Joint submission to the Community Services and Health Industry Skills Council: Consultation on AOD VET qualifications.

INTRODUCTION

The VET sector offers several AOD-specific qualifications, including the Cert IV (AOD), Dip CS (AOD), Dip CS (AOD/MH), and AOD skill sets/stand alone units. It is of the utmost importance that these qualifications equip the future AOD workforce with the skills and knowledge necessary to effectively deal with AOD issues. However, recent research and discussions with key stakeholders have highlighted significant reservations pertaining to the delivery and quality of these qualifications. There exist several issues of concern regarding the qualifications themselves, the trainers and student outcomes.

This submission provides information on the challenges currently facing AOD education, and recommendations for improving VET sector AOD qualifications. Section 1 details priority issues for immediate review. Section 2 provides information on related concerns that are of lesser immediate importance; this section is intended as contextual information to provide a greater understanding of the issues that result from, or contribute to, the concerns presented in Section 1. Section 3 details recommendations to address these issues, while Section 4 lists signatories to this submission.

SECTION ONE: ISSUES FOR IMMEDIATE REVIEW

1. Move from AOD-specific to generalist qualification.

The CHC08 Training Package removed several AOD-specific units from earlier AOD qualifications, replacing them with generic units. There is a perception amongst managers of AOD services and training providers that this has led to a more generalist qualification, with insufficient attention paid to issues and knowledge specific to AOD work. Some individuals are concerned that as a result, AOD qualifications are not equipping students with the skills, knowledge and attitudes necessary to work in this field. One example of this is the lack of attention directed towards relapse in the new Cert IV.

AOD services and programs have risk registers and case outcomes needing specific skills and knowledge. The interaction between AOD misuse and the biopsychosocial context of clients is far from general. AOD workers are also likely to work as part of a team, both within

programs and across agencies. An AOD-specific skill set therefore gives greater value and improves the chances of a positive outcome.

The funding–service agreements of state and Commonwealth funding streams also point to "specificity" rather than "generalicity". It is reasonable to suggest training should follow such need indicators given the slim staffing numbers in most NGO's.

2. Lack of clear guidelines in CHC08 Training Package.

The current Training Package does not provide clear guidelines in terms of the required content and focus of AOD qualifications. As a result, RTOs develop curriculum resources in isolation, leading to considerable variability in content.

Of particular concern is the reliance by many providers on purely online delivery platforms. This is compounded by the removal of workplace training units, in particular CHCAOD408B and CHCAOD411A. Similarly, neither CHCAOD406 nor CHCAOD5xxx are assessed in the workplace.

A large part of developing skills for AOD interventions, such as screening, assessment, counselling etc., requires face-to-face and hands-on content and practice delivery. However, these shortcomings in the Training Package mean that many newly recruited workers may have widely different knowledge, skills and attitudes, as well as little practical experience. This places a burden on organizations by requiring a larger number of supervision hours from already stretched units, as well as doubling up costs in certain roster and shift management situations.

3. Skills Set.

A review of the skills set is warranted to reflect introductory and more advanced levels. Organisations need assistance in building "depth" rather than "breadth" in staff skills and experience. They also need training structures and product packages which allow for the growth and development of staff, i.e. more staff being able to bridge from a Cert IV to a Diploma and beyond.

As the number of complex presentations increases through a "no wrong door" policy, services need to have access to staff with higher skill levels. The funding to assist in achieving this has not been forthcoming. If growth in government service procurement from the NGO sector is a real objective, it would be beneficial to invest in skill development as well as curriculum content.

4. **Collapsing of CHAOD402B and CHCAOD406E.**

A large portion of the content within the existing CHCAOD402 B has been lost in its merger with CHCAOD6E, into the new competency "Work with clients affected by alcohol and/or other drugs". This is crucial underpinning content which must be retained. There is no logic to the merger of these two distinct competencies and many advantages to having separate competencies.

SANDAS has successfully trialled a 2 day separate module "Safe Care of Intoxicated People". This can be targeted at those front line programs that engage actual intoxication. A preliminary assessment shows that it RPIs well into Cert IV AOD.

5. **Separation of units of competency & assessment requirements.**

CS&HISC have proposed to divide Units of Competency into two documents. This approach will separate the 'Units of Competency' from the 'Assessment Requirements'. For those not regularly involved in training and assessment, the Units of Competency often prove difficult to understand. Furthermore, training and assessment activities are developed and delivered with the whole unit in mind. As such, including all materials relating to a particular unit of competency within a single document will contribute to a consistent understanding of expectations amongst training providers and candidates.

