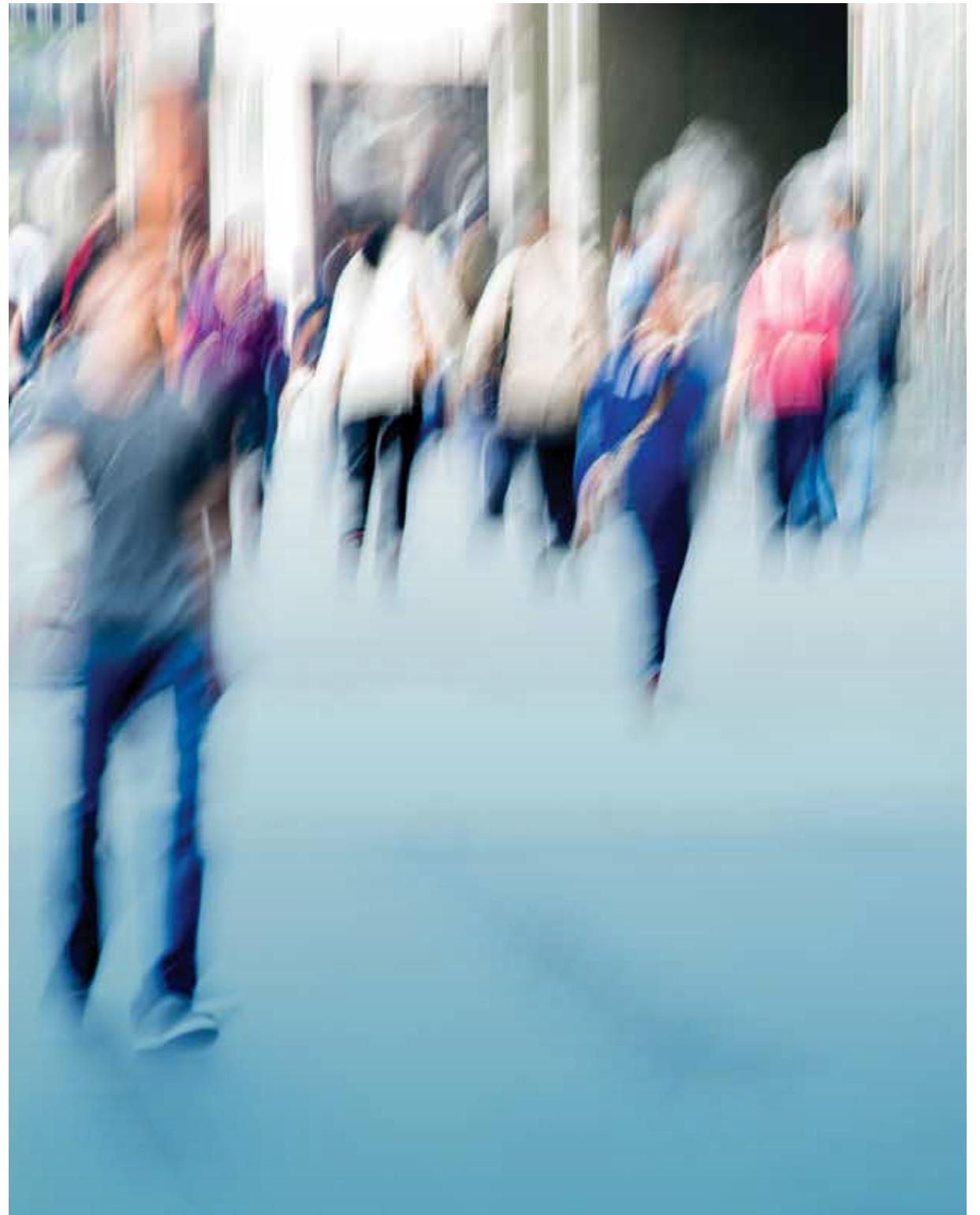


NADA
network of alcohol & other drugs agencies



**Responding to alcohol
and drug related harms
in NSW**

Mapping the NSW non government
alcohol and other drugs sector

NOVEMBER 2014

PUBLICATION DETAILS

Network of Alcohol and other Drugs Agencies (2014). *Responding to alcohol and drug related harms in NSW: Mapping the NSW non government alcohol and other drugs sector.* NADA, NSW Australia.

