Component 3 case study 1: 
Psychostimulants Expert Reference Group

Introduction and background
The National Psychostimulants Initiative (NPI) was established by the Australian Government in 2003-04 to address problems associated with the increased availability and use of psychostimulant drugs in Australia. Over $15 million has been provided to the NPI from 2003-04 to 2009-10 to undertake prevention, harm reduction and educational activities.

According to the 2001 NDS Household Survey, following cannabis, amphetamines were the second most commonly used illicit drug in Australia, with about 1.4 million Australians aged 14 years or over using amphetamines at least once in their lifetime. At the same time, 1 million Australians aged 14 years or older over had used ecstasy/designer drugs and 700,000 had used cocaine in their lifetime. The most recent funding for the NPI was provided in the 2006-07 budget under the “combating emerging trends in illicit drug use” measure. This measure also included funding for Phase 3 of the National Drugs Campaign implemented in 2007.

DoHA is the lead agency responsible for implementing the NPI. It has undertaken a variety of activities with a focus on:
- identifying and disseminating good practice models and approaches for the treatment of psychostimulant use
- exploring effective treatment options for drug users
- providing support and training to general practitioners and other health workers to improve treatment outcomes for psychostimulant users
- providing information for at-risk youth and families

The current phase of the NPI (2006-2010) focuses on strengthening the capacity of frontline workers to deal more effectively with users of psychostimulants.

The National Psychostimulants Initiative Expert Reference Group (NPIERG) is responsible for providing advice to the Department on implementation of the current phase of the NPI.

Purpose of the case study
The current case study was selected to examine the extent to which the advisory structures and expert advice have been instrumental in the development and implementation of the NPI. In particular, this case study examines the functions, processes and outcomes of the NPIERG.

It describes the NPIERG, the expert advice sought, and the extent to which advice provided has been adopted in developing and implementing the NPI nationally and at State and Territory level, in both government and non-government sectors, and the private and not-for-profit sectors.

Observations on this case study may provide insights into how advice is achieved and used in developing and implementing national initiatives.

Proposition tested by the case study
The proposition of this case study is that the NPIERG and expert advice provided were effective in supporting the development and implementation of the National Psychostimulants Initiative.

A set of research questions was formed to test the proposition.
Research questions

1. How was the psychostimulants issue placed on the agendas of the NDS advisory structures, and how was the NPIERG formed?

2. How did the advisory structures formulate advice on the development and implementation of this NPI?

3. What expert advice was provided and how was it sought?

4. To what extent was the advice provided through the advisory structures informed by research evidence? What data sources or evidence were used and how useful were they?

5. How useful was the expert advice that was obtained? To what extent was expert advice incorporated into the advice provided by the advisory structures and in decision making?

6. To what extent has the NPI been developed and implemented in accordance with the advice provided?

7. To what extent and how have the NPIERG facilitated the uptake of this NPI across jurisdictions (including government and non-government, private and not-for-profit sectors)?

8. To what extent and how have the advisory structures and expert advisors been able to act proactively to address the aims of the NPI?

9. To what extent and how have the advisory structures been able to respond to challenges and overcome barriers associated with implementing this NPI?

10. What other factors (at the system, organisation, personnel and community level) influence the capacity of the advisory structures and expert advisors to support the development and implementation of this NPI?

Method

This case study used two data collections strategies: analysis of relevant documents, and interviews with informants. The document analysis reviewed:

- The NPI Strategic Plan
- The NPI Background Paper prepared for the Expert Reference Group (November 2006)
- The Group’s Terms of Reference
- Three options papers providing project outlines
- Meeting briefs used by DoHA to chair these three NPIERG meetings
- A conversation track documenting a brainstorming session at the first NPIERG meeting in November 2006
- Tools to facilitate advice on matters such as priorities and support for proposals
- IGCD, ANCD and MCDS meeting agendas, resolutions and communiqués for items relating to the development and implementation of the NPI
- IGCD annual report to the MCDS for 2005-06

The discussion protocols for the informant interviews were based on the research questions. It is important to note the marked limitations on documentation and consultation. First, the NPIERG was established in 2006, and the Group has held three meetings. Secondly, limited documentation of these meetings or resolutions arising from them was available.

Informant interviews were held with people associated with developing and implementing the NPI (including relevant advisory group members). Most of the participants who contributed information to the case study said they were able to make only limited comments. Six informants were able to provide more substantial comments on the NPI or the Expert Reference Group.

National Psychostimulants Initiative Expert Reference Group functions

The NPIERG is a time-limited advisory body established and endorsed by the former Secretary to the Minister for Health and Ageing, Mr Christopher Pyne. A NPI Background
Paper (November 2006) was prepared by the Drug Strategy Branch for the NPIERG and circulated prior to its first meeting on 17 November 2006. The NPIERG Background Paper presented to members the terms of reference for the NPIERG. The terms of reference stated that the NPIERG would provide advice to the Department on implementation of the current 2006-2010 phase of the NPI (that is, strengthening the capacity of workers to more effectively deal with psychostimulant users).

