NADA
network of alcohol & other drugs agencies

TRAINING NEEDS ASSESSMENT

of NGO Alcohol and Other Drugs Agencies in NSW

for

Network of Alcohol and Other Drugs Agencies

Prepared by

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- Final Report -

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EXECUTIVE SUMMARY

This training needs assessment documents the workforce development needs of the membership of the Network of Alcohol and Other Drugs Agencies (NADA) NSW.

Specifically, it assesses:

- Current workforce development standards and delivery methods;
- Key workforce development needs;
- Barriers to workforce development;
- Views of the membership on minimum qualification standards; and
- Workforce development roles for NADA.

NADA is the peak organisation for non-government alcohol and other drug agencies throughout NSW. It currently has 101 members.

The assessment used written surveys (46 respondents), interviews and workshops to determine the workforce development needs of the membership.

In general the membership reflects a sector which is well qualified. Most frontline positions require minimum qualifications of a Certificate IV in Alcohol and Other Drugs (AOD) or another tertiary qualification. Minimum experience of one to two years is also required for most frontline staff.

Member agencies use a wide variety of training delivery methods. Current training is mostly delivered by short courses, coaching by managers or executive officers, and via external conferences, workshops and events. Overall, these methods were viewed as effective in meeting staff needs.

The main barrier to undertaking training is the availability of staff to backfill for those away on courses. Also creating barriers are: time available to train, course costs, and insufficient training budgets. Reducing these barriers is mainly identified as an issue of more resources.

Agencies in rural and regional areas face particular barriers. There is a strong desire for more courses to be offered locally, and specifically in locations other than inner metropolitan Sydney (i.e. in regional centres as well as in outer western Sydney).

The strongest demand for training is for that in mental health issues (i.e. working with clients with dual diagnosis). There is also strong demand for training in managing aggressive behaviour, case management, new treatments for substance abuse issues, group skills, and basic computer skills.

Overall there is a strong preference for practice-based and skill-related training rather than for theoretical courses.

NADA members suggested that the specific needs of staff working in residential rehabilitation services are not fully catered for in most of the available AOD training. It is recommended that AOD training providers aim to better cater for this sector, and that the Certificate IV in AOD include more course content on these service models.

Some experienced staff in the sector are seeking further opportunities to improve their qualifications in AOD. This suggested the need for a focus on AOD career pathways. Higher level courses in dual diagnosis were specifically singled out as a current unmet training need.

In general, NADA members support the current Certificate IV in AOD as a good base qualification for working in the AOD sector. A majority of survey respondents support making the Certificate a minimum qualification standard for the sector - although some are wary of the possible consequences of a mandatory minimum standard on their current staff and on future recruitment.

In terms of future roles for NADA in workforce development issues, there was strong support for NADA's current workforce development and training program, and specifically its ongoing provision of training subsidies to help offset the cost of staff attending training and conferences.

There was also clear support for NADA to add to its information dissemination roles and to further assist members to share their skills, resources and training opportunities with other members, including in particular with smaller AOD services.

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REPORT

1. INTRODUCTION

This report was commissioned by the Network of Alcohol and other Drugs Agencies (NADA) as part of its Workforce Development Program. Prepared by independent consultants- Edwina Deakin and Anni Gethin- it contains the outcomes of a training needs assessment of managers and workers employed by non-government alcohol and other drugs (AOD) agencies in NSW.

The assessment was undertaken between August 2006 and January 2007. It incorporates both quantitative and qualitative feedback from the NADA membership.

The report provides a strong evidence base upon which future workforce development options and strategies can be developed aimed at enhancing NGO staff's capacity to successfully work with clients with AOD issues.

2. BACKGROUND

2.1 About NADA

The Network of Alcohol and Other Drugs Agencies is the peak organisation for non-government alcohol and other drug agencies throughout NSW.

NADA has 101 current member agencies ranging from one or two staff member organisations to very large providers. These agencies include metropolitan, regional and rural based organisations providing services such as in-patient and out-patient withdrawal services, counselling and case management, residential rehabilitation, after-care programs, health promotion and community development activities, as well as services for clients who have been before the courts (so called diversion clients).

NADA provides leadership, information and support for its member agencies. It aims to build the capacity of the alcohol and drugs sector through advocacy and advice. It also initiates and supports numerous strategic projects and collaborations within the sector, and between government, non-government and community based services involved in AOD issues.

NADA's Business Plan 2005-07 outlines its focus areas and plans for the coming years as built around three objectives:

- Build capacity of member organisations;
- Promote NGO growth in existing and new markets; and
- Enhance NADA's information management capability.

NADA is a not-for-profit organisation governed by a Board of Directors made up of representatives from member agencies. NADA is funded by NSW Health.

2.2 Context for Workforce Development

Workforce development describes a broad range of strategies that are used to ensure effective work practices within organisations. These strategies may focus on individuals, organisations or systems[1] .

Whilst effective staff education and training are key components, workforce development also focuses on change at the organisational, systems or infrastructure levels, specifically in terms of building capacity in a sustainable way. This involves strategies covering issues such as planning the workforce (including workforce mapping and recruitment), providing adequate training (in terms of competency development and work practice change), managing the workforce in a manner that maximises performance (including management, supervision, staff support, retention and incentives), as well as evaluation and feedback mechanisms[2]. It also involves investigating partnerships and linkages between organisations and how they interact with other related services at local, regional and/or higher levels.

This broad based approach has been used to inform the NADA approach to workforce development. It is also informed by a number of state and national initiatives focused on capacity building specifically for the AOD sector including the outcomes of:

- NSW Department of Education and Training *Drug and Alcohol Issues: An Agenda for Workforce Development in NSW*, 2005;
- NSW Health *Workforce Action Plan*, July 2004;
- National Centre for Education and Training on Addition (NCETA) *Workforce Development and the Alcohol and Other Drugs Field: A literature review of key issues for the NGO sector*, 2003;
- NADA Alcohol and other Drug Workforce Development Australia *The assessment of needs and the identification of strategies to achieve sustainable change*, Jurisdictional Reports, NSW, QLD and ACT, December 2003;
- NSW Health *Training Needs Review Report*, November 2000; plus
- NADA's Business Plan 2005- 2007 (this includes a significant capacity building component).

2.3 About NADA's Workforce Development Program

Since 1999 NSW Drug Summit, NADA has taken a workforce development approach to assist its members agencies to improve and maintain their ability to respond to drug and alcohol issues.

In 2001, NADA received funding from NSW Health to run a two year Workforce Development Project (2002-2004). The Project aimed to improve treatment services provided by non-government AOD treatment agencies by assisting managers to implement workforce development systems and practices.

The Project focused on managers in seven Area Health Services in Greater Sydney and the Hunter regions.

In 2004, following the success of this initial project, NADA received additional NSW Health funding to extend the Project into a three year Workforce Development Program (2004-2007).

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1 Allsop, S and Helfgott, S- *Whither the drug specialist? The workforce development needs of drug specialists staff and agencies.* Drug and Alcohol Review, 2002.

2 Australian Government of Heath and Ageing, NCETA- *Workforce issues and the treatment of alcohol problems: A survey of managers of alcohol and drug treatment agencies*, De Geyndt, August 2003

The stated goal of the Program is to:

> Increase the capacity of member organisations to work at increased levels of quality, effectiveness and efficiency through the provision of targeted support in priority areas of need.

The Workforce Development Program is integrated into the NADA Business Plan 2005-2007. The Program has six aims:

1) Inform, develop and progress workforce development, policy and planning in the AOD sector;
2) Work in partnership with state-wide initiatives including the Centre for Drug and Alcohol and the NSW Workforce Development Council;
3) Assist member agencies build and re-orientate systems to workforce development;
4) Build awareness and address current system and structural faults that impede workforce development;
5) Build capacity of current structures to respond and implement workforce development initiatives; and
6) Provide processes for the early identification of workforce development issues.

The NADA Workforce Development Program is staffed by a full-time Manager- Vanessa Long- with additional support provided by other NADA personnel.

3. ABOUT THE TRAINING NEEDS ASSESSMENT

Building the skills and knowledge of the alcohol and other drugs workforce has been a priority for government since the 1999 NSW Drug Summit. Whilst numerous workforce development initiatives have been successfully pursued by NADA and other organisations since that time, it has been seven years since a comprehensive review of the sector's needs has been carried out[3].

As such the NADA Board determined that a 2006 Training Needs Assessment would be undertaken of the NGO sector in NSW as part of its Workforce Development Program.

3.1 Aim

The NADA training needs assessment was commissioned to determine the current training, learning and development needs of the NGO AOD sector in NSW. It aimed to:

- Identify areas for development required for the workforce to deliver services now and into the future;
- Indicate what mix of skills and knowledge the NGO and AOD workforce needed; and
- Identify the best methods to deliver these skills and knowledge given the diversity in the location, size and services provided by the sector.

3.2 Consultancy

In July 2006 NADA commissioned Edwina Deakin, of EJD Consulting and Associates, and Anni Gethin, of AGA Consulting, to design and conduct the training needs assessment.

Research commenced on the assessment in August 2006 and concluded with some additional data analysis in January 2007.

The final Training Needs Assessment Report was submitted to NADA on 31 January 2007.

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3 NSW Health *Training Needs Review Report,* November 2000.

3.3 Methodology

The target group for the training needs assessment was NGO AOD agencies in NSW.

This group was accessed through NADA's member agencies consisting of 101 services.

To access the views of this sector, the consultants designed and implemented the following methodology:

3.3.1 Membership Survey

The key data gathering instrument used was a written survey of all NADA member agencies (a copy of which is included at Attachment 1).

On 25 August 2006 the surveys were distributed to the Managers or Coordinators of NADA member organisations both in print and electronic forms.

By the end of September 2006, a total of 46 survey responses were received. Taking into account the fact that some members were part of larger organisations that consolidated their response, the response rate was calculated at 45%.

See Attachment 2 for a full breakdown of the survey data.

In addition to these surveys of managers, the consultants also undertook a mini-survey of workers employed in the NGO sector. Forty copies were distributed at the NADA Conference on 10 October 2006.

A total of 11 worker responses were received. While no statistical analysis of this small sample has been undertaken, the survey feedback has been reflected in the qualitative feedback provided in the report.

It should be noted however that there was no significant difference in the feedback provided via the worker surveys compared to the manager surveys previously discussed.

3.3.2 Workshops

To complement the quantitative survey data, the consultants conducted two qualitative workshops with the sector.

The first workshop entitled *Your Skills and Knowledge* took place as part of the NADA 2006 Conference held on 10 October 2006.

A total of 14 participants took part, mainly frontline NGO AOD workers and managers.

A second workshop was undertaken with the NADA Board members on 20 November 2006. Six board members were present at this workshop, plus two NADA staff members.

3.3.3 Interviews

Following analysis of the survey data, the consultants also conducted a number of interviews with selected stakeholders. Interviewees were selected to reflect the breadth of NGO service types and geographical areas.

A total of nine interviews were conducted, all via the phone using a structured interview format.

In addition, the consultants met and discussed the training needs assessment with NADA staff, and in particular the Workforce Development Manager, on at least four occasions.

Included as Attachment 3 is a list of all interviewees.

Note: All interview input was provided on the basis of anonymity. As such all direct quotes from respondents (provided in either the interviews or surveys), are indicated in *italics* though are not attributed to specific individuals or organisations.

4. TRAINING NEEDS ASSESSMENT FINDINGS

As previously noted (see Section 3.3.1), in August 2006 NADA distributed its Training Needs Assessment Survey to all 101 of its member organisations.

A total of 46 responses were received representing 45% response rate.

All the quantitative data is drawn from these survey responses.[4]. Attachment 2 contains a complete set of survey data.

The qualitative responses are drawn from both the open-ended questions gathered from the membership survey (full transcripts also included at Attachment 2), as well as from respondent feedback in the workshops and interviews described in Section 3.3.2 and 3.3.3.

Based on the high response rate, and the spectrum of respondents covering all AOD service types and geographic locations, the survey data was found to be representative of NGO AOD organisations in NSW. As such the following findings are a good measure of NADA members' current views on AOD workforce development and training.

4.1 Organisation Profile

4.1.1 Geographic Location

The survey respondents' organisations were located as follows:

- 64% were based in metropolitan areas (namely Sydney [56%], Wollongong or Newcastle);
- 32% were based in rural, regional or remote parts of NSW (i.e. non-metropolitan areas);
- 4% were described solely as other (eg. NSW wide, ACT).

4.1.2 Type of Service

Organisations reported they offered the following type of service:

- 65% offered residential services (eg. residential rehabilitation or therapeutic communities);
- 41% offered outpatient care (e.g. outreach, aftercare or counselling);
- 26% provided health promotion;
- 11% provided supported assisted accommodation; and
- 7% undertook policy and/or advocacy work.

A small number of organisations (11%) also noted they provided other types of services including:

- Women only counselling,
- Parenting assistance, and
- Referrals and court reports.

[4] Note: The percentages given include those who did not respond to the specific question. As such some of figures presented in the report may not add to 100% (see Attachment 2 for details).

The main services offered by respondent organisations were (in descending order):

- Residential rehabilitation (70%);
- Outpatient counselling and case management (39%);
- Services to diversion clients (35%);
- Health promotion and/or community development (30%);
- After care programs (30%);
- Withdrawal services (13%);
- Inpatient withdrawal (11%); and
- Day programs (9%).

A small number of organisations (9%) reported that were currently undertaking a special project. Those listed included projects on:

- Strengthening families,
- Crisis retrieval,
- A health clinic,
- A young women's pregnancy/ parenting group, and
- A Smart Recovery group.

13% of respondent organisations also reported that they offered 'other services' to those listed above. Those listed included:

- A crisis centre,
- Welfare assistance,
- General practitioner,
- Psychiatrist,
- Gambling counselling, and
- Referrals and court reports.

4.1.3 Client Group

The client groups served by NADA member organisations who responded to the survey consisted of:

- 35% offered services to women;
- 33% offered services to men;
- 28% offered services to the community or clients in general;
- 22% offered services to young people; and
- 7% offered services to families.