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ACKNOWLEDGEMENTS

NADA acknowledges and thanks all organisations and individuals that contributed to this report through survey, consultation and interview.

NADA acknowledges the invaluable input of the Expert Advisory Group.

Siggins Miller for partnering with NADA in the design of the project and for undertaking data collection and analysis.

NSW Ministry of Health, Mental Health and Drug and Alcohol Office (MHDAO) for financial support for the Sector Mapping Project.

ABOUT THE NETWORK OF ALCOHOL AND OTHER DRUGS AGENCIES

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW.

NADA represents over 100 organisational members that provide a broad range of services including alcohol and drug health promotion, early intervention, treatment, and after-care programs. These community based organisations operate throughout NSW. They comprise both large and small services that are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery.

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

NADA provides a range of programs and services that focus on sector representation and advocacy, workforce development, information management and data collection, governance and management support plus a range of capacity development initiatives.

NADA is governed by a Board of Directors elected from the NADA membership, and is primarily funded by the NSW Ministry of Health.

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

FOREWORD

This mapping report was commissioned by NADA and the Mental Health and Drug and Alcohol Office (MHDAO) of the NSW Ministry of Health as a prelude to the Partnerships for Health NGO reform program. Its objective was to develop a comprehensive mapping and sector taxonomy of the specialist non government alcohol and other drugs sector funded by the NSW Ministry of Health. The report maps organisations funded under the Ministerial Grants program and supplemented by specific streams of drug and alcohol funding to the non government sector by NSW Health since the 1999 Drug Summit and subsequent funding streams. The purpose of the mapping report was to inform the review of the non government alcohol and other drugs sector moving from the old grants program to the specific purchasing of services by non government organisations under the new reform procurement scheme.

This report provides an overview of the specialist non government alcohol and other drugs program, what it has achieved over the past decade, and our proposed future direction for new funding arrangements. It also describes the opportunity for enhancement of the sector under the reform program and the government's policy of outsourcing more alcohol and other drugs service delivery to the sector. The report demonstrates the capacity of the sector and where it can be enhanced to take a bigger role as a major provider of alcohol and other drug health services to the NSW community. We hope it will lead to improved relationships and integration between the non government sector and the specialist government alcohol and other drugs service delivery system.

It is anticipated the report will inform the upcoming planned review process and the associated services purchasing plan to be developed by MHDAO over the next 12 months. The report will be of great use in a range of planning exercises in the areas of workforce development, electronic data gathering and reporting, and contract performance management. NADA will use the recommendations in the report and other material gathered from the mapping exercise to inform its work over the coming years. The report will also act as a useful guide to a wide variety of stakeholders in understanding the role and function of the specialist non government alcohol and other drugs sector in NSW.



Larry Pierce
Chief Executive Officer
Network of Alcohol and other Drugs Agencies



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1. EXECUTIVE SUMMARY

It is well understood that use and harms related to drugs and alcohol are “*complex multi-determined social problem[s]*”¹. Tobacco, alcohol and other drug use causes significant harm to individuals, families and communities across Australia. These harms include mental and physical health disorders, blood borne virus transmission, criminal and antisocial behaviour, social exclusion, overdose and death.

The National Drug Strategy 2010–2015 and its predecessors are based on the principle of, and evidence for, harm minimisation and have been recognised internationally as playing a critical role in Australia’s success in addressing drug and alcohol use and harm. The Strategy’s three pillars of demand reduction, supply reduction and harm reduction incorporate actions across jurisdictions and across the law enforcement, health, social services, government, and non government sectors.

The NSW non government alcohol and other drugs sector is a key partner in reducing alcohol and drug related harms, as well as contributing to the broader health and well-being of individuals, families and communities. Many years working with marginalised populations and entrenched social issues has created a skilled and experienced sector which provides a continuum of care services from harm reduction, through to health promotion and harm prevention, treatment, and extended/continuing care.

Many challenges are being faced by organisations and service providers across the non government alcohol and other drugs sector. The nature of the client group which organisations serve are becoming more complex, therefore increasing service demand. Unstable government funding and NGO grant program reforms has negative flow on effects to service planning, workforce, service delivery and organisation sustainability, and income has generally not kept pace with costs of service delivery or service demand. Despite these challenges, the sector has made significant achievements. Through a commitment to quality improvement, and learning and development, many organisations and programs are recognised as leaders in the field, are contributing to the evidence base through engagement in research, and are providing specialist services with complex, hard to reach and highly marginalised populations.

