curricula**
- on the job: training, job rotation**
- near the job: project work, quality circles, E-learning**

Continuing education is provided in various ways but mostly 'off the job'. There is a wide array of short courses, seminars and conferences offered and these are usually of a high standard. Attendance at such short training opportunities is determined by several factors including the registration cost, travel cost and an AOD organisation's ability to cover the cost of back filling a position (ie paying for replacement staff when someone is away at a conference or on training).

Backfilling is reported to be one of the major impediments to attendance at short courses.

There is some 'on the job' training but it is sometimes regarded as a second best option. There is little job rotation but it is supported as a good and potentially valuable strategy.

There is growing interest in 'gap' training. This involves an assessment of a worker's skill base and then tailoring the provision of training to specifically meet the needs of that individual and the identifies gaps in their skill base. This is mostly offered through the TAFE sector.

2.2 Is there formal regulation of the courses provided and do they satisfy formal standards?

In general there are no formal regulations or standards governing the content or nature of AOD courses. The exception to this is in relation to pharmacotherapy training as noted above and the competency based training provided through the TAFE sector. Beyond this, the courses provided by the university and TAFE sector are required to comply with their institutions' own standards and regulations.

2.3 At what level of the national educational system are the courses and curricula positioned (according to the International Standard Classification of Education ISCED)?

Training is offered at three distinct levels:

1. Technical And Further Education (TAFE) sector – vocational training
2. Undergraduate University courses
3. Graduate level University courses

There is little AOD training offered at the under graduate level. This is seen by some as a major oversight. There is one exception to this at the Edith Cowan University in Western Australia which offers an extremely popular undergraduate level course. As a recruitment strategy into the AOD field it is strongly encouraged that more undergraduate level course, such as psychology, social work, and medicine include AOD content in their core content. This however has been difficult to achieve for various reasons.

During the 1990's the Commonwealth government provided the then ten medical schools in Australia with \$50,000 each for three years to enhance AOD teaching at the undergraduate level. In some instances this significantly improved training of undergraduate medical students.

The other main area within the national education system where AOD training is offered is through the Technical And Further Education (TAFE) sector. The TAFE sector caters mostly for young people who have not long left school and it provides a basic form of training in a range of different areas. For the non-professional worker in the AOD field in Australia, training through the TAFE system is the most common form of training received. TAFE courses can be undertaken at the levels of Certificate II, III and IV. They also offer more advanced training at the Diploma level and this can provide an entry qualification for university level training.

2.4 Do the qualifications thus acquired affect salary and/or employment?

In the non-government sector qualifications do not generally affect salary levels. The award structure that governs the NGO sector means that agencies are better off employing a better qualified person than one with fewer formal qualifications as they will be paid on the same scale.

In the government sector there is considerable scope for an advanced qualification being rewarded by an increase in salary. This is also true for specific disciplines such as nurses who are paid in terms of their qualifications.

The recently established Chapter of Addiction Medicine within the Royal Australasian College of Physicians means that medical practitioners who qualify for membership of the Chapter and pass their courses are eligible to be paid on higher salary scales if employed within the public health system.

2.5 What agreements (time, costs) do professionals in this field have with their employers with regard to participation in continuing training?

Agreements with employers regarding ongoing professional development and training are informal and highly variable across and between organizations. There is however an increasing expectation on the part of employees that they will be offered a substantial levels of professional training as part of their employment. AOD organisations that are limited in terms of what they can offer in salaries can sometimes compensate for this through the provision of in-house professional development.

In an increasing number of cases employers require new or ongoing staff to undertake specific training. In some cases employers are prepared to cover the costs of such training or partly subsidise it.

Section 3. Content

3.1 Are there national guidelines (general concept) as a reference point for the content of continuing training programmes that are under development?

No there are no national guidelines with the exception of the TAFE courses that are developed to comply with specific sets of designated competencies.

3.2 How does the circular process of defining needs, developing programmes and evaluating results, and vice versa, take place?

There is usually a consultation process with employers and 'industry' to determine what the courses should contain in terms of content, levels and approach. Beyond that, the ideal iterative processes that should apply operate very much on the basis of informal feedback, anecdote and casual observation.

There have been a limited number of studies undertaken to evaluate:

1. changes in the number of AOD teaching hours over time;
2. the impact on skill acquisition comparing various modes of teaching (changes in practitioner behaviours after training exposure to didactic versus interactive teaching methods).

Insufficient work has been conducted on the optimum pedagogical methods to apply in teaching AOD topics. Training providers that are better resourced will often undertake their own in-house process evaluations.

3.3 How does knowledge transfer between vocational training (theory), research, practice and continuing training take place?

