SUPPORT DOCUMENT

The role of VET in alcohol and other drugs workforce development: support document

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This document was produced by the authors, based on their research for the report *The role of VET in alcohol and other drugs workforce development*, and is an added resource for further information. The report is available on NCVER's website: <http://www.ncver.edu.au>

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State		Major Cities of Australia	Inner Regional Australia	Outer Regional Australia	Remote Australia	Very Remote Australia	OSPC	**Total**
ACT	n (% of State)	74 (100%)	-	-	-	-	-	74 (100%)
	% of Total	4.1%	-	-	-	-	-	4.1%
NSW	n (% of State)	294 (58.4%)	164 (32.6%)	43 (8.5%)	1 (0.2%)	1 (0.2%)	-	503 (100%)
	% of Total	16.1%	9.0%	2.4%	0.1%	0.1%	-	27.6%
NT	n (% of State)	-	-	10 (83.3%)	1 (8.3%)	1 (8.3%)	-	12 (100%)
	% of Total	-	-	0.5%	0.1%	0.1%	-	0.7%
VIC	n (% of State)	569 (62.9%)	295 (32.6%)	39 (4.3%)	1 (0.1%)	-	-	904 (100%)
	% of Total	31.2%	16.2%	2.1%	0.1%	-	-	49.5%
QLD	n (% of State)	103 (58.9%)	41 (23.4%)	9 (5.1%)	20 (11.4%)	2 (1.1%)	-	175 (100%)
	% of Total	5.6%	2.2%	0.5%	1.1%	0.1%	-	9.6%
SA	n (% of State)	45 (77.6%)	8 (13.8%)	4 (6.9%)	-	1 (1.7%)	-	58 (100%)
	% of Total	2.5%	0.4%	0.2%	-	0.1%	-	3.2%
TAS	n (% of State)	-	24 (66.7%)	12 (33.3%)	-	-	-	36 (100%)
	% of Total	-	1.3%	0.7%	-	-	-	2.0%
WA	n (% of State)	50 (83.3%)	7 (11.7%)	1 (1.7%)	2 (3.3%)	-	-	60 (100%)
	% of Total	2.7%	0.4%	0.1%	0.1%	-	-	3.3%
Overseas	n (% of State)	-	-	-	-	-	3 (100%)	3 (100%)
	% of Total	-	-	-	-	-	0.2%	0.2%
Total	n (% of State/ Total)	1135 (62.2%)	539 (29.5%)	118 (6.5%)	25 (1.4%)	5 (0.3%)	3 (0.2%)	1825 (100%)

[1]Location of residence was derived from postcode details and classified using the Australian Bureau of Statistics *Standard Geographical Classification Remoteness Area* classification.

Table 2 Previous highest education level of vocational education and training Certificate IV and Diploma students (2008)

	VET alcohol and other drug Topics *n (%)*			
Previous highest education level	CHC41702 - Cert IV in Alcohol and Other Drugs Work[1]	CHC51102 - Diploma in Alcohol and Other Drugs Work[1]	Education Year Level Totals	**Overall Total**
	Total Cert IV	**Total Diploma**		
Year 8 or lower	**487 (35.4%)**	**108 (24.1%)**	16 (0.9%)	**595 (32.6%)**
Year 9			37 (2.0%)	
Year 10			150 (8.2%)	
Year 11			106 (5.8%)	
Year 12			286 (15.7%)	
Cert III or lower	**578 (42.0%)**	**201 (44.8%)**	286 (15.7%)	**779 (42.7%)**
Cert IV			243 (13.3%)	
Diploma			198 (10.8%)	
Advanced diploma or associate degree			52 (2.8%)	
Bachelor degree or higher	**140 (10.2%)**	**92 (20.5%)**	232 (12.7%)	**232 (12.7%)**
Not known	**171 (12.4%)**	**48 (10.7%)**	115 (6.3%)	**219 (12.0%)**
Miscellaneous education			104 (5.7%)	
Total	**1376 (75.4%)**	**449 (24.6%)**		**1825 (100%)**

Table 3 Full list of Field of Education codes for Field of Education Types 'Health' and 'Society and Culture'

HEALTH Field of Education (FOE) codes		**SOCIETY AND CULTURE** Field of Education (FOE) codes	
Code	**Field of study**	**Code**	**Field of study**
60000	Health not classified	90000	Society and Culture not classified
60100	Medical Studies	90100	Political Science and Policy Studies
60101	General Medicine	90101	Political Sciences
60103	Surgery	90103	Policy Studies
60105	Psychiatry	90300	Studies in Human Society
60107	Obstetrics and Gynaecology	90301	Sociology
60109	Paediatrics	90303	Anthropology
60111	Anaesthesiology	90305	History
60113	Pathology	90307	Archaeology
60115	Radiology	90309	Human Geography
60117	Internal Medicine	90311	Indigenous Studies
60119	General Practice	90313	Gender Specific Studies
60199	Medical Studies not elsewhere classified	90399	Studies in Human Society not elsewhere classified
60300	Nursing	90500	Human Welfare Studies and Services
60301	General Nursing	90501	Social Work
60303	Midwifery≤	90503	Children's Services
60305	Mental Health Nursing	90505	Youth Work
60307	Community Nursing	90507	Care for the Aged
60309	Critical Care Nursing	90509	Care for the Disabled
60311	Aged Care Nursing	90511	Residential Client Care

60313	Palliative Care Nursing	90513	Counselling
60315	Mothercraft Nursing and Family and Child Health Nursing	90515	Welfare Studies
60399	Nursing not elsewhere classified	90599	Human Welfare Studies and Services not elsewhere classified
60500	Pharmacy	90700	Behavioural Science
60501	Pharmacy	90701	Psychology
60700	Dental Studies	90799	Behavioural Science not elsewhere classified
60701	Dentistry	90900	Law
60703	Dental Assisting	90901	Business and Commercial Law
60705	Dental Technology	90903	Constitutional Law
60799	Dental Studies not elsewhere classified	90905	Criminal Law
60900	Optical Science	90907	Family Law
60901	Optometry	90909	International Law
60903	Optical Technology	90911	Taxation Law
60999	Optical Science not elsewhere classified	90913	Legal Practice
61100	Veterinary Studies	90999	Law not elsewhere classified
61101	Veterinary Science	91100	Justice and Law Enforcement
61103	Veterinary Assisting	91101	Justice Administration
61199	Veterinary Studies not elsewhere classified	91103	Legal Studies
61300	Public Health	91105	Police Studies
61301	Occupational Health and Safety	91199	Justice and Law Enforcement not elsewhere classified
61303	Environmental Health	91300	Librarianship, Information Management and Curatorial Studies
61305	Indigenous Health	91301	Librarianship and Information Management
61307	Health Promotion	91303	Curatorial Studies
61309	Community Health	91500	Language and Literature
61311	Epidemiology	91501	English Language
61399	Public Health not elsewhere classified	91503	Northern European Languages
61500	Radiography	91505	Southern European Languages
61501	Radiography	91507	Eastern European Languages
61700	Rehabilitation Therapies	91509	Southwest Asian and North African Languages
61701	Physiotherapy	91511	Southern Asian Languages
61703	Occupational Therapy	91513	Southeast Asian Languages
61705	Chiropractic and Osteopathy	91515	Eastern Asian Languages
61707	Speech Pathology	91517	Australian Indigenous Languages
61709	Audiology	91519	Translating and Interpreting
61711	Massage Therapy	91521	Linguistics
61713	Podiatry	91523	Literature
61799	Rehabilitation Therapies not elsewhere classified	91599	Language and Literature not elsewhere classified
61900	Complementary Therapies	91700	Philosophy and Religious Studies
61901	Naturopathy	91701	Philosophy
61905	Traditional Chinese Medicine	91703	Religious Studies
61913	Acupuncture	91900	Economics and Econometrics
61999	Complementary Therapies not elsewhere classified	91901	Economics
69900	Other Health	91903	Econometrics
69901	Nutrition and Dietetics	92100	Sport and Recreation
69903	Human Movement	92101	Sport and Recreation Activities

69905	Paramedical Studies	92103	Sports Coaching, Officiating and Instruction
69907	First Aid	92199	Sport and Recreation not elsewhere classified
69999	Health not elsewhere classified	99900	Other Society and Culture
		99901	Family and Consumer Studies
		99903	Criminology
		99905	Security Services
		99999	Society and Culture not elsewhere classified

Note – shaded codes used in analysis of higher education data

Managers survey detail

Table 4 Main work role of alcohol and other drug managers

Main work role	n (%)
Purely management role (no client contact)	56 (30.1)
Management + Assessment / clinical / counselling / therapy	57 (30.6)
Management + Education / training / information delivery	33 (17.7)
Management + Research / Policy development	13 (7.0)
Management + Other	24 (12.9)
Not answered	3 (1.6)
Total	186 (100)

Table 5 Time worked as manager and in the alcohol and other drug field

Worked in alcohol and other drug field	n (%)	
	Time as Manager	Time in alcohol and other drug field
Less than 12 months	18 (9.7)	5 (2.7)
1-2 years	31 (16.7)	13 (7.0)
3-5 years	44 (23.7)	26 (14.0)
6-10 years	53 (28.5)	38 (20.4)
More than 10 years	38 (20.4)	103 (55.4)
Total	184 (98.9)	185 (99.5)
Not answered	2 (1.1)	1 (0.5)

Table 6 Highest formal qualification completed by alcohol and other drug managers

Highest formal qualification completed	n (%)
Some High School – less than Year 12	2 (1.1)
High School – completed Year 12	3 (1.6)
vocational education and training/technical and further education (Certificate, Diploma, Advanced Diploma)	35 (18.8)
Undergraduate (Bachelor degree or Honours)	40 (21.5)
Postgraduate (Graduate Certificate, Graduate Diploma, Masters, PhD/Doctorate)	100 (53.8)
Other	6 (3.2)
Total	186 (100)

Table 7 Highest formal alcohol and other drug qualification completed by alcohol and other drug managers

Highest formal alcohol and other drug qualification completed	n (%)
None	31 (16.7)
Non-accredited alcohol and other drug training	35 (18.8)
Accredited alcohol and other drug short courses	18 (9.7)
vocational education and training/technical and further education alcohol and other drug qualification	45 (29.1)
Undergraduate qualification with explicit alcohol and other drug content	11 (5.9)
Postgraduate alcohol and other drug qualification	44 (28.5)
Other	1 (0.54)
Total	185 (99.5)
Not answered	1 (0.5)

Table 8 Highest formal education level of managers by alcohol and other drug qualification

Highest education level	Highest formal alcohol and other drug qualification							
	None	Non-accredited training	Accredited short courses	VET/TAFE[1] qualification	Undergraduate qualification	Postgraduate qualification	Other	*Total*
Year 12 or less	2 (1.1%)	1 (0.5%)	1 (0.5%)	1 (0.5%)	-	-	-	5 (2.7%)
VET/TAFE[1] (Cert, Dip, Adv Diploma)	3 (1.6%)	7 (3.8%)	3 (1.6%)	19 (10.2%)	-	1 (0.5%)	-	33 (17.7%)
Undergraduate (Bachelor degree or Honours)	14 (7.5%)	8 (4.3%)	4 (2.2%)	7 (3.8%)	5 (2.7%)	2 (1.1%)	-	40 (21.5%)
Postgraduate (Grad Cert, Grad Dip, Masters, PhD/ Doctorate)	11 (5.9%)	15 (8.1%)	9 (4.8%)	17 (9.1%)	6 (3.2%)	39 (21.0%)	2 (1.1%)	99 (53.2%)
Other	1 (0.5%)	4 (2.2%)	1 (0.5%)	-	-	1 (0.5%)	1 (0.5%)	8 (4.3%)
Not answered								1 (0.5%)
Total	31 (16.7%)	35 (18.8%)	18 (9.7%)	44 (23.7%)	11 (5.9%)	43 (23.1%)	3 (1.6%)	186 (100%)