The Sector Mapping Project focused on 57 NSW based non government alcohol and other drugs ‘specialist’ organisation who are members of NADA, and whose sole or primary focus is alcohol and other drugs prevention, community development and/or treatment service delivery. This grouping makes up just over half of the full NADA membership.

¹ Ritter A, King T, Hamilton M (2013). Drug Use in Australian Society. Melbourne: Oxford University Press. (page xxv)

Summary of sector mapping findings

- 57 alcohol and other drugs specialist organisations operate across NSW. All but one NSW Health Local Health District incorporates a non government alcohol and other drugs specialist organisation within its geographic boundary.
- Over 75% of non government alcohol and other drugs specialist organisations primarily provide services to adult men and women.
- The most commonly provided services across the sector are: counselling, case management, and residential rehabilitation treatment services for a wide range of client profiles. This includes a variety of clinical and other therapeutic interventions, and information/education as part of a health promotion and harm prevention programs.
- In the 2012/13 financial year among those member organisations included in the NADA Sector Mapping project, over 9600 completed episodes of treatment were provided to the NSW public – of which 96% was for those concerned about their own drug use. Overall, those accessing those services were more likely to be male (67%), between 19 and 39 years of age (63%) and non-Indigenous (80%).
- The non government alcohol and other drugs sector staff are experienced and qualified. The average length of time of staff working in the alcohol and other drugs sector is 7.7 years, and 5.1 years with their current organisation. Almost half (48%) of respondents hold a university qualification (undergraduate degree, graduate certificate, graduate diploma, master’s degree or PhD/doctorate), and 57% hold a specific alcohol and other drugs qualification.
- The sector is firmly engaged in organisational review and development through formal quality improvement programs. 90% of organisations are members of a quality improvement certifying body, with 67% of these having already attained formal accreditation.
- The majority of organisations across the sector are utilising validated clinical screening and assessment tools to assess clients and measure outcomes as a part of the treatment program provided.
- Almost all organisations receive income from multiple sources. The most common income source is NSW Health with 82.5% receiving funds, followed by the Commonwealth Department of Health, and client contribution.
- In the 2012/13 financial year, 50% of organisations indicate their operating budget is \$1M or less.

- In line with all human services industries, an organisation's main operating expense is staff salaries averaging 68% of all costs.
- Almost half of the sector (46%) partners with research institutions for research activities and over half of the sector (54%) undertake independent research activities (in addition to service/program evaluation), providing a significant contribution to the evidence base of what works.
- The three main issues reported by organisations and the broader non government alcohol and other drugs sector over the next three years are:
 - Adequate funding to meet administrative/operational costs
 - Adequate funding to meet client and community service delivery costs
 - Service provision to clients presenting with complex needs.

RECOMMENDATIONS

Recommendation 1 – Collaboration with Government

NADA and the sector to work with government in strategic and service level planning to develop and fund a whole of system approach to alcohol and other drugs prevention and treatment services in NSW.

Recommendation 2 – Use the sector mapping data

Government to use the sector mapping data to assist in planning and purchasing services. NADA to use the data to inform participation in reviews, consultations and sector development activity. The sector to use the data at the local level to further develop local partnerships, networks and referral pathways.

Recommendation 3 – Apply funding principles that consider infrastructure and operational costs

Government should apply the funding principles for non government organisations providing alcohol and other drug treatments outlined by the Australian National Council on Drugs. These principles consider key areas such as service delivery needs, administrative and incorporation costs, infrastructure and operational resource needs, and workforce and organisational development needs as described in the mapping report.

Recommendation 4 – Outsource contract administration

MHDAO should explore options to outsource contract administration to NADA for the new contract system under the Partnerships for Health reform agenda.

Recommendation 5 – Develop sector leaders

NADA to explore the development of sector leadership groups or communities of practice that focus on i) governance and leadership ii) clinical practice processes to improve quality, share practices and identify priorities.

