


Midland Addictions Qualifications Paper – Feedback from Stakeholders

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
Wol Hansen – submitted on behalf of 3 Hauora in BOP		<p>1. Is there anything within the paper that needs clarification? We are not sure where Psychology stands as a qualification, especially if the degree contains a Psychology major and also contains addiction papers. It seems to us that the weight given to nurses as preferred professionals presupposes that addictions are an illness and the general tenor of this discussion paper sits with a preference to the medical model perspective of addictions. We can see the 2 sets of groupings - nurses on the 1 hand and addiction specialists on the other and the undercurrent for the need for the addiction field to upskill in terms of acquiring professional registration e.g. DAPAANZ as well as Diploma's that are addiction focused but it appears to us that, as stated above Psychology has been side lined.</p> <p>We also wondered about the paucity of information and comments about mental health as a factor in addictions and more specific ideas about qualifications in this aspect of addictions – CEP as an integral part of this. So does the field ask for either mental health qualifications or addiction qualifications or a combination of both to complete the skill set for a competent AOD worker.</p> <p>4. Any other comments?</p> <ul style="list-style-type: none"> ▪ 'We' were 7 AOD workers from 3 different Ngo's within the Western Bay. ▪ The document appears to diminish AOD workers skills and the profession itself in relation to other professionals. 	<p>Yes section to be amended to include 3c and essential / desirable grid</p> <ul style="list-style-type: none"> ▪ Sector specific qualifications ▪ Spell out qualifications <p></p> <p>S:\LDHB Planning & Funding\Midland Regi</p> <p>Qualifications Grid</p> <p>Add sections page 10 & 17: 3C – Health Professional working in sector 3D – Equivalent AOD qualification</p>	
Denise Giles & the Waikato CareNZ Team		<p>Is there anything within the paper that needs clarification?</p> <ul style="list-style-type: none"> ▪ What are the implications for current staff employed that do not meet these criteria? ▪ Current contracts with Waikato allow for lower threshold of qualifications for current staff is this likely to change? ▪ Are there plans to introduce a specific CEP qualification? ▪ Are leadership roles in AOD ie Senior counsellor, Team Leader <p>4. Any other comments?</p> <ul style="list-style-type: none"> ▪ Is there a risk of focusing too much on qualifications & less consideration given to personal recovery, experience in field? ▪ What are the timeframes if any of this is introduced? ▪ Are AOD/MH leadership specific qualifications to be considered? <p>Current staff not meeting these requirements currently, & working towards acceptable qualifications & Dapaanz Reg where will this sit now?</p>		<p>Feedback to questions No – not to be included as specific to Waikato</p> <ul style="list-style-type: none"> ▪ Yes ▪ Yes Dip CEP ▪ Yes ▪ Yes, up to provider to manage this ▪ Determined by local PMgrs ▪ Yes outlined in JDs ▪ Level 1 & 2 qualifications
Carley Jones, Cathy Sheely &	Page 10	<p>1. Is there anything within the paper that needs clarification? You make mention on pg 10 of provision for allied health professional without</p>	Yes covered in previous discussion and	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
Michael O'Connell	<p>Pages 11-12</p> <p>Page 14</p>	<p>generic AOD qualifications such as nurses, "Nurses are generally not included in the Allied health professional group, we are Clinical health practitioner. In addition, particularly with reference to the competencies listed later in the document across pages 11-12 these form part of the undergraduate training of a comprehensive nurse and I would regard nurses having generic skills in working with AOD clients. In addition many mental health nurses have undertaken postgraduate work.</p> <p>Also the statement seems to be contradicted later on page 14 when you refer to the HPCA Act allowing health practitioners such as nurses being able to legally practice in AOD on the basis of the scope of practice for their core qualification. Again you are also referring to nurses as allied health practitioners.</p> <p>4. Any other comments? The framework provided and acknowledges skills around pathology but we would also like to emphasize the person centered and Holistic nature of the work needed. There is a concern that in closely structuring the framework that DHBs will lose the ability to employ health practitioners who are appropriately skilled for the widely differing contexts and population groups that each DHB has.</p> <p>We agree that the expense of registration could remain a barrier, given that health professionals may belong already to one or more professional bodies. (for example the NZNO and the College of NZ MH Nurses)</p>	<p>inclusion of 3c and grid</p> <p>No as paper is about clinical qualification – holistic skills is a provider issue Addressed in previous discussions</p>	