In addition, the terms of reference stated that advice would also be sought on the following issues provided to the NPIERG:

- Current trends
- Activities being undertaken across Australia
- Current workforce capability, training programs, training requirements of frontline workers
- Available pharmacotherapies and the necessity (or otherwise) for further research/trials
- Research on the effect of psychostimulants on the brain and on the behaviour of users
- Creative options for dissemination of information to a range of audiences, eg pre-contemplators, and current users, internet and SMS messaging

The NPIERG Background Paper also outlined some of the current activities within the NPI and more broadly across government, and identified current challenges and possible areas of focus for the NPI. It highlighted to NPIERG members that the purpose of the first meeting would be to focus on immediate, medium and longer priorities under the NPI.

The NPIERG is chaired by DoHA, and its members are experts in treating problem users of psychostimulants, pharmacology, and mental health (see Table 2). Members of NPIERG consist of 10 individual experts currently working at alcohol and drugs related organisations (such as ANCD, AFP, University of Sydney, University of Melbourne, ADCA) and a person with relevant life experience. Members were appointed as individuals rather than representatives of their organisations. Membership is for the term of the NPI (2006-2010). The Drug Strategy Branch of DoHA performs the secretariat function.

From the available documents, it is impossible to tell whether the NPIERG members were part of the NEAP or selected independently. Members are reimbursed for travel and incidental expenses for attending NPIERG meetings. There does not appear to be a sitting fee.

The NPIERG holds face-to-face meetings three times a year, with out-of-session input as required. Since its inception, the membership and invitees to meetings appear to have varied.

### Table 2: NPIERG members as at September 2007

<table>
<thead>
<tr>
<th>Member</th>
<th>Expertise/organisation</th>
</tr>
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<tbody>
<tr>
<td>Associate Professor Robert Ali</td>
<td>ANCD</td>
</tr>
<tr>
<td>Mr Tony Negus (as proxy for the Deputy Chair of ANCD, Commissioner Keelty)</td>
<td>ANCD</td>
</tr>
<tr>
<td>Professor Ian Hickie</td>
<td>ANCD</td>
</tr>
<tr>
<td>Mr Tony Gill</td>
<td>Treatment</td>
</tr>
<tr>
<td>Ms Joanne Lunn</td>
<td>Treatment</td>
</tr>
<tr>
<td>Professor Jason White</td>
<td>Pharmacology</td>
</tr>
<tr>
<td>Dr Dan Lubman</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Ms Tamara Speed</td>
<td>A person with relevant life experience</td>
</tr>
<tr>
<td>Dr David Spain</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Mr David Templeman</td>
<td>ADCA</td>
</tr>
</tbody>
</table>
The NPIERG reports to the Drug Strategy Branch which is responsible for the NPI. It has no direct connection with other bodies in the NDS advisory structure. DoHA’s IGCD representative chairs the NPIERG, attends ANCD meetings, and provides NPIERG updates to these bodies. Informants said that DoHA’s representative informs ANCD and IGCD when an NPIERG meeting has taken place and updates them on the progress of current and possible NPIERG activities.

ANCD agendas indicate that, in December 2005, a background paper on psychostimulant issues was compiled to brief ANCD members, but it was unclear who prepared the background paper and whether it was related to the NPI. At the same meeting, the ANCD encouraged funding bodies to support research into the psychostimulant issue, and requested updates from DoHA. In its May 2007 communiqué, the ANCD acknowledged the significant increase in contributions from the Australian Government for the NGO sector for a range of issues related to psychostimulants, and particularly for treatment. It is difficult to document direct links between ANCD and NPIERG.

Some informants who commented on the development of the NPI and the formation of the NPIERG felt both were ad hoc and politically motivated rather than strategically designed to deal with the psychostimulants problem in the community.

Informants also raised concerns about the adequacy of consumer representation. In shaping the NPI, the importance of the consumer’s voice had been emphasised (contributing to issues about current trends and contexts in which people use psychostimulants; or funding to AIVL for research on these issues). Several informants said that consumers were not as well represented in the Expert Group or consulted as they should be. However, the NPIERG membership does include an ADCA representative, and a consumer representative with relevant life experience.

NPIERG processes for formulating advice

Before the NPIERG came into existence in late 2006, in September 2004 the IGCD noted completion of guidelines for GPs, police, ambulance officers and emergency department workers on the management of acute psychostimulant toxicity. In the following year, IGCD approved the final resources on developing information and resources on psychostimulants for frontline workers.

The IGCD annual report for 2005-06 described the NPI, and stated that IGCD/MCDS supported the NPI. While the NPI was not discussed, psychostimulants was on the agenda of the ANCD meeting in December 2005. ANCD (2007) also produced a position paper on methamphetamines during this time.