One fifth of the respondents (20%) also reported they served other client groups. Those listed included:

- Aboriginal and Torres Strait Islander (ATSI) community,
- Children,
- Homeless people,
- Dual diagnosis clients,
- Transgender people, and
- Clients from culturally and linguistically diverse (CALD) backgrounds.

Table 1 contains data on how client groups are distributed for each service type. It indicates what proportion of each service type has particular client groups as their main client group (noting that services may have more than one main client group).

For example, 30% of metropolitan based services have community and general clients as their main client group. Generally there are no substantial differences between services (particularly when small sample sizes are allowed for), however, the following points are of interest:

- Only 6% of diversion services have youth as a main client group;
- 38% of non residential services have youth as a main client group; and
- Very few services have family as their main client group, although 19% of non residential services have family as their main client group.

Table 1: NADA Members: Percentage Distribution of Client Group by Organisation Type (n= 46)

	Community and General	Family	Men	Women	Youth	Other
All organisations	28	7	33	35	22	20
Metropolitan	30	7	26	33	18	15
Rural and Regional	27	7	47	47	27	20
Diversion	30	0.0	47	53	6	18
Offers Residential Services	23	0	27	43	13	20
Does not Offer Residential Services	38	19	20	19	38	13

Source: NADA Training Needs Assessment Survey, 2006. (Gethin and Deakin)

4.2 Staffing Profile

4.2.1 Employees

A total of 378 full time equivalent (FTE) staff were reported to be employed across the 43 NADA member organisations who responded to this question in the survey. This figure translated to an average of 8.8 FTE staff per organisation.

A total of 345 part time staff were employed in 42 organisations with an average of 8.2

Most respondent organisations (77%) employed 10 or less FTE staff. Other employee data included:

- 44% employed 5 or less FTE staff,
- 33% employed between 6 and 10 FTE staff;
- 13% employed between 11 and 25 FTE staff;
- 9% employed between 26 and 100 FTE staff; and
- 2% had over 100 FTE staff.

Based on the survey data, the consultants estimate that the number of FTE staff employed by all NADA member organisations in NSW is approximately 1,100 people.

4.2.2 Type of Staff

NADA member organisations employ a broad cross section of workers performing a variety of staffing roles. The distribution of job roles across organisations is show in detail in Table 2. The percentages of organisations with each job role are as follows.

a) In terms of management and administration staff:

- 94% had managers;
- 57% had team leaders; and
- 76% had administrative staff.

In addition, the following management and administration job roles were represented in at least one organisation: Chief Executive Officer, Assistant Manager, Coordinator of all frontline staff, and Operations Manager (for example in Information Technology or Quality Assurance).

b) In terms of client focused or front-line staff:

- 46% had counsellors;
- 57% had AOD case workers;
- 39% had residential support workers;
- 22% had welfare workers;
- 15% had intake officers;
- 9% had nurses;
- 9% had child care workers;
- 9% had vocational education workers;
- 7% had medical practitioners; and
- 6% had night staff.

The following client focused or frontline job roles were also represented in at least one organisation:

- Domestic violence support worker,
- Community care worker,
- Parenting worker,
- Clinical support team,
- Trainee counsellor,
- Trainee AOD worker,
- Placement/aftercare worker, and
- MERIT worker.

Table 2: NADA Members: Profile of Staff Employed in NSW (n=46)

Staffing positions	Frequency (in orgs)	Range	Total (across orgs)	Average (across orgs)
Management / Administration				
Manager	43	0.4- 6	55.4	1.2
Team leader	26	0.5- 7	41.0	0.9
Administrative staff	35	0.2- 6	53.4	1.2
Other	13	1.0- 4	17.0	0.4
Frontline				
AOD case worker	26	0.2- 36	101.0	2.2
Intake officer	7	1.0- 2	7.0	0.2
Counsellor	21	0.8- 11	54.6	1.2
Residential support worker	18	1.0- 20	91.2	2.0
Welfare worker	10	1.0- 5	22.5	0.5
Medical practitioner	3	1.0- 5	7.0	0.2
Nurse	4	1.0- 10	16.4	0.4
Client support				
Child care worker	4	.94- 5	9.9	0.2
Vocational education worker	4	1.0- 18	23.0	0.5
Other	4	-		
Policy/ Health Promotions /Community Development				
Project officer	4	0.2- 5	8.2	0.2
Health promotion worker	5	0.2- 5	7.8	0.2
Community Development Worker	1		2.0	0.0
Researcher	1		1.0	0.0
Policy / advocacy worker	1		2.0	0.0

Source: NADA Training Needs Assessment Survey, 2006. (Gethin and Deakin)

c) In terms of other workers employed by NADA members:

- 11% had a health promotion worker, and
- 9% had a project officer.

In addition the following job roles were represented in at least one organisation:

- Community development worker,
- Researcher,
- Policy advocacy worker,
- Trainer,
- Group facilitator,
- Housing worker,
- Property maintenance person,
- Housekeeper, and
- Marketing.

4.2.3 Volunteers

Volunteers were reported as being used in nearly half (48%) of NADA members organisations. A total of 671 were currently engaged across all respondent organisations, at an average of 15 per organisation.

Of the organisations who used volunteers, some are highly volunteer dependent and deploy hundreds of volunteers, others use one or two on an occasional basis.

Based on the survey data, the consultants estimate that the number of volunteers used by all NADA member organisations in NSW is approximately 1,500.

4.3 Workforce Skills and Qualifications

4.3.1 Minimum Qualifications

NADA members were asked about the qualifications required to perform different job roles in their organisation. They were asked whether the role had a minimum qualification, and, if so, details of that qualification. Table 3 summarises the results of the survey feedback.

When respondents commented on minimum qualifications there was a range of feedback provided. For example, whilst some organisations consistently required Certificate IV AOD for all frontline staff positions, others (including those outside metropolitan centres) commented that this was a desirable but not essential criterion of recruitment. As one rural based interviewee commented:

- *What we mainly look for in staff is someone with the right attitude. We've had staff in the past with Cert IV in AOD who were 'crap', and we've had staff with no formal qualifications but heaps of experience who were fabulous.*

Table 3: NADA Members: Profile of Required Qualifications by Staffing Positions (%) (n= 46)

Role	Required Qualification	Cert III	Cert IV AOD	Other Cert IV	Bachelor Degree	Post Graduate	Other/ Not specified
Team leader	100%		40%**	3%	45%	5%	8%
AOD case worker	100%		71%***		25%***		4%
Intake officer	90%		60%		20%		20%
Counsellor	96%		52%		48%	5%	
Residential Support Worker	80%	10%	68%	16%			53%
Welfare Worker	70%			62%	25%		12%
Project Officer*	100%						
Community Develop./ Health Promo. Worker*	83%						
Researcher*	83%						

Source: NADA Training Needs Assessment Survey, 2006. (Gethin and Deakin)

* Note: Small sample size (distribution of qualifications too small to be meaningful).
** One organisation also required a team leader certificate
*** One organisation required both / one required either.

4.3.2 Minimum Experience

NADA members were asked about the minimum experience required for the different job roles in their organisation. They were also asked whether roles had a minimum experience requirement, and if so, details of the requirement.

Table 4 summarises the survey feedback provided. (See Attachment 2- Section 8 for details).

All respondents (100%) indicated that team leaders were required to have minimum levels of experience. Mostly this was specified as 2 to 4 years experience, though some required 10 years or more. The minimum required was stated as 2 years.

All respondents (100%) also indicated that counsellors were required to have minimum levels of experience. Between one and three years was the range given.

In terms of AOD case workers and intake officers, the vast majority of respondents (96% and 85% respectively) indicated that minimum experience was required. In most cases 2 years were specified, though some indicated up to 4 years were required for case workers. One year was the minimum experience stated for both positions.

In terms of other positions surveyed (see Table 4 below) respondents demonstrated a range of minimum experience requirements. For example 65% or less of respondents set minimum experience levels for positions such as project officers, community development or health promotion positions and researchers.

Table 4: NADA Members: Minimum Experience Required of Staff Positions Expressed in Years (n= 46)

Role	Most Common Minimum Experience Required in years	Range of Minimum Experience in years*
Team Leader	2- 4	2- 10
AOD Case worker	2	1- 4
Intake officer	1- 2	1- 2
Counsellor	2	1- 3
Residential support worker	1- 2	6mths- 2 yrs
Welfare worker	1- 2	1- 2
Project officer	1	0- 3
Community development/health promotion worker	1	0- 3
Researcher	1	0- 2

Source: NADA Training Needs Assessment Survey, 2006. (Gethin and Deakin)

* Ranges are based on 75% or more respondents stating minimum experience required

4.4 Current Workforce Development

4.4.1 Staff Development Process

Most survey respondents (76%) reported their organisation had a formal staff development process.

Only 17% reported that their organisation did not have a formal staff development process (the remaining 7% did not answer the question).

When asked why their organisation undertakes staff training and development, the most common reasons given were:

- Improve quality of service;
- Improve clinical skills;
- Ensure best practice;
- Ensure that staff skills remain current (including latest treatment options);
- Increase staff knowledge;
- Better serve clients; and
- Professional development and job satisfaction.

4.4.2 Training and Development Delivery

Survey respondents reported using a range of methods to train and coach their frontline staff.

The most regularly used methods included:

- Coaching by managers or executive officers (72%);
- Short courses (57%);
- External conferences, workshops and events (52%);
- Formal mentoring and buddy schemes (44%); and
- Coaching by external practitioners (35%).

The methods that were reported to be used sometimes were (in descending order):

- Coaching by external practitioners;
- External conferences, workshops and events;
- Formal education courses (e.g. degree or certificate);
- Formal mentoring and buddy schemes; and
- Job rotation, secondment and/or shadowing.

The two methods which were reported to be never or rarely used were:

- Blended learning programs (combination of distance and face-to-face); and
- E-learning (i.e. online material).

Respondents also mentioned that they used the following other methods of training and development:

- Guest speakers,
- Paying for university courses, and
- SAAP training.

When workshop participants were invited to comment on preferred training and development options there was strong support for workplace learning in general. The stated benefits included:

1) Capacity to tailor training specifically to the organisation's needs and potentially for the benefit of all staff;
2) Opportunity to schedule training at a time convenient to staff and the organisation;
3) Opportunity to discuss new skills and knowledge within the context of a '*real world organisation context*', including how they might impact on the organisation's *'actual policies and procedures'*; and
4) Capacity to purchase a specific, quality trainer or training provider.

4.4.3 Evaluation of training methods

Respondents were asked to rank training methods for frontline treatment staff in terms of which they used.

The training and development methods used most often were (in descending order):

- Short courses;
- External conferences, workshops and events; and
- Coaching by managers or executive officers.

The training and development methods found to be most effective were (in descending order):

- Short courses;
- Coaching by external practitioners; and
- External conferences, workshops and events.

The training and development methods which respondents would like to use more frequently (if improved delivery options became available) were:

- Short courses;
- Coaching by external practitioners;
- Formal education courses; and
- External conferences, workshops and events.

In short, NADA members did not identify a preference for different training methods to those already being used.

4.4.4 Training Quality

Survey respondents were asked to rate the standard of AOD training currently available in NSW:

- 55% rated it as either excellent or good;
- 28% rated it as neither good nor poor; and only
- 4% rated it as poor.

Whilst based on a very small sample (11), the AOD workers who were surveyed similarly rated the staff training and development opportunities available to them in their organisations. Based on the same five-point scale, 70% rated the training quality as good, with the remaining 30% indicating it was neither good nor poor.

Survey respondents, interviewees and workshop participants offered some suggestions as to ways AOD training in NSW could be strengthened. Feedback included:

- Increasing the emphasis on practice focused training or 'how tos', rather than theoretical training;
- Increasing the involvement and input of experienced AOD frontline workers;
- Providing a greater number of courses pitched an advanced or experienced staff level (as opposed to beginner level courses);
- Providing more opportunities for clinical placements as part of formal training. (This included a number of respondents specifically referring to more placements in residential rehabilitation services. [See comments below]);
- Increasing course availability outside Sydney (see comments Section 4.5);

- Increasing access to funding and training subsidies including for traineeships;
- Increasing access to tertiary level training and training pathways (see comments Section 4.7.3);
- Increasing the availability of mental health training (see comments Section 4.6.2 E]); plus
- Further training with an abstinence focus.

It was noted by a number of interviewees and workshop participants that, as a rule, most external training tended to focus on out-patient service models. This meant that training often lacked sufficient emphasis on residential-type services, and particularly those challenges that occur in the context of staff-client interactions that are developed and sustained over periods of time.

The failure to adequately address residential service issues was a noted shortcoming of some AOD training. As a consequence some residential services appeared to be electing to purchase in-house training so as to provide staff with training that specifically catered to their work situations. (See benefits of in-house training listed at Section 4.4.2).

4.4.5 Management Issues

Some service managers who participated in the workshops and interviews also commented on a number of management issues related to current workforce development practice.

The feedback indicated that there was considerable variation in how workforce management and development practice operates across the NGO AOD sector in NSW. Some organisations reported having formal training plans for each staff member linked to their organisation's business plans, whilst others reported more flexible and opportunistic approaches based on manager or staff member requests and/or what courses were available.

Some managers noted that management imperatives and funding availability often played a key role in the type and extent of training staff received in any one year. Staff requests to attend specific courses or conferences often had to be reviewed within the broader organisational and financial context. As one respondent put it:

- *Sometime staff wants [for training] did not always balance with the manager's or the organisation's needs.*

One final management issue that was noted by a number of respondents (with a degree of frustration) related to the issue of staff changes. Whilst some organisations indicated they had a very stable workforce, others appeared to suffer from high staff turn-over. This turn-over placed a strain on organisations, no just in relation to training budgets, but also in relation to management's ongoing preparedness and *'goodwill'* to purchase external training.

As one smaller service manager summed up:

- *It can be very frustrating to have invested considerable amounts of time and money in upskilling a staff member, only for them to turn around and leave.*

  I know this is an inevitable part of the modern workplace, but it really does impact on a small NGOs like ours…. We already spent our training budget for the year, and yet some other organisation is reaping the benefits of 'our' improved worker!