TUMT		<p>1. Is there anything within the paper that needs clarification?</p> <ul style="list-style-type: none"> ▪ Does this fit with the National Training Plans? ▪ Is this document reflected in DHB and Midland Workforce Plans? <p>2. Is there anything within the paper that needs correcting or amending?</p> <ul style="list-style-type: none"> ▪ Page 4 contradicts the DHB Contracts. ▪ Page 13 'working with Maori or Pacific Peoples' or if it's about competencies the Takarangi and Sei Tapu as its written through out the document as 'Maori and Sei Tapu'. ▪ Is there an obligation to work with training providers within Midland to ensure there is relevant training available in Midland i.e. work with Anamata to develop the dip to degree level (CEP) <p>4. Any other comments? Consideration needs to be given to providers that spend significant resources training backwards and supporting staff with clinical and cultural competencies.</p> <p>We would like DHB's Planning and Funding to give consideration to those at Associate Level with similar degree and who have chosen to complete the Applied CEP Dip with Anamata and who have been in the sector for one or more years, this is more relevant as it trains people how to work with whaiora rather than a 4 post grad papers that do not teach how to work directly with whaiora. The post grad is a</p>	<p>Yes Sei Tapu to be amended to Pacific people</p>	<p>Yes it is included in the national competency framework for AOD workers Yes it is in the Midland Workforce Strategic Plan</p> <p>No this is a PTO issue. Matua Raki is the workforce centre that the Regional WFC works with</p> <p>Yes, this needs to be negotiated with local PMgrs</p> <p>This is a local provider and PMgr discussion. However the definition will clearly identify</p>

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
George Furstenburg		<p>means to an end rather than teaching the technical skills.</p> <p>QUERY Has consolation been sought with the various professional bodies? This document seems to make generalized assumptions about basic professional training and specialist progressions. This can end up being very costly for us as training and credentialing process are duplicated in an effort to meet purchasing unit descriptions.</p> <p>RESPONSE There has been consultation (face to face meetings) with various representatives- specifically Matua Raki (Terry Huriwai), DAPAANZ /NCAT/CADS (Robert Steinhauser), Auckland University (Dr Peter Adams) and others such as MOH (Jenny Wolfe) and the Midland AOD group. Terry Huriwai has also liaised with various sector reps regarding the qualification framework. A copy of the document was also recently emailed to the AOD Training Providers Network.</p> <p>The assumptions are that the DAPAANZ and 'Get Real' criteria are widely accepted by the AOD sector. The framework is essentially aligned to the current DAPAANZ levels and associated requirements. The advanced level refers to speciality areas including advanced cultural competencies. Yes membership costs are an issue. The key issue acknowledged by the various professional bodies is that it will be a costly process particularly for practitioners credentialed under HPCA Act who will also be required to pay DAPAANZ fees. It is expected that funding will be sufficient to cover the costs of membership.</p>	<p>Yes discussed in full re essential and desirable grid</p> <p>Yes discussed in full and covered in the essential and desirable grid</p>	<p>clinical roles and non-clinical.</p>
Graeme Judson for the Taranaki A&D service and Sue Philipson for Families		<p>1. Is there anything within the paper that needs clarification?</p> <ul style="list-style-type: none"> ▪ Does the recommendation apply to all clinicians that work in an A&D service? Or does it apply to those who would come under DAPAANZ (and does not include doctors, detox nurses and dual diagnosis nurses or other nurse specific roles)? ▪ It would be useful to also include a counselling qualification in the list of qualifications under comments (P10, P18 level 3b) and that to be an A&D worker they too require an A&D specific qualification. ▪ Clarify the term practitioner as this is a generic term and doesn't recognise the value of having a team derived from different disciplines (including counselling, psychology, social work, OT and nursing) <p>2. Is there anything within the paper that needs correcting or amending?</p> <ul style="list-style-type: none"> ▪ Taranaki DHB when advertising for A&D counsellors and or case managers request an A&D qualification in the job specification <p>4. Any other comments? Following written and verbal consultation with AOD family & whanau, I have the following feedback which is centred around section 12, page 15 of the document: Families were unanimous in their comments about the trends in recruiting HPCA</p>	<p>Answered in previous discussion and covered with the inclusion of a 3C and desirable and essential grid</p> <p>Family whanau feedback to be</p>	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>qualified staff rather than those with DAPAANZ or specialised AOD qualifications for AOD positions.