The NPIERG met first in November 2006. Limited documentation was available to determine how issues were placed on the NPIERG agendas. Its advice was sought in several ways:

- Agendas and options papers were sent to members two to three days before meetings
- DoHA chaired NPIERG meetings, using briefing papers as a guide
- At one day NPIERG meetings, the Drug Strategy Branch sought advice on priorities and activity proposals
- A summary of the meetings were disseminated to the Drug Strategy Branch
- DoHA occasionally sought out-of-session endorsement from NPIERG members

Informants believed that the process for formulating advice was limited and that insufficient time was allocated to the functions and processes of the group, which in turn affected their capacity to provide high quality, evidence-based advice. They also commented that second drafts of proposals were not available to members for final comments and editing. However, from the procurement agency’s point of view, group members were provided with as much time as possible given the constraints and urgency to implement the initiative. Departmental officers also highlighted the importance of meeting timelines and the impact of probity rules on ensuring funding activities are undertaken in a transparent manner.
Research and evidence-informed advice

There was general consensus among the informants about a lack of research and evidence presented or used in deliberations during NPIERG meetings. In general, advice provided by NPIERG was delivered in the form of expert opinion, much of which appears to have lacked explicit supporting evidence. Members relied heavily on their background and expertise rather than presenting evidence to support their proposals. The reason for the lack of evidence, one informant suggested, was the poor quality of data – the psychostimulants issue was raised before data from early warning systems were available. According to DoHA, members of the NPI ERG were provided with an opportunity to present possible activities for funding, but were not made privy to the discussions and advice around the activities they tabled.

Agenda documents suggest that evidence was used to provide guidance in formulating advice on at least one occasion. At the February 2007 meeting, a member from ANCD was invited to present ANCD’s position paper on methamphetamine issues. That paper contained a number of recommendations that the Australian Government was considering among its proposed activities under the NPI. A discussion took place about the paper’s impact on the strategic directions of the NPI. However, the response to the presentation of the ANCD paper and any subsequent advice provided by NPIERG about its implications for the NPI is not documented.

NPIERG members were given an opportunity to present possible activities for funding, but were not included in discussion and advice around possible activity they may have tabled.

Areas of NPIERG advice

A background paper was prepared for members of the NPIERG and circulated before their first meeting. It gave an overview of the range issues that had been identified from preliminary research, and the areas of advice they were asked to provide:

- Current trends in use and activities being undertaken across Australia
- Potential activities that could be undertaken under the NPI to improve current workforce capability to deal with psychostimulant issues – for example, assessing the effectiveness of training programs in addressing the needs of frontline workers such as GPs
- Available pharmacotherapies and the necessity (or otherwise) for further research and trials
- Research on (i) the characteristics and demographics of psychostimulant users; (ii) consumer perceptions about different routes of administration eg injecting, ingesting and inhaling; (iii) the effect of psychostimulants on the brain and on the behaviour of users; and (iv) new treatment options
- Options for dissemination of information to a range of ongoing psychostimulant users (pre-contemplators and current users): (i) further activities to communicate with young Australians about the harms associated with psychostimulant use; and (ii) strategies to make better use of the internet and mobile phones as an anonymous means of communication to at-risk groups

The NPIERG’s Terms of Reference similarly identified the following areas of advice in scope:

- Implementation of the 2006-2010 phase, including:
  - Current trends
  - Activities being undertaken across Australia
  - Current workforce capability, training programs and training requirements of frontline workers
  - Available pharmacotherapies and the necessity (or otherwise) for further research/trials
  - Research on the effect of psychostimulants on the brain and on the behaviour of users
  - Creative options for dissemination of information to a range of audiences eg pre-contemplators, and current users eg internet and SMS messaging
The Drug Strategy Branch also consulted the NPIERG on immediate, medium and long term priorities for the implementation plan by asking members to provide their preferences on a priority mapping tool. Revisions were undertaken at the second NPIERG meeting. In later meetings, the Drug Strategy Branch sought advice on other activities that could be undertaken under the NPI (eg research on ways to attract and retain methamphetamine users into treatment). Papers relevant to these activities were circulated before the meetings.

Advice was sought mainly through comments on option papers or draft proposals for activities, and in one instance a draft strategic plan. Informants said the purpose of the meetings and agenda items lacked clarity and specificity, partly because inadequate funds were allocated for the group to operate effectively. Typically, several approaches to carrying out a project would be presented, with pros and cons listed under each approach. At meetings, members were then asked about their preference for each approach, as well as their views on scope, method, usability and feasibility. Informants also said advice was sought on funding of the NPI Strategic Plan.

Use and usefulness of NPIERG advice

Only a small number of informants commented on the operations of the NPIERG, and most of them were not positive about its functioning. They believed dissemination and use of the advice was limited. Although the DoHA reassured the NPIERG that their comments would be taken into account for proposed activities, members could not tell whether their input was reflected in the resulting documents.