4.5 Barriers to Training

NADA members were asked if their organisation faced barriers in providing staff training and development: 80% indicated there were barriers; with only 20% indicating there were not. (See Attachment 2, Section 10 for other responses to barriers to training).

4.5.1 Most Common Barriers

Of those organisations who did face barriers, the following factors were rated by 90% or more of respondents as creating either a 'major' barrier or 'somewhat' of a barrier to staff training and workforce development in their organisations:

- Availability of staff to backfill;
- Time available to train;
- Cost of courses; and
- Insufficient training budget.

(See comments at Section 4.5.5 below regarding specific barriers to non-metropolitan services).

When interviewees and workshop participants were asked what were the challenges faced in terms of backfilling staff, a number of issues emerged:

1) Cost of backfilling staff. As one interviewee commented:

   It's a real financial burden paying double salaries for up to three/ four days or more especially if more than one staff member is involved [in training].

2) Logistical and rostering challenges, especially for residential services that have 24 hour shifts; and

3) Availability of suitably qualified staff to backfill, especially in non-metropolitan areas and where shift works is involved.

4.5.2 Other Barriers

The following factors were rated by 40% of respondents as creating a 'major' barrier or 'somewhat' of a barrier to staff training and workforce development in their organisation:

- Funding cycle incompatible with long term training; and
- No suitable training available (also see comments in Section 4.5.6 below).

The following factors were rated by over 20% of respondents as creating 'somewhat' of a barrier to staff training and workforce development:

- Staff reluctance to engage in learning; and
- Insufficient access to technology (e.g. for online learning).

However one interviewee did comment that in her organisation there was *ongoing staff resistance to training.* The interviewee was unable to explain why, other than that staff were:

- … *set in their ways;* and that
- … *there was currently not a strong culture of up-skilling in the organisation.*

4.5.3 Non Barriers

The following factor was rated by 68% of respondents as not being a barrier to staff training and workforce development:

- Lack of senior management support.

4.5.4 Training Resources

A number of respondents in both the surveys, interviews and workshops provided commentary on the specific difficulties with resourcing training. Comments included:

- *Disruptions to the agency due to inconsistency of care to clients due to short staffing whilst other/s is/are training. We are an agency with small numbers of staff in two different premises so it is hard to keep long term casuals if inconsistent work is available.*
- *Staff availability is not as much a problem as the cost of backfilling. We can dig up enough money to send staff on courses - the killer is two wages.*

Numerous respondents specifically commented on the difference the current NADA Workforce Development Program training subsidies had made to their staff's access to training. Comments included:

- *Some of these barriers have been removed through access to NADA Workforce Development grants.*
- *[As a rural based service provider], there is no way we could have afforded for our staff to attend the specialist training in Dubbo, had we not received a grant from NADA.*

Access to adequate training resources, on an ongoing basis, was clearly identified a major issue for NADA members.

4.5.5 Non-Metropolitan Barriers

Whilst there were similarities in regard to barriers to training across all respondent groups, organisations based in regional and rural NSW indicated they faced particular barriers. For example, most non-metropolitan respondents noted that the costs of training (and specifically costs associated with travel and accommodation), plus the challenge of finding qualified staff to backfill positions when staff were absent for training, were two of the most substantial barriers to training.

Comments about barriers from the open ended survey questions, interviews and workshops included:

- *Added cost of travel/accommodation due to courses only being held in capital cities.*
- *Given our (rural) location, it's next to impossible for us to send more than one staff member to training at a time as there is not staff available to backfill.*
- *For one of our staff to come to a short course in Sydney say, may take 3 or 4 days out of the office, not to mention the cost of airfares or petrol. We really can't do it that often.*
- *Recently two staff members needed to attend a course in Dubbo. All up it cost us around $4,000 with return airfares into Sydney and back out to Dubbo plus accommodation for 2 nights. NADA grants helped but we were still short around $2,000. That's hard on a small service like ours.*

When questioned as to what might overcome these types of barriers, virtually all respondents offered two suggestions:

1) Increase in funding to cover the costs of training for non-metropolitan services (specifically the costs of travel and accommodation); and

2) Increase in the number of regional training opportunities.

The desire for there to be more locally available training opportunities was also evident in some outer metropolitan member responses. For example:

- *[Our] staff do not like to travel to [central] Sydney- could training be arranged at major suburban areas e.g. Liverpool, Parramatta, Penrith, Campbelltown?*

4.5.6 Other Barrier Issues

Whilst only a minority of respondents (40%) listed 'no suitable training available' as a barrier to training, some interview and workshop participants noted that the quantity of training information they received, plus difficulties in selecting appropriate courses, did create a barrier to training. As one interviewee commented:

- *I know there is plenty of training around, but it is a case of information-overload. Who has the time to trawl through dozens of emails each week just on the off chance one staff member might be suited to attend?*

Interviewees and workshop participants also noted a number of other challenges associated with AOD training:

- A tendency for some training to be insufficiently *practice-focused*. More emphasis need to be placed on 'how-to' perspectives, and providing trainees with opportunities for practicing their new skills and approaches;
- The quality of some training was less than desirable. This included the issue that sometimes trainers were insufficiently knowledgeable about current AOD topics and clinical practice;

  Some respondents suggested NADA could assist in providing the sector with advice (for example on a website or via a chat room) about which courses and which trainers provided good value-for-money (see comments in Section 4.8);
- Occasionally planned courses being cancelled due to lack of demand; and
- An abundance of courses pitched at beginner level revealing a need for more higher level courses or training for experienced staff.

4.6 Future Workforce Skills and Knowledge

4.6.1 Demand for New Training

NADA members were asked if they foresaw changes or challenges (either in their organisation or across the sector) that would require their staff to acquire new skills or training:

- 63% said yes;
- 11% said no; and
- 22% were unsure.

The most common stated reason for why staff need new skills or training (in the open-ended survey question) was:

- *To enable staff to work effectively with clients with dual diagnosis.*

Other reasons given as to why staff would need new skills or training included:

- New substance abuse treatments;
- Upgrading skills;
- Quality improvement;
- Legislative changes;
- Accreditation requirements;
- Information technology;
- Information management;
- Increased numbers of staff; and
- To work with particular target groups, e.g. children, ATSI.

4.6.2 General Skills and Knowledge Needs

The most important skills and knowledge needs by worker type were identified as follows:

a) Frontline treatment staff

- Dual diagnosis and mental health related training;
- Case management;
- Counselling skills;
- General knowledge/ skills in relation to drugs and clients with substance abuse issues;
- Group work;
- Working with challenging clients; and
- IT and database skills.

b) Managers / Team Leaders

- Supervision/ staff management/ leadership;
- Business plans/ strategic plans and budgeting;
- Communication;
- Quality improvement;
- Governance;
- Legislative requirements and accreditation;
- Grant submissions;
- Organisational and time management; and
- IT and database skills.

c) Administration staff

- IT skills;
- Financial management/ budgeting;
- Client records;
- Accidental counselling/ first point of calling; and
- Organisational and time management.

With a specific focus on frontline treatment staff, NADA members were asked a series of questions indicating what type of topics staff might require training in over the next twelve months (see Attachment 1, Questions 18-25). They were also asked to rank their preferences given the options provided.

What follows is a summary of the survey results using the weightings provided to indicate the most sort after training topic in each topic area. (Complete survey data on these options is available at Attachment 2, 8-25).

A) Generic Skills

87% of survey respondents reported that their frontline treatment staff might require training to improve their generic skills over the next year.

The three most required generic skills were (from highest to lowest demand):

1) Managing aggressive behaviour (see discussion i] below),
2) Case Management, and
3) Assessment.

Other generic skills sought, though to lesser degrees, were (in descending order):

4) Communication skills,
5) Knowledge of the effects of drugs and drug interactions (see discussion ii] below),
6) Work with other services (referral and information sharing) (see discussion iii] below),
7) Work with clients who are intoxicated, and
8) Withdrawal management services.

i) Aggressive Behaviour

A number interviewees and workshop participants also emphasised the need for more training for frontline staff in managing aggressive and confrontational behaviour specifically in AOD clients. That is, whilst there are general aggressive behaviours courses available, there are specific challenges in dealing with aggressive behaviour or non-compliance as it relates to AOD clients. These challenges suggest the need for specialised AOD sector courses.

This issue was specifically evident amongst respondents from residential rehabilitation and diversion programs who reported dealing with non-voluntary clients or clients who had high levels of denial or blame about their substance misuse.

As one respondent put it:

- *I know there are courses out there for dealing with aggressive behaviour, but I think there are specific issues associated with the aggression that comes with some AOD clients. I would really like to see a short course specifically on how to manage aggression with AOD clients.*

ii) Substance Issues

When interviewees and other respondents expanded upon what they were seeking in terms of substance issues (see 5] above), respondents largely shared a common view. This included information on:

- Pharmacology of drugs (including regular refresher courses);
- Trends in Substance Abuse (specifically in terms of what to look for in an assessment, their pharmacology and clinical impacts). Specific topics requested were:
  - Speed/ ice pharmacology and clinical issues,
  - Poly-drug use impacts,
  - Street morphine,
  - Alcohol abuse (including long term usage and brain damage issues), and
  - Marijuana (especially impacts of strong hydroponic usage and long term use impacts); and
- Current treatment options and success rates. As one respondent summed up:

- *We need to have regular updates on what's available and what works.*

iii) Local Services

Numerous interviewees supported the need for more local courses or workshops on what services were available and how to refer in their given area. As one respondent noted:

- *The [NGO] sector is changing so rapidly. It would be great to get refresher courses on who's doing what in the local area on a year to year basis.*

When questioned, respondents requested that these types of courses be held regularly (for example annually) and incorporate:

- Basic local service information (or as one respondent stated '*who's doing what').* Specific reference was made in each instance to what mental health services were available and how to refer;
- Referral procedures and eligibility criteria;
- How to jointly case manage common clients;
- Where local specialist counsellors can be accessed (for example on sexual assault); plus
- Opportunities to network with other local service staff.

One manager proposed that these local service workshops also be used for sharing information between ser vices on what challenges were being experiencing, and how staff were meeting those challenges. As she explained:

- *They could operate as peer support forums where local managers could support each other. They could even provide peer support and mentoring opportunities where managers of larger services could assist smaller services (and especially new managers) to gain skills and expertise they may lack initially.*

iv) Court Processes

A number of respondents observed that there appeared to be a unique set of knowledge and skill areas staff required when working with AOD clients in diversion programs, who were before the courts, or who were exiting the criminal justice system. These skills areas included:

- General knowledge of the criminal justice system and court processes;
- Policies and procedures regarding diversion programs;
- Case management and client intervention skills (especially for managing non-voluntary clients); plus

- Preparing reports for court or official communication skills.

Whilst it was noted that a lot of this information was currently being gained through on-the-job training, the growth in diversion programs may warrant some targeted training specifically catering to this sub-group of AOD service providers.

As one respondent commented:

- *There may be a demand for a specific course for staff who are involved in diversion programs generally. …it might have units in understanding the court system, how to work with non-voluntary clients or non-compliance, plus dealing with aggressive behaviour etc.*

B) Client Intervention Skills

91% of survey respondents reported that their frontline treatment staff might require training in client intervention skills over the next year.

The four most required client intervention skills were (from highest to lowest demand):

1) Dual diagnosis (see Section E below),
2) Case management,
3) Motivational interviewing, and
4) Cognitive behaviour therapy.

Other client intervention skills sought, though to lesser degrees, were (in descending order):

5) Advanced group work,
6) Solution focused therapy,
7) Relapse prevention,
8) Brief interventions, and
9) Grief and loss counselling.

Feedback provided in the open-ended survey questions, interviews and workshops also echoes some of these themes and added the following possible client intervention skills training topics:

- Basic counselling techniques (especially for new recruits or recent graduates of the Certificate IV AOD)
- Group skills,
- Reflective listening,
- Managing self-harming behaviour,
- Narrative therapy,
- Family therapy, and
- Advanced Gestalt therapy.

In the course of the interviews, a number of participants also requested that there be courses on intake processes. It was observed that many organisations had developed their own intake systems over the years, however, it was thought that these could probably be improved. Most beneficial would be an intake course specifically tailored to AOD NGO administrative or management staff, which presented best practice intake models and systems.

As one respondent observed:

- *This may require NADA to commission some specific training in this area to ensure it is relevant to the AOD sector, including residential rehab services.*

C) Practice Skills

85% of survey respondents reported that their frontline treatment staff might require training in practice skills over the next year.

Required practice skills were (from highest to lowest demand):

1) Occupational Health and Safety,
2) Duty of Care,
3) Ethics for the AOD sector (see discussion i] below), and
4) First Aid.

i) Ethics and Professional Boundaries

Interviewees and workshop participants strongly supported the need for further staff training in staff-client ethics and defining professional boundaries. When respondents were questioned as to what this might involve, feedback included:

- Privacy and confidentiality issues,
- Ways to maintain professional boundaries particularly in residential settings where relationships between client and worker are built over time,
- How to encourage staff to *not bring their personal issues to work*,
- How to manage information and counselling processes in a team-based environment,
- How to *prevent [staff-client] roles from becoming 'blurred'*, and
- Practice-based skills (rather than theoretical lectures) about what do in specific scenarios.

On this latter point, one 'scenario' referred to related to managing family involvement. More specifically it related to the procedures and ethics of balancing the client's confidentiality with a family's or spouses capacity to provide an appropriate level of support and encouragement for completing the treatment.

D) Client Group Skills

89% of survey respondents reported that their frontline treatment staff might require training in client group skills over the next year.

The four most required client groups skills were (from highest to lowest demand):

1) Working with clients with dual diagnosis (see Section E below),
2) Aboriginal and Torres Strait Islanders (ATSI) (see discussion i] below), and
3) Child protection (see discussion ii] below).

Other client group skills sought, though to lesser degrees, were (in descending order):

4) Working with Families,
5) Culturally and Linguistically Diverse communities (CALD) (see discussion iii] below), and
6) Young People (see discussion iv] below).