Knowledge and training transfer is a crucial issue. It is given insufficient attention and is largely left to serendipity. However, some specific efforts have been directed to optimizing training transfer. Examples include the introduction of a supervisory/mentoring element to the accreditation of newly trained medical practitioners in pharmacotherapy (whereby they would be closely supervised for the first 5 to 10 cases that they were involved with).

In other instances, mentoring has been increasingly introduced as a mechanism by which to maximize training transfer.

Similarly, clinical supervision is receiving increasing attention as a means to ensure appropriate and adequate skill development of new clinical staff. New resources and guidelines have recently been developed in relation to clinical supervision to facilitate this process.

3.4 Are programmes developed on an occupation-specific or a cross-occupational basis (inter/ multidisciplinary or inter/multiprofessional)?

Most courses are developed to cater for multi-disciplinary or cross disciplinary interests. But there are a few exceptions to this for example, pharmacotherapy training for medical practitioners caters specifically for doctors and pharmacists.

Another exception is in relation to groups such as police. Over the past decade police in most states in Australia have developed and implemented a wide range of AOD training courses for officers at different levels within the police force.

With the introduction of diversion programs (similar to drug courts) there has been a need to provide training for police, correctional services officers and other members of the criminal justice system about AOD problems in general and the diversion programs in particular.

Feedback on generic courses that cater simultaneously for multi-disciplines has been quite positive. As AOD work requires good team work it is advantageous to offer the training to the groups that are required to work together in real world settings.

3.5 Which of the occupational groups active in the care and treatment of addicts has the implicit or explicit "lead", in terms both of their work with addicts and in continuing training?

Medical practitioners would probably be the group with the most generally acknowledged 'lead' role. They are usually (but not always) the team leaders in a multi-disciplinary setting in Australia and are highly regarded in terms of their level of technical knowledge and skill. Moreover, as the role of pharmacotherapies has become more prominent in recent years so too has the role of medical practitioners as a lead professional group in the field.

In other settings nurses are seen to play a pivotal frontline role in the care of addicts. The nurses have also been highly energetic and active in relation to the development of new short courses that respond to current issues and needs.

In settings where the 'talking therapies' are central to care the psychologists hold a prominent and/or lead role.

Among trainers a majority would have backgrounds as psychologists. This allows them to cover technical and theoretical issues associated with addiction.

The issue of which professional group should take the lead role is not without tensions. Inherent with this issue is the ideological position taken by different professional groups (eg doctors are more likely to see the problem and potential solutions in terms of 'disease' models whereas psychologists and social workers are more inclined to see it in terms of behavioural problems that require behavioural solutions).

Section 4. Quality

4.1 Does continuing training (whether individual courses, curricula or programmes) and/or institutionalized continuing training providers have to satisfy quality requirements, and who defines these requirements?

Quality requirements vary according to the training providers and their institutional setting. Universities for instance have their own quality requirements and methods of determining compliance with these.

4.2 By whom and how is the quality of continuing training evaluated?

From time to time, there are independent assessments undertaken of continuing training options. In addition, most trainers conduct regular process evaluations of their courses and student satisfaction levels. These are largely ad hoc and not undertaken on a national basis.

External reviews are sometimes undertaken of AOD courses where an independent review panel is established for the specific purpose of examining all aspects of a course.

In light of the deficits in the area of training evaluation the National Centre for Education and Training on Addiction recently completed a large project examining evaluation issues in the AOD field. The following set of comprehensive documents were produced:

Addy, D., Skinner, N., Shoobridge, J., Freeman, T., Roche, A.M., Pidd, K., Watts, S., (2004) [The Work Practice Questionnaire: A training evaluation measurement tool for the alcohol and other drugs field](#). Adelaide: National Centre for Education and Training on Addiction (NCETA).

Pidd, K., Freeman, T., Skinner, N., Addy, D., Shoobridge, J., Roche, A.M., (2004) [From Training to Work Practice Change: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field](#). Adelaide: National Centre for Education and Training on Addiction (NCETA).

Addy, D., Skinner, N., Shoobridge, J., Freeman, T., Roche, A.M., Pidd, K., Watts, S., O'Neill, M., (2004) [Handbook for the Work Practice Questionnaire \(WPQ\): A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field](#). Adelaide: National Centre for Education and Training on Addiction (NCETA).

O'Neill, M., Addy, D., Roche, A.M., (2004) [Guidelines for Evaluating Alcohol and Other Drugs Education and Training Programs](#). Adelaide: National Centre for Education and Training on Addiction (NCETA).