Informants questioned the usefulness and robustness of proposals made on their behalf, since no documented resolutions were circulated to members after meetings. NPIERG members did not know if their comments were accepted or rejected, as there were no public releases and no feedback circulated to members from DoHA. The operation of NPIERG relied heavily on ‘in-house’ DoHA contributions, and the NPIERG reported to DoHA rather than through NDS advisory and decision making structures. This was reflected in the absence of any coverage of NPI in IGCD and MCDS agendas and decisions.

Impact of NPIERG advice on the NPI

In the agenda and briefing documents for NPIERG meetings, members were assured that their advice would be taken into account during the development of tender documentation for NPI proposed activities. However, most said that they had limited capacity to judge the extent to which the advice provided by the NPIERG was useful, and the extent to which its advice was used in the development and implementation of the NPI. The group has held only a few meetings since its inception, and feedback was not provided.

While these informants indicated that they were not aware that an NPI Strategic Plan was produced in September 2007, the Drug Strategy Branch said that members of the NPI ERG were provided with a copy of the draft Strategic Plan which was the main discussion at the September 2007 meeting, that their advice was provided and included within the next iteration of the document. The Strategic Plan provides a summary of work currently under way or completed to date, agreed activities beginning 2007-08, and the general strategy of focusing activities under the priority areas (information and prevention; expanding awareness and access to treatment services; expanding treatment options; workforce development; and research to respond to emerging trends).

The NPI ERG provided advice on, and agreement to, five short term projects as outlined in the Strategic Plan arising from the September 2007 meeting. One of the five projects listed below (see Table 3) resulted from a proposal generated by the NPIERG. Other projects on the list may have been proposals that the Drug Strategy Branch presented to the NPIERG for comment during meetings. But the NPIERG members interviewed said that they were unaware of outcome incorporated in the Strategic Plan.
Table 3: NPIERG endorsement of projects as recorded in the NPI Strategic Plan

<table>
<thead>
<tr>
<th>Projects</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of targeted resources on how to manage challenging behaviours associated with psychostimulant use for various AOD treatment settings</td>
<td>Completed</td>
</tr>
<tr>
<td>The development of methamphetamine treatment guidelines for frontline workers in the various AOD treatment settings</td>
<td>Completed</td>
</tr>
<tr>
<td>Management of patients with psychostimulant use problems – Guidelines for general practitioners</td>
<td>Completed</td>
</tr>
<tr>
<td>Proposed Psychostimulants First Aid Training package (PSFA)</td>
<td>Not yet progressed</td>
</tr>
<tr>
<td>Proposed Qualitative research into the patterns of use and harms associated with specific populations of methamphetamine users</td>
<td>Completed</td>
</tr>
</tbody>
</table>

NPIERG action to promote the aims of the NPI

Facilitation of the uptake of the NPI was not part of the Terms of Reference of the NPIERG.

No informant commented on how or how far the Group has actively addressed the aims of the NPI – that is, to identify and disseminate good practice models and approaches for the treatment of psychostimulant use, provide support and training to GPs and other health workers to improve treatment outcomes for psychostimulant users, and provide information for at-risk youth and families.

NPIERG meeting records indicate that some measures have been initiated, but the NPIERG appears to have been responsive to the Drug Strategy Branch’s guidance rather that initiating these interventions. Actions taken to address each goal of the NPI are outlined below.

In addressing the first aim of the NPI (identify and disseminate good practice models and approaches for the treatment of psychostimulant use), the Drug Strategy Branch sought advice from the NPIERG about the feasibility of conducting research on drug user characteristics and routes of administration, the effects of psychostimulants on the brain and user behaviours and new treatment options. The NPIERG agreed that funding should be allocated to developing targeted resources on strategies to manage challenging behaviours among psychostimulant users. It also recommended a research project into the patterns of use and harms associated with specific populations of methamphetamine users. This project was close to starting at the time of the Strategic Plan.

On the second NPI aim (Provide support and training to GPs and other health workers to improve treatment outcomes for psychostimulant users), NPIERG advisors were asked to comments on potential activities to help the current frontline workforce to deal with psychostimulant issues. The Reference Group supported the development of resources on how to manage challenging behaviours, and methamphetamine treatment guidelines for AOD frontline workers. NPIERG also agreed to wide dissemination of a resource targeted at GPs to manage patients with psychostimulant use problems.