There was very little demand reported for training in the following client group skills: Men, Women, and People with disabilities.

i) ATSI

When interviewees were asked to elaborate on what aspects of ATSI they felt staff needed training in, responses included:

- Cultural needs of ATSI clients;
- Impacts of incarceration;
- How to engage with family members (including the extended family) in the ongoing support of their Aboriginal relatives; and
- How to modify standard case management practice to be culturally safe and appropriate.

Whilst some interviewees noted additional ATSI training would be beneficial to staff, other interviewees said their services already had staff well experienced of working with Aboriginal clients. Another respondent commented that:

- *It is very difficult to find trained Aboriginal Drug and Alcohol workers.*

One final interviewee commented that *'it was a kind of vicious circle'*:

- *Without Aboriginal staff or techniques for specifically outreaching to local Aboriginal communities, we know we are not accessing them as we should. Some training in how to make our service more appropriate and acceptable to the ATSI community would be great.*

The topic of training in grief and loss counselling was also raised in the context of Aboriginal clients, albeit rated low in the survey feedback (see data in B] above).

ii) Child Protection and Parenting

A number of interviewees noted the need for staff to be trained in child protection matters. It was observed that as most AOD services were not funded by the Department of Community Services, they often were not eligible for the free training available.

Two interviewees commented on the need for some AOD staff to also receive training in parenting skills. These skills could then be shared with their residential rehabilitation clients as part of their ongoing counselling and case plans.

As one interviewee commented:

- *Teaching our Mums about positive parenting techniques, and ways to have positive and appropriate relationships with their children, can be critical to their recovery. Some of our clients have experienced years of dysfunctional or discontinuous parenting and for staff to provide them with new techniques (incorporated into their case plans) is really important.*

iii) CALD

A number of interviewees noted that their frontline staff would benefit from specialist training in various cultural issues, taboos and practices. For example, one interviewee commented on the need for cultural training in Pacific and South Sea Islander communities (including Maori) given the growing number of clients with these backgrounds presenting at their service.

Another interviewee noted that dealing with clients with Chinese or other Asian backgrounds had been know to pose challenges to staff, especially when other family members were involved.

As the respondent summed up:

- *Clearly some topics (such as gay issues) are taboo in some cultures. If [local AOD] counsellors were more aware of how to communicate appropriately, especially with family members, then that may make the young people we refer more likely to access services.*

  I think more cultural sensitivity training in general, (and specific local CALD issues in particular), would be a great idea.

iv) Young People

In terms of young people, a number of interviewees and workshop participants raised the need for more AOD workers to have improved youth-specific counselling skills. When questioned what might need to be covered in training in regards to young people, the following suggestions were made:

- Basic communication skills for engaging with young people;
- Interviewing techniques that were aimed at breaking down barriers and building rapport;
- Understanding contemporary adolescent culture, language and styles of interactions; plus
- Modified case management or referral techniques.

As one interviewee commented:

- *With young people you can't expect them to just go to an appointment if referred. Counsellors need to understand how to follow-up with calls and support to get kids into the next stage of treatment or support. It's about a different style of engagement to those used with adults.*

Another interviewee commented on the need for some AOD staff to receive additional training in institutionalised young people. This included information on the impacts of out-of-home care or time spent in the juvenile justice system. It also included specific techniques in newer techniques such as:

- *Life stories and how to unpack their complex pasts in order to help them move forward.*

v) Sexual Assault

In addition to the listed client group skills in the survey, numerous respondents also noted that training in sexual assault was required, including dealing with adult survivors of child sexual abuse. As one (residential rehab) respondent noted:

- *Between 70%- 90% of our clients have been victims of sexual assault or domestic violence. Some staff counselling skills specifically in this area are essential as it emerges regularly in their life stories and needs to be dealt with in the treatment options we develop.*

Whilst it was noted that specialist sexual assault counsellors exist in most areas, and need to be brought in, some AOD workers (including in particular those in residential services catering for women) nonetheless needed to have basic skills in managing and counselling the consequences of childhood abuse and sexual assault.

Male victims of sexual abuse therapy was also indicated as a client group skill need in one survey response.

vi) Sexuality Issues

One final client group issue raised by two interviewees was sexuality issues, and the need for some AOD staff to receive basic training in sexuality counselling, lesbian and gay issues, as well as information relating to sex work.

As one respondent commented:

- *Many of our counselling staff just don't have experience in these [lesbian] issues. Clearly some basic knowledge on sexuality issues in general would assist them in their overall counselling skills.*

One respondent also noted eating disorders as a possible training topic.

E) Dual Diagnosis

Whilst training in dual diagnosis had already been listed in other survey questions (see results in B and E above), NADA members were also asked a specific question on this topic.

91% of respondents said that their frontline treatment staff might require training in dual diagnosis skills over the next year.

The two most required dual diagnosis skills were (from highest to lowest demand):

1) Assessment of dual diagnosis, and
2) Management of clients with dual diagnosis.

There was also strong demand for each of the other topics listed (in descending order):

3) Understanding mental illness,
4) Mental health first aid, and
5) Use of psychotropic medications.

The need for dual diagnosis training, or mental health training generally, was also very strongly borne out in the open-ended survey questions, interviews and workshops. For example, a majority of respondents noted that increasing numbers of clients were presenting with mental health problems and disorders. This often posed problems to AOD staff who *did not have the confidence and skills required*.

As another respondent noted:

- *Our staff seem to be able to breeze through even the most complex D&A issue- their skills are great. But as soon as they sense that a client has mental health issues, they appear to completely lose confidence in their skills and judgement.*

Whilst many respondents noted that introductory mental health courses- such as Mental Health First Aid- provided a good introduction to mental health issues generally, others noted that the level of detail was usually insufficient for working with dual diagnosis clients. This was reported as specifically evident when conducting detailed client assessments, preparing case plans, or in residential rehabilitation contexts in general.

Other feedback on dual diagnosis training included:

- *Whilst the First Aid in Mental health course is a good first step, it is not extensive enough for acute care.*
- *What is required is some specific mental health or dual diagnosis training specifically for D&A staff.*
- *Our staff really need Dual Diagnosis training.*

When interviewees were further questioned as to what might be included in a dual diagnosis course specifically for AOD workers, suggestions included:

- A focus on how to recognise [mental health] symptoms;

- Basic mental health counselling techniques, including calming strategies and techniques to minimise or prevent:
  - aggressive or anti-social behaviours;
  - self-harm; and/or
  - suicidal situations;
- Detailed information on different types of mental illness including personality disorders;
- Basic counselling techniques;
- Information on interactions between AOD histories and usage patterns, and common mental health problems and disorders. For example, long terms use of marijuana, amphetamines etc.;
- Appropriate treatment options and management plans (how to co-manage these with other providers where necessary);
- How to deal with mental health issues within a residential context;
- Knowledge of what local mental health providers were available and how to refer clients; and
- Understanding of the mental health service system, including the role of hospitals and crisis mental health teams.

One respondent commented it was essential that any mental health training have a strong practice-focused or '*how-to*' approach.

Another respondent (with a background in mental health) suggested a tailored dual diagnosis course specifically for AOD workers would probably need to be *around three days in length*:

- *This would allow time to do some role-plays and really get into to some of the practical challenges of managing clients with mental health problems.*

F) Other Professional Skills

77% of survey respondents reported that their frontline treatment staff might require training in health promotion, prevention and community development skills over the next year.

The five most required skills were (from highest to lowest demand):

1) Submission writing,
2) Planning and/or project management,
3) Needs assessments,
4) Training and presentation skills, and
5) Facilitation techniques.

Other health promotion, prevention and community development skills sought, though to lesser degrees, were (in descending order):

6) Develop and implement community programs (health education & promotion), and
7) Evaluation techniques (including literature reviews).

In addition to general comments regarding improved computer skills overall (see Section G below), interviewees and workshop participants also emphasised the need for staff to improve their report writing skills. This was specifically evident amongst a number of diversion program staff interviewed who commented on the challenges of preparing formal letters including those to be used in court processes. (See comments in Section 4.6.2 A- iv]).

There was very little demand reported for the last option listed namely 'Working with the Media'.

G) Information Technology

NADA members were asked to describe the status of their current information technologies and information management systems:

- 57% rated them as excellent or good,
- 37% rated them as neither good nor poor,
- 7% rated them as poor, and
- 0% rated them as very poor.

In terms of skills, 89% of survey respondents reported that their staff might require training in IT or computer skills over the next year.

The four most required skills were (from highest to lowest demand):

1) Basic computer knowledge (e.g. word processing, emails etc),
2) Database use,
3) Computer presentations (e.g. PowerPoint), and
4) Finance packages (e.g. Quicken, MYOB).

There was also strong demand for the following listed topics (in descending order):

5) Database development, and
6) Web site design and management.

There was much less interest in internet/ web skills.

In the course of the interviews and workshops, a number of respondents commented on the need for staff to have improved computer skills in general. As one interviewee commented:

- *Virtually everything we do these days needs to be documented and put on a computer. Many staff find this part of the job difficult and it certainly takes up too much time. If they all had basic computer use skills, that would save a lot of time and a lot of grief.*

Other interviewees commented that often it was the older, more experienced staff who seemed to *struggle most with computers* and who were in most need of additional IT training.

Other open-ended survey feedback and comments from interviews also demonstrated a need for some additional staff training in the use of databases, Excel, and in the use of spreadsheets.

It was noted however that, unlike most of the other training discussed, the IT training required for AOD staff was not unique to the sector and could be supplied by trainers in the open-market.

H) Other Requested Training Topics

Respondents to the surveys, interviews and workshops were also invited to nominate any other training topics they felt should be available to the AOD sector. Requested training topics (not already canvassed above) included:

- Suicide prevention and self-harm issues; plus
- Assisting clients with personal management issues.
  As one respondent noted:

- *A lot of what we do [in this service] is to teach clients how to manage and control their lives. To beat their substance issues, they need skills to reduce their chaotic lifestyles. Some staff training regarding how to teach this [in an AOD context] would be very beneficial*

4.7 Sector Standards and Qualifications

4.7.1 Certificate IV AOD

Unlike some other states in Australia, there are currently no minimum standards required for working with AOD clients in NSW. Many NGO AOD staff do, however, undertake a Certificate IV qualification offered by TAFE focused on alcohol and other drugs issues (so called Cert IV AOD).

The Certificate IV AOD is held by up to 75% of frontline treatment staff employed by NADA member organisations.[5] Some organisations report that all or the vast majority of their frontline staff have this qualification.

Respondents were asked for their views on the Certificate IV as preparation for working in the NGO AOD sector. The majority of respondents in both the surveys, interviews and workshops indicated that they thought the Certificate IV AOD was a reasonable preparation for working in the sector. Comments included:

- *Excellent basic requirement that gives workers an overview of the whole sector that increases referral options for clients.*
- *Very useful to staff in the AOD field.*
- *[It would] improve the professionalism of the sector.*
- *Our most recent graduates [of the Cert IV course] were amazing… big improvement in knowledge and skills taught compared to five years ago.*

A small minority expressed dissatisfaction with the Certificate IV AOD. For example:

- *[The course] needs to be reviewed – not in touch with the reality of drug and alcohol abuse.*

Respondents offered some suggestions as to ways the Certificate IV AOD could be strengthened, for example:

- Increased practical components or placements with AOD agencies (see comments below),
- Additional mental health modules,
- More clinical and paid work experience,
- Additional individual and group skills,
- More involvement of external trainers who are currently in the industry in various areas, and
- Improved understanding and explanations of long term treatment options.

At least two respondents also asserted that the Certificate IV course needed to include compulsory units on residential or therapeutic communities. As one respondent commented:

- *Without this [placement] experience, new graduates sometimes struggle with understanding long term treatment programs.*

There were also requests for the Certificate IV course to provide 'advanced standing' in some modules for those with extensive experience in the AOD sector.

[5] Data provided for this question was of variable reliability.

4.7.2 Minimum Standards

NADA members were asked if they thought there should be a minimum standard for workers in the AOD field of either a Certificate IV AOD or higher qualification including an AOD component:

- 72% said yes;
- 15% said no;
- 11% were unsure.

A number of organisations reported that they already used the Certificate IV AOD as an essential criterion for all frontline or clinical staff recruitments.

Respondent comments supportive of having a minimum standard included:

- *The need for formal training in AOD issues in important for the delivery of services in a best practice model.*
- *There needs to be a benchmark for the industry. I feel that the Cert IV AOD is a solid foundation to begin with.*
- *To hire someone with the basic understanding makes their inclusion into the service a little easier. To have someone come in without any understanding can be tiring for staff but also very unprofessional for the young person. Some knowledge is always needed.*
- *It is a complex field and basic training in AOD should be a standard requirement.*
- *Some staff with no AOD background find working with AOD clients daunting. Having done the course could give them a necessary grounding in what to expect.*
- *A baseline of core competencies is a necessary pre-requisite for work so employers can deploy people confident in the knowledge that they can do the job.*

Respondent comments querying Certificate IV AOD as a minimum standard included:

- *Cert IV is good basic training, but it can't substitute for staff experience in working in the sector.*
- *I believe that traineeships us the best way to enter the sector.*
- *I would not like to set this standard because …reduction in number of qualified applicants for positions…Instead I would like to…within one year of employing staff actively encourage them to advance their qualifications within the resources that we can provide.*
- *The right type of person could be put off by having a qualification impost. Training could start when they start work; there is no reason why it wouldn't be the same level as a certificate after time.*
- *It could drive off good people. There are lots of staff that have the right skills from related industries. We need to ensure they can still work in our sector.*
- *I would be a bit worried if the Cert IV was mandatory especially to start in a job. Some of our best recruits have had no formal training, and one of our worst had just finished the Cert IV AOD. I wouldn't want any system that prevented me from hiring the best person for the job, regardless of their qualifications or experience.*
- *Experience is better than qualifications.*

There were also some other comments in regard to issues around a minimum standard, for example:

- *In addition to the Cert IV – the person's life experience skills and abilities to work and relate to people need to be considered.*

- *… If a worker has other skills- and [an] agency is able to provide training in the AOD components- depending on [their] potential, this can be okay too.*
- *AOD services employ some staff who have had "life experiences" and are excellent case workers/ counsellors/ welfare workers.*
- *I'm happy to set an ideal standard but not to shut the door on people.*
- *We need to have some standard, but it doesn't necessarily have to be educational qualifications. It could be working experience- years, and/or issue certificates.*

4.7.3 Career Pathways

Whilst this research did not formally investigate career pathways in the AOD sector, the researchers did note a number of trends on this issue.