Recommendation 6 – Increase and maintain sector capacity

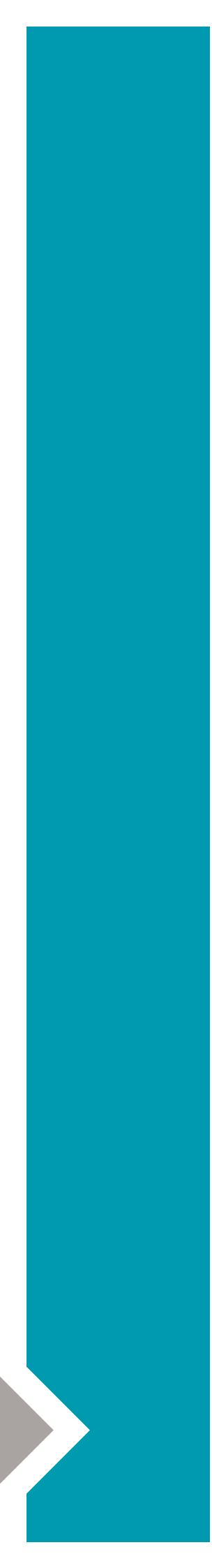
Maintain NADA's effective workforce, organisation and sector development priority activities as the key enablers of change and a more integrated and evidence based AOD service system.

Recommendation 7 – Improve data systems

Appropriately resource NADA and the sector to enhance quality client data collection and performance reporting, with a particular focus on improving client outcome data collection and utilisation.

Recommendation 8 – Embed research and evidence

NADA and the sector to work with research centres, government and key players to increase the research capacity of the sector, apply evidence based approaches, and inform future research priorities.



2. CONTEXT AND OVERVIEW

2. CONTEXT AND OVERVIEW

2.1 CONTEXT OF THE SECTOR

An effective alcohol and other drug service system provides a range of treatment options that are client-centred, flexible, strengths-based, meets the needs of diverse populations, and can be accessed quickly at different stages. Success of treatment is usually categorised by reducing the use of alcohol and other drugs; reducing the risk of infectious disease; improving physical and psychological health; reducing criminal behaviour; and improving social functioning.²

2 Australian National Council on Drugs (ANCD) (2001). Evidence supporting treatment: the effectiveness of interventions for illicit drug use. Canberra, ANCD.

3 NIDA (2009) Principles of Drug Addiction Treatment: A Research-Based Guide. 2nd edition, National Institute on Drug Abuse, United States Department of Health and Human Services

2.1.1 NSW alcohol and other drugs service system

The NSW Ministry of Health supports the executive and statutory roles of the NSW Minister for Health and Minister for Medical Research, as well as the Minister for Mental Health. It monitors the performance of organisations in the NSW public health system, known collectively as NSW Health. The Ministry of Health also guides the development of services and investments in the NSW public health system.

The Mental Health and Drug and Alcohol Office (MHDAO) is responsible for developing, managing and coordinating NSW Ministry of Health policy, strategy and program funding for mental health and drug and alcohol. MHDAO works in partnership with Local Health Districts (LHDs), pillars and networks, as well as NGOs, research institutions and primary health.

Figure 1: Components of comprehensive alcohol and other drug treatment



Adapted from the National Institute on Drug Abuse³

The NSW Ministry of Health allocates approximately 80% of its alcohol and other drugs (AOD) budget to LHDs to provide treatment services.

2.1.2 NSW public sector and NSW Ministry of Health funded NGO AOD services

The following AOD services are provided by the NSW public sector services:

- Pharmacotherapy services (opioid prescribing and dosing)
- Detoxification and withdrawal management services (inpatient hospital-based and outpatient ambulatory detoxification)
- Rehabilitation and counselling services
- Case management for AOD users seeking assistance
- Consultation liaison services to ensure that hospitals have timely access to specialist staff to assist in the management of patients presenting with mental health and AOD problems
- AOD medicine
- A small number of health promotion and community education services
- Specialist treatment services, for example:
 - Stimulant Treatment Programs (Darlinghurst and Newcastle)
 - Cannabis Clinics (6 in NSW)
 - Substance Use in Pregnancy Services
 - Involuntary Treatment Unit (Nepean).
- In addition to those direct services provided by LHDs, the NSW Government provides funding for NGOs and other agencies to provide:
 - Residential rehabilitation services
 - Education and prevention services
 - Encouragement to pharmacists to engage with the pharmacotherapy program.