On the third aim (information for at-risk youth and families), the NPIERG made comments on options for disseminating treatment and prevention information to current users, at-risk youth and their families. At this meeting, members noted ways of better using internet and mobile phones to communicate with young people about the harms associated to psychostimulant use. However, there is no record to confirm the outcomes of these discussions. The NPIERG additionally suggested that the Psychostimulants First Aid Training Package (PSFA) be developed to support families of drug users. The first aid concept was based on the fact that family and peers are often the first to notice substance abuse. The PSFA provides community education/training on how to respond to common emergency situations, and initiate referral to appropriate health professionals. This activity is yet to be progressed.
NPIERG and barriers confronting the NPI

Since very little has been implemented so far, there is no information about the challenges associated with implementing the NPI, or the NPIERG’s potential role.

Contextual factors affecting NPIERG’s capacity to support the NPI

The capacity of the advisory structures and expert advisors to support the development and implementation of the NPI is largely influenced by contextual factors. At the system level, one of the issues raised by informants was funding. A majority of informants believed that the funding allocated to the NPI was insufficient to address the psychostimulant issue in Australia. The NPI had been inappropriately conceived as a ‘national’ initiative when they felt resources were stretched too thin for work to be done in every State and Territory. They proposed that, before the NPI was rolled out nationally, funding should be focused in the States with the largest drug markets (Brisbane, Sydney and Melbourne). This would allow the intervention to be tested first to minimise the risks of failure.

Organisationally, the design and set-up of the NPIERG processes affected the group’s capacity to contribute to the development and implementation of the NPI. The design of the group processes, as reported, lacked sufficient funding and strategic directions (and this was reflected in the lack of clarity and specificity in the group’s Terms of Reference). Consequently, the group did not have the capacity to produce advice that was evidence-based, or an opportunity for members to be proactive and contribute directly to the advisory structure. Members of the NPIERG were not given enough time to review proposals by the Drug Strategy Branch before commenting at the meetings.

The individual members in the Reference Group also determined its operational capacity. Informants believed that health professionals were better represented in the composition of the group than law enforcement professionals, and as a result, law enforcement issues were underrepresented.

Summary

Analysis of this case study was limited by the type of documentation available and the number and capacity of informants to comment on the workings of the group. Only meeting resolutions were available, and consultations were based on the few who felt they were knowledgeable enough to comment.

Another limiting consideration is NPIERG’s brief development as a group – it has met only three times, and it is possible that the group is in its initial stages of team building and negotiating, and over time may adopt different processes as it matures. Nevertheless, some consistent issues emerged from the document review and consultations.

The starting proposition was that the advisory structures and expert advice provided by NPIERG effectively supported development and implementation of the National Psychostimulants Initiative. The intended outcomes of the advisory structures were evidence-informed advice to governments for policy investment strategies and program development, and advice on increasing engagement and buy-in to the NDS and its implementation. The NPIERG’s terms of reference did not include a formal role in the advisory structure’s encouraging engagement and buy-in to the NPI.

There was a strong impression among informants that the NPIERG was set up as an ad hoc, time-limited, and function-specific advisory body. The NPIERG is chaired by and reports to the Drug Strategy Branch, and does not directly report to other bodies in the advisory structure. A meeting is held about three times per year, and out-of-session advice is sought from the experts as required. Members were provided a Background Paper on the NPI and the purpose of the NPIERG in the first meeting.

Typically, several days before a NPIERG meeting the members would be given a briefing paper describing potential activities that may be taken under the NPI. Members discuss the
proposals during the meetings, with little reference to the evidence base, and after the meetings the resolutions return to the Psychostimulants Team in the Drug Strategy Branch. There are no formal methods to structure group meetings. All NPIERG papers are displayed on screen for members to view. Agreed advice is typed into the document for all members to view and reach final agreement.

After the meetings, the members rarely receive a record or feedback about responses to their input. Members interviewed were unaware that their approval of initiatives had been listed in the NPI Strategic Plan. The Plan indicated that the group agreed to the launch of five projects.

According to the Drug Strategy Branch, all five projects agreed to by the NPIERG were generated through discussion and advice at the ERG meetings. The NPIERG can provide advice, comments and agreement on activities only, but because they are not a legal entity, they are not able to endorse projects.

Other projects were Drug Strategy Branch proposals sent to the NPIERG for comment and endorsement. The Drug Strategy Branch said that occasional updates about the NPI were given to IGCD and ANCD, but it is unclear from the minutes whether NPIERG advice was included in these updates. Further, the Drug Strategy Branch indicated that as part of the relationship between the Branch and the ANCD, it provides updates on all licit and illicit initiatives related to the health portfolio. Specific to the NPIERG, information relating to this group, and activities endorsed by the Minister for Health and Ageing are provided to the ANCD in regular meeting updates.

Critical success factors identified in this case study included:

- Direct opportunity to provide input to the NDS advisory structures, IGCD and ANCD
- Sufficient time for experts to review proposals and research evidence before giving advice
- Greater opportunity to initiate proposals or give independent advice
- Feedback cycles and transparency – for instance, agreeing on resolutions during the meeting, identifying when resolution is not possible, and disseminating resolutions and minutes to members

**Observations**

As a subject-specific group, this case study on the NPIERG provides guidance and lessons on establishing similar groups in the future. First, the Terms of Reference may be more specific in key deliverables expected of the group, in order to set a clearer direction – that is, whether the group is purely consultative, or to what extent the experts are involved in designing policy. Terms of Reference may also define some expectations about the ways in which advice will be used.