Numerous respondents observed that significant proportions of current AOD staff employed in the sector tended to remain over many years. Anecdotal evidence also suggested that the workforce was less mobile and subject to churn than other comparable NGO sectors, such as the mental health sector. For example, as two interviewees commented:

- *More than half our staff have been with us for five years or more.*
- *We have a very stable workforce who have been with us for many years. I don't see this changing in the near future.*

Given this situation, some respondents commented on the need for staff to have access to ongoing training and development options to further qualify themselves in the AOD areas. Although most staff were reported to be using short courses to keep abreast (see comments in Section 4.4.2), others noted that they would like to be able to suggest to staff that they pursue Diploma or Degree courses specifically focused on alcohol and other drugs issues.

Whilst some AOD staff that already have the Cert IV AOD were reported to be undertaking welfare diplomas and other tertiary study, it was observed by a number of respondents that often these types of general qualifications did not have sufficient AOD related content to be of direct relevance to their work. As one manager summed up:

- *[To further qualify themselves] some of our staff are now enrolled in the Welfare Diploma. But frankly they are finding it a bit too general to be of use to our clients. What they are really looking for is high level training in the dealing with AOD clients.*

4.8 Role of NADA

Respondents were asked what role they saw for NADA in terms of workforce development for the NGO sector in the future.

As Table 5 indicates, overall there was strong support for all the suggested roles, and in particular for providing training grants and brokering training.

The only role for which respondents expressed significant uncertainty was that of providing advice to members on developing formal staff training and development systems. No respondents indicated that NADA should have no role in workforce development.

The following options had the support of 80% or more respondents:

- Providing grants for members to attend training;
- Brokering specific training (e.g. assisting training providers to design courses that meet members' needs);
- Distributing information on learning and development options; and
- Providing advice and consultancy on workforce development issues.

The following options had the support of between 70% and 80% of respondents:

- Advocating for members' workforce development needs;
- Supporting managers in workforce development (e.g. with clinical supervision, mentoring, partnerships); and
- Researching the sector's professional development needs.

The following option had support of just over 60% of respondents:

- Advising members on ways to develop formal staff training and development systems.

Table 5: NADA Members: Preferred Roles for NADA in Workforce Training and Development (%) (n= 46)

Role	Yes	No	Not Sure
Providing grants for members to attend training	94	0	0
Brokering specific training (e.g. assisting training providers to design courses that meet members needs)	89	0	9
Distributing information on learning and development options	85	2	4
Providing advice and consultancy on workforce development issues	83	0	7
Supporting managers in workforce development (e.g. with clinical supervision, mentoring, partnerships)	78	2	9
Researching the sector's professional development needs	74	2	13
Advocating for members' workforce development needs	74	0	11
Advising members on ways to develop formal staff training and development systems	61	2	22
No role	0	0	0

Source: NADA Training Needs Assessment Survey, 2006. (Gethin and Deakin)

Respondents offered suggestions as to other roles they would like NADA to undertake in relation to workforce development. These included:

- *For workers who do not have any qualifications but have worked in AOD more than 5 years, could NADA look at an accreditation or advanced standing for their experience/knowledge while working in AOD?*
- *Greater emphasis on integrating capacity building with workforce development to improve systems, facilitation and knowledge*
- *Increase funding application skills*
- *Establishment of managers support network- addressing staff burnout*
- *Continue providing support and guidance to small services like this one*
- *Encouraging, even 'policing,' the level of professionalism across the [AOD] sector*
- *Providing smaller organisations with professional development assistance, including in relation to preparing staff training plans, linked to overall business and service planning advice*

- *Facilitating local forums of AOD services to enable information sharing and cross service support opportunities* (see comments in 4.6.2- A] iii]).

One significant suggestion made regarding NADA, was for the organisation to take on an increased role in pooling and disseminating information. This related to three roles:

1) NADA become a clearing house for training or resources prepared by member organisations. As one respondent explained:

- *Many larger D&A organisations spend quite a bit of time and money designing in-house courses and resources for staff on specific issues, for example dual diagnosis or sexual assault. If these organisations gave NADA copies of the programs or resources, then other organisations might be able to use them as the basis for their own.*

2) NADA assist member organisations to promote their in-house training to enable other AOD staff to attend.

   For example, where a guest speaker or specialist training session has been organised by one organisation, and there is capacity for other staff to attend, then NADA could assist in linking external AOD staff with the host organisation or visa versa.

3) NADA collecting feedback from members (for example via a chat room) on the quality of specific AOD courses and/or trainer expertise that can then be accessed by other members (see discussion Section 4.5.6).

In general the consultants found NADA had very good standing with its member organisations. Members commented on the quality and value of NADA conferences. They also positively valued NADA's capacity to assist AOD staff across the state to attend the conferences and other relevant training. This capacity was repeatedly noted as making a significant contribution to NGO AOD workforce development and training in NSW.

5. CONCLUSION

The NADA Training Needs Assessment was commissioned by NADA to determine the current training, learning and development needs of the NGO AOD sector in NSW.

On the basis of NADA members' feedback in written surveys, interviews and workshops, the Assessment found that the NGO AOD workforce is generally well qualified. Most staff are required to have minimum qualifications and experience on recruitment. Currently the minimum requirement for most frontline positions is either a Certificate IV in AOD or another tertiary qualification.

In terms of minimum experience, one to two years experience in the AOD sector is most often required, although some positions can be undertaken with no prior AOD experience.

In general, NADA's members support the current Certificate IV in AOD as a good base qualification for working in the sector. Whilst there was majority support for making it a minimum standard, some respondents were wary of the possible consequences of this on their current and future staff recruitment. This was particularly true of non-metropolitan services where qualified staff and training opportunities were less available. As such, a carefully managed transition strategy, including support for existing staff to become qualified, would be necessary before a mandatory minimum qualification standard be introduced in NSW.

Three quarters of the respondents indicated their organisation had formal staff development processes. In general, most respondents indicated they did not have problems with accessing information about relevant training, though other barriers to participation were evident (see below).

The vast majority of training currently undertaken by AOD staff consisted of coaching by managers or executive officers, short courses, and external conferences, workshops and events. Overall these methods were viewed as effective in meeting staff needs.

Quality short courses, run by skilled and qualified trainers, were viewed as an effective means for upskilling staff. The benefits included a capacity to match individual staff needs to appropriate training, manageable amounts of staff time away from the service, affordable costs (for the most part), plus opportunities to network.

The majority of respondents reported that the quality of AOD training in NSW was good or excellent, with only two respondents reporting the quality as poor.

In terms of required training for frontline staff, there was considerable diversity in the feedback provided by NADA's members. The stand out exception to this was the high level demand for dual diagnosis training. Other most requested training topics included new substance abuse treatments, motivational interviewing, managing aggressive behaviours, case management, and group work.

Overall there was a strong preference for practice-based and skill-related training rather than theoretical courses.

Training in ethics and professional boundaries, and how to effectively work with ATSI, CALD and young clients also emerged from the feedback, as did more courses in upskilling staff in basic computer skills.

Some experienced staff in the sector are seeking further opportunities to improve their qualifications in AOD. This suggested the need for a focus on AOD career pathways, including greater access to diplomas and degrees with an AOD specialisation. Higher level courses in mental health and dual diagnosis in particular were specifically singled out as a current unmet training need.

There was a strong desire for more courses to be offered locally, and specifically in locations other than metropolitan Sydney. This included a call not only for more courses in regional centres, but also for more courses in other locations within Sydney (for example, in outer western Sydney).

The consultants found that the specific needs of staff working in residential rehabilitation services were not fully catered for in most of the available AOD training. Given the sustained staff-client relationships and treatment options available in this model of service, AOD training providers should aim to better cater for this sector. It was also recommended that the Certificate IV AOD include more course content on these service models as a compulsory part of the qualification.

In terms of barriers to training, the most substantial problem was the availability of staff to backfill for those away on courses. Also creating barriers were: time available to train, course costs, and insufficient training budgets. Reducing these barriers was mainly identified as an issue of more resources – for example, to pay for backfilling positions or subsidising travel and accommodation costs.

Regional and rural based agencies faced higher barriers relating to accessing appropriate training. These barriers included lack of local courses, high costs associated with travel and accommodation (usually to come to Sydney), in addition to the problem of finding suitably qualified staff to backfill for staff absences. Residential services consistently identified challenges associated with backfilling when shift work was involved.

In terms of future roles for NADA in workforce development issues, there was strong support for NADA's current workforce development and training program, and specifically its ongoing provision of training subsidies to help offset the cost of staff attending training and conferences.

There was also clear support for NADA to add to its information dissemination roles and to further assist members to share their skills, resources and training opportunities with other members, including in particular with smaller AOD services.

In conclusion the consultants found NADA'S members in NSW had a demonstrated commitment to ongoing workforce training and development. Whilst access to funding for training remains an impediment, the NGO AOD sector clearly recognise the need to upskill staff, and provide them with relevant training opportunities, in order to maintain and improve the quality of services they provide to AOD clients across NSW.

* * * *

GLOSSARY

AOD	Alcohol and other drugs
ATSI	Aboriginal and Torres Strait Islanders
CALD	Culturally and Linguistically Diverse
Cert	Certificate- refers to TAFE accredited courses for example Certificate IV (AOD).
D&A	Drugs and alcohol
Dual diagnosis	A co-existing mental health and substance misuse problem. This is often referred to as co-morbidity.
EFT	Equivalent full-time
Member	Refers to the NADA membership consisting of NGO AOD service providers
IT	Information technology
NADA	Network of Alcohol and other Drugs Agencies
NGO	Non-Government Organisation
Respondents	Representatives of NADA member organisations who completed the surveys or participated in interviews or workshops.

* * * *

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NADA TNA Report-FINAL-2.doc
January 2007

ATTACHMENTS

ATTACHMENT 1

NETWORK OF ALCOHOL AND OTHER DRUGS AGENCIES

NON-GOVERNMENT ALCOHOL AND OTHER DRUGS WORKFORCE

- TRAINING NEEDS ASSESSMENT SURVEY -

This survey is to ascertain the current and future training needs of staff employed in non-government organisations (NGO) providing alcohol and other drugs (AOD) services in NSW.

It is part of a three year Workforce Development Program being conducted by the Network of Alcohol and other Drugs Agencies (NADA) in NSW. The Program aims to facilitate access to quality training and development opportunities across its member agencies.

The survey is designed to be completed by the **Coordinator or Manager** of the NGO agency. As it will require some knowledge of staff skills and qualifications in the agency, some familiarity with current personnel and their job descriptions would be useful.

There is one survey for each member organisation of NADA (including sub-branches of larger organisations). The survey should take about 15 minutes to complete.

All responses will be processed anonymously. The contact information provided on this cover page will be immediately separated from the survey upon its return. It is being gathered only to enable NADA to identify which organisations may require additional time or follow-up calls to complete the survey.

Two consultants are assisting NADA with the Training Needs Assessment. Should you have any queries regarding the survey, in the first instance, please contact Anni Gethin of AGA Consulting on **4734 8632** or **0422 415 469**, or on email:**anni@annigethin.com**

Alternatively Vanessa Long, Manager Workforce Development at NADA can be contacted on **9898 8669** or email: **vanessa@nada.org.au**

PLEASE COMPLETE THE SURVEY IN PEN AND RETURN

NO LATER THAN COB TUESDAY 12 SEPTEMBER 2006

BY POST TO: NADA Training Needs Assessment
c/- AGA Consulting PO Box 515 Hazelbrook NSW 2779
Thank you in advance for taking the time to complete this important survey

To enable any required survey follow up, could you please fill-in the details below.
(These details will not form part of the data analysis).

Organisation Name _____

Specific Service or Sub branch (if applicable) _____

Contact Officer (for this survey) _____

Telephone _____ email _____

	ORGANISATION DETAILS
1.	**Client group** (*who are your organisation's main clients?)* ☐ Community/ General ☐ Family ☐ Men ☐ Women ☐ Youth ☐ Other *(please specify)* _____
2.	**Geographic location(s)** *(where is your organisation based in NSW?)* ☐ Sydney metro ☐ Other metropolitan area (Newcastle or Wollongong) ☐ Regional centre ☐ Rural town ☐ Remote ☐ Other (please specify) _____
3.	**Type of service** *(please tick as many as appropriate)* ☐ Health promotion and/or community development ☐ Outpatient care (e.g. outreach, aftercare, counselling etc) ☐ Residential (e.g. residential rehabilitation, therapeutic communities etc) ☐ Supported assisted accommodation ☐ Policy and/or advocacy ☐ Other (please specify) _____
4.	**Main service(s) offered** *(please tick as many as appropriate)* ☐ Withdrawal services ☐ Inpatient / residential withdrawal management ☐ Outpatient withdrawal management ☐ Outpatient counselling and case management ☐ Residential rehabilitation (e.g. group work, living skills, etc) ☐ Services to diversion clients (MERIT) ☐ Day programs ☐ After care programs ☐ Health promotion and/or community development ☐ Special project(s) (please specify) _____ ☐ Other (please specify) _____

	STAFF PROFILE
5.	**Staff** *(in your organisation or sub branch)* Total full time equivalent (FTE) staff *(circle one)* (1-5) (6-10) (11-15) (16-25) (26-50) (51-99) (100+) No. current full time employees: _____ No. current part time employees: _____

STAFF PROFILE (CONTINUED)

6.