6. **First aid as elective.**

AOD workers are commonly confronted with emergency interventions as part of frontline work. A large number of clients may present with adverse effects relating to their substance use. As such, it is important that AOD workers are qualified to deliver first aid interventions. It is therefore concerning that First Aid is proposed as an elective in the new Cert IV, rather than a core requirement. In contrast, no First Aid elective is included within Diploma courses, despite its importance. It is vital that all AOD workers are exposed to at least a basic level of first aid training, and that those who wish to are able to build on this knowledge at Diploma level.

7. **Increasing emphasis on comorbidity/MH.**

There has been a growing emphasis on mental health skills for AOD workers in recent years. This has substantially increased the popularity of MH electives, and dual qualifications

in AOD/MH. Including comorbidity units within AOD qualifications is highly appropriate given the number of comorbid presentations in AOD intake processes. However, many trainers do not have the knowledge, experience or resources to confidently present on mental health topics. Adding to this difficultly is generally poor access to clinical supervision.

A similar issue relates to the proposed Diploma of Support Work as a replacement for the Dip CS (AOD/MH). The structure of the proposed course requires candidates to choose between AOD and mental health, and is therefore not consistent with best practice. As such it is recommended that the current Dip CS (AOD/MH) be maintained.

It may not be possible to include a high level of mental health content in the Cert IV due to time and content restraints. An alternative may be to promote a better mix of Cert IV and Diploma level staff within organisations, as well as lobbying funding bodies and senior management to assist with the provision of clinical supervision.

8. Difficulty in finding qualified, clinically-experienced trainers.

The calibre of trainers can impact directly on the quality of AOD qualifications. It is important for trainers to have recent, relevant clinical experience to draw on when presenting material. Due to current industry demands, they must now also be knowledgeable on the topics of comorbidity and mental health. Skill in designing curricula and presenting material to a diverse range of students is also vital. Currently there are insufficient numbers of individuals who meet these criteria, and this is impacting negatively on the quality of courses.

9. Students who are not work-ready/lack clinical skills.

Trainers and employers are noting a proportion of students who graduate with a Cert IV (AOD), but have insufficient skills and knowledge to work effectively in the AOD field. Many of the issues discussed above contribute to this. The move to a more generalist qualification may result in clinical and AOD-specific skills being neglected. Furthermore, ambiguous guidelines within the Training Package lead to inconsistency in content and coverage, with individual trainers designing the curriculum. Students enrolled in the same qualification, but at different institutions, may therefore learn about different drugs, and have access to different amounts of RPL. In some cases, this may result in students graduating with insufficient knowledge and skills.

In addition, the Certificate IV is designed to be an entry-level qualification, but does not purport to qualify students to work autonomously after graduation. There may be a misunderstanding in the industry as to what Cert-IV graduates are capable of.

10. Lack of consultation with stakeholders.

Significant changes to the content and structure of AOD qualifications must be made only after a comprehensive consultation process. At all times relevant stakeholders must be kept apprised of proposed changes, and be given the opportunity for review and comment. This will ensure the Training Package and qualifications reflect the current priorities and needs of the industry, workforce and clients.

SECTION TWO: OTHER ISSUES

RPL processes subjective and inconsistent.

As a result of the ambiguous guidelines detailed in Issue 1 above, RPL processes are highly variable and inconsistent. No specific drugs are required to be covered in RPL, and it is often the trainer and/or student who determines the assessment content. In some cases (contravening government guidelines) no RPL is available at all. This leads to students in different institutions potentially receiving different outcomes for the same process.

Content (and quality) dependent on trainer.

Issue 1 additionally results in the individual trainer deciding what content should be delivered. The knowledge, skills, experience, interest and attitudes of the trainer influence what they choose to present, and how they present it. This provides little scope for quality control, and contributes to inconsistency between institutions.

Lack of attention paid to less "glamorous" drugs.

As it is the trainers who dictate course content, they may commonly choose to present information on the drugs in which they, and the students, are most interested. This may result in considerable attention being paid to the "harder" or more "glamorous" drugs, while those which are more prevalent, but less political (e.g. cannabis and tobacco) are neglected.

Lack of on-going professional development for trainers.

Trainers hold responsibility for designing and delivering training, and must be knowledgeable about a range of issues and topics. In addition, they must keep up-to-date with trends in

AOD use and research regarding best practice. In order for trainers to deal effectively with these issues, and provide high-quality, up-to-date content, it is essential for them to have access to on-going professional development. The lack of provision for PD contributes to Issues 5 and 6 above – i.e. the difficulty of finding suitable trainers knowledgeable in a wide range of areas.