</p> <ul style="list-style-type: none"> ▪ All felt strongly that specialised AOD qualifications are essential in delivering quality service to our people. ▪ All commented on the essential need to build C.E.P. capacity across AOD and MH services but that this must not be done at the expense of specialised services for AOD. ▪ All recognise and value the strong multi-disciplinary skills within the AOD team and feel this would be lost if the specialised AOD expertise was “watered down”. ▪ Most also commented on the value of clinicians with their own lived experience in strengthening the therapeutic relationship between counsellor and client. <p>In conclusion, families showed a strong preference for continued employment of fully qualified AOD specialist staff. They favour the Quadrant Model for C.E.P. capacity across the service and feel that the service risks “watering down” the quality of service if the specialised qualifications are lost. – Sue Philipson</p>	included in paper	
Hester Hattingh		<p>1. Is there anything within the paper that needs clarification?</p> <p>Better clarity/guidance with regards to dual registration – for staff with an Allied Health qualification working within CADS Service in the BOPDHB the expectation is that they are also registered with the appropriate professional body in order to secure a salary under the “Allied Health” salary scales.</p> <p>If they choose to register with DAPAANZ rather than their appropriate professional body, their remuneration is done through the AOD salary scale. There is a difference of \$20,000- in the salary caps between these two salary scales. Therefore 95% of the Allied Health staff choose to register with their appropriate professional body.</p> <p>As highlighted in the report, for those practitioners who meet the criteria for the HPCA Act and DAPAANZ, or NZSWA Social Workers Association and DAPAANZ, the cost of registration will be a key issue.</p> <p>An AOD competent, ‘multi-disciplinary’ workforce, is key to the AOD sector. Social workers, nurses and other disciplines are significant groups that make up the AOD workforce. They have their own respective professional bodies and maintain their respective registrations. The expense of dual registration will remain a barrier if this is not addressed by Funders and Providers.</p> <p>2. Is there anything within the paper that needs correcting or amending?</p> <p>See my comment under question 4 – recruitment focus on health related tertiary qualification as well as specific AOD experience within the Midland DHB contexts. Rather that specific AOD qualifications as suggested in this document. The latter is</p>	<p>Yes covered in previous discussion</p> <p>Covered in desirable and essential grid</p> <p>Covered in desirable and essential grid</p> <p>Covered in desirable and essential grid</p> <p>Covered in desirable and essential grid</p> <p>Yes covered in desirable and essential grid</p>	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>an advantage rather than essential.</p> <p>4. Any other comments?</p> <p>It is my experience that in recruitment for AOD positions (within the Midland DHB's) the emphasis is on clinical staff who meet HPCA requirements and have AOD experience and less emphasis on specific AOD qualifications. The latter is an advantage but is not essential – the former is essential though.</p> <p>The focus of this discussion paper is to define the clinical qualifications and competency in the AOD workforce. As we move through this process it is important to bear in mind that in order to encourage a workforce to upskill we need to make upskilling easy! Some short-term training is now available in our area, thanks to Matua Raki and Te Pou, but staff who want to do more in-depth study need to travel long distances, incur significant monetary costs and often use their annual leave to attend classes/exams. We need to look at what support AOD services can provide to staff to encourage them to put in the effort.</p>		<p>No - the paper is a guidance document – locally discussion with the PMgr will determine how this will be implemented in each of the DHBs</p>
<p>Katherine Fell & Rachel Poaneki</p>		<p>This document contains feedback from Waikato DHB in relation to the Midland Alcohol & Drug Clinical Qualifications Discussion Paper June 2011</p> <p>We have not used the feedback form provided but if this was required in terms of collating responses we are happy for our comments to be included as part of Section 4 Any other comments.</p> <hr/> <p>Two discussion documents were made available during the consultation period which is confusing to the sector.</p> <ul style="list-style-type: none"> ▪ Discussion paper dated June 2011 circulated by email 4 July 2011 ▪ Discussion paper July 2011 on the regional website <p>This feedback is based on the Discussion paper dated June 2011 circulated by email 4 July 2011 from Eseta which was circulated as requested to our sector for feedback.