Second, a secretariat may be allocated to a reference group to ensure that pre-meeting documents are disseminated in advance of the meeting, and to give ample opportunities for experts to collate research evidence to support their advice. Agenda items should clearly detail the purpose and content of the meeting. The commitment to meetings and availability to give out-of-session should be clearly stated.
Component 3 case study 2:
The advisory role of the National Drug Research Centres of Excellence in AOD workforce issues

Purpose of the case study
This case study explores the contribution of the National Drug Research Centres of Excellence (NDRCE) – the National Drug and Alcohol Research Centre (NDARC), the National Drug Research Institute (NDRI) and the National Centre for Education and Training on Addiction (NCETA) – in providing advice to the NDS on AOD workforce issues, as an example of how the advisory structures of the NDS operate.

The National Drug Strategy 2004-2009 specified development of workforce, organisation and system as one of the eight Priority Areas for action. The advisory role of the NDRCEs in these issues is therefore of particular interest. The three Research Centres are university-based, but receive their core funding from DoHA.

Method
Document analysis and informant interviews were used to collect data. Documents reviewed included contracts between each NDRCE and DoHA; annual reports of the Centres; agendas and resolutions of the IGCD, MCDS and ANCD; and the Workforce Development Strategy and associated documents. We interviewed 16 informants, including the Directors of NCETA and NDRI. The Director of NDARC was not available for interview during data collection.

Themes were identified, based on these research questions, and analysed qualitatively:

<table>
<thead>
<tr>
<th>Research questions</th>
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</thead>
<tbody>
<tr>
<td>1 How were AOD workforce issues placed on the agendas of the NDS advisory bodies?</td>
</tr>
<tr>
<td>2 How was the advice of the National Research Centres sought by NDS advisory bodies?</td>
</tr>
<tr>
<td>3 How did the Research Centres formulate and contribute advice on AOD workforce development and planning?</td>
</tr>
<tr>
<td>4 What expert advice was provided?</td>
</tr>
<tr>
<td>5 To what extent did Research Centres provide expert advice to inform advisory bodies in relation to workforce development?</td>
</tr>
<tr>
<td>6 How useful was the expert advice that was provided by the Research Centres? To what extent was the expert advice incorporated into the advice provided by the advisory structures and in decision-making processes in relation to AOD workforce issues?</td>
</tr>
<tr>
<td>7 To what extent and how have the Research Centres promoted their advice through their advisory structures?</td>
</tr>
<tr>
<td>8 To what extent and how have the Research Centres been able to be proactive in addressing AOD workforce development?</td>
</tr>
<tr>
<td>9 What other factors (at system, organisation, personnel and community level) influence the capacity of the National Research Centres to support planning and development of the AOD workforce?</td>
</tr>
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Findings
Workforce development and the National Drug Research Centres of Excellence have both been prominent parts of the NDS since its inception. The National Drug Strategy Framework 2004-2009 document commits NDS policy makers and managers to prepare and implement a workforce development strategy:

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16See Appendix B for the informant list
NDS Priority Area 5: Development of the workforce, organisations and systems:

It has become increasingly evident that, although education is a necessary part of a workforce development strategy, it is not sufficient to facilitate and sustain the workforce. The National Drug Strategy recognises that a multifaceted approach to develop the workforce is required, which should address the range of factors that impact on the ability of the diverse workforce to function with maximum effectiveness.

During this phase of the National Drug Strategy, action will be taken to:

- Develop a framework for a national strategy that will prepare the workforce for future challenges, raise their professional status and improve their capacity to adopt more effective innovations
- Undertake analysis of effective dissemination strategies, the role of education and training, and the barriers to research uptake and ways of overcoming them
- Improve the capacity of community-controlled and mainstream organisations to provide quality services to Indigenous communities

Although this undertaking has not yet been achieved, progress towards doing so occurred in 2008 and is likely to increase in 2009.

National workforce development under the NDS

Most informants identified NCETA as the Centre most directly involved with and responsible for aspects of workforce development, consistent with its charter. Its products are well known, widely used, and considered to be of high quality. Members of the AOD sector were familiar with its research activities and its production and dissemination of evidence-informed training and education resources (e.g., the particularly valuable kit, *Workforce Development TIPS: Theory into Practice Strategies*).

NDARC and NDRI also devoted some attention to workforce development (for example, by publishing resource materials on drug-related harm and interventions for workers in the field, and undertaking training and education activities). Their core focus, however, is research, not workforce development. An exception has been the major workforce development initiative in which NDRI is engaged - the large Commonwealth-funded project on capacity building for Indigenous AOD agencies across the country. Its focus is to translate mainstream evidence on clinical interventions so that they can be applied in Indigenous organisations and communities.