2.1.3 Private sector AOD services

AOD services provided by the private sector are primarily hospital and clinic based, including:

- Inpatient treatment and outpatient counselling
- Inpatient and outpatient methadone (pharmacotherapy) programs.

2.1.4 Criminal justice AOD services

The criminal justice sector also provides a number of programs and services, that include the:

- Magistrates Early Referral to Treatment program (MERIT)
- Adult Drug Court
- Compulsory Drug Treatment Centre

2.1.5 NSW NGO alcohol and other drugs specialist service providers

NGOs have been providing alcohol and other drugs harm reduction, health promotion and treatment services in NSW since the mid 1970's and initially worked with general practitioners and psychiatrists in the absence of specialist government alcohol and other drugs services. Many services were built on the self-help models Alcoholics Anonymous and later Narcotics Anonymous of providing residential and out-client support to assist the 'addict' to recover from drug and alcohol abuse.

The origins of government funding to the sector were largely through the NSW Health Ministerial grant contribution program (currently under review) and the Commonwealth 'National Campaign Against Drug Abuse' (now the National Drug Strategy). Since the NSW Drug Summit in 1999, extensive investment in service delivery and service improvement have positioned the NSW non government AOD sector well in relation to the aims of Commonwealth and NSW Health service reform and performance.

The Sector Mapping Project collected primary data in a survey of NSW NGO AOD specialist service provider organisations. The organisations in scope for the Project included the 57 NADA alcohol and other drugs specialist members, whose sole or primary focus is alcohol and other drugs prevention, community development and/or treatment service delivery.

The NGO AOD sector in NSW provides the following specialist prevention and treatment service types:

- case management
- psychosocial counselling
- alcohol and other drugs health promotion and prevention inclusive of individual and group information, education, and community development
- psychosocial after care/continuing care
- withdrawal management
- day program rehabilitation
- residential rehabilitation
- methadone to abstinence and methadone stabilisation
- supported living/transitional housing programs (as a component of a treatment program).

3. OVERVIEW OF THE NSW NON GOVERNMENT ALCOHOL AND OTHER DRUGS SECTOR

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NSW has a diverse, strong and effective non government alcohol and other drugs sector which has been providing services to individuals, families and communities for more than 40 years. The sector has been critical in responding to the health and welfare needs of those affected by drugs and alcohol, particularly those experiencing marginalisation and complex social issues.

Over 50 alcohol and other drugs specialist organisations operate across NSW. All but one NSW Health Local Health District incorporates a non government alcohol and other drugs specialist organisation within its geographic boundary. Additionally, a similar number of organisations provide some form of alcohol and other drugs service delivery as part of a broader health and/or social welfare service.

The geographic distribution of non government alcohol and other drugs specialist organisations in NSW¹ is similar to both all treatment organisations in Australia and all treatment organisations in NSW⁴, according to remoteness classification⁵.

4 Australian Institute of Health and Welfare (2013). Alcohol and other drug treatment services in Australia 2011–12. Drug treatment series 21. Cat. no. HSE139. Canberra: AIHW.

5 Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA)

3.1 ROLE OF THE SECTOR

Community based non government, public and private sectors provide the majority of alcohol and other drugs services in NSW which is complemented by public and private hospital systems.

The NSW Non Government Alcohol and Other Drugs Service Delivery Taxonomy (over page) describes the continuum of care services being provided, from harm reduction, through to health promotion and harm prevention, treatment, and extended and continuing care. This taxonomy structures service types, settings and workforce according to needs of individuals and populations, and the intensity and duration of interventions. The service types are informed by the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), documentation of service types in international, national and state/territory frameworks, and publicly available information from early work of the DA-CCP.⁶

The most commonly provided services across the sector are: counselling, case management, residential rehabilitation, and information/education as part of a health promotion and harm prevention program.

Historically, the types of services provided by non government organisations and government has been fairly fixed, for example, residential rehabilitation is provided

6 Drug and Alcohol Clinical Care and Prevention (DA-CCP) is a population planning tool for alcohol and drug services, developed by NDARC DPMP.

Figure 2: Alcohol and other drugs treatment organisations/agencies by ASGC-RA: Australia, NSW and NSW NGOs