</p> <ol style="list-style-type: none"> 1. Overall the discussion document did not stay to the project scope which is disappointing as the clarity sought has not been provided. Of particular concern is that it appears to provide a pathway for HPCA which is not required by the national service specifications. We believe this approach is outside of the scope of the project. 2. The document is very pro-DAPAANZ. There is no legal obligation for AOD practitioners to be registered under DAPAANZ at this present point in time. We would therefore not support a move to impose this requirement on practitioners at a local/regional level when this has not been agreed at the national level and would have cost implications for the sector that have not been articulated in the document. 	<p>Discussed that for AOD staff without a HPCA membership to DAPAANZ would be essential to ensure alignment to national</p>	<p>No - the website version was amended to include the Midland branding as required by the CEs. The content was as per the version sent out via email on the 4th</p> <p>No - The scope changed following consultation with MR ADD to ensure that HPCA clinicians were included in the framework</p>

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>3. We have not made specific comments in relation to the flow of the document but suggest as part of the finalisation process and prior to being submitted to the portfolio managers that the document is reviewed to ensure all areas are clear.</p> <p>4. The remainder of our feedback is in relation to the national service specifications and the approach to these outlined in the discussion document.</p> <p>The national service specifications determine national purchase units that allow clinical FTE to be purchased under classification 'C'. Classification 'C' allows purchasing for clinical positions in relation to 'nursing and allied health staff'. Specific feedback on approaches in the discussion document are discussed in the following sections</p> <p>Nursing Health professionals regulated by the Health Practitioners Competence Assurance Act 2003 are clinical and this is confirmed in the purchase unit which allows purchasing in relation to 'nursing and allied health staff'. Therefore we would not expect or support any further requirements for this workforce group outside of national process. We disagree with the recommendation that practitioners registered under HPCAA also be required to be DAPAANZ registered.</p> <p>Allied health staff (i) DAPAANZ We understand the discussion document suggest only DAPAANZ Registered Competent Practitioners are accepted as clinical. This is supported.</p> <p>We therefore understand the document recommends the DAPAANZ Associated AOD Practitioners and DAPAANZ AOD Support workers are not considered clinical. This is supported.</p> <p>We would accept DAPAANZ Registered Competent Practitioners being accepted as clinical and able to be purchased under the 'allied health staff' component of the purchase units.</p> <p>(ii) Another health or social service professional body The document does not clarify which 'other health or social service professional bodies' may be accepted under the allied health criteria. This was one of the key areas where clarification was sought via the project.</p> <p>We support the position taken in the discussion document that AOD practitioners should hold a minimum level seven (7) qualification, but suggest this is strengthened.</p> <p>We propose practitioners that are registered with other health or social service</p>	<p>standards of best practice</p> <p>Contract specification to be amended</p> <p>Discussed – inclusion of 3C and essential and desirable grid will provide better guidance</p> <p>Discussed at length. Inclusion of 3C and essential and desirable grid will clarify this</p> <p>Yes the inclusion of the essential and desirable grid will cover the other health professionals and registration boards</p>	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>professional bodies that also hold a minimum level seven or higher (7+) AOD specific qualification be accepted as clinical AOD FTE. eg Registered NZAC with Weltec - Bachelors in AOD.</p> <p>5. To ensure consistency we would also suggest the discussion document list;</p> <ul style="list-style-type: none"> ▪ all the professional bodies where registration would be acceptable, and ▪ all the level seven or higher AOD qualifications that would be acceptable, and ▪ all the learning institutes, where achievement of the minimum qualifications would be acceptable. 	<p>Yes agreed – paper to be amended to reflect this and list qualifications</p> <p>Yes paper to be amended to reflect this</p>	
Maraea Craft		<p>GENERAL COMMENT</p> <p>It is a good comprehensive discussion document. It gives clarity around expectations of what to fund and qualifications AOD clinical positions need and the issues to consider e.g. dual registration costs. This statement was made by one of our stakeholders “AOD is going to drive CEP development – therefore need to invest in AOD workforce”.</p>		<p>No - CEP is a two service approach – that is mental health and addiction coming together with their skills sets to wrap around the persons needs.</p>