Difficulty in accessing up-to-date, evidence-based resources.

While some jurisdictions have access to good resources and training materials (e.g. from Turning Point), these are not available in all areas. Providers operating in rural, remote and regional areas find it particularly difficult to access quality, up-to-date and evidence-based resources. This contributes not only to poorer quality qualifications, but also to greater inconsistency compared to organisations which do have access to resources. Furthermore, there is a lack of culturally-appropriate resources for Indigenous students and clients. This contributes to Issue 5 – i.e. many trainers do not have access to the resources which would allow them to present material on mental health.

SECTION THREE: RECOMMENDATIONS

- Reduce the number of generic units within AOD qualifications. Increase the number of AOD-specific units and include some co-morbidity (mental health and AOD) units, in particular CHCCM404A (Undertake Case Management for Clients with Complex Needs).
- Ensure CHCAOD513A (Provide Relapse Prevention Strategies) is included at Cert IV level.
- Ensure that the content of the units within these qualifications is targeted to match funding program requirements and equip workers with the skills necessary to work effectively in the AOD field.
- Develop qualifications suited to worker profiles. E.g., separate qualifications for peer based and non-peer based clinical workers.

- Develop clear and specific guidelines for all AOD qualifications including:
    - which drugs should be covered,
    - the degree of focus to be allocated to each
    - key knowledge requirements for students, especially in relation to particular drugs (e.g., tobacco, alcohol, cannabis, illicit, prescription etc.)

- Ensure these guidelines are disseminated and consistently implemented by all RTOs offering these qualifications (i.e. incorporate the changes into the requirements of the qualifications and units to ensure that they are audited).
- Ensure all RTOs have the support required to meet these guidelines.

- Create an additional skill set at a more advanced level, ensuring this is available to candidates as a stand-alone. E.g. CHCAOD411, CHCAOD510, CHCAOD511, CHCMH408.
- Develop a "dual diagnosis" skill set.
- Establish a panel to review the medium to long term business needs of AOD organisations to secure tenders which have higher level clinical requirements.

- Do not merge CHAOD402B and CHCAOD406E; revert to original structure of two distinct competencies, an overarching orientation to the AOD sector and a specific competency on how to manage intoxication.

- Include all materials relating to units of competency in one document, including performance criteria and assessment requirements.

- Maintain First Aid as a core unit in the Cert IV (AOD).
- Provide Fist Aid as an elective within the Dip CS (AOD).

- Develop a new Cert IV (AOD/MH) to reflect the current focus on comorbidity.
- Support trainers to up-skill in regard to mental health skills, including within the context of AOD.
- Develop a register of trainers (or support networks to do so) who can provide training to meet the MH gap faced by some providers.
- Retain a Dip CS (AOD/MH) with units that focus on working within the comorbidity context rather than a blend of units.
- Support the provision of clinical supervision.

- Amend the qualification requirements for trainers in the Training Package to include a requirement for recent clinical practice.

- Develop incentives for experienced AOD workers to move into the training field (e.g. salary, benefits, supports etc.).
- Implement advertising campaigns to raise awareness about this career path.
- Develop return to industry project for existing trainers as part of on-going PD and encourage use of guest lecturers/trainers drawn from industry.

- Ensure the skill levels associated with different qualifications are documented and disseminated to employers in the AOD field.
- Specify more clearly in the scope of each qualification (i.e., in the Training package), the level at which a graduand should be able to operate.

- Improve mechanisms for consultation with key stakeholders for this and future reviews of the Community Services Training Package.

SECTION FOUR: CONTIBUTORS

National Centre for Education and Training on Addiction (NCETA)

NCETA is an internationally recognised research centre that works as a catalyst for change in the alcohol and other drugs (AOD) field. We offer information and access to a wide range of AOD resources and research. Our mission is to advance the capacity of health and human services organisations and workers to respond to alcohol and drug-related problems.

Our core business includes the promotion of workforce development (WFD) principles, research and evaluation of effective practices, investigating the prevention, prevalence, and effect of alcohol and other drug use in society, and the development and evaluation of intervention programs and resources for workplaces and other organisations.

Alcohol Tobacco and Other Drug Association ACT (ATODA)

ATODA is the peak body representing the non-government and government alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). ATODA seeks to promote health through the prevention and reduction of the harms associated with alcohol, tobacco and other drugs.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health, human rights and social justice.