Substantial gaps in knowledge about the size, nature and composition of the national AOD workforce, particularly in the NGO sector, have been a long-term impediment to sound strategy development in this area. While this should not impede the production and implementation of workforce development policies and action plans, it is a constraint on progress in this area.

Currently, no national strategy for AOD workforce development exists, and there is a disjunction between national and State and Territory positions. Some of the States and Territories (either government AOD agencies or non-government AOD peaks) have created their own workforce development strategies and are implementing them through their own action plans. Some are sector-wide, and others focus on particular components of the workforce and its needs. An example is *Drug and Alcohol Issues: An Agenda for Workforce Development in NSW* (online at http://www.nada.org.au/index.php?option=com_content&task=view&id=16&Itemid=24).

Wasteful duplication of effort may also occur in the absence of a national strategy for AOD workforce development. Our informants highlighted the value of national consistency in key workforce issues across the States and Territories, as well as between the government, NGO, and private sectors. Many informants identified the need for national consistency in such
workforce issues as remuneration, minimum qualifications, education and training opportunities, and the mix of skills and professions.

Evolving concepts of workforce development

People working in the AOD sector are increasingly becoming aware of the fact that workforce development is about far more than education and training. This shift in emphasis, as NCETA calls it, has been described as follows:

*Workforce development is a broad umbrella term used to encapsulate a wide range of factors pertaining to individuals, the organisations within which they operate and the systems that surround them. Workforce development represents a multi-faceted and multi-level approach to supporting and sustaining effective AOD work practice. It includes strategies at the level of the individual worker, team, organisation and broader system (ie government policy, funding, legislation and regulations)*...

*Workforce development involves a major paradigm shift. It refocuses our thinking away from an exclusive orientation on training to one which encapsulates factors such as organisational development, change management, evidence-based knowledge transfer and skill development.*

*Workforce development also involves strategies to facilitate and support evidence-based practice and focuses on removing or reducing barriers to effective practice. The ultimate goal of workforce development is to provide more effective treatment and prevention services.*

*Workforce development is a complex construct and operates at multiple levels across a diverse range of issues. Application of only a single workforce development strategy is likely to be of limited effectiveness.*

*For optimal impact, workforce development requires the simultaneous implementation of strategies across multiple levels* (Skinner *et al* 2005, 4).

NCETA has played an important role in shifting workforce development from education and training to this more sophisticated approach that acknowledges, at both service and policy levels, the breadth and depth of workforce development. We are now at a turning point where this new understanding can be translated into action, resources and new structures for implementation.

The shift in understanding of workforce development and its relevance in the AOD field has been slow and gradual, but it is maturing, and has prompted the attention given to workforce development in the advisory structures, as well as the extent to which NCETA’s advice is sought and used.

NCETA’s focus has changed over the years from developing and delivering AOD training programs (it filled a problematic gap in this area in its early days) to research on workforce development issues. This research provides much of the evidence for workforce development policies and action plans. NCETA remains the chief centre of excellence for workforce development.

The NDRCEs’ strategic and business plans

To help understand how the NDRCEs contribute to the work of the advisory bodies in the NDS, we reviewed their strategic and business plans to identify mentions of the advisory structures and how the NDRCEs relate to them.

NCETA’s documents were the most explicit. They identified five key strategies for 2004-08, and two of them deal (or potentially deal) with the advisory structures:

2. *Keeping decision makers well informed. Specifically, NCETA will:*
   *Distil the latest national and international development relevant to the AOD workforce and make them available to decision makers*
3. Promoting a workforce development approach

- ... Provide advice on strategies to improve the effectiveness of the AOD workforce (eg legislation, policy, resources, supports)

The other three strategies not directly associated with the advisory structures were (1) monitoring developments in the field; (4) identifying points of leverage and intervention strategies; and (5) managing projects aimed at supporting effective AOD work practice and wellbeing of the AOD workforce.

The statement of NCETA’s role included ‘coordinate or contribute to a formal partnership’ with organisations, committees, or individual practitioners on workforce development projects in the AOD field.

NCETA’s Strategic Plan 2004-08 includes under the heading ‘Building systems capacity’, ‘Provide advice and guidance on systemic strategies for workforce development ... Disseminate emerging information to key decision makers in relevant sectors and government’; and under ‘Increasing organisational capacity’, ‘Provide advice on evidence-based strategies to support workers’ wellbeing and effective practice’.