Maggie Armstrong		<p>1. Is there anything within the paper that needs clarification?</p> <p>Why are AOD clinicians not being replaced in this service, all vacancies are advertised for social workers – OTS – Nurses. If nurses are trained for AOD why cannot AOD be trained for MH??</p> <p>2. Is there anything within the paper that needs correcting for amending?</p> <p>Would it not be simpler to train AOD in Co-existing than ask nurses to pay two registrations – that way only DAPAANZ has to be paid??</p> <p>4. Any other comments</p> <p>Here in Thames we have worked together with MH for many years it has been very successful. Okay I had to do postgrad co-existing but this backed up my AOD degree. So why is this being torn down if work so well – cannot anyone see outside the square and these are clients in the MH somewhere as well. Cheaper for me to do more MH papers. This does not make me a nurse but I certainly know my job can work alongside them as well as my alone.</p>	<p>Discussion in length previously</p> <p>Inclusion of essential and desirable grid will provide clarity</p>	<p>Not sure what this relates to but group agreed that this was local issue</p>
Feedback submitted by Pam Armstrong		<p>COMMENT</p> <p>Has consolation been sought with the various professional bodies? This document seems to make generalized assumptions about basic professional training and specialist progressions. This can end up being very costly for us as training and credentialing process are duplicated in an effort to meet purchasing unit descriptions.</p> <p>RESPONSE</p> <p>Agree. Training is costly for dual registration. Can claim professional expertise according to scope of registration but not AOD expertise / competence.</p>		
Phyllis Tangitu		A well written clear paper		
Steven King		Unreferenced feedback i've received		

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>The concern: There is a growing trend of disbanding alcohol and drug treatment teams and integrating practitioners into mental health teams. This has shown:</p> <ol style="list-style-type: none"> 1. that whereas AOD practitioners used to be able to access training and career development, this has become increasingly difficult with preference given to those registered under the HPCA Act, 2. that increasingly AOD vacancies are being filled by nurses without experience and AOD practitioners, even with post-grad qualifications, are being turned down on the grounds that they are not covered by the HPCA Act, 3. that therefore AOD expertise is not being replaced in many DHBs, 4. this expertise has taken time and commitment to grow and is now widely felt to be under threat within many DHBs, 5. that this trend shows itself at sector leaders' days which used to be attended by all the DHB AOD managers. At the last meeting, just two attended which is the lowest representation in a steadily declining pattern of attendance. DAPAANZ also understands that in some DHB management restructures, the AOD Manager role has been disestablished and merged within mental health. Often the mental health manager does not have an addictions background. <p>Dapaanz acknowledges the intent of the Ministry's Co-existing Problems project of acknowledging the specialist core business of AOD and mental health services and not diluting this. Key messages portray that integrated care at the point of the consumer is essential – not necessarily integrated teams. Perhaps the abovementioned trend is an unintended consequence of the translation of the CEP project?</p> <p>The practice issues:</p> <ol style="list-style-type: none"> 1. Treatment is effective in the moderate to severe bracket. 2. AOD professional practice draws from a range of specialist models and approaches which are evidence-based. 3. AOD treatment interventions at the moderate severity level are not a luxury but essential. 4. The full range of interventions on the continuum has the most impact. 5. The health related cost of AOD use will not decrease, if such AOD treatment is not delivered (and resourced). 6. AOD practitioners are an essential and core group in the range of professionals to deliver this treatment. 7. The Ministry has invested considerable funding and resources into increasing the capacity and capability of AOD practitioner practice including supporting the review of the addiction competencies- this is being undermined by the practices outlined above 8. There could be considerable risk to services of inadequately addressing AOD 		<p>Agreed by the group that most of these comments were not specifically relevant to a high level guidance paper. The inclusion of 3C and the grid will cover off on the relevant comments.</p>

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>issues.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. that DHBs recognise DAPAANZ registration as equal to registration under the HPCA Act, 2. AOD practitioners be recognised for and recruited for their expertise in delivering a skilled response to the 80% of mental health patients with AOD problems and the 50% of AOD patients with mental health problems, 3. training, team support and career pathway opportunities be equally available. 		