These resources are available in hard copy or can be downloaded from www.nceta.flinders.edu.au

Section 5. Trends

What are the challenges, opportunities and risks which affect continuing information and which you would like to see addressed in the symposium, regarding the future of professional care and treatment of addicts in particular - and continuing training in the substance-dependence field in general, independently of the care and treatment of addicts?

The challenge of a rapidly expanding knowledge base and increasingly high levels of technical sophistication in the prevention, identification and management of AOD problems necessitates better trained and skilled workers. A number of factors operate as impediments to achieving this. First is the low salary level of many workers and the lack of incentives to achieve high qualifications that are not rewarded through financial remuneration. In addition, the increasing cost of university education is prohibitive for many workers.

At the very time that increased training is required more than ever before in the AOD field the number of barriers and impediments is also increasing.

Encouragingly however, we have seen a significant professionalisation of the AOD field over the past decade. This brings with it a greater acceptance of the value of education and training and also an acceptance of the concept of ongoing life-long learning.

The difficulties posed by a diverse workforce with widely varying backgrounds, skill levels and differing levels of prior education and training means that an adequate professional development and continuing education system needs to be broad and comprehensive to cater for such diverse needs.

Some specific areas that have been over looked to-date include the specific training and professional development needs of managers of AOD services. Training in 'management' has been indicated by managers as a high priority for them.

Section 6. Input

What specific know-how can you contribute to the symposium (knowledge, skills, literature, tools, documentation)?

Australia is increasingly taking a broader 'work force development' approach to improving the skills of AOD workers and enhancing service system responses to clients with AOD problems. One of Australia's three national research centres, the National Centre for Education and Training on Addiction (NCETA), has developed a suite of resource materials to assist the AOD field to understand and implement WFD strategies. These resources include:

- a recently released resource kit on Clinical Supervision,
- a small resource on Mentoring and
- an extensive package on the key principles of Workforce Development as they apply to the AOD field.
- A comprehensive WFD literature review.

These resources are available in hard copy or can be downloaded from www.nceta.flinders.edu.au

In addition, NCETA has recently undertaken a number of large scale surveys examining factors related to retention and reward among workers in the AOD field. Further to this there is work underway examining stress and burnout among workers and managers in AOD clinical services. NCETA has also completed a national survey of managers including questions about their views about professional development and ongoing training.

NCETA is currently undertaking a national survey of AOD workers in relation to issues affecting retention and recruitment to the field. A sample of 900 workers has been achieved to date and data analysis will commence in September 2005.

Another resource, on stress and burnout among workers in the AOD field, is currently being finalized. A copy of the text (in a non-desk topped format) is available on request.

A Workforce Development Perspective

As noted above training and ongoing professional development is considered to be a high priority for the AOD field. However, training in and of itself is limited and is unlikely to achieve the end goal of improved service delivery and the consistent implementation of best practice. What is needed is a broader workforce development perspective (which includes training but is not limited to it). The rationale for this position is outlined below.

The alcohol, tobacco and other drug field has undergone major changes in the past two decades. Increasing demands are placed on workers as the complexity of problems grow. The shift to polydrug use, expanded pharmacotherapies,

greater awareness of co-existing mental health disorders and the increasingly young age of those engaged in problematic drug use all contribute to this growing complexity. The research base that the field can draw on has also increased, and educational and service delivery models have changed; there is pressure on both organisations and their staff to keep up-to-date. These factors, together with difficulty in recruiting and keeping staff with appropriate skills, experience and training, pose a challenge for many AOD services. One important, if under-utilised response to these issues is Workforce Development.

Workforce development (WFD) is now seen as a crucial factor in providing effective responses to AOD problems. WFD is not a new concept, but it is not one that is always well understood. For some, the term is used synonymously with 'training'. In reality, however, it can and should mean much more. The concept of WFD involves an understanding of the wide range of factors that impact on work practices. Importantly, it also involves a system's perspective. WFD can address individual factors such as staff attitudes, willingness to intervene in situations, confidence in providing responses, role legitimacy as well as knowledge and skills. It also encapsulates factors related to the working environment, such as collegiate and organisational support, management and feedback mechanisms, professional development opportunities, and reward and remuneration

There are a range of current trends that will impact upon the AOD workforce in the future, these include:

- increases in consumer demand (due to factors such as ageing population, and increased education levels)
- new developments in technology which impact upon education and training and can change the nature of health care
- changing models of care, including the possibility of making greater use within managed frameworks of competition in service delivery
- an increase in knowledge of genetic factors impacting upon disease and a trend towards more targeted therapies an increasing trend towards shorter working hours in the health workforce (partly due to ageing factors within the health workforce and also generational change).

A workforce development perspective is required that can address all these factors.