ATODA coordinates the Minimum Qualification Strategy for the ACT AOD sector. For further information about the sector-wide policy and its implementation please see: http://www.atoda.org.au/projects/mqs/

South Australian Network of Drug and Alcohol Services (SANDAS)

Formed in 2004, SANDAS is the peak body representing the state's NGO Alcohol and Other Drugs (AOD) sector. SANDAS works with its members and stakeholders to reduce the harmful impact of alcohol and other drugs through independent representation at national and state levels, providing opportunities for networking, and collective action through information sharing, advocacy, training and policy review.

Victorian Alcohol & Drug Association (VAADA)

VAADA is the peak body representing Alcohol and Other Drug (AOD) services in Victoria; and provides leadership, representation, advocacy and information to both AOD and non AOD related sectors. VAADA's purpose is to ensure that the issues for people experiencing the harms associated with alcohol and other drug use and the organisations that support them are well represented in policy and program development and public discussion.

Network of Alcohol and other Drug Agencies (NADA)

NADA is the peak organisation for the non-government drug and alcohol sector in NSW, and is primarily funded through NSW Health. NADA has approximately 100 members providing drug and alcohol health promotion, early intervention, treatment, and after-care programs.

These organisations are diverse in their philosophy and approach to drug and alcohol service delivery and structure.

NADA's goal is *'to support non-government drug and alcohol agencies in NSW to reduce the alcohol and drug related harm to individuals, families and the community'.*

The NADA program consists of sector representation and advocacy, workforce development, information/data management, governance and management support and a range of capacity development initiatives. NADA is governed by a Board of Directors primarily elected from the NADA membership and holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014.

Further information about NADA and its programs is available on the NADA website at www.nada.org.au.

Queensland Network of Alcohol and Drug Agencies (QNADA)

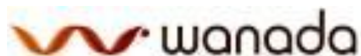
QNADA is the peak organisation representing the views of the non-government (NGO) Alcohol and other Drug (AOD) sector. QNADA is committed to supporting our members to deliver high quality service to individuals, families and communities affected by alcohol and other drugs. Our primary functions include:

- supporting and advancing the Queensland AOD sector to build its capacity to respond to existing and emerging harms caused by alcohol and other drugs
- supporting the information and technology needs of our member agencies, particularly with regard to State and Federal data reporting requirements
- sharing information through regular forums, events and workshops on key sector issues
- providing advice and information regarding available funding opportunities.

QNADA was established in 2007 to deliver professional, quality, and relevant services that will assist in the development and growth of the NGO AOD sector across Queensland. QNADA also liaises with key government, industry and social sector representatives.

Western Australian Network of Alcohol and other Drug Agencies (WANADA)

WANADA is committed to supporting services to improve the quality of life for individuals, families and communities affected by alcohol and other drugs. WANADA is driven by the passion and hard work of our member agencies, which include community drug services, therapeutic communities and residential rehabilitation centres, sobering-up shelters, harm reduction services, and counselling services. WANADA is the independent voice on alcohol and other drug sector issues throughout WA.



Alcohol, Tobacco & other Drugs Council Tas Inc (ATDC)

The ATDC is the peak body representing the interests of the community service organisations that provide services to people with substance misuse issues in Tasmania. The ATDC has a key role in advocating for adequate resources for the delivery of evidence-based alcohol, tobacco and other drug initiatives. In this regard, the ATDC represents the interests of a broad range of service providers and individuals concerned with prevention, early intervention, treatment and supply reduction and research.

The ATDC places a significant focus on workforce planning and development and has engaged extensively with the VET sector to attract significant funding to deliver the Certificate IV in alcohol and other drugs to both existing workers and job seekers; the Diploma in Community Services (Alcohol, other drugs and mental health) and various individual, and groups of, competencies to existing workers. Ongoing demand for qualifications and competencies in the alcohol and other drug area has been identified by extensive workforce profiling in both 2010 and 2012. Continuing work on a minimum qualifications strategy for the sector and a workforce plan across both community and government sectors are also high priorities for the ATDC.

The Alcohol and other Drugs Council of Australia (ADCA)

ADCA is the peak, national, non-government organisation representing the interests of the Australian alcohol and other drugs sector, providing a national voice for people working to reduce the harm caused by alcohol and other drugs. ADCA works collaboratively with the

government, non-government, business and community sectors to promote evidence-based, socially just, approaches aimed at preventing or reducing the health, economic and social harm caused by alcohol and other drugs to individuals, families, communities and the nation.