<p>Tina Berryman-Kamp</p>		<ol style="list-style-type: none"> 1. Is there anything within the paper that needs clarification? <ul style="list-style-type: none"> ▪ Clarify the pathway from here – how will the decision be made from here? Will there be further stakeholder consultation prior to this? How will this be done? ▪ Cultural issues/qualifications/expertise needs more consideration – this issue will need to be resolved as more alternatives in training evolve – who sets the criteria for these? ▪ For non-AOD qualifications as a base, the nature of these may need to be acknowledged in the variety of depth – eg a Clinical Psychologist’s knowledge base to draw on for clinical formulation would be more comprehensive to a Nurse or Social Worker, due to the extent of training and clinical practicum within 3. Is there anything within the paper that needs to be removed? No, but the document appears to be quite lengthy and some repetition, especially in background/introduction – could be cut back to be easier and quicker to read 4. Any other comments? A difficult area to clarify but necessary. I agree that qualification alone does not equate to competence. There is always the issue of people with lots of experience and possible competence with few actual qualifications (ie long term practitioners who started before all of the training became available) – how do we recognize their skills and contribution? They may be more valuable in service provision than a highly qualified but little experienced clinician. 	<p>Yes – National Workforce Centres. Matua Raki will take the lead Yes discussed at length previously</p> <p>Yes paper to be amended</p> <p>Essential and desirable grid will assist but at a local level this will be determined by the PMgrs and providers</p>	<p>Not included - The final draft will be circulated at the same time that it goes up for sign off by the GMs P&F.</p>
<p>Wilhelm van Rooyen</p>		<p>QUERY Yes, I would like clarification on the following:</p> <p>On page 5 of your document it states that: “For community based A&D positions the service specifications stated that they are to be filled by a multi- disciplinary team of people with skills and experience in alcohol and other drug intervention, treatment and support, and who belong to one of the following categories:”</p> <ul style="list-style-type: none"> ▪ Health professionals regulated by the HPCA ▪ People regulated by DAPAANZ or another health or social service professional 	<p>Discussed at length in previous question. Inclusion of 3c and essential and desirable grid will provide clarity</p>	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>body.</p> <p>My question is, what about employees, like myself, who are registered psychologists and really work with co-existing disorders, meaning the mental health- as well as the addiction/ substance abuse/ dependence component. Where do we fit in? Our position is definitely not clear. Also, what about the payment of annual registration fees if one is registered with more than one professional body eg. DAPAANZ and PSYCHOLOGISTS BOARD. Can you please clarify these issues for me.</p> <p>RESPONSE</p> <p>Thank you for your feedback. I will add your comments to the feedback log we are keeping.</p> <p>Yes, Registered psychologists are part of the multi disciplinary group that make up the AOD workforce. The multi disciplinary group are faced with two lots of registrations which is a barrier as costs will / can mean less will apply for DAPAANZ registration. This issue should ideally be recognized in the funding levels for contracts and then be covered by the Health Provider. Essentially a health practitioner can be recognized for their respective qualifications and registrations and can therefore work in an AOD multidisciplinary team but cannot refer to themselves as a registered AOD practitioner unless they have met the criteria outlined in the framework. The DAPAANZ registration indicates a level of specialized knowledge and competence specifically in AOD. A nursing, psychology, social work qualification and registration does not necessarily indicate AOD specific competence. The same applies for a specialist Kaupapa Maori practitioner , they are part of a multidisciplinary AOD team and are recognized for their kaupapa expertise but cannot hold the title of registered AOD practitioner.</p> <p>This whole topic does warrant lots of discussion and has been raised with the national training providers network and I have had discussions with Jenny Wolf (MOH) and others.</p> <p>I do think it comes down to a key question ie Is AOD a specialised area of practice? (and of course the AOD sector does see AOD as specialist) and MOH appears to share that view.. Then that being the case.. the challenge is what constitutes the levels of qualifications, competencies for a specialized body of AOD practice. Most of the feedback leads us to: a recognized AOD / Addictions registration body - DAPAANZ.</p> <p>The Qualifications framework is the next step towards an agreed pathway with levels of funding under allied health service specs.</p>		