Staffing positions *(please indicate number and type of positions in your organisation)*

Occupation	No. FTE staff
Management and administrative staff	
Manager	
Team leader	
Administrative staff	
Other *(please specify)* _____	
Frontline treatment staff	
AOD case worker	
Intake officer	
Counsellor	
Residential support worker	
Welfare worker	
Medical practitioner	
Nurse	
Other *(please specify)* _____	
Client support workers	
Child care worker	
Vocational education worker	
Other *(please specify)* _____	
Policy / health promotion / community development workers	
Project officer	
Health promotion worker	
Community development worker	
Researcher	
Policy / advocacy worker	
Other *(please specify)* _____	
Other position *(please specify)* _____	

7. **Volunteers**

☐ No
☐ Yes *Please indicate average number* _____

MINIMUM QUALIFICATIONS AND EXPERIENCE

8.

*Please answer the following questions in relation to positions that **exist in your organisation** – leave blank if not applicable.*

Minimum qualifications

If you were to advertise any of the positions listed below, please indicate whether the position would have a minimum qualification, and what that minimum qualification would be (e.g. Bachelor degree, Cert IV AOD etc)

	Minimum qualification	Details of qualification
Team leader	Yes / No	
AOD case worker	Yes / No	
Intake officer	Yes / No	
Counsellor	Yes / No	
Residential support worker	Yes / No	
Welfare worker	Yes / No	
Project officer	Yes / No	
Community development or health promotion worker	Yes / No	
Researcher	Yes / No	

Minimum experience

If you were to advertise any of the positions listed below, please indicate whether the position would have a minimum experience requirement, and what that minimum experience would be (e.g. 2 years client experience in AOD)

	Minimum experience	Type and years of experience
Team leader	Yes / No	
AOD Case worker	Yes / No	
Intake officer	Yes / No	
Counsellor	Yes / No	
Residential support worker	Yes / No	
Welfare worker	Yes / No	
Project worker	Yes / No	
Community development or health promotion worker	Yes / No	
Researcher	Yes / No	

FACTORS INFLUENCING STAFF TRAINING AND DEVELOPMENT

9.

Rationale for staff training and development

Why does your organisation undertake staff training and development?
(Please list the two most important reasons).

1) _____

2) _____

10.

Barriers to staff training and development

Does your organisation face any barriers in terms of providing staff training and development? ☐ No (please go to question 11)
☐ Yes

If yes, please rate the importance of each of the following barriers to staff training and development in your organisation.

(Options: Not a significant barrier, somewhat of a barrier or a major barrier)

Barrier	Significance Rating
Insufficient training budget	Not / somewhat / major
Cost of courses	Not / somewhat / major
Time available to train	Not / somewhat / major
Availability of staff to backfill	Not / somewhat / major
Lack of senior management support	Not / somewhat / major
Staff reluctance to engage in learning	Not / somewhat / major
No suitable training available	Not / somewhat / major
Funding cycle incompatible with long term training	Not / somewhat / major
Insufficient access to technology (e.g. for online learning)	Not / somewhat / major
Other *(please state)* _____	Not / somewhat / major

Any comments regarding barriers to staff training:

TRAINING AND DEVELOPMENT DELIVERY

11. Does your organisation have an established staff development process?

☐ Yes ☐ No ☐ Not sure

12. Please tick which of the following training and development options your organisation currently uses with <u>frontline treatment staff</u>.

	Regularly	Sometimes	Rarely or Never
Professional development			
Coaching by managers or executive officers			
Formal mentoring and buddy schemes			
Job rotation, secondment and/or shadowing			
On-the-job training			
e-learning (i.e. online material)			
Coaching by external practitioners			
Blended learning programs (combination of distance and face-to-face)			
Instructor led off-the-job training			
Formal education courses (e.g. degree or certificate)			
Short Courses			
External conferences, workshops and events			
Other training and development delivery options used *(please state)*			

13. Of the above methods, which two (2) would your organisation <u>use most often</u> to provide training and development to your frontline treatment staff?

1) _____

2) _____

14. Of the above methods, which two (2) are the <u>most effective</u> at imparting appropriate skills and knowledge of relevance to your frontline treatment staff?

1) _____

2) _____

15. Of the above methods, which two (2) would you <u>most like to use more frequently</u> should improved delivery options become available (e.g. through NADA advocacy or support)?

1) _____

2) _____

GENERAL SKILLS AND KNOWLEDGE NEEDS	
16.	**Demand for new training** Over the next 12 months, do you foresee any changes or challenges (either in your organisation or across the sector) that will require staff to acquire new skills or training? *(e.g. introduction of new services, technological change, new therapy, regulatory change, quality improvement etc)* ☐ Yes ☐ No ☐ Not sure If yes, please provide details:
17.	**General skills and knowledge needs** Over the next 12 months, what do you see as the two (2) most important skills or knowledge needs that staff in your organisation will require? For frontline treatment staff? 1) _____ 2) _____ For managers / team leaders? 1) _____ 2) _____ For administrative staff? 1) _____ 2) _____

SPECIFIC SKILLS AND KNOWLEDGE NEEDS

18.

Generic skills

What generic skills might your frontline treatment staff require training in over the next 12 months? *a) Please tick as many options as required, then b) Please rank in order of importance (1, 2 and 3 etc).*

☐ None – Staff skills are currently adequate in these areas *(go to question 19)*
☐ None – Not applicable *(go to question 19)*

Rank

____ ☐ Assessment
____ ☐ Case Management
____ ☐ Withdrawal management services
____ ☐ Knowledge of the effects of drugs and drug interactions
____ ☐ Communication skills
____ ☐ Work with clients who are intoxicated
____ ☐ Managing aggressive behaviour
____ ☐ Work with other services (referral and information sharing)
____ ☐ Harm reduction
____ ☐ Other *(please specify)* _____

19.

Client intervention skills

What client intervention skills might your frontline treatment staff require training in over the next 12 months? *a) Please tick as many options as required, then b) Please rank in order of importance (1, 2 and 3 etc).*

☐ None – Staff skills are currently adequate in these areas *(go to question 20)*
☐ None – Not applicable *(go to question 20)*

Rank

____ ☐ Case management
____ ☐ Cognitive behaviour therapy
____ ☐ Motivational interviewing
____ ☐ Relapse prevention
____ ☐ Solution focused therapy
____ ☐ Advanced group work
____ ☐ Grief and loss counselling
____ ☐ Brief interventions
____ ☐ Dual diagnosis
____ ☐ Other (please specify) _____
____ ☐ Other (please specify) _____

SPECIFIC SKILLS AND KNOWLEDGE NEEDS (CONTINUED)

20.

Practice skills

What practice skills might your frontline treatment staff require training in over the next 12 months? *a) Please tick as many options as required, then*
b) Please rank in order of importance (1, 2 and 3 etc).

☐ None – Staff skills are currently adequate in these areas *(go to question 21)*
☐ None – Not applicable *(go to question 21)*

Rank

____ ☐ Occupational Health & Safety
____ ☐ Duty of Care
____ ☐ First Aid
____ ☐ Ethics for the AOD sector
____ ☐ Other *(please specify)* _____
____ ☐ Other *(please specify)* _____

21.

Health promotion, prevention and community development skills

What health promotion, prevention and community development skills might your staff require training in over the next 12 months?
a) Please tick as many options as required, then
b) Please rank in order of importance (1, 2 and 3 etc).

☐ None – Staff skills are currently adequate in these areas *(go to question 22)*
☐ None – Not applicable *(go to question 22)*

Rank

____ ☐ Needs assessments
____ ☐ Planning and/or project management
____ ☐ Evaluation techniques (including literature reviews)
____ ☐ Develop and implement community programs (health education & promotion)
____ ☐ Facilitation techniques
____ ☐ Training and presentation skills
____ ☐ Working with the media
____ ☐ Submission writing
____ ☐ Other *(please specify)* _____
____ ☐ Other *(please specify)* _____

SPECIFIC SKILLS AND KNOWLEDGE NEEDS (CONTINUED)

22.

Client group skills

What client groups/ special needs might your staff require training in over the next 12 months? *a) Please tick as many options as required, then*
b) Please rank in order of importance (1, 2 and 3 etc).

☐ None – Staff skills are currently adequate for the client groups we service *(go to question 23)*

Rank

____ ☐ Aboriginal and Torres Strait Islanders
____ ☐ Culturally & Linguistically Diverse communities
____ ☐ Families
____ ☐ People with disabilities
____ ☐ Child protection
____ ☐ Other *(please specify)* _____

____ ☐ Men
____ ☐ Women
____ ☐ Young people
____ ☐ Dual diagnosis

23.

Dual diagnosis

What specific dual diagnosis/ mental health skills might your staff require training in over the next 12 months? *a) Please tick as many options as required, then*
b) Please rank in order of importance (1, 2 and 3 etc)

☐ None – Staff skills are currently adequate in this area *(go to question 24)*
☐ None – Not applicable *(go to question 24)*

Rank

____ ☐ Assessment of dual diagnosis
____ ☐ Management of clients with dual diagnosis
____ ☐ Use of psychotropic medications
____ ☐ Understanding mental illness
____ ☐ Mental health first aid
____ ☐ Other *(please specify):*_____

24.

Information technology systems

How would you describe the status of your current IT and information management systems? (*Please circle one*)

Excellent/ Good/ Neither Good/ nor poor Poor/ Very Poor

25.

Information technology skills

What IT or computer skills might your staff require training in over the next 12 months?
a) Please tick as many options as required, then
b) Please rank in order of importance (1, 2 and 3 etc)

☐ None – Staff skills are currently adequate in this area *(go to question 26)*
☐ None – Not applicable *(go to question 26)*

Rank

____ ☐ Basic computer knowledge – (e.g. word-processing, email etc)
____ ☐ Computer presentations (e.g. PowerPoint)
____ ☐ Database use
____ ☐ Database development
____ ☐ Finance packages (e.g. Quicken, MYOB)
____ ☐ Internet/ web skills
____ ☐ Web site design and management
____ ☐ Other *(please specify)* _____

CERTIFICATE IV AOD

26. How many of your frontline treatment staff have the Certificate IV Alcohol and Other Drugs (AOD)?

_____

27. What is your view on the Certificate IV AOD as preparation for working in the sector?

_____

_____

28. Are there ways the Certificate IV AOD could be strengthened or improved?

Details:_____

_____

TRAINING QUALITY

29. Overall, how would you rate the standard of AOD training available in NSW
(Please circle)

Excellent/ Good/ Neither Good/ nor Poor Poor/ Very Poor

30. AOD training in NSW could be strengthened by….

Details:_____

ROLES FOR NADA

31.

Preferred roles

Which of the following roles would you like to see NADA undertake in terms of workforce development for the NGO sector in the future?

(*Tick Yes, No or Unsure for each.*)

Role	Yes	No	Not Sure
Distributing information on learning and development options	☐	☐	☐
Providing advice and consultancy on workforce development issues	☐	☐	☐
Researching the sector's professional development needs	☐	☐	☐
Brokering specific training (e.g. assisting training providers to design courses that meet members needs)	☐	☐	☐
Advising members on ways to develop formal staff training and development systems	☐	☐	☐
Providing grants for members to attend training	☐	☐	☐
Supporting managers in workforce development (e.g. with clinical supervision, mentoring, partnerships)	☐	☐	☐
Advocating for members' workforce development needs	☐	☐	☐
No role	☐	☐	☐

32.

Other roles

Are there any other roles you would like to see NADA undertake in relation to workforce development (*please specify*):

_____

_____

_____

_____

MINIMUM STANDARDS IN AOD SECTOR

33.

Minimum qualification

Some states have moved to require people wanting to work in the AOD field to have a Certificate IV in alcohol and other drugs work, or a higher qualification that includes a specified AOD component.

Do you think this is an appropriate policy standard for the NSW non government AOD workforce?

☐ Yes ☐ No ☐ Not sure

Please explain reasons:

_____

_____

_____

_____

FURTHER COMMENTS

34.

Please add any further comments you wish to make about workforce development issues:

Thank you for filling in this survey

Your time and answers are greatly appreciated

Please post your completed survey by COB Tuesday 12 September to:

NADA Training Needs Assessment
c/- AGA Consulting
PO Box 515 Hazelbrook NSW 2779

If you have any other comments or queries regarding this survey please feel free to contact Anni Gethin (independent research consultant assisting NADA) on
Tel: 4734 8632 or 0422 415 469 email: anni@annigethin.com

ATTACHMENT 2

NADA TRAINING NEEDS ASSESSMENT SURVEY 2006

- DATA ANALYSIS -

Notes:

- 46 surveys were received (n= 46)
- All frequencies and percentages include nil responses
- Data of particular interest is underlined.
- Open ended responses in Part 2.

PART 1 – Quantitative Responses

1) Client group

Client group	Freq	%
Community/ General	13	28.3
Family	3	6.5
Men	15	32.6
Women	16	34.8
Youth	10	21.7
Other	9	19.6

Other includes:

- Aboriginal and Torres Strait Islander (ATSI) community,
- children,
- homeless people,
- dual diagnosis clients,
- transgender people, and
- clients from culturally and linguistically diverse (CALD) backgrounds.

1a) Client group distribution for each service type.

Service type/ Client group	Comm. and general	Family	Men	Women	Youth	Other
All organisations	28	7	33	35	22	20
Metro	30	7	26	33	18	15
Rural and regional	27	7	47	47	27	20
Diversion	30	0.0	60	53	6	18
Offers residential services	23	0	43	43	13	20
Does not offer residential services	38	19	19	19	38	13

2) Geographic location

Location	Freq.	%
Sydney Metro	25	54.3
Other Regional	5	10.9
Regional Centre	4	8.7
Rural town	9	19.6
Remote	2	4.3
Other	4	8.7

Other includes:

- All of NSW.