[1]VET = Vocational education and training TAFE = technical and Further Education College

Table 9 Location (geographical remoteness area) and type of agency managed

Geographical location of agency(ies) managed	Agency type n (%)				
	Government	NGO[1]	Private	Other	Total
City/metropolitan only	18 (10.0%)	45 (25.0%)	2 (1.1%)	0	65 (36.1%)
Regional only	8 (4.4%)	7 (3.9%)	0	0	15 (8.3%)
Rural only	7 (3.9%)	6 (3.3%)	0	0	13 (7.2%)
Remote only	1 (0.6%)	1 (0.6%)	0	0	2 (1.1)
City/metropolitan & regional	2 (1.1%)	11 (6.1%)	1 (0.6%)	0	14 (7.8%)
City/metropolitan, regional & rural	0	7 (3.9%)	0	0	7 (3.9%)
City/metropolitan & rural	1 (0.6%)	1 (0.6%)	1 (0.6%)	0	3 (1.7%)
Regional & rural	5 (2.8%)	1 (0.6%)	1 (0.6%)	0	7 (3.9%)
Regional, rural & remote	3 (1.7%)	3 (1.7%)	0	0	6 (3.3%)
Regional & remote	3 (1.7%)	0	0	0	3 (1.7%)
Rural & remote	1 (0.6%)	1 (0.6%)	0	0	2(1.1%)
All Locations	18 (10.0%)	23 (12.8%)	0	2 (1.1%)	43 (23.9%)
Total	67 (37.2%)	106 (58.9%)	5 (2.8%)	2 (1.1%)	180 (100%)

Not answered (n=6)

[1]NGO = non-government

Table 10 Main agency services offered: category 'Other'

Other main services indicated include:	n
Children services / Youth program	3
Education	2
Home based withdrawal	1
Church community based.	1
Comorbidity assessment and counselling	1
Dual-diagnosis policy implementation; ATODIS system management; criminal justice system programs; ATSI programs	1
Dual Diagnosis services	1
Family support & inclusion of family in client treatment, child focused interventions including addicted parents, specialised supported accommodation, training.	2
Gender specific (Women), Children, couples and family therapeutic and recreational services	1
Group CBT Programs, Reintegration services - housing, family, employment, education, etc	1
Group Cognitive Behavioural Therapy Programs	1
Harm reduction, NSP	2
Health education	1
Hospital consultation / liaison	1
Medically supervised injecting centre	1
Needle and syringe exchange programs	1
Prevention activities - Event support Program, Alcohol accord.	1
Primary Health Centre for IDU	1
Professional development services, information, education and training for other agencies, / Workforce development	2
Queensland indigenous Alcohol Diversion Program	1
Referral and transition to other alcohol and other drug SERVICES	2
Sobering Up Shelter, Intervention services to binge drinkers	1
Sobering Up Shelter and Night Patrol	1
State NGO peak body	1
This is a specific drug and alcohol service	1
Training and development / Training and Education	4

Table 11 Barriers that may prevent employing alcohol and other drug specialist workers with the preferred alcohol and other drug qualifications

Barriers	Frequency n (%)
Insufficient numbers of workers with these qualifications	72 (32.0)
Restrictions on what I can pay due to Salary/Award conditions	54 (24.0)
Insufficient funding to pay relevant salaries	50 (22.2)
Can only offer short-term contracts	21 (10.2)
None	15 (6.6)
Other	13 (5.7)
Total	225 (100)

Not answered n=57

Table 12 Managers suggested minimum level qualification for alcohol and other drug specialist workers

Minimum level qualifications for alcohol and other drug specialist workers	n (%)	n (%)
Certificate III in alcohol and other drug	7 (5.5)	78 (61.4)
Certificate IV in alcohol and other drug	48 (37.8)	
Diploma in alcohol and other drug	20 (15.7)	
Advanced diploma in alcohol and other drug	3 (2.4)	
Relevant university undergraduate degree (e.g. Bachelors or Honours in Health or Social Sciences)	16 (12.6)	37 (29.1)
Relevant university undergraduate degree PLUS non-accredited alcohol and other drug training	4 (3.1)	
Relevant university undergraduate degree PLUS accredited alcohol and other drug training	11 (8.7)	
Relevant university undergraduate degree PLUS accredited vocational education and training alcohol and other drug qualifications	4 (3.1)	
Undergraduate degree in alcohol and other drug work	2 (1.6)	
Graduate certificate in alcohol and other drug	3 (2.4)	12 (9.5)
Graduate diploma in alcohol and other drug	2 (1.6)	
Masters in alcohol and other drug	1 (0.8)	
Other	6 (4.7)	
Total	127 (100)	

Not answered n=59

Table 13 Vocational education and training alcohol and other drug courses (2008)

vocational education and training Alcohol and Other Drugs Work courses	*n*	*%*
CHC41702 - Certificate IV in Alcohol and Other Drugs Work	1,376	75.4
CHC51102 - Diploma of Alcohol and other Drugs Work	449	24.6
Total	1,825	100.0

Table 14 Age and gender of students undertaking vocational education and training alcohol and other drug courses (2008)

	Age (years)		Gender	
	Range	*Median*	*Male n (%)*	*Female n (%)*
Certificate IV	17-73	36	442 (32.1)	302 (67.3)
Diploma	18-70	40	147 (32.7)	650 (67.0)
Total	17-73	36.5	589 (32.3)	1,236 (67.7)

Table 15 Undergraduate higher education students' area of study and course type (2008)

Higher education undergraduate students (N=42,032)		**n (%)**
Area of Study	Health	2289 (5.4)
	Society and Culture	39743 (94.6)
Course type enrolled	Bachelor's Graduate Entry	506 (1.2)
	Bachelor's Honours	2151 (5.1)
	Bachelor's Pass	38242 (91.0)
	Associate degree	242 (0.6)
	Advanced Diploma (AQF terminology)/Diploma (pre-AQF terminology)	384 (0.9)
	Diploma (AQF terminology)/ Associate Diploma (pre-AQF terminology)	242 (0.6)
	Other undergraduate award course	150 (0.4)
	Enabling course	115 (0.3)

Managers survey: thematic analysis of open ended items

Table 16 Thematic analysis of Q14: Please expand on your views of a compulsory minimum alcohol and other drug qualification level for specialist workers

Theme 1: No minimum necessary
I have found that well trained professionals such as counsellors/social workers/psychs pick up alcohol and other drug knowledge and skills very quickly. This then complements their counselling skills and professionalism in delivering an alcohol and other drug service to clients. For this reason, I prefer to employ recent graduates in the above fields and support their development of alcohol and other drug skills and knowledge. This has worked for my agency in the absence of alcohol and other drug qualified candidates for advertised positions. I would support improved alcohol and other drug training but would prefer to see it delivered with existing courses as seems to be the current trend. I would have concerns about imposing a minimum alcohol and other drug qualification level because it may make it more difficult to recruit staff. For this reason I prefer to operate from a staff development perspective as described earlier.
I think if you have a level of educational qualifications in a health related area and are enthusiastic about working in the field another barrier to commencing employment needs to be avoided. On the job training & orientation can result in sufficient basic knowledge that can then be enhanced through training.
I think to ensure that clients get up to date evidence based practice rather than moral or personal based information.
I think we need different professions. I have people qualified in Aboriginal health work, nursing, social work and medicine. I do think we need a bigger focus on clinical skills development for workers, like myself, who come from a more generalist counselling or mental health backgrounds.
The difficulty with the minimum qual (and I have it and have taught it) it has become an industry standard and in many ways dumbed down the workforce. Whilst it is fine when a worker has another tertiary qualification in health and welfare on its own it is insufficient training for staff to adequately deal with the complexities of client presentations they are required to ordinarily deal with
The fact that the list above does not even mention harm reduction workers sums up why I don't necessarily think that we should have a specific minimum qual. The minimum quals only ever include treatment and that is only one facet of working with people who use drugs.
There are many good staff with years of experience that contribute far more than "qualified" staff. Too many staff come through with alcohol and other drug training (at all levels) who simply do not understand ANYTHING about the alcohol and other drug sector. They work poorly with clients, and do not understand ANYTHING about illicit drugs. There is an idea that some training will provide people with all the skill and knowledge they need. This is a nonsense. I suspect you couldn't really give a damn, as you want to force feeble qualifications onto the sector. There is nothing funnier than seeing a social worker, or diploma holding worker front up to a long term poly drug user. The worker can offer nothing more than weak platitudes that sets everything back months.
We employ a number of psychologists that are very capable and now very experienced in their work. However in a number of instances they have highlighted that throughout their university training thy had limited exposure to addiction related matters. They have grown professionally from their time with our service. * (10)
Well, I'm nearly at the end of my career and I got away without an alcohol and other drug qual, so I can dictate to others with impunity. Seriously, I think that it should not exclude entry into the field; rather, those without an alcohol and other drug qual should be able to pick it up during their first few years working in the field.
Whilst I have no formal certified training, my background is Social Work and I have been working in this field and others which are associated with drug and Alcohol. I think it is necessary for all workers to undergo either corporate e.g. health, run programs, or with recognised bodies who have this area of expertise. This should be run in conjunction with a position as sometimes with just training; the whole exercise becomes one which is purely theoretical. Putting new-found skills into practice along with theoretical education is a more effective way of educating those who choose alcohol and other drug as a work choice.
With some qualifications, there is nothing much that's 'special' about alcohol and other drug work over other work with people with behavioural issues or disadvantaged groups. Thus, psychologists and social workers can usually adapt quickly to the area and need only some content knowledge in relation to pharmacology, broader statistical trends etc.
Theme 2: Real life experience is equally or more important than qualifications
I neither agree nor do I disagree with a compulsory minimum alcohol and other drug qualification for alcohol and other drug specialist worker. In my opinion, the important point within this view is a general qualification with clinical training in psychology, counselling, psychotherapy, social work etc. as it is always about the relationship and not about the modality of a qualification. A professional can have as many qualifications as they want but unless they can gain that crucial rapport with the consumer, all of their qualifications will mean nothing to the consumer. The worker can always learn these basic techniques of harm minimisation, client management, etc. on the job. All of my staff are highly qualified and clinically trained professionals, and yet none of them had either alcohol and other drug experience or alcohol and other drug qualifications, and yet I still get the best results from the clients through their unconditional positive regard. *(12)
I think that there needs to be a certain degree of knowledge on the subject but relationships with clients will always come first

It depends on the person and their experience. *(8, 10)

Qualifications are important but they are just as important as life skills.

The value of workplace experience should not be underrated; qualification is important, but experience is equally so. A worker who has not had opportunity to accreditation but who has demonstrated capabilities should be of value as would be a qualified worker, within appropriate boundaries. Qualification and accreditation can be separate things. A means for provision of appropriate accreditation for 'experience' should be more accessible.

Theme 3: Compulsory minimum should be required, but the level is not specified

Apart from people who may have experienced significant alcohol and other drug use problems at a personal level, I think basic training to understand key concepts is necessary. This may be either key concepts within the alcohol and other drug field, or it may be a framework of "understanding" at a discipline level.