Louise Leonard		1. Is there anything within the paper that needs clarification?	Yes DANA to be	

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>This paper makes no mention of the “Addiction Specialty Nursing Knowledge & Skills competency Framework” July 2011 – which is nearing its final draft DAPAANZ registrations is not necessary for nurses whose competencies can be demonstrated using the document. Nurses will have membership of DANA NZCMHN (hard to understand writing) – available via Matua Raki website.</p> <p>2. Is there anything within the paper that needs correcting for amending? Yes – must include Addiction Nursing Framework. The final version for the last consultation round is being proof read currently and will go out.</p> <p>4. Any other comments? Please call me to discuss further: Louise Leonard Clinical Nurse Specialist CADS International Vice President of Drug & Alcohol Nurses of Australasia Ph: 07 834 6902</p>	included. Paper to be amended to reflect this	
Adele Tierney via Kathy Grace		<p>I have read the above document and make the following observations:</p> <ol style="list-style-type: none"> 1. This is a discussion initiated by the Midland DHBs to bring consistency to the definition of clinical qualifications and competency in the addictions workforce. Thus the purpose of the document is to: <ol style="list-style-type: none"> a. Recommend a list of qualifications, competencies and / or regulation by acceptable professional bodies that service providers and staff employed by AOD services must have to meet the requirements of clinical and cultural competence within the Midland region, b. Develop a clear and concise clause regarding qualifications, competence and / or regulated membership of professional bodies, to be included in AOD service agreements as part of provider specifications. c. Develop the discussion paper with qualification pathways for approval by the Midlands DHBs, GMs Planning and Funding and Māori Health. 2. The qualifications and competencies they recommend are: <ol style="list-style-type: none"> a. Four distinct qualification levels with each level having a respective clinical or non-clinical rating. b. Categorising qualifications, competencies and DAPAANZ criteria into the four distinct levels as follows: <ol style="list-style-type: none"> i. Level 4 – Advanced AOD Practitioner – clinical ii. Level 3A – AOD Practitioner - clinical iii. Level 3B – AOD Practitioner – clinical iv. Level 2 – Associate AOD Practitioner – non-clinical v. Level 1 – AOD Support Worker – non-clinical 		Not for inclusion as local issue to be discussed at a local level

Feedback from:	Section in Report	Feedback / Discussion	Approved	Not Approved and Justification
		<p>3. A basic requirement for an AOD Practitioner is a level 7 qualification or higher,</p> <p>4. DAPAANZ registration is also a pre-requisite for an AOD practitioner recognised as 'clinical.'</p> <p>At the meeting held on the Monday 5th July Connie Hui outlined the stance of the BOPDHB which appears to be along the lines of Midlands Health, that is unless a practitioner is fully registered with DAPAANZ (which requires level 7 qualification as pre-requisite) they would not be regarded as 'clinical.'</p> <p>Connie further outlined options available to providers who currently do not meet the clinical component of their service specifications:</p> <ul style="list-style-type: none"> • To recruit appropriately qualified and competent practitioners as 'clinical.' • To amend the service specification from a clinical to non-clinical. • To exit the clinical service specification. <p>However, it is clear that the Bay of Plenty region has a workforce crisis in AOD. Currently there are only four AOD Practitioners Māori that qualify as 'clinical' holding both a level 7 qualification as well as full registration to DAPAANZ.</p> <ul style="list-style-type: none"> • Recruitment of qualified practitioners to work within a kaupapa Māori provision would be exceedingly difficult as by all accounts that are only 25 – 30 Māori practitioners in the entire country. • Amending the service specifications to non-clinical will not address workforce issues nor empower the service provider to develop their staff clinically. • Exiting clinical will impact negatively on kaupapa Māori service provision in terms of removing the incentive to develop a clinical component and will also create a gap for clients seeking kaupapa Māori service provision. <p>While BOPDHB signaled the changes in 2008/2009 the pathway to full registration DAPAANZ is a minimum of three years. We currently have 11 practitioners at level 6 through Anamata with some holding associate DAPAANZ registration. They require a further year, at least, of further study / practice before they can be recognised as 'clinical' under the criteria set by BOPDHB.</p> <p>From my understanding DAPAANZ would be in agreeance to associate DAPAANZ at level 6 being recognised as clinical subject to supervision by a fully registered DAPAANZ practitioner (this could be done through Cat Siely, as a senior clinical practitioner, and in her role with KMCSS).</p>		