3) Type of service

Service	Freq.	%
Health Promotion	12	26.1
Outpatient Care	19	41.3
Residential	30	65.2
Supported assisted accommodation	5	10.9
Policy	3	6.5
Other	5	10.9

Other includes:

- Women only counselling,
- Parenting assistance, and
- Referrals and court reports

4) Main services offered

Service	Freq.	%
Withdrawal services	6	13.0
- Inpatient withdrawal	5	10.9
- Outpatient withdrawal	0	0.0
Outpatient counselling and case management	17	37.0
Residential rehabilitation	32	69.6
Services to diversion clients	16	34.8
Day programs	4	8.7
After care programs	14	30.4
Health promotion and/community development	14	30.4
Special projects	4	8.7
Other	6	13.0

Other includes:

- Welfare assistance, GP, psychiatrist
- Gambling counselling
- Crisis centre
- Case management
- Referrals and court reports

5) Staff (FTE)

	Freq	%
1-5	20	43.5
6-10	15	32.6
11-15	2	4.3
16-25	4	8.7
26-50	4	8.7
51-99	0	0.0
100+	1	2.2

Note: Full and part time (data incomplete for some orgs)

	Total	Avg/
FTE	378	8.8
P/T	345	8.2

6) Staff profile

Staffing positions	Freq. (in orgs)	Range	Total (across orgs)	Avg. (across orgs)
Management / Administration				
Manager	43	0.4-6	55.4	1.2
Team leader	26	0.5-7	41.0	0.9
Administrative staff	35	0.2-6	53.4	1.2
Other	13	1 - 4	17.0	0.4
Frontline				
AOD case worker	26	0.2-36	101.0	2.2
Intake officer	7	1.0-2	7.0	0.2
Counsellor	21	0.8-11	54.6	1.2
Residential support worker	18	1.0-20	91.2	2.0
Welfare worker	10	1.0-5	22.5	0.5
Medical practitioner	3	1.0-5	7.0	0.2
Nurse	4	1.0-10	16.4	0.4
Client support				
Child care worker	4	.94-5	9.9	0.2
Vocational education worker	4	1.0-18	23.0	0.5
Other	4			
Policy/ Health Promotions /Community Development				
Project officer	4	0.2-5	8.2	0.2
Health promotion worker	5	0.2-5	7.8	0.2
Community Dev't. Worker*	1		2.0	
Researcher*	1		1.0	
Policy / advocacy worker*	1		2.0	

*Sample size insufficient to give range.

Other positions include:

Management/administration:

- Chief Executive Officer,
- Assistant Manager,
- Coordinator of all frontline staff, and
- Operations Manager (for example in Information Technology or Quality Assurance).

Frontline:

- Domestic violence support worker,
- Community care worker,
- Parenting worker,
- Clinical support team,
- Trainee counsellor,
- Trainee AOD worker,
- Placement/aftercare worker, and
- MERIT worker.

Policy/ Health Promotions /Community Development

- Researcher,
- Policy advocacy worker,
- Trainer,
- Group facilitator,
- Housing worker,
- Property maintenance person,
- Housekeeper, and
- Marketing

7) Volunteers

	Freq.	**%**
Yes	22	47.8
No	19	41.3
No response	5	10.9
Total/ Average	671.0	14.6

8) Minimum qualifications and experience

Minimum qualifications

Minimum qualifications	Yes	No	Total	Cert III	Cert IV AOD	Other Cert IV	Bachelor Degree	Post graduate	Other/not specified
Team leader	38	0	100%		40%**	3%	44%	8%	6%
AOD case worker	28	0	100%		71%***		25%***		7%
Intake officer*	10	1	90%		60%		20%		20%
Counsellor	21	1	96%		52%		48%	5%	
Residential support worker	19	5	80%	10%	68%	16%			53%
Welfare worker	7	3	70%			62%	25%		12%
Project officer*	5	0	100%						
Community development/health promotion worker*	5	1	83%						
Researcher*	5	1	83%						

* Sample size insufficient for breakdown of qualifications.
** One organisation also required a team leader certificate
*** One organisation required both / one required either.

Minimum experience

Role	Minimum experience required	Details
Team leader	100%	Min 2 years experience. Most 2 to 4 years in AOD. Up to 10 years. Some also management experience and direct client experience.
AOD case worker	96%	Min 1 year client experience. Most around 2 years. Up to 4 years.
Intake officer	85%	1-2 years experience
Counsellor	100%	1-3 years experience
Residential support worker	76%	6mths-2 years experience
Welfare worker	77%	1-2 years.
Project officer*	64%	1-3 years
Community development/health promotion worker*	64%	Some experience to 3 years
Researcher*	50%	1-2 years

* Potentially unreliable data due to small sample size.

10) Barriers to staff training and development

Barriers	Freq.	%
Yes	37	80.4
No	9	19.6
No response	0	0.0

Of those who said their organisation faced training barriers:

Barrier	Major	Major %	Some what	Some what %	Not	Not %	No answer	Total
Insufficient training budget	14	37.8	20	54.1	1	2.7	2	37
Cost of courses	14	37.8	20	54.1	1	2.7	2	37
Time available to train	14	37.8	20	54.1	1	2.7	2	37
Availability of staff to backfill	21	56.8	13	35.1	3	8.1	0	37
Lack of senior management support	2	5.4	3	8.1	25	67.6	7	37
Staff reluctance to engage in learning	0	0.0	9	24.3	21	56.8	7	37
No suitable training available	1	2.7	14	37.8	16	43.2	6	37
Funding cycle incompatible with long term training	5	13.5	10	27.0	14	37.8	8	37
Insufficient access to technology (e.g. for online learning)	2	5.4	8	21.6	20	54.1	7	37
Other	3	8.1	0	0.0	0	0.0		3

Other barriers include:

- Access to training in rural areas
- Cost of backfill

11) Established staff development process

Process	Freq.	%
Yes	35	74.5
No	8	17.5
No response	3	6.5

12) Training and development options

Options/ Frequency	Regularly	Regularly %	Sometimes	Sometimes %	Rarely/ Never	Rarely/ Never %
Coaching by managers or executive officers	33	71.7	3	6.5	5	10.9
Formal mentoring and buddy schemes	20	43.5	14	30.4	7	15.2
Job rotation, secondment and/or shadowing	6	13.0	14	30.4	14	30.4
e-learning (i.e. online material)	5	10.9	9	19.6	19	41.3
Coaching by external practitioners	16	34.8	20	43.5	3	6.5
Blended learning programs (combination of distance and face-to-face)	4	8.7	12	26.1	19	41.3
Formal education courses (e.g. degree or certificate)	14	30.4	18	39.1	7	15.2
Short Courses	26	56.5	14	30.4	4	8.7
External conferences, workshops and events	24	52.2	19	41.3	1	2.2

Other options include:

- Needs specific in-house training
- SAAP training
- Guest speakers
- Subsidised university

16) Demand for new training

Demand	Freq.	%
Yes	29	63.0
No	5	10.9
Not sure	10	21.7
No response	2	4.3

SPECIFIC SKILLS AND KNOWLEDGE NEEDS

18) Generic skills

Skills adequate 8.7%

N/A 4.3%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Assessment	6	6	4	18	12	4	34
Case Management	6	6	7	18	12	7	37
Withdrawal management services	1	1	1	3	2	1	6
Knowledge of the effects of drugs and drug interactions	3	4	2	9	8	2	19
Communication skills	5	3	4	15	6	4	25
Work with clients who are intoxicated	0	3	4	0	6	4	10
Managing aggressive behaviour	11	6	5	33	12	5	50
Work with other services (referral and information sharing)	1	3	5	3	6	5	14

19) Client intervention skills

Skills adequate 2.2%

N/A 6.5%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Case management	10	2	3	30	4	3	37
Cognitive behaviour therapy	5	7	3	15	14	3	32
Motivational interviewing	6	5	8	18	10	8	36
Relapse prevention	1	4	5	3	8	5	16
Solution focused therapy	0	6	7	0	12	7	19
Advanced group work	3	7	4	9	14	4	27
Grief and loss counselling	0	2	1	0	4	1	5
Brief interventions	1	2	2	3	4	2	9
Dual diagnosis	13	6	2	39	12	2	53

Other client intervention skills include:

- Groups skills,
- Reflective listening;
- Managing self harming behaviour,
- Narrative therapy,
- Family therapy, and
- Advanced Gestalt therapy

20) Practice skills

Skills adequate 13.0%

N/A 2.2%

Skills/Rank	**Frequency**			**Scoring**			**TOTAL SCORE**
	1.	**2**	**3**	**1st = 3**	**2nd = 2**	**3rd = 1**	
Occupational Health & Safety	19	3	4	57	6	4	67
Duty of Care	7	17	5	21	34	5	60
First Aid	4	6	10	12	12	10	34
Ethics for the AOD sector	8	8	6	24	16	6	46

21) Health promotion, prevention and community development skills

Skills adequate 10.9%

N/A 13.0%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Needs assessments	8	3	0	24	6	0	30
Planning and/or project management	3	8	5	9	16	5	30
Evaluation techniques (including literature reviews)	3	3	5	9	6	5	20
Develop and implement community programs (health education & promotion)	5	2	1	15	4	1	20
Facilitation techniques	4	5	5	12	10	5	27
Training and presentation skills	5	5	5	15	10	5	30
Working with the media	0	1	1	0	2	1	3
Submission writing	6	6	5	18	12	5	35

Other health promotion, prevention and community development skills include:

- Linking community development and clinical interventions

22) Client group skills

Skills adequate 8.7%

N/A 2.2%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Aboriginal and Torres Strait Islanders	8	6	7	24	12	7	43
Culturally & Linguistically Diverse communities	2	5	3	6	10	3	19
Families	4	3	2	12	6	2	20
People with disabilities	0	1	0	0	2	0	2
Child protection	3	7	1	9	14	1	24
Men	1	1	0	3	2	0	5
Women	0	2	0	0	4	0	4
Young People	3	3	1	9	6	1	16
Dual Diagnosis	18	6	5	54	12	5	71

Other client group skills include:

- Male victims of sexual abuse -

23) Dual diagnosis

Skills adequate 2.2%

N/A 2.2%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Assessment of dual diagnosis	21	8	4	63	16	4	83
Management of clients with dual diagnosis	11	20	4	33	40	4	77
Use of psychotropic medications	1	2	15	3	4	15	22
Understanding mental illness	6	5	9	18	10	9	37
Mental health first aid	3	7	3	9	14	3	26

24) Information technology systems

Rating	Freq.	%
Excellent	6	13.0
Good	20	43.5
Neither	17	37.0
Poor	3	6.5
Very Poor	0	0.0
No response	0	0.0

24) Information technology skills

Skills adequate 6.5%

N/A 4.3%

Skills/Rank	Frequency			Scoring			TOTAL
	1.	2	3	1st = 3	2nd = 2	3rd = 1	SCORE
Basic computer knowledge – (e.g. word-processing, email etc)	20	0	0	60	0	0	60
Computer presentations (e.g. PowerPoint)	4	12	4	12	24	4	40
Database use	9	9	3	27	18	3	48
Database development	2	7	6	6	14	6	26
Finance packages (e.g. Quicken, MYOB)	2	7	10	6	14	10	30
Internet/ web skills	1	1	4	3	2	4	9
Web site design and management	2	5	4	6	10	4	20

Other computer skills include:

- Spreadsheets

25) Frontline staff with Cert IV AOD

Estimated that up to 75% of frontline treatment staff have Cert IV AOD. (Note: this estimate is based on data of variable accuracy).

29) Training quality

Training quality	Freq	%
Excellent	2	4.3
Good	25	54.3
Neither good nor poor	13	28.3
Poor	2	4.3
Very poor	0	0.0
No response	4	8.7%

31) Roles for NADA

Role	Yes	No	Not Sure
Distributing information on learning and development options	84.8	2.2	4.3
Providing advice and consultancy on workforce development issues	82.6	0.0	6.5
Researching the sector's professional development needs	73.9	2.2	13.0
Brokering specific training (e.g. assisting training providers to design courses that meet members needs)	89.1	0.0	8.7
Advising members on ways to develop formal staff training and development systems	60.9	2.2	21.7
Providing grants for members to attend training	93.5	0.0	0.0
Supporting managers in workforce development (e.g. with clinical supervision, mentoring, partnerships)	78.3	2.2	8.7
Advocating for members' workforce development needs	73.9	0.0	10.9
No role	0		

33) Minimum qualification

Minimum qualification	Freq	%
Yes	33	71.7
No	7	15.2
Unsure	5	10.9
No response	1	2.2

PART 2 – Open ended responses

9) Rationale for staff training and development
Why does your organisation undertake staff training and development? ***(Please list the two most important reasons).***
REASON 1
1) Staff morale, confidence and knowledge
2) Staff need to improve their skills – stay up to date with latest practices
3,12,18) Skills development for the worker
4) Effective service delivery
5) Quality improvement
6) Contribute to developing workforce skills/esteem
7) Further education in relation to AOD practice
8, 9, 16, 19, 30) Up date skills / latest treatment options
11) Supports policy and best practice
13) Doesn't, 2 staff. 2000 people through the door each week
14) To improve the quality of service provided
15) To enhance staff skills specific to residential treatment services
17) for greater knowledge and collective knowledge
20) Ensure quality services
21) To update service provision
22) Build capacity of organisation
23) Ensure staff are trained in best practice available
24) To develop and up skill workers
25) Skills to carry out work
26 40, 44) Improve / develop/ enhance skills
29) To ensure that staffs knowledge/skills remain current
31, 46) Personal and professional development
32) Staff are always current and up to date

33) Improve overall organisations performance
34) Maintain and develop clinical staff skills
35) Maintain best practice
36) To enhance and develop service delivery
37) Improve skills and service provision
38) Increase knowledge/ skill base
39) Quality Assurance
41) Ensure current competency for client work
43) To better help clients
45) Enhances skills for quality service delivery

REASON 2
1) Improve client care outcomes
2) Some staff need training to bring them up to levels that are relevant to their duties
3) Increased skills within the team
4) Improve standards
5) Improved service delivery
6) Enhance skills in working with a complex client group
7) Based on needs assessment for individual counsellors
8) To broaden skills
9) Give clients access to latest treatment options.
10) Improve client outcome
11) Maintain high standard of professionalism
12) To be up to date with relevant info/ literature / legislation etc.
14) To improve skill base available to organization.
15) To keep up to date with current information and to develop a cohesive staff team
16) To increase quality of services
17) For the professional development of the individual
18) Staff development
19) Better understanding of clients
20) Staff retention
21) Staff upskilling, satisfaction and acknowledgement
22) Address identified gaps
23) To be informed of new techniques and emerging trends
25) Keep up to date with changing trends
27, 29) Improve service delivery
31) Update skills