NDARC’s strategic plan was less explicit on providing advice, simply mentioning ‘information and training’ as one of its key research areas. The strategic plan said that its development was guided among other things by ‘Strategy documents generated by National Expert Advisory Committees and The Indigenous Reference Group’. Its key results areas included:

‘Disseminate research findings to policy makers...in order to increase awareness of drug related harms and effective prevention strategies:
- Provide balanced factual information on drug-related harms and preventive strategies
- Increase probability of NDRI and other related research findings being applied to policy and practice development at national, state and local community level ...
- Provide regular briefings and submissions to government and parliamentary inquiries, policy advisors and relevant national and state committees on merging issues in the prevention of drug-related harms

‘NOTE: on average, 6 staff will be identified on the IGCD National Expert Advisory Panel each year.’

AOD workforce issues on the agendas of the NDS advisory bodies

In an earlier period, the IGCD and the MCDS paid more attention to the training and education aspects of workforce development than to infrastructure issues such as the professional mix of the workforce, its qualifications, and remuneration.

In 2002, the IGCD agreed on a definition of workforce development. At that time, some States and Territories were developing their own workforce strategies consistent with the NDS definition, which emphasised that multifaceted workforce approaches were needed to support the AOD workforce to respond effectively to drug-related problems.

In 2004, the IGCD commissioned a National Alcohol and Other Drug Workforce Development Strategy, produced under the auspices of the WA Drug and Alcohol Office with a working group comprised of members of NCETA and others. At its February 2005 meeting, rather than agree to implement it, the IGCD referred the report to the States and Territories to consider the implications of the report in terms of their own workforce development activities and report back to the IGCD.

One informant suggested that the 2005 Strategy was ahead of its time in that AOD policy-makers were still focusing on the education and training needs of the sector, and were not yet ready to address the deeper infrastructure issues that were the central thrust of the Strategy.

IGCD papers show DoHA was to progress discussions with NCETA about the work undertaken so far and how it could be best managed in the future, and there would be a
presentation from relevant experts at the September 2005 IGCD meeting. However, the presentation was not on the agenda and did not take place.

The February 2006 meeting of IGCD agreed that DoHA would discuss implementation of the strategy with NCETA and report back to the IGCD in September 2006. The previous report produced in 2004 contained no action plan and development of the strategy had languished. In July 2008 the IGCD received the Scoping Paper prepared by NCETA to inform development of a new national AOD workforce development strategy (Roche & Kidd 2008). It proposed a contemporary, national approach to AOD workforce development, and was discussed at the IGCD workshop in July 2008.

Observations

The usefulness of expert advice on AOD workforce provided by the National Drug Research Centres of Excellence

A central observation from this case study is that, with the exception of NCETA’s preparation of the Scoping Paper, the National Drug Research Centres of Excellence have not promoted workforce development through the national advisory structures. This reflects both the relatively low status of workforce development in the priorities of the NDS (despite the priority status given to it in the NDS Framework document), and the lack of direct access to the advisory structures by the NDRCEs over the 2004-2009 phase of the NDS. The latter seemed largely to be because the standing expert advisory committees on which staff of the NDRCEs had been represented had been disbanded in favour of the National Expert Advisory Panel (NEAP). In addition, the Strategic Plans for NDRI and NDARC place their emphasis on drug research rather than workforce development.

The contents of the draft 2005 strategy are considered to be sound but were apparently not acceptable to the States and Territories at that time. Further, despite an IGCD resolution on the matter, the Commonwealth did not successfully pursue further development of the strategy with NCETA. The IGCD was not able to translate the document into something that the States and Territories were willing and able to implement in a nationally consistent manner. Informants now believe that attitudes have changed since 2005, and the Scoping Paper presented by NCETA has a better chance of being adopted as the framework for a national strategy.

Implications for the next phase of the NDS

A central issue is what is widely seen as a current and increasing national crisis with respect to the health and welfare workforce. Challenges in recruiting and retaining sufficient numbers of adequately qualified personnel are faced across the health and welfare sectors, not just in the AOD sector. This means that the AOD sector’s workforce development strategies need to be cognisant of, and part of, wider workforce initiatives.

Given this reality, a need still exists for a national AOD workforce development strategy. This should address both the specialist AOD sector’s needs and how to harness the mainstream and broader health workforce as well. While a broad focus is needed, education and training remain important. Commitments need to be obtained from the States and Territories for AOD training from the vocational level to universities, with clarity about targets for the size and composition of the workforce an essential component. A need exists for more commitment to the issue by the advisory bodies (the IGCD and MCDS), and active initiatives from the NDRCEs to develop and implement a national workforce strategy.

NDRI and NDARC, as centres of excellence in AOD research, do not have significant functions in workforce development, apart from building the evidence for policy and practice. NCETA, as the chief centre for AOD workforce development in the NDS, should collaborate with broader national, State, and Territory activities in consistent workforce development policy and practice, both inside and outside the AOD sector. It should be supported to address
the wider aspects of workforce development beyond education and training by rapid endorsement and implementation of the strategies set out in its Scoping Paper.