As a manager it gives me some starting point when employing staff if there is a minimum requirement. We have a minimum of cert four even for residential care workers. New staff at least have a little idea about what the job is about before they apply.

As a manager of nurses, I feel that staff should have a basic level of understanding of alcohol and other drug issues when they commence, or have the opportunity to access training opportunities to develop these. As present the Cert IV that is offered is not appropriate for clinical staff, so there is a gap in nursing education I feel *(13)

As in Victoria, there should be an absolute minimum standard of selected competencies from the Community Services training package, in addition to their other qualifications - psych, social work etc

Baseline quals are needed - professional quals are needed such as tertiary quals in related field.

Because we are dealing with complex situations, it is imperative that people should have a minimum level of understanding, competence and or qualifications

Due to the side effects of many of the prohibited substances currently being used, the training provided gives you a better understanding of the trigger points associated with client responses, a better understanding of better ways of working with clients with substance use/abuse issues and their families and how to better assess the situation in summing up whether your service is suited to the current needs of the client or whether they may need to be referred.

Essential for quality services and the appropriate intervention by multi-disciplinary teams. Particularly in relation to the specialist skill and knowledge level that is required to provide evidenced based service to the client group.

Essential to understand -the principals of harm minimisation, -the levels and complexities of alcohol and other drug dependence. -Knowledge of the process and best approach to enhance behaviour change. -Knowledge of the various drug groups and symptoms of withdrawal. -Counselling approaches. -knowledge of bio-psycho-social assessment

For specialist workers... YES but for generic workers and management not necessarily so however I think managers should have management qualifications

For the safety of the employee and the client I believe that all staff need to have a minimum training or be based in a traineeship to allow for support and mentorship

Generally, I think the Cert IV should be more advanced, also the training should include identification & treatment responses for people with co-occurring mental health conditions & the course title should reflect this. The current level of a cert IV as a minimum standard is not sufficient for my work place unless prospective staff have another degree or significant previous counselling experience. The client group of an alcohol and other drug service are those with sever alcohol and other drug problems and have other complex issues, usually in more than one of the following areas, mental health, forensic involvement, accommodation, employment , & limited interpersonal skills, socialisation difficulties, family & parenting concerns. Because of this, clinicians/workers need to be competent in counselling practices. As such training needs to include skills development in networking, active referral & active engagement etc. Further to this, most alcohol and other drug services are under resourced & have limited capacity to train on the job, clinicians need to be able to take on a client load at start of employment after initial orientation. A clinician in training, who has no other training in counselling & who has no previous experience, I think, should have a long placement (at least 6 months, at least 4 days a week, with a client case load) in an alcohol and other drug agency to develop some cursory skills. The agency also may need support in supervision during this time. As it stands, for my agency people wanting a placement who only have a Cert IV are not skilled enough & placement length is not long enough to give them a client case load & because most of the work is individual, its often not appropriate for students to observe sessions, as such they often end up doing admin tasks & have no idea of the work involved in direct client care. *(11, 10, 4)

I agree that there should be a minimum qualification for specialist D&A workers, but not necessarily a D&A qualification. In our service we employ people with relevant tertiary qualifications and registration with a professional board (psychologists, nurses etc). I think it is important for the professionalism of the sector. I understand that this would be difficult in rural areas. *(4)

I agree with having a compulsory qualification for specialist workers. The draw back is the fact that there is a lack of qualified personnel to fill the positions. Qualified and unqualified workers receive the same remuneration rate. Until such times as qualified personnel are recognised for their qualification with a premium on their pay rate it is pointless completing studies for a qualification. At this point in time a qualified worker is disadvantaged in the pay system because they have gained a qualification and a debt for the qualification. The wage rate for unqualified and qualified workers is the same. The qualified person then pays back the debt for their education putting them behind the unqualified person financially. While the qualified person was struggling financially through the education process for four or so years the unqualified person was on full pay. Why do a qualification?? *(4)

I believe that their should be a course that is Drug & Alcohol specific, that allows Nurses (specialist D&A Nurses with perhaps a minimum of 5 yrs in the field and a criteria) to become methadone/Buprenorphine prescribers. Their practice could be overseen by a medical officer. This would assist in alleviating the prescriber shortage in NSW and also make access to treatment faster for patients. I don't believe that a Nurse

should have to do an additional course to get into the D&A field as this would make recruitment almost impossible.

I believe that a minimum qualification needs to be determined according to role. For all staff an alcohol and other drug Cert IV including reception, clerical and admin staff. Case Managers Cert IV plus a tertiary diploma, counsellors 3 year tertiary with major in counselling - then ongoing vocational training in models of counselling. *(8)

I believe that to provide a truly comprehensive service to clients with alcohol and other drug issues you require a mix of workers all with appropriate skills for the client's requirements. Mental Health workers and generalist Medical Practitioners have a good generalist knowledge of alcohol and other drug issues as they have a significant effect on the clients the manage in their day to day activities, those clinicians can be provided with the correct support and specific training in alcohol and other drug issues, would be considered as part of an alcohol and other drug specialist service and be considered Specialist Workers. I would be ensuring that those staff continued with further education in alcohol and other drug as well as other areas such as Mental Health Co-Morbidity. *(8)

I do not believe that all tertiary university human services degrees (which are more or less the minimum requirement for employment in a government agency) provide adequate knowledge and skills about alcohol and other drug. It is essential for people to have a good understanding of the alcohol and other drug models, frameworks, assessment, treatment and other skills and knowledge to work effectively with clients.

I think as a specialist training it is great, however I do believe that this does not cover all you need to be an alcohol and other drug worker ...

I think it is important as a) base knowledge coming into an alcohol and other drug agency, b) ensures that people are aware of some of the issues that they will be coming up against, c) helps to stop people romanticising about working in the alcohol and other drug sector and d) gives us a baseline to recruit against. *(9)

I think that it should be more focused on psychosocial rather than medical possible within Social work

I very strongly agree that staff, particularly nurses should have basic qualifications in drug and alcohol, especially motivational interviewing, assessment skills, brief interventions and basic cognitive behaviour therapy skills. Nurses should have grad dip in drug and alcohol studies.

Important to have a benchmark for service and staff competence

In a service such as mine that implies that it offers professional interventions, there should be minimum qualifications. Some services which offer non-professional support may not require the same level of training.

In addition to qualifications in the alcohol and other drug field it would be desirable to see cultural and mental health qualifications as well.

In terms of the increasing complexity of needs of clients, the rapid development and sophistication of treatment paradigms and the evolving diversity of the systemic approaches and agencies within the field, having a minimum qualification standard to provide a basis for quality service provision to be maintained is paramount for consumers and industry employers and peer/colleague confidence and effectiveness.

It is a specialist area which requires specific knowledge / skills

It is an area that requires specific knowledge and should be acknowledged for this - and minimum qualifications are a way of recognising this

It is vital that workers understand the issues that have impact on the alcohol and other drug client and have a range of treatment options, strategies and a general right approach to working with the is client. A lot of this can be picked up along the way with experience in the field, but these days this means almost nothing there is a desire in employers to employ people with university credentials.

It will assist with ensuring high quality of care and service delivered. However it must also be balanced with practice not just theory; particularly when there is a current shortage of specialist alcohol and other drug clinicians *(10)

Many alcohol and other drug workers have been in the field for many years and have had consistent training over those years. To bring in a minimum qualification for alcohol and other drug specialist workers you would need to take that into consideration and not reinvent the wheel. I would imagine that new alcohol and other drug workers could have compulsory alcohol and other drug courses to complete but workers in the field should be given a Needs Review to see what training they further need to complete or are interested in. A compulsory Minimum Qualifications were brought in for Gambling Counsellors in NSW without taking into account the years of experience that workers already had. Having to complete these vocational education and training qualifications by very experienced university trained staff created some dissension. By all means have Minimum Qualifications but recognise that making these compulsory can be an overkill. I would prefer MQ with recommendations to have staff trained in 3, 6 or 12 mths.

Need to develop a core set of competencies for workers across the field. This is a risk factor for consumers and agencies. In particular, alcohol and other drug is not recognised as a specialty in nursing and therefore no baseline consistent training provided. This has huge implications for the field and places enormous responsibility on agencies to provide support and education/training. Alcohol and other drug competencies should be based on evidence and best practice, and range from entry to advanced practitioner level.

People have the right to be offered the same standard of care, evidenced based, from any service that they may wish to attend. A minimum alcohol and other drug qualification level would help ensure this happens.

Provides an acceptable level of skills to work in the alcohol and other drug field

so there is consistency in all domains across the spectrum of treatment

They need to have the appropriate level of training, qualifications, skills and knowledge to deliver appropriate services to specific client groups.

This ensures appropriate knowledge of the sector and service. It ensures a standard level of knowledge and expectation. It helps to manage a professional standard of service delivery.

This is essential, however within the ACT this may introduce further challenges for recruitment - and salaries need to reflect completion of job specific qualifications *(4)

This is my opinion: It should be mandatory to have minimum qualifications to provide support to clients and provide a certain standard for service delivery with positive client outcomes. There is an essence of responsibility from clinical service delivery to clients and it takes an amount skill to provide support and do no harm which is the main point I think. I have seen clinicians provide a service with below minimum qualifications that did more harm than good; the client had complex issues relating to his alcohol and other drug use that the clinician did not take into consideration. This resulted in the client not returning for treatment, relapsed and did not want to seek help again and has a bad overview of counselling in general. With this point I strongly agree that there should be a minimum level of qualification if you are going to interact with clients and provide a clinical service for the clinician's safety regarding burnout and the safety of the client.

To uphold the professionalism and quality of delivery of services to our clients. So we also have a consistency in the delivery of services over the States, which allows for a professional to go from State to State and work effectively in what ever arena they chose to work.

Until recently in Victoria there was no minimum qualification for 'specialist workers' - In the late 1990's approximately 30% had no post-secondary schooling qualifications. This has now changed with the introduction of the minimum qual of Cert 1V in alcohol and other drug work. The challenge now will be for the sector to identify roles that require higher qualifications and make this mandatory. This will apply to most roles. Government will be reluctant to do this because it will be costly *(8, 4)

Untrained/uneducated workers can unknowingly have a negative impact on client's attitudes/lives. It is important to be aware and knowledgeable in alcohol and other drug for this reason

We are dealing with a vulnerable client base who bring multi-layered and complicated and often delicate and or volatile issues to the agency. They are entitled to professional support on every level. Unprofessional support, though well intentioned, can prove disastrous in this environment. Agencies that deal with vulnerable clientele can attract predatory individuals, whether on a physical, emotional philosophical level, these workers can do much damage to the client, themselves and the profession, and too often do. Compulsory minimum alcohol and other drug qualifications, especially around issues of communication, professional boundaries and mental health issues, and presented with some degree of intellectual rigor can assist in filtering out those who may approach this work with an inappropriate, naive or romantic agenda.

We are working with an extremely vulnerable client group who need specialised support. Even workers who come from a background of life experience should have a grounding in professional theory.

We need a way to ensure people who work in the health industry have a minimum qualification set.

Whilst I have worked with a range of people who have had an interest in the field as a range of their own or others D&A use & some of those people have been great I think it is important that all who work in the field should have at least a base line from which all are starting. By this I mean that all are able to provide consistent information to the people being seen about specific drug types & what effect /impact they have. It is also important for people to have a baseline of what is meant by professional boundaries & ethical behaviour. Some basic counselling skills would also be of advantage

Workers need a sound knowledge of the complexities of dependency, addiction, withdrawal, poly drug use, the effects on all aspects of health, effects on behaviour on family, knowledge of pharmacotherapy, a high level and knowledge of therapeutic approaches to counselling. Skills in assessment

Working with people with addictions issues is complex, a minimum qualification will increase the benefit to clients and minimise the risk to staff.

Workplace assessed competencies in all aspects of the alcohol and other drug field including knowledge, skills and attitudes

Theme 4: Compulsory minimum desired, but practical issues need to be considered (increased difficulty with staff recruitment, reassessment of the current employee's qualifications, etc.)

How will the step up to a minimum qual be funded and what transitional arrangements be in place? This question is too worker orientated and not adequately probing the issues for organizations and how they fit into alcohol and other drug engagement structures.

Whilst in the ideal world, it would be beneficial for all alcohol and other drug staff to have a minimum alcohol and other drug qualification; the reality is that it is becoming increasingly difficult to find suitable staff that have at least had experience working in the alcohol and other drug field.

Would be preferable, but already difficult to recruit without a compulsory minimum.

Theme 5: Minimum Certificate IV in alcohol and other drug should be the norm

A minimum Certificate 1V in alcohol and other drug and dual Diagnosis capable I believe are all that is required to work within this field. Workers bring with them a range of other experience and qualifications that can add to the work done in treatment.

a minimum of cert 4 training

Addiction Studies - Certificate 1V TAFE

All staff in our service must hold as a minimum qualification Cert IV alcohol and other drug.

Alcohol and other drug is a specialised field and therefore at least a minimum of a cert 3 qualification should be required.

Cert IV (alcohol and other drug)

Cert IV alcohol and other drug

Cert IV in Alcohol and Other Drugs

Cert IV in alcohol and other drug should be the min qual for working in any D&A setting.

Certificate IV should be minimum, even feel staff who have completed tertiary studies should complete the Cert IV as a practical and hands on approach to the alcohol and other drug work required - find tertiary employees have knowledge but very limited practical application

In recent years a number of Australian states have introduced a minimum qualification strategy for their alcohol and other drug workforce. While it is acknowledged that there is an extensive depth of knowledge and skills within the Australian alcohol and other drug workforce, the recent move towards the introduction of minimum qualification strategies highlights the need for alcohol and other drug workers to have accredited credentials specific to their field. That is, that there be a consistent approach to learning and skills development based on nationally recognised standards. In line with this, I believe there should be a minimum qualification. At this stage I believe it is reasonable to expect a Certificate IV in alcohol and other drug Work to be the minimum qualification. However I believe this should be reviewed in the future.

Minimum standard should be at least a certificate 3\4 in alcohol and other drugs

Probably a Cert IV as a minimum standard

There needs to be a shared understanding of basic skill sets pertinent to assessment, counselling and alcohol and other drug intervention/support practice. For working with alcohol and other drug clients a good understanding of assessment and counselling skills should underpin intervention. Frontline workers need a working understanding of a range of different approaches to alcohol and other drug problems (medical models of problem definition, abstinence based approaches, harm minimisation, client centred practice, motivational interviewing).I think that for any roles involving client assessment and interaction, a Cert III or IV is essential (along with the ongoing guidance of a more experienced counsellor or clinician). Also, an understanding of the need for reflective practice, and modelling appropriate behaviours is crucial too. People doing alcohol and other drug work need to cultivate and build on a professional ethos that is characterised by respect for clients and co-workers, commitment to ongoing development, non judgmental approaches and good communication (including assertiveness skills, listening skills, learning to challenge in a non-confrontational way, appropriate documentation and all aspects of confidentiality considerations). *(12)

Workers need up to date training on alcohol and other drugs work specifically in addition to other qualifications, e.g. psychology, social work. Undergraduate and masters degrees in other fields do not provide the scope of specialist knowledge required.

Theme 6: Minimum Bachelor's Degree in an alcohol and other drug related field should be the norm

3 year degree in Nursing, Social Work, Psychology

3 year degree in nursing, social work, social welfare, psychology or human behaviour

All need at least a Bachelor's degree with a strong component in human service delivery, communication and consultation skills and behaviour change. They need to be able to understand and explain complex ideas, think broadly and understand the broad social context and be capable of learning from the literature. Then they need specific alcohol and other drug knowledge - including the theoretical underpinnings of various types of assessment and treatment and how they fit together into an overarching conceptual framework, and specific skills including motivational interviewing, client centred counselling, Cognitive behavioural therapy, etc. The Cert 4 is completely inadequate - my experience is that many staff who only have this qualification, while having specific knowledge about drugs and their effects, and being competent in delivering specific interventions, have no theoretical framework for what they do, often do not know why they do what they do, and are very narrowly focused and highly resistant to change in response to new evidence. *(11)

At our service all alcohol and other drug clinicians are required to have at minimum a degree to obtain employment. Mentoring and on hands experience for those with a degree has shown to be sufficient therefore I do not agree that alcohol and other drug qualification should be compulsory. However once a person has obtained employment in D&A, if needed they should be given the time to attend TAFE and gain qualification in order to expand their knowledge. This would be beneficial for some workers. I believe this to be an individual decision as many are able to update through reading, in-service and furthering their own education.

bachelors degree

Graduate level only, i.e. Nursing, Psychology, Social Work and Occupational Therapy

I believe that D&A workers should have a basic undergraduate degree in nursing, psychology or social work with training specific to managing client behaviours more focussed on anger management and professional boundaries.

Tertiary qualifications in a recognised field e.g. nursing, psychology or social work. alcohol and other drug content can be learned via training and support at orientation and on the job

The minimum alcohol and other drug qualification should be set at a tertiary level. Ideally, a Bachelors degree, but practically, a diploma in counselling / alcohol and other drug would be more achievable.

Undergraduate degree level is now a standard selection criteria for employment within our services. It provides a specific level of knowledge and skills, both clinical and systems, that ensures a baseline for our service delivery

University with strong emphasis on counselling skills as well as alcohol and other drug background, history, knowledge of services, models, mental issues.

We do not employ any alcohol and other drug workers below a Bachelor degree which includes alcohol and other drug specific study

Theme 7: Graduate Diploma in alcohol and other drug work should be the norm

Advanced diploma or Degree PLUS core competencies in alcohol and other drug and Mental health as a min

Due to the complexity of the clients, the specialist nature of the treatment and assessment the minimum qualification requires post graduate standard at least. We have misled those who have attained Certificate IV or Diploma qualification with their expectation that they are able to work in the alcohol and other drug field.

Firstly the employee should be a registered health professional with preferably a postgraduate qualification such as Grad Cert in Health (addiction studies). With the current emphasis on dual Diagnosis it is medico legally inappropriate, ineffectual and does not meet government policy if non registered health personal completes a health assessment and case management. How does someone who has never completed any pharmacology training understand about medication & appropriately encourage Opioid treatment clients or dual diagnosis clients to comply with their mental Health medication regimes as well as Pharmacotherapies including Opioid Treatment, with the drug and alcohol program. As well if unqualified staff are performing assessment and case management they are not responsible for that care - the responsibility is with the qualified health person who delegates such duties to that person. It is paramount this inappropriate behaviour is urgently addressed - clients accessing drug and alcohol services have a multitude of medical conditions, it is imperative that the have professional treatment by health professionals with understanding of care and requirement - The days of senior staff saying 'why would anyone need qualifications to work in drug and alcohol' demonstrated a gross misunderstanding of the fact that clients do have addictions to prescription medication & the Pharmacotherapies prescribed for addiction treatment must be monitored by health professionals with qualifications and understanding to work towards most appropriate client outcomes. To employ less then qualified staff is effectual discrimination - all other persons access in health services are provided qualified care. *(8)

Graduate Diploma in alcohol and other drug work

I strongly believe that a specialist post graduate qualification following an undergraduate degree in either Social Work or Psychology. I strongly disagree with Universities offering post grad places to TAFE diploma graduates this loophole is undermining the industries credibility. I have been a TAFE drug and alcohol trainer for 15 years and see many students do inappropriate expensive courses as post graduated when they don't even have an undergraduate degree. They still cannot get a job

Theme 8: Minimum should vary depending on the specific work position

Depending on the skill and value base from which the worker comes (e.g. whether they are a nurse who has worked in detox, therefore strongly medically orientated but with few counselling skills, or whether from a counselling or recovery background with little knowledge of pharmacology or with a particular counselling orientation, e.g. abstinence vs. harm minimization). Ideally, workers should have the skills to operate within the addictions field that include some basic knowledge of the pharmacology of illicit and frequently misused licit substances, an awareness of the value bases that shape alcohol and other drug service provision and an understanding alcohol and other drug assessment and counselling approaches (e.g. motivational interviewing vs. client centred non-directive counselling).

Trainee Alcohol and Other Drug Support Worker - Certificate IV Alcohol & Other Drugs Alcohol and Other Drug Support Worker - Diploma of Professional Counselling, clinical supervision Alcohol and Other drug Counsellor - Diploma of Professional Counselling, four advanced study majors,18 months to two years internal training, clinical supervision

Theme 9: Minimum qualification is needed for competency and basic skill level

Addiction is a complex condition with multiple common significant co-morbidities. *(3)

Minimum qualification provides the workers with basic knowledge and skills to work in the field. - To obtain certain qualification, the workers prove that they are competent

Theme 10: Balance between experience and training

A balance between experience and formal training is foundational to optimum service delivery and clinical skill.

Adequate and minimum qualifications would be of great benefit however practical experience should not be overlooked. If implementing minimum qualifications, consideration needs to be given to the impact upon the workplace such as ability to arrange appropriate cover if staff attend lectures/classes and the varying academic ability of staff for theoretical education.

Currently Cert IV alcohol and other drug would be minimum requirement backed with valuable work experience during that process this would be more for NGO facilities able to train onsite *(5)

I would consider demonstrated on the job experience to be equivalent to a qualification. It is the experience we are looking for and a qualification goes some way toward providing that but I would certainly consider someone with demonstrated experience even if they didn't have an alcohol and other drug specific qualification. Some of my staff have undertaken courses so that they can meet the minimum criteria even though they have experience above the course. They would qualify for RPLs but that can be more work than doing the course!

Minimum qualifications meet certain basic quality standards, however, and most importantly they do not provide the working 'experience', which of course only develops over time - unless the person has a personal background of alcohol and other drug.

Theme 11: Certificate IV is insufficient

A lot of staff that I work with do not have alcohol and other drug qualifications and if they do they have Cert IV, I do not believe that this is enough for case mgt staff that provide intensive support to clients through the journey. I think that in the courses there should also be a change in the content that includes things like motivational interviewing, more dual diagnosis training etc. It would improve the services to clients and would also provide for more confident workers that are able to assist clients from a strong theoretical and practice based framework.

I believe in order for the alcohol and other drug sector to be recognised as the specialist service it is the education and qualifications of staff need to reflect this. I believe the current Cert IV Minimum Qualification in Victoria is grossly insufficient particularly for 'enhanced' services. My preference would be to employ staff from disciplines such as nursing, social work and psychology who has post graduate qualifications in alcohol and other drug, work.*(8)

Theme 12: Vocational education and training diploma

Due to the lack of adequate funding the level of qualification would need to be Diploma. People with degree quals usually are short term and move off to better paying positions.

I believe that the Diploma alcohol and other drug is a sufficient baseline for less technical approaches to client support e.g. some counselling/withdrawal support/diversion work. In concert with relevant experience, it provides basic knowledge. However I believe those managing more complex clients really need further study in alcohol and other drug or related disciplines (e.g. social work, psychology, medical sciences) to best support the high needs areas and particularly to better understand multi-disciplinary approaches to treatment, to be able to easily incorporate research into practice and to view issues like advocacy at sector level.

I believe there should be a minimum compulsory alcohol and other drug qualification set at a TAFE level i.e. Diploma in Community Service/ Diploma in Drug & Alcohol. This would give staff an understanding and skills re Govt systems, NGO's , legislation, policy and procedures, client/ staff boundaries, ethics & accountability, case management, DV, Child Protection, marginalised communities, Aboriginal and CALD communities, and a range of other understanding and skills related to the Welfare industry.

* Statement relates to more than one theme. Theme number in brackets.

Table 17 Thematic analysis of Q17b: If you agree your alcohol and other drug workers need more alcohol and other drug training, please comment on the nature of the training you think they need

Theme 1: Certificate III

ONE WORKER NEEDS BASIC CERT 3 TRAINING

Theme 2: Certificate IV

Cert III - IV in Comm Svcs (alcohol and other drug)

Cert IV course could provide more training in one on one counselling & group facilitation strategies.

Frontline alcohol and other drug workers should have at least Cert IV in alcohol and other drug.

Minimum standard = Certificate 4 alcohol and other drug studies

Not everyone has the 4 minimum competencies yet. We're working on it!

Some of our alcohol and other drug Specialists are currently undertaking their Cert IV.....so they are incomplete. To this end, they require more alcohol and other drug training

We arte in the process of ensuring all our Indigenous staff have postgraduate qualifications and at a minimum cert 4 in TAA

Theme 3: Postgraduate diploma in alcohol and other drug work

Minimum of a post graduate diploma. Those with TAFE qualifications or generic undergraduate degrees in social welfare just don't achieve or perform at a satisfactory level.

Post graduate qualifications that are based on the worker already having a discipline such as nursing, social work or psychology. More emphasis on the neurological pathways of addictive substances advanced counselling, pharmacotherapies and evidence based practice. ***(5e, 5a)**

Postgraduate Basic Skills including Assessment and Interventions, Discharge Planning, Medical issues in alcohol and other drug, Risk management ***(5i, 5c, 6)**

To continue study to degree levels

Theme 4: General ongoing training as alcohol and other drug sector is continually changing

Administration (report compilation), case note management, computer skills, theory and framework backgrounds (community development principles), life balance to prevent burnout, clinical supervision training, communication skills, alcohol and other drug knowledge (addiction, withdrawal process, related issues) ***(5h, 5j)**

All of us can continue to learn more to assist people with substance use disorders as science tells us more about the interaction of drugs and the brain**. *(5e)**

All staff need to expand their knowledge on current practice and keep abreast of the field. Mostly staff know what they require and often request training. Only problem is that there is limited funding for courses within our field. Perhaps making workforce development funding compulsory would be the way to go.

Alcohol and other drug specific training is lacking in most generic health professional training

As trends in drug use are continually changing it is important for alcohol and other drug workers to update their knowledge and skill level.

Can never have enough training

competencies in the filed need to be assessed to plan worker development

emerging evidence based practice across a range of areas

EVERYONE needs ongoing training... our field is moving forward constantly. Specific areas include mental health care, CBT, ACT and pharmacotherapy basics**.*(5c, 6, 5e)**

Historically the service has employed a number of workers without undergraduate degrees. There are a number with TAFE and other qualifications, and some without any qualifications. This seriously limits the level of service that is provided to clients - i.e., these staff tend to provide supportive services rather than therapeutic interventions. There are also risk issues when staff with limited knowledge and skills are managing clients with complex (including medical) problems. ***(5c, 6)**

I believe that all staff should be continuing with their education in the alcohol and other drug or related fields. Counselling skills is an area of great need within the alcohol and other drug field and is greatly under provided in the NT ***(5a)**

I believe that the alcohol and other drug sector is a continually changing area and continuing training is beneficial for all.

I believe there is a need to update to keep relevant with the industry, can be a one day seminar etc

Impact of alcohol on functioning, physical affects, Stages of Change model, intervention, language of motivation, as well as how to work with challenging behaviours (related to intoxication) ***(5a, 5b, 5c, 5e)**

Ongoing skill development required to ensure that skill level is maintained and that new evidenced based practice is incorporated as available.

People can always benefit to access to regular training and updates.

Regular, ongoing In-service training sessions (that are accessible on a rotation basis for teams that operate 24/7 services) are always required to keep staff updated re latest research findings, implications of research findings on clinical practice, new treatment modes & or pharmacotherapies. ***(5e, 5d)**

Some new the organisation from other fields, would benefit from more alcohol and other drug training.

Some of the staff are very experienced in the filed whilst others are still learning and are encouraged take up courses provided by QH alcohol and other drug training unit and other courses available

some requiring such basic training as drug groups and their actions, assessment, withdrawal identification and management, motivation enhancement, relapse prevention, knowledge of local services ***(5f, 5i, 5g)**

Specialists training and ongoing professional development to adapt to emerging issues

Thinking skills, learning from the literature, motivational interviewing, CBT, group facilitation for therapeutic groups, theoretical frameworks, effective interventions, reintegration, relationships between drug and alcohol problems, mental health and offending behaviour. ***(5b, 5c, 6)**

Training is an ongoing process in this agency.

Training is required on a continual basis due to changes in research / best practice.

Training should be ongoing. Each of the staff in my service hold a degree for their discipline as a minimum qualification.

Updating professional and sector knowledge. Continual professional development.

Working with people is not static. Everyone can always improve on service delivery

Thinking skills, learning from the literature, motivational interviewing, CBT, group facilitation for therapeutic groups, theoretical frameworks, effective interventions, reintegration, relationships between drug and alcohol problems, mental health and offending behaviour. ***(5b, 5c,6)**

Theme 5: Core alcohol and other drug skills

5a: Counselling

More training on counselling skills - services available information - Mental health issues ***(6)**

As before. Extensive and appropriate counselling skills. Early and brief interventions as well as how to work long term with clients based on psychological research not just 12 step philosophy. Extensive knowledge of services and their philosophy. Knowledge on mental health issues and how this effects drug and alcohol use**. *(5c, 6)**

Counselling skills

Counselling skills and group processes. At present I have to supply this training in my spare time ????????

Ongoing Counselling and Pharmacotherapy training a requirement. Some work experience in hospital drug and alcohol programs. Attendance at Australian Institute of Counselling in Addictions is mandatory for ongoing counselling education and training. ***(5e)**

5b: Motivational interviewing

Communicating with clients; being non-judgmental. (I work in an Indigenous Community and the community members I employ are often very judgmental of those who attend the service. Practical group training, individual counselling and time management. ***(5a)**

Motivational interviewing Pharmacology Developing a professional ethos How to effectively engage in case management work How to effectively deliver education sessions ***(5e, 5g)**

Motivational interviewing, confidentiality training

5c: Interventions

interventions

more in the different cognitive models and strategies to address anxiety and depression ***(6)**

Specific to their role. E.g., MERIT, detox ...

They need a wider-view of treatment approaches ***(5d)**

5d: Evidence based treatments

Understanding what evidence base treatment is. Family inclusive practice. Co-morbidity ***(6, 5c)**

5e: Pharmacotherapy

Social workers employed in the service have never completed any pharmacology training & need support to understand treatment programs and Mental Health medication. Non nursing staff do not understand diabetes & some staff over the years have needed extensive training re HIV< Hepatitis C, hepatitis B and how to support clients with such conditions. ***(6)**

5f: Withdrawal management

Training in CBT, DBT, Stepped Care, pharmacology, clinical assessment of withdrawal, interpretation of pathology results, family therapy, drugs in pregnancy ***(5c, 5d, 5e, 5i)**

5g: Relapse management

MI, relapse prevention, harm reduction - everything. Just because a person has worked in an area a long time, doesn't mean they actually have formal training in the area! ***(4, 5a, 5b)**

5h: Case management

Cert IV is not enough people need more counselling and case management training. Could add mental health and family to the list and whilst this does not have to be alcohol and other drug specific it would be good if it was set in that context. I think we should move toward graduate level qualifications. ***(5a, 6)**

In relation to what a clients is trying to achieve in their lives and in particular with the drugs are the drugs successful. Is there an unwanted cost. Can the result be sustained by drugs? Is there an exit plan if the drug succeeds or fails? What is any other methods as well as drugs or instead of drugs are there of achieving the desired result. ***(5f, 5g)**

More intensive training on supporting clients through difficult times, training more often on new treatments that are shown to be working (keep options for clients open and broad to be able to tailor more suitable treatments and pathways from addiction), counselling techniques, dual diagnosis, self care ***(5c, 5d, 5a)**

5i: Assessment

Assessment Co-morbidity issues (specifically mental health) Culturally appropriate interventions ***(6)**

Assessment skills, pharmacology, clinical assessment of patients in withdrawal / intoxication or patients with D&A related conditions, co-morbidity, drugs in pregnancy, counselling skills, family therapy ***(5f, 6, 5a, 5e)**

Specific alcohol and other drug clinical information (e.g. assessing who can withdraw in community, who needs inpatient care). Specific training on brief intervention and motivational interviewing. Skills in delivering mentoring, coaching and clinical supervision. For some, cultural specific counselling/intervention skills for Aboriginal clients. ***(5c, 5b, 5j)**

5j: Clinical supervision

I believe everyone should keep their skills updated and training is one means but also better access to clinical supervision and conferences etc as well as access to online journals. ***(4)**

Theme 6: Co morbidity

Comorbidity is easily identified as requiring attention in training and development of staff. Mental health support for alcohol and other drug clients should be part of any alcohol and other drug rehabilitation service portfolio and professional development for staff should include at least fundamental training or specialist training where appropriate. Not all staff need to be specialists, but awareness and referral pathways need to be more broadly developed.

I take every opportunity to support alcohol and other drug staff to engage in further training. Co-morbidity is currently a priority training area; funding permitting.

I think that it is imperative that clinicians continue to gain education and training in specific areas i.e.: mental health and in any new or specific counselling models. ***(5a)**

Mental illness, methamphetamine use and other complexities make the work more difficult ***(4)**

Training in Mental Health, specific pharmacotherapy training, treatment planning, case management ***(5e, 5h**)

Training on working with mental health clients with alcohol and other drug issues, especially senior first aid Training on Occupation health & safety around alcohol and other drug alcohol and other drug trigger points Responding in an emergency

We are having in house comorbidity training this year.

Working with families alcohol and other drug and comorbidity Pharmacotherapy and withdrawal management ***(5e, 5f)**

*Statement relates to more than one theme. Theme number in brackets.

Table 18 Thematic analysis of Q21b: If some alcohol and other drug specialist positions took four or more months to fill, please comment on why you think this might be the case.

Theme 1: Difficulty with recruiting in remote areas
Geographical location - rural. Short term contracts. Recruitment management system. Lack of skilled workforce in the area. *(7, 3, 5)
In Remote areas of the state qualified people are few and far between. Working in a government department is of greater financial benefit than working in the equivalent position for a NGO *(2, 5)
It is hard to recruit to remote areas. In the two positions we have filled we have filled with people lacking the skills to do the job with the idea of on the job development. Otherwise we have transferred people across internally from our inpatient services to fill the role. We still have three positions unfilled. Area Health systems have also slowed down recruitment for some positions.
Rural area & whilst we had applicants some of the had no specific quals /or experience & would not have been able to successfully fulfil the requirements of the position or they would be the only D&A Worker in a specific location & this would have potentially created problems in terms of appropriate supervision *(2)
Rural/remote locations are more difficult to recruit to.
The location of the role, the pay scale - we simply can not pay enough to get the level of qualification and experience we require *(5)
the regional location
We are a rural/regional service so difficult to find the right people.
Theme 2: Lack of applicants that meet job application requirements
Aboriginal alcohol and other drug workers are difficult to recruit and retain. It took 4 months to recruit our current worker.
All nursing positions - Possible lack of identification of alcohol and other drug as a specialist service, lack of suitably qualified persons to apply.
As previously mentioned, it is difficult to find staff that have had suitable experience working in the alcohol and other drug field.
field too specialised
Inadequate skilled people within the community. We have taken on two trainees who are working towards their Cert 3 In primary health.
Indigenous alcohol and other drug staff scarce
lack of skill set by applicants
Lack of skilled appropriately qualified staff
Limited pool of specialist or requiring workers where staff shortages are well documented (i.e. nurses and medical officers
Need a female employee with experience working with Aboriginal clients;
No minimum standard exists in Queensland, lack of trained qualified staff
no suitably qualified or experienced applicants
Rather than employing underskilled and unqualified clinicians and managers we have waited for appropriate applicants. The isolation of Tasmania and very low standard of care provided by its ADS also contributes to this.
Specialist positions such as Medical Officers and higher than base grade positions have been difficult to recruit to because of the level of experience and skill required. Able to recruit to base grade positions and provide training however often necessary to fill more specialist roles and this has not always been possible.
the difficulty is when the position requires additional specialist knowledge other than alcohol and other drug such as family work and mental health

We have a high standard for our alcohol and other drug counselling staff that requires undergraduate degree + alcohol and other drug qual + Counselling Qual, whilst this standard has eventually resulted in exceptional staff it was extremely difficult to establish and required 3 rounds of recruitment processes to finally recruit the appropriately qualified staff.

Theme 3: Complex recruitment process or complex government recruitment policy

Delays in the recruiting at a departmental level, attracting staff to rural, areas, seeking staff with a 3 year degree

E-Recruit is problematic to the employment process and how long it takes to get an appointment approved by the fifty thousand people the application has to go through!!!!!

It just takes that long to get anything through Queensland Health HR processes.

paper work

Partly due to HR processes within the organization and sometimes there are limited experience staff that meets the key skill requirements for the positions *(2)

Slowness of government processes; People with little experience of alcohol and other drug work or sector apply for the jobs; this is a regional agency so lack of collegiate support for alcohol and other drug workers; many other alcohol and other drug agencies in the region struggle to recruit, and hire people who not only can't do the job but create a negative impression of the agency and the work. *(1, 2)

Slowness of public service processes, changes in government (freeze on recruitment) Need to offer housing and relocation - resourcing issues and gaining required permissions Lack of suitable applicants *(4, 2)

The recruiting process itself has a long turn around period and often those looking for employment find something else in the meantime. There is difficulty finding suitable applicants *(2)

We have several vacant positions waiting to be advertised. There is a freeze on in Govt recruitment.

QLD government recruitment and selection processes

Theme 4: Inadequate funding

Health Department funding

limited resources to spend time on recruitment processes, re-advertising, have temporary arrangements for the interim

Theme 5: Inadequate pay

For NFP positions, pay scale is often considerably less than that with government and private practice for more advanced practitioners. This forms a major barrier.

We have had some issues filling residential support worker roles, especially for senior staff. This isn't because they're not qualified; rather it is to do with the pay-scales.

Theme 6: Stigma of working in the field

a lack of interest in working with people with comorbid Mental health and substance use disorders

reluctance to work in the correctional environment

Theme 7: Work conditions

The above number of positions advertised is in relation to permanent part/full time positions which are filled internally from casuals. Casual staff are difficult to recruit and retain due to an inability to offer regular hours. Recruitment of casuals can take more than 6 months.

*Statement relates to more than one theme. Theme number in brackets

Table 19 Thematic analysis of Q22: Why do you think that you do not get enough applicants when advertising for alcohol and other drug specialist workers

Theme 1: Remote area
Because of the remote location of the services
Difficulty attracting qualified, competent and experienced staff. Regional location, more money elsewhere in other positions. *(2, 3)
Hard to get people in rural areas. Usually only 1 or possibly 2 suitable out of about 8 - 10 applicants.
In Remote areas of the state qualified people are few and far between. Working in a government department is of greater financial benefit than working in the equivalent position for a NGO. Short term contracts due to government funding arrangements are less attractive than working in a government funded agency. *(2)
Large problem is our geographic location being remote/rural. Also being a residential Therapeutic Community means we are very particular about staff.
Many applicants can't demonstrate the required skills. The government application process is difficult and requires good internet access. If we recruit from outside the region we need to demonstrate that we have adequate funding to relocate and house workers. If we can do that then the relocation and housing negotiation process is difficult and time consuming. Local recruits aren't entitled to subsidised housing (effectively pays most of a rental) so there is a financial disincentive for locals. *(3)
minimum qualification regional and rural recruitment issues *(2)
Not enough applicants in regional and rural areas. Lack of adequate remuneration *(3)
remote & isolated location, harsh climate, small knowledge and skill pool, difficult field within which to work in this region, *(2, 4)
Rural and remote location. Particular interest in working with Aboriginal communities. This is a sector also where lots of people have come through the AA/twelve step programs, and we are looking for a more evidence based practice, community based, harm minimisation type approach. Also, we are looking for high level skills for our clinical staff to be able to operate in isolated communities with limited support. We have had to compromise around cultural, clinical, community development and training and development skills and build a multi-disciplinary team. *(2, 5)
Rural areas, little scope for career advancement, D&A not viewed as an attractive field to work in, limited availability of clinical supervision or professional development *(4, 6)
Rural/remote location. Lack of professionalism in the workforce detracts from ability to recruit more qualified staff. *(6)
the regional location and lack of incentives to live in remote locations *(3)
Theme 2: Applicants do not possess required experience or qualifications
A yes or no is not appropriate here. It depends on the area of specialty and where you are asking them to work. Very remote is very hard to recruit to. *(1)
applicants do not have the experience and or qualifications for the position
except where additional specialist knowledge/skills are required
Generally yes but not always adequate, and many haven't worked out in the initial probation period, as they had inadequate skills.
Get many, many applications with only very few considered appropriate
I am not sure but I don't think that there are many workers out there with alcohol and other drug qualifications
If less than adequate is less than 6 applicants. Most staff don't want to work in the D&A area as it is regarded as too hard. Difficult complex clients lacking in motivation who often don't turn up for appointments. Generally new staff learn on the job as the training is not available through Uni courses. Often when they have been working with D&A staff find it very easy to get jobs in related workforces as they have the D&A experience behind them. *(4)
In the last two or three years I have noticed that applicants with specialist alcohol and other drug skills have been harder to find. This may be due to higher than usual employment opportunities in the West and greater rates of pay in the government or profit sector. *(3)
It was clear from advertisement that key selection criteria required certain qualifications this reduced number of appropriate candidates to interview, we did however have a large number of inadequately qualified applications that were not considered for interview.
Lack of applicants that meet the requirements
Lack of places for workers to train. We are often the unit where untrained graduates come to begin their alcohol and other drug specific training.
Lack of skill set
lack of skill set by applicants
Many applicants have no experience in site specific counselling i.e.: therapeutic communities and show very little understanding of the differences between i.e.: out patient counselling and program counselling.

My organisation has relatively demanding selection criteria, and requires workers to have a minimum qualification. This may restrict the number of available applicants, as many workers in this field have limited qualifications.

Our specialty is dual diagnosis. Sometimes the minimum qualifications & experience we ask for is intimidating to potential applicants.

Recently I have noticed a decline in the number of applicants with sufficient alcohol and other drug work experience. This is possibly due to high employment and more attractive remuneration in government and for profit sectors. *(3)

Require alcohol and other drug qualifications plus TAA qualifications. Very difficult to find applicants with both areas of expertise and experience.

There is not a big enough 'pool' of alcohol and other drug specialist workers in the work force. It is a difficult field to work in. There needs to be better incentives to encourage health workers to consider working in the alcohol and other drug field *(3, 6)

This is a yes and no answer where I have had ample applications that were hard decide due to quals but others I had applications where no one was qualified and we had to re-advertise. Also it think it depends on the position specs too.

We receive many applications that do not match/meet our essential criteria.

We seem to get lots of applications but from people who have very little or no D&A experience. It is possible the increase in funding to the D&A sector over the last few years has drained the qualified pool.

Generally advertise for more qualifications.

Theme 3: Low rate of pay

Income levels and because we are principally policy focussed

Pay is the biggest barrier to people with specialist skills coming to work in this sector and this organisation. The pay is low and does not compete with other opportunities. This means that often we employ new graduates that do not have the practice work and when they get this they leave for better paying jobs.

Poor remuneration, low unemployment, lack of people specialising in field *(2)

Rate of Pay is low. Perhaps not enough people interested in this type of work. generally poor employment conditions when compared to other similar type roles (mental health, counselling/therapy) & in this service the physical environment for staff & clients is inadequate no private space for staff etc . *(4, 6)

The main issue is the poor remuneration level.

The positions do not pay well, but require experienced people who abstain from drugs and alcohol *(2)

varies, but mostly the wages are too low

Wage levels compared to the private and public sectors

Wages are the most common reason given. Disparity between NGO (not for profit) and government/private sector remuneration.

Theme 4: Drug and alcohol area is not a highly desired field to work in

D&A not attractive for people to work in, no career structure for nurses.

I do not think that Drug & Alcohol is seen as a reasonable career pathway by some sectors, it isn't seen as "nice" or "rewarding" as working with other groups & I believe there is still the general concept in the wider community that this is a self inflicted problem.

Industry burn out. Pressure on staff through large waiting lists *(6).

not appealing to most

Not everyone wants to work in this field.

Not very attractive places to work - remote towns, extreme weather, isolation, little collegiate support, limited agency support (manager not on site), extreme intractable problems, and very political environment. *(1, 6)

Peoples perceptions of alcohol and other drug Clients/Stigma

Stigma of working in this area, although often feel it is one of the best kept secrets of how good it is to work in this area. Lack of local specialists - high demand for a small pool of people. *(2)

Theme 5: Position requires special skills (e.g., bilingual)

Some of the positions require bilingual counsellors/ workers. This makes it hard to fill the positions. 6- It is also difficult to recruit people if the job is part time

Theme 6: Work conditions (e.g., shift work, part time)

Shift work, requiring people to have interest in working with people under the influence, wages, competing with Public Service salaries *(4, 3)

*Statement relates to more than one theme. Theme number in brackets

Table 20 Thematic analyses of Q27: Please provide comments for your preferences for particular alcohol and other drug qualifications

Theme 1: Vocational education and training qualifications provide more practical and relevant skills
In my experience I have found that the TAFE training is very suitable for our service. I deem it very fortunate if I get someone with higher qualifications. Even then I believe the TAFE training as well is a great benefit. Especially the alcohol and other drug training. On the job training is very important in Therapeutic Communities.
Non-accredited alcohol and other drug training can be inconsistent and levels of participation difficult to ascertain. Attainment of vocational education and training qualifications at least offers hope that there is some attainment of competencies.
Specific qualification in alcohol and other drug more relevant to the workplace than university degree with related training
Vocational education and training qualifications come with hands on experience and competency in the area. Postgraduate qualifications are based on theory only
Specific alcohol and other drug education is more relevant than an university degree
Theme 2: Postgraduate qualifications provide more professionalism and higher skills overall
All positions are within professional stream either RN or AHP so relevant university undergrad degree is a given. Positions not open to those with vocational education and training alcohol and other drug qualifications only. Of those with relevant university undergrad degrees, prefer those with relevant post grad alcohol and other drug qualifications as this generally minimises amount of "on the job" training that needs to be provided
Postgraduate alcohol and other drug provides higher professionalism, better overall skills, knowledge and evidence based assessment and intervention, higher ethical standards and it minimizes the amount of “on the job” training
I would prefer my employees to concentrate on a general undergraduate & post graduate qualifications with essential clinical training. The agency I manage is non-residential which caters to short, medium & long term counselling. It is essential my staff have the knowledge and counselling experience to work with all types of clients with all sorts of issues and not just an alcohol and other drug symptom.
If a person has post graduate alcohol and other drug qualifications that's beneficial, but not necessary. I prefer Post-grad as I assume a higher level/quality of information to be provided.
Most preferred are postgraduate quals whether D&A or not. EG. postgraduate in counselling or psychology or nursing would be as good as postgraduate in D&A.
Post graduate alcohol and other drug qualifications would ensure evidence based assessment and intervention, professionalism and free my senior staff from the incessant need to provide basic training to underqualified team members. Although you would not accept a Level 2 first aid qualification for a withdrawal nurse position it is common practice to recruit non-qualified of TAFE qualified staff into clinical positions.
Post graduate most preferred but often not available - most often available undergraduate specialisation plus some training courses.
Post graduate qualifications work from the perspective of the particular discipline having covered ethical and professional standards to base further education on.
Prefer degree + post grad alcohol and other drug qual because of overall skills, knowledge & professionalism.
Staff are mostly RN's , Psychologists and Doctors *(3)
The Addiction Counselling Services Programs clientele are predominantly professional people. The alcohol and other drug workers who have been employed by ACS are also required to have some work experience/training in a professional setting (e.g. hospital, outpatient programs) and attendance at the Australian Institute of Counselling in Addictions to further their education and skills in the areas of counselling, record keeping, family programs, confidentiality and privacy issues, etc. *(3)
The organisation is responding to pressure from the trend in structured service excellence and quality improvement to employ workers with at least University degree in a relevant discipline which doesn't have to be alcohol and other drug. Currently we have a number of excellent employees who are TAFE trained but I am told that in the near future in our advertising for positions we will be requiring at least University Qualifications, (which isn't necessarily my personal opinion). *(3)
Vocational education and training alcohol and other drug qualifications only provides practical skills only whereas Undergraduate degree provides the strategic overview and theory.
We are actually trying to move away from having specialist alcohol and other drug workers towards embedding alcohol and other drug work into all roles. Obviously we would like all our workers to have post graduate qualifications if we could, however, Undergraduate degrees with explicit alcohol and other drug content or relevant university undergraduate degree plus accredited alcohol and other drug education and training would be very good too. I have added 'education' to your term 'accredited alcohol and other drug training' as it is essential that it includes a sound theoretical framework and ability to think critically as well as the desired knowledge, skills and attitudes *(5).
Theme 3: University degree with alcohol and other drug training provides a mix of theory and practice and ensures professional registration
Government agencies have a preference for workers with tertiary qualifications. As the section I manage is responsible for training and education the more qualified the better, however, we always take into account a persons relevant experience , which can be more valuable that a formal qualification at times. *(5)

I think as long as the person has a basic undergrad qualifications with relevant alcohol and other drug training

University degree with alcohol and other drug training because the first ensures professional registration

I think having the academic qualification assists with registrations etc.. (i.e. counselling and quality of this work) and the vocational education and training element ensures practical competency so my preferred staff member has both.

I think that the TAFE alcohol and other drug course is not particularly focused on harm reduction. Often it is easier to work with someone who has a basic degree in social science or nursing and for us to do the HR training ourselves. *(7)

It depends also on the type of worker and years of experience. We compromise for Aboriginality. There is a credibility gap for vocational education and training trained staff - even if a staff member is very good and very experienced, some agencies would prefer a "registered professional" with no experience over an experienced vocational education and training qualified worker, particularly for counselling tasks. Obviously there are some things, particularly to do with detox and pharmacotherapies where medical or nursing qualifications are required for safety.

Most preferred would actually be - relevant undergraduate or equivalent generic training, plus previous alcohol and other drug work experience, and then additional formal alcohol and other drug qualifications.

Most staff employed by this service require Degrees in relevant fields associated with alcohol and other drug. The service positions available require degrees with only a small number being open to staff with no degree. I am happy to employ staff in the open positions who have a vocational education and training qualification only or who are working towards obtaining one.

Staff need a undergraduate diploma etc. as a base qualification to work in welfare, then specific training for specialist area, such as alcohol and other drug. Alcohol and other drug could be a component of a undergraduate qualification as there is considerable overlap.

The degree and the vocational education and training alcohol and other drug qualifications often presents with a more well rounded candidate that often has associated life experience which is helpful. Our experience of undergraduates has, at times, been characterised by a high level of theoretical and intellectual expertise but little life experience.

Theme 4: Client is likely to benefit more if an alcohol and other drug worker is more qualified

The more qualifications the better for the clients. The least knowledge I tend to think of the clients wellbeing in the care of the clinician. *(2, 3)

Theme 5: Preferred qualification depends on the nature of the work required

Qualifications alone are not the decider for effective recruitment. Relevant demonstrable skill sets which generally are found in qualified persons make part of someone's employability. Attitude, adaptability, learning ability and team fit are also important. Alcohol and other drug specialist workers would ideally have a relevant degree and alcohol and other drug specific accredited certification, but often a mix of qualification, experience and skills is the most effective fit for broad-based client groups.

This is a really difficult question to answer. We recruit for a REALLY wide range of roles within our agency, from entry level support workers in our residential units, nurses, counsellors for rehab, counsellors for prison settings. The MINIMUM we expect is the 4 alcohol and other drug competencies. Depending on the role depends on what other quals they need. We also recruit heavily based on experience.

to be honest it depends on the nature of the work they are doing in our case, it is more important that they have good research and analytical skills and interpersonal skills

We will employ people who have a mixture of qualification and or experience

Compromise on educational requirements for Aboriginal workers

Theme 6: Quality/content of vocational education and training not good

Because of rural location we would welcome new grads - very difficult to attract experienced staff. Vocational education and training alcohol and other drug qualifications don't provide a good theoretical framework for managing clients with complex needs.

Some vocational education and training sector qualified staff cannot demonstrate skills or competencies that should have been attained at the appropriate level. I think there is much inconsistency out in regional and remote RTOs, and a lack of scrutiny of the work of some of these RTOs. Some are good, but I have found that when prospective applicants tell me they have trained at certain organisations, I consistently find that they cannot demonstrate even the most basic alcohol and other drug assessment skills and they lack knowledge of the sector. While some of these vocational education and training sector providers are funded based on throughput, they will remain motivated to just keep people enrolled, whether they attend or not, or whether they achieve the required standards or not. I suspect many of the people I've interviewed who have vocational education and training sector qualifications have either not fully attended a course, or the RTO wasn't adequately scrutinised.

Vocational education and training in alcohol and other drug alone is not adequate because it does not provide a good theoretical framework

Vocational education and training in alcohol and other drug varies greatly, with students often lacking in basic knowledge

The standard of the vocational education and training course available in ACT is not great, hence low preference

Theme 7: Vocational education and training qualifications more appropriate due to low levels of pay for alcohol and other drug work

Cert IV quals are quite good & with a bit of coal face experience, provide a good mix. They also fit within funding budgets.

Coal face workers need to have theory to inform their practice. The wage level that we pay alcohol and other drug workers would not be appropriate for University Graduates.

Easier for workers to access and complete

Poor remuneration due to inadequate funding prevents the acquisition of staff with higher levels of education.

Vocational education and training in alcohol and other drug is good as the pay level is adequate for that type of education, but not adequate for university graduates

Other

*Statement relates to more than one theme. Theme number in brackets

Table 21 Thematic analysis of Q29: What barriers may prevent you from employing alcohol and other drug workers? ("Other' category)

Theme 1: Specific requirements of the job/ applicants attributes

A number of those completing Cert IV alcohol and other drug qualifications have criminal records which would prohibit them from being considered and a number have only recently overcome alcohol and other drug dependence.

interest in specific area of alcohol and other drug work offered through this team

remote locality, low knowledge and skill pool

Sometimes it is difficult to mesh the required personal beliefs required for harm reduction work with people who have recently completed certain quals (i.e.: psych, nursing, social work). However, it is always more about the individual.

The positions we advertise are 50d positions, their are a limited number of Indigenous people with the formal qualifications in remote areas. also lack of housing

Insufficient personal skills

rural, remote location. cultural issues

Theme 2: Competing for applicants with other agencies, particularly government

Competing with Public Service re salaries and positions. Shift work only attracts a small % of workers *(1)

Competition with other agencies, particularly government

Others

D&A not seen as an attractive career choice

Limited by available resources

Cumbersome government recruitment processes, inequities in the entitlement system (people from outside the region get subsidised housing, locals don't), lack of career structure - to get promotions or higher level, you need to be part of one of the 'specified callings' - a psychologist, social worker, nurse or occupational therapist. Bachelor of Health or Social Science, with or without post grad, will not get you a senior position. Alcohol and other drug work is not recognised as a bona fide professional specialty.

Table 22 Thematic analysis of Q30b: Please comment on your reasons for satisfaction or dissatisfaction with the types of vocational education and training organisations indicated above.

Theme 1: Poor quality vocational education and training assessment

Having taught A&OD at the local TAFE I was surprised at the number of students who were 'assisted' through by TAFE coordinators and passed without sufficient merit. In regard to private providers my experience has been that often it is just " delivery only".*(2)

TAFE students are often "guided" through their courses/tasks to the extent where they do not always show self-initiative. In comparison, university education places responsibility on the individual to ensure the completion of educational requirements. For example, if an assignment is not completed on time at university, their is no "prompting or guidance" from lecturers and the consequences fall on the individual student. Personally, I believe "guiding" TAFE students to the extent that occurs results in a potential staff member that needs prompting and does not utilise initiative.

I like the Aboriginal Health College. I find that TAFES tend to take a long time and people drop out. Often they also use language that is unnecessarily complex. Sometimes, they seem to pass Aboriginal people without checking that they actually have the skills. Sometimes they put pressure on me to confirm that people have competencies when I think they don't, so someone can get through the course. Also, I think there is not enough practical clinical content, and too many generic units. I find that private providers have often provided training by correspondence. I think this is ridiculous in a profession that is all about people skills. Again, there seems to be pressure to get people through rather than to ensure that they have the skills to do the job, and often no real connection between what they are learning in their units, and what they must do for me. *(2, 9)

Theme 2: Vocational education and training is a 'commercial' operation

Chosen for workability and necessity rather than contribution to actual organisational or client work. Qualification in itself does give people structured learning and confidence. The content one has to surrender to.

Overall I have found the vocational education and training program to have become a commercial operation with poorly skilled and experienced people providing training in fields they know little about. Unless some serious quality controls are put in to the vocational education and training system of training I feel the whole value of a minimum qualification set becomes a nonsense. Please find ways to evaluate the impact and efficacy of vocational education and training.

Theme 3: Training content out of date or out of touch

Some of the educators are out of touch with the current developments in the field

Feedback has been that some of the content is old and from presenters who have not worked in the field for years. Relevance vs. cutting edge information. Also not much reference to best practice and research re interventions. *(9)

Most of the students I see are not prepared well enough for the job at hand. I believe this is because the people teaching these subjects are out of touch with what is happening on the floor. *(9)

Theme 4: Working with industry provides better trainees

Private providers do on the job, hands on training relevant to the work required, whilst also have access to best services to get student placements, they consult individual managers/services to work out needs of the staff, the trainer becomes an important member of the team where staff can reflect and gain on the job support. Enrolment systems in Unis are to cumbersome and confusing for many staff, plus take long time to gain response or receive info TAFE & Uni continue to operate in block training modes, hence staff are away for long periods from work, don't have good partnership arrangements with services for access and good practical application of skills.

Private/Specialized RTO's deliver and assess on the job and have the benefit of best practice placements in the alcohol and other drug sector

We are in a position where we have quite a few TAFE placements so we often use this as a way of looking at a prospective employee. Because of these practical placements in services these students have a better understanding of what the job entails.

We have only ever had alcohol and other drug vocational education and training people from TAFE, most have been very good, after working for a while. TAFE at least provide placement time for students, this gives them some exposure. Psych graduates come from Uni & have absolutely no idea. They have the theory but zero exposure after 4 years. This is ridiculous; kids come through school into Uni, complete a Psych degree & actually believe they know what they are doing. Placement hours need to be made part of the degree.

Alcohol and other drug agencies that deliver accredited training tend to have graduates that are more familiar with issues pertaining to alcohol and other drug sector and familiarity with clients

Theme 5: Inconsistency in the quality of training

Private providers can be very inconsistent. The best provider I've seen is based in a State government agency and concentrates on training Indigenous alcohol and other drug workers. This is the only provider I've had experience with that can produce prospective alcohol and other drug workers who can actually articulate and demonstrate basic counselling and alcohol and other drug skills. Other providers, especially in the NT, seem to produce graduates with very limited competencies. Some of the TAFEs have also been inconsistent, although there is one TAFE locally that has a good Cert II and III for local alcohol and other drug workers. Universities seem to produce better equipped workers, although again, there are some inconsistencies. Ideally, someone who has an undergraduate degree with alcohol and other drug orientation, then some focussed, skills based vocational education and training with a reputable provider is the ideal choice for alcohol and other drug work.

private trainers vary greatly, even within the one private training service, some of their courses are good, others crap

There are some training providers that so the job well and one which I think needs to improve the quality of the course content and assessment

Private providers and TAFE are inconsistent and the quality of education depends on the actual institution that provides it

All interviewees with private acquired training have been shocking and would not employ regardless. Other accredited training orgs have had a higher degree professionalism

Don't know where staff got their qualifications. I am generally dissatisfied with Cert IV regardless of who provided it.

I Have not employed anyone with these as generally they are unable to respond to specific questions asked at interview

Some of the teachers in TAFE in our area don't have the relevant training, skills or qualifications to deliver a high quality level of training. Private training has been of a higher standard*(3)

Theme 6: Higher education training longer and more in-depth

Although I have a good understanding of the skills required at each level, I find the vocational education and training qualified workers tend not to draw on what she learned. It seems that the longer engagement at undergraduate level (e.g. doing Addiction Studies) produces better understandings and more potential for building on skill sets.

I believe it is difficult to cover aspects of professionalism, such as maintaining empathy, engagement, boundaries and ethics, that are covered in a degree program over a course such as cert, dip or advanced dip

Theme 7: TAFE is preferred
The regulation around formal training in Tafes etc provides a more secure feel
Theme 8: Vocational education and training requires more practical experience
Experience and ability to work with specific client groups are fundamental requirements - None of these providers can give the necessary experience but they can provide the work-related knowledge
Lack of exposure to anything but common counselling settings i.e.: out patient, is evident.
They simply cannot perform at a clinical level, demonstrate a profound inability to undertake assessments, keep accurate file notes, develop evidence based interventions and seem to get caught in a merry go round of counter transference and confusion. *(9)
Theme 9: Training content inconsistent with job requirements
Lack of professionalism, poor interpersonal general skills set.
Lack of real counselling skills. Many university graduates lack this as well. Inability to even engage difficult clients
low quality, lack of understanding of the content, material was out of date, teachers were not in touch with current developments in the field *(3)
Lack of correspondence between what is learned through training and the actual skills required for the job
*Statement relates to more than one theme. Theme number in brackets

Table 23 Thematic analysis of Q31: How could training/education for vocational education and training qualifications in alcohol and other drug work be improved? ("Other" category)

Theme 1: More emphasis on alcohol and other drug specific (core) topics
Brief intervention counselling models aimed at stabilizing.
Brief interventions, motivational interviewing.
Counselling skills, with specific focus on motivational interviewing type skills and addressing interpersonal dynamics and gently but firmly challenging and supporting clients in progressing realistic and achievable plans. Being able to work with clients who have personality traits, this is the majority the client group. *(2)
Each client is very different so the applications of knowledge/perspectives to a range of clients is a complex skill to be practiced and requires more than CBT/MOTIVATIONAL interviewing/reflective listening, harm reduction- comprehensive legal and housing knowledge is at least as useful. Harvard works solely with workshopping complex cases and this might prepare workers in alcohol and other drug well. *(2)
More emphasis on counselling skills - reflective practice (through feedback and supervision), motivational interviewing, assertiveness, conflict resolution, challenging in a non-confrontational way, listening skills. Self-watching -managing burnout and stress, reflecting on own alcohol and other drug or other potentially damaging behaviours, self care, professional development, developing a professional demeanour and ethos. *(2)
Motivational interviewing, counselling techniques, community development *(2)
counselling skills
Counselling skills to me is one of the biggest limitation of the current courses available. For our service this is the area of need and the one the staff are requesting greater training in. If staff do not have the ability to correctly counsel the clients the other areas of knowledge are not provided this is to the detriment of both the clients and the staff themselves.
Theme 2: More emphasis on other relevant alcohol and other drug issues
Ethical decision making
Ethical issues including issues regarding confidentiality
More work on skills relevant to a primary health care context (e.g. screening, brief intervention, motivational interviewing). More training on how to provide mentoring and support to general practitioners, and other generalist health workers who have clients with drug and alcohol issues who will not accept a generalist referral. Specific training in issues around correctional system (coerced) clients and the ethics and values of that work, as well as practical strategies.
More evidence on theory and conceptual frameworks and understanding of contextual issues and connections to other areas.
That drugs are part of a complex life. They are not to be considered in isolation (like all the above do) And increased drug knowledge! What a joke. Slang differs suburb by suburb!
Cultural and linguistic diversity issues

Greater emphasis on client interaction, particularly with clients who are difficult to engage.

Theme 3: More emphasis on the quality of vocational education and training delivery and assessment

I am not sure the content of the training is what is lacking it is the assessment tasks and follow-up of trainees. Maybe more insitu observation of how people work would be beneficial prior to getting an endorsement.

More professional delivery. Acting on feedback received from participants and more timely provision of relevant written materials. Greater focus on skills assessment.

More scrutiny of RTOs and agencies that provide the training. I'm sure some places just sign people's competencies off without really having ascertained that they are actually competent.

More placements

*Statement relates to more than one theme. Theme number in brackets

Table 24 Thematic analysis of Q33: Do you have any further comments you would like to makeabout vocational education and training qualifications in alcohol and other drug work or minimum qualification levels for alcohol and other drug specialist workers?

Theme 1: More placements

It would be great if vocational education and training can have a placement program to provide practical training for students who are new in the field.

Empathy cannot be taught at any level, it is inherent in a person. A vocational education and training trained worker with empathy, and a non judgmental view of others will do equally as well with the skills and knowledge they have learned as a post grad who may have had little experience with either clients or life. Field experience will always be the most appropriate part of the learning, so a vocational education and training course should include placements both in an alcohol and other drug and mental health setting.

Some vocational education and training opportunities, such as RPL, are more about the qualification than the learning. I do not support the newer quicker ways of gaining a vocational education and training qualification, there is no skills building and no sharing of knowledge and experience in the "classroom" setting, which I believe is critical for the development of new workers in the field. Sometimes it is too easy and too quick to gain the qualification.

University graduates need more practical training

Vocational education and training candidates tend to have hands on skills taught to them from day 1 whereas university graduates can tend to be theory based and in some cases have had no client contact prior to graduation. some Psychology students in particular

Theme 2: A national standard for work in the alcohol and other drug field

Australia should have a national standard for work in the alcohol and other drug field. It should be a Government objective to make sure a base line is offered to people who have been working in the field without formal qualification to offer an appropriate level of Care/Treatment/Support to the service users.

There are diverse standards across jurisdictions and no set national standards. There are different requirements for different types of alcohol and other drug work and the environment in which it occurs... therefore there is a need for flexible training options to suit staff in different work environments. *(6)

Theme 3: Better consistency in vocational education and training

Build in better consistency of the vocational education and training program across the nation. If we are having a nationally recognised qualification we need to be absolutely sure that what training occurs in one region or state replicates that of another. We also need to encourage advanced training beyond minimum qualifications. The alcohol and other drug sector requires a greater investment in its staffing profiles. *(2, 4, 5)

There is a huge inconsistency in vocational education and training qualified workers. Some with a Cert III or IV or even a Diploma appear to have no idea of even the most basic alcohol and other drug sector knowledge. Others appear to have a strong working knowledge of the sector and are capable an competent to perform alcohol and other drug assessments and counselling with clients. I think it depends on the RTO they trained with (and each individual as well). I think that entry level alcohol and other drug skills would be basic alcohol and other drug assessment (including use of appropriate models and approaches to problem definition and identification), motivational interviewing, appropriate referral, working knowledge of harm minimisation and how it looks in clinical and community practice and some demonstrable good written and verbal communication skills. *(6)

Theme 4: More funding

Qualified workers need to be recognised for their qualification in the remuneration package within all agencies. Until such times as the qualified workers are recognised, unqualified workers are at a greater advantage financially. Qualified personnel: - pay for their education. Out of the workforce during the education time. Receive the same pay rate as unqualified workers Net annual income is less due to the Hex dept.

There is a need for greater investment in the alcohol and other drug sector

For the NGO sector - the ability to have backfill funded was of great assistance in the ACT to get us the employers on board with enrolling our staff - great initiative it removed many barriers

Generally, funding to services is inadequate & consequently, rate of pay for staff is unattractive to keep people in the industry for any length of time.

There is a relationship between minimum qualifications and funding for services. Minimum qualification standards often reflect government funding formulas. Alcohol and other drug work is increasingly requiring specialist knowledge such as mental health, families, children, etc which requires increasing staff skill base

Theme 5: More flexible training options

There should be more short postgraduate courses in alcohol and other drug

There is a need for flexible training options

advocate for workplace assessments and the training of workplace assessors

Others

Preference for acceptance into TAFE courses should be based on a person's ability to work within the sector. For instance if a person has recent criminal convictions for drug/violence related offences or is a current or recent drug user, the chances of them being employed within the industry (other than peer education) are slim. In addition, there should be greater emphasis placed on the responsibility of students to ensure TAFE work is completed on time and leeway should only be given under certain circumstances. Furthermore, TAFE work should be graded similar to that of university (fail, pass, credit, distinction, high distinction) to give TAFE students incentive to produce high quality work. Currently TAFE work is graded at "passed" regardless of quality of the work.

Indigenous issues need to be more prominent

All managers of alcohol and other drug services should currently be concerned about the skill and expertise of some of the current workers in the field. They should be continually upskilling their staff if the field is to have any credibility.

Personal characteristics of workers are also very important, especially empathy and a non-judgmental attitude

*Statement relates to more than one theme. Theme number in brackets