32) New workers
33, 39) Professional development of staff – addresses jobs satisfaction and reduces burnout
34) To provide staff with opportunity to network and keep updated with development in the treatment field
35) Increase body of knowledge
37) Promote professional development
38) Improved quality care to clients
39, 41) Professional development
40) Keep up to date with latest development and information
43) To better help staff
44) Promotion to other vacancies within organisation and their own future graduation.
45) Workplace where staff can work
46) Awareness of best practice

10) Comments regarding barriers to staff training
1) Staff availability is not as much a problem as the cost of backfilling. We can dig up enough money to send staff on courses the killer is 2 wages.
9) Staff do not like to travel to Sydney, could training be arranged at major suburban areas e.g. Liverpool, Parramatta, Penrith, Campbelltown.
11) Being rural
18, 34) Added cost of travel/accommodation due to courses only being held in capital cities
29) Some of these barriers have been removed through access to NADA Workforce Development grants
38) Disruptions to agency due to inconsistency of care to clients either due to short staffing whilst other/s is/are training. We are an agency with small numbers of staff in two different premises so hard to keep long term casuals as inconsistent work is available
43) Wider subject base needed, more funds required for staff training
44) Mission has a good training system available but we could always use more, like NADA training grants

17) Over the next 12 months what are the two most important general skills and knowledge needs that staff in your organisation will require?
FRONTLINE TREATMENT STAFF
Accreditation x2
Anger management
AOD ethics
Assessment
Better knowledge of other services
Case management x4
CBT
Challenging clients x2
Change management
Coherence in development of an organisational model
Counselling x3
Crisis management
Diploma of AOD
DOCS reporting children at risk
Drug knowledge/Methamphetamine x2
Dual diagnosis/mental health x15
Group Work/advanced group work x4
IT/systems/records managementx5
Knowledge of disease control eg. HIV, Hepatitis
Management of clients using stimulants x2
Managing clients using stimulants
OH&S
Practical skills – first aid
Problem Solving Skills
Promoting safe environment
Quality Assurance related x4
Report writing x2
Self care
Skills to support more child focused work
Staff turnover
Understanding of GROW'S 12 Step Program and structure
Update skills/new treatment options x4
Working % resistance

MANAGERS / TEAM LEADERS
Accreditation related
AOD knowledge
Appropriate referral sources for those who are not admissioned
Attend management conferences
Business plan/strategic plan/ budgetingx5
Change management skills
Clinical case management skills
Coaching Training
Communication x3
Complex staffx2
Compliance issues
Dip in AOD
Extending formal training
Frontline management
Fundraising
Governance/legislative x4
HRx2
Interviewing
IT training - database development and use x5
Keeping in touch with staff
Leadership Recruiting
Leadership Training x3
Managing difficult staffx2
OH&Sx2
Organisational Skills
Partnerships
Planning
Policy Development
Quality improvementx5
Risk Management
Self-care
Staff development
Staff management/ supervision in the workplacex9
Submission writing x4
Supervision x2
Team buildingx2

Technological change
Time management x3
Working with personalities

ADMINISTRATION
Accidental counselling/ first point of callingx3
Accreditation
Client files
Changes in clinic
Client database managementx4
Communication skills
Dealing with change of management
Dealing with client drop ins
Financial management/ accounting skills /book keeping x9
First point of calling
ITx18
Managing work set
Mental Health
OH+S
Organisation
Prospect management
Quality assurance relatedx2
Report writing
Responding to audit reports
Risk Management
Self-care
Time Management x4

16) Demand for new training – details
1) Information technology, working with families, mental health and substance abuse.
2) Staff need to meet quality standards. Quality improvement initiatives, accreditation process.
3) Development of new skills to incorporate children's work into the service, skills in policy development, team building and training to support coherence in development of organisational model.
5) The need for training staff in mental health issues.
7) I feel that a shift towards acknowledging the effects of DD is currently being adopted. Further specialist training may be required.
11) Quality training – maintaining accreditation, traineeship D&A – core competencies up skill, IT training – maintain data.
12) New or changes in legislation, new therapy/ AOD changes, regulatory changes, into of new services, best work practices- e.g. statistical evidence based.
13) We constantly work on issues related to supervision of staff. Even more constant is the need to keep inspiration, information and fun, flowing for our volunteers.
14) Technological change, strategic geographical expulsion, quality improvement system.
15) Additional funding will be provided to increase staff numbers therefore recruitment and training of new staff, upgrading skills of present staff.
16, 20, 28) Quality improvement.
17) Cost of backfill.
23) Treatment of methamphetamine clients.
24) Working case management.
25) Improvement of organisations information management.
27) IT training.
29) Managing clients with MISA.
30) New data base system.
33) IT Challenges. Ongoing quality improvement. Increasing incidence of dual diagnosis presentation in client group. New therapies around substance abuse.
34) Training to acquire new skills /therapies/technology – mental health- family therapies- New treatment in D&A. New services.
35) Increase staff levels- orientation- workshops to gain accreditation.
38) First time going for accreditation, lack of group skills with current staff, technological changes.
40) Training in DD.
41) Quality improvement – working with clients with DD.
42) ATSI and how to deal with that user group more efficiently.
43) Technology change, quality improvement.
45) Looking at mental health training as increase in client target group with mental health issues.
46) Ongoing amphetamine training.

27) What is your view on the Certificate IV AOD as preparation for the sector?
1) The 2 year course is pretty good. The short selected module course is a worry.
2) Needs to be reviewed – not in touch with reality D&A abuse.
3) Additional other qualification would be needed.
3, 18) Reasonable preparation for working in the sector.
4) Essential tool in supporting young people.
5) Useful qualification.
6, 21) helpful re broad overview and understanding of AOD issues.
7) This is dependant on the student and their level of motivation. The course is accurate.
8) Basic requirement.
9) Not worked with anyone with this training.
11) Good basic information, little hands on components.
12) It is a vital tool to have as it gives you insight + exp into the AOD field.
13) Important- but its not a question threat is often posed.
15) Useful to gain general knowledge about the sector of AOD but each agency has own knowledge requirements.
16) Very comprehensive, good basis for this type of work.
17, 19) Good preparation.
23) It is preparation but not adequate for our small team on its own.
25) A start if combined with mental health.
26) Essential.
27, 29) Satisfactory/ Mostly sound.
28) Good information but not practical enough.
30) Very useful to staff in the AOD field.
33) Basic all round course.
35) Inadequate relating to counselling and 12 Step Abstinence.
36) Generally a helpful basic.
38) Important foundation for all workers.
39) Appears to be a good course.
40) Very beneficial.
41) Very helpful- Would be good for all frontline staff to have
42) Excellent basic requirement that gives workers an overview of the whole sector that increases referral options for clients.
43) Alright.
44) I don't know anything about it.
45) Very good.
46) Good theoretical background.

28) Are there ways the Cert IV AOD could be strengthened or improved?
1) More placement hours required.
3, 8, 15, 16, 26, 30) Not sure.
5) More time spent on dealing with mental health training.
6) Include report writing skills.
7) Better assessment and practical components of the source e.g. Proper agency placement.
11) Calculation of perspective students appropriateness in the field.
12) Should be more health focused not so welfare focused.
18) Current course seems to meet industry needs.
21) Higher percentage of traineeships for practical experience and more emphasis on in depth group facilitation.
23) It doest provide students with adequate counselling skills.
25) Combine mental health component.
27) Training on different residential models e.g. TC.
28) By being explained in a more practical way.
29) Increase in regard to Therapeutic Communities / Residential services.
33) More rigor.
35) More understanding of abstinence based programs.
36) Widen availability- reduce teachers' personal bias.
37) No training on drug effects and groups is currently offered.
38) It was excellent.
40) No.
43) Less time.
45) Increase mental health modules.
46) More clinical and paid clinical work experience i.e. like the enrolled nurse package.
6) More practical applications.
23) The ethics of AOD could be improved.
28) On the job training as part of the module.
33) More comprehensive focus on individual and group skills training.
35) Lecturers from a broad base – not just health department.

30) AOD Training in NSW could be strengthened by ….
1) Injection of “training specific” funds.
5) Focusing more on the issues faced at the coal face.
6) Application of theory to practice while at TAFE.
7) More input from frontline workers regardless of education status.
8) Not sure.
11) Longer practical experience.
12) Courses being free of charge, therefore more staff can attend.
13) Training on is often abundant and excellent but inaccessible.
16) Health funded Cert IV Courses.
17) More in strategies in regards to treatment possibilities/theories/options.
18) Degree course after Cert IV AOD.
21) Improved integration of training skills e.g. combining mental health an AOD issues.
22) Training at a tertiary level – greater emphasis on prevention – greater management support.
25) Unknown- new member.
28) By a lot more on the job training, by money being available for traineeships.
29) More inclusion of residential work.
30) More emphasis on clinical placement and assessment, treatment for DD.
35) Placement for work experience and lecturers who are not harm minimisation i.e. controlled use focused – who have experience and understanding of abstinence as part of harm reduction.
36) Teach and access without prejudice and bias being strongly communicated.
38) Having minimum requirements for all workers.
39) More courses outside Sydney.
41) Access in rural areas.
45) Increase mental health modules from depression right through to schizophrenia.
46) Local Training Options/ Video conferencing/ distance/ education.

32) Other roles
1, 6) Not at this time.
7) To continue providing support and guidance to small services like this one.
9) Yes, for workers who do not have any qualifications but have worked in AOD more than 5 years, could NADA look at an accreditation or advanced standing for their experience/knowledge while working in AOD.
12) N/A.
16) No.
18) As a new member we are relatively happy so far.
21) Greater emphasis on integration of capacity building integrating with workforce development to improve systems, facilitation and knowledge.
22) Establishment of managers support network- addressing staff burnout.
28) Charles Stuart University Dubbo is putting together an AOD course specific to the industry. It has consulted with a number of rehabs, P+P, health agencies, it might be an idea for NADA to check it out to see if there can be some sort of collaboration.
46) Increase funding application skills.

33) Do you think this is an appropriate policy standard for the NSW non government AOD workforce?
2) In addition to the Cert IV – the person's life experience skills and abilities to work and relate to people need to be considered.
3) Yes, however, if worker has other skills- and agency is able to provide training in AOD component, depending on potential, this can be okay too.
4) It is important to have standardised levels of competency and proficiency in dealing with complexities around AOD issues.
5) The need for formal training in AOD issues in important for the delivery of services in a best practice model.
7) There needs to be a benchmark for the industry. I feel that the AOD is a solid foundation to begin with.
8) It is a complex field and basic training in AOD should be a standard requirement.
9) AOD services employ some staff who have had " Life experiences" and are excellent case workers/ counsellors/ welfare workers.
11) Support professionalism in the field, recognition of base line training in all sectors.
12) See Q27.
13) I'm happy to set an ideal standard but not to shut the door on people.
15) Past experience has taught us that it is not essential to have Cert IV AOD.
16) But only if the state government is willing to fund these courses.
17) Positions are difficult to fill even without ruling people out, however with increased pay this would be a sensible requirement.
18) Cert IV AOD is useful, a bachelor degree in AOD would be useful as well for team leaders if it contains supervision, research, database use, design and management, group design etc.
19) However I believe that traineeships the best way to enter into the sector.

21) This would eliminate the concept of a multi disciplinary team (Staff from different training e.g. social workers, psychologists) from working in the field also would more challenging than it already is'.
22) Provides minimum standard, improves credibility of sector.
23) There are some skills from mental health that are transferable to the sector.
28) I personally believe that a minimum standard is a good idea. Especially AOD information which can be put into practice while on the job.
30) We need to have some standard but it doesn't necessarily have to be educational qualifications. It could be working experience- years, or/and issue certificates.
33) Baseline of core competencies is a necessary pre-requisite for work so that employers can deploy people confident in the knowledge that they do the job.
35) All social welfare programs should include a minor in their courses – from University/ TAFE/Online etc. The reason being after 20 years working with AOD clients – the misinformation/ misunderstanding and lack of compassion has left the clients with high need AOD problems and little options of care. Rehabilitation has been minimised as an option by Health Dept. and therefore funding has been limited.
37) Employees need to provide AOD training opportunities.
38) Working in AOD today is a little more complex due to the changes in drug patterns. There are a lot more mental health issues requiring skills in appropriate referral/assessment and ongoing case management.
40) It can be very damaging and even dangerous to clients if people are not adequately trained to work with them.
42) But in some cases being engaged in training with significant experience should also not be overlooked.
43) Right type of person could be put off by having a qualification impost. Training started when starts work, no reason why it wouldn't be the same level as a certificate after time.
44) To hire someone with the basic understanding makes their inclusion into the service a little easier. To have someone come in without any understanding can be tiring for staff but also very unprofessional for the young person. Some knowledge is always needed.
45) I would not like to set this standard because: reduction in number of qualified applicants for positions. The completion from case management positions – salaries in other sectors of mental health. Instead I would like to: within one year of employing staff actively encourage them to advance their qualifications within the resources that we can provide.
46) In a two year commitment there is often more workplace training needed.

34) Further comments
6) NADA is doing a great job so far in the workforce development role.
13) It is unlikely that we will be able to afford any real participation for the next 12 months in preferred roles for NADA.
14) Some questions difficult to answer as the Peer Support Foundation do not work directly in the area of AOD. The program provides a wider model of intervention focusing on aspects of social organisation – that affect children and their wellbeing
40) It is very difficult to find trained Aboriginal D+A workers

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ATTACHMENT 3

INTERVIEWEES

Name	Organisation
Linda Beltrame	Alcohol and Drug Foundation of NSW
Phinn Borg	The Gender Centre
Travis Good	Adele House, Coffs Harbour
Clifton Green	Rawson Centre, Mission Australia
Amanda Hardie	Catherine Booth House, Salvation Army
Fiona Hastings	Guthrie House
Norm Henderson	The Lyndon Community
Sharon Mestern	Odyssey House
Chloe Wooten	READY Centre, St George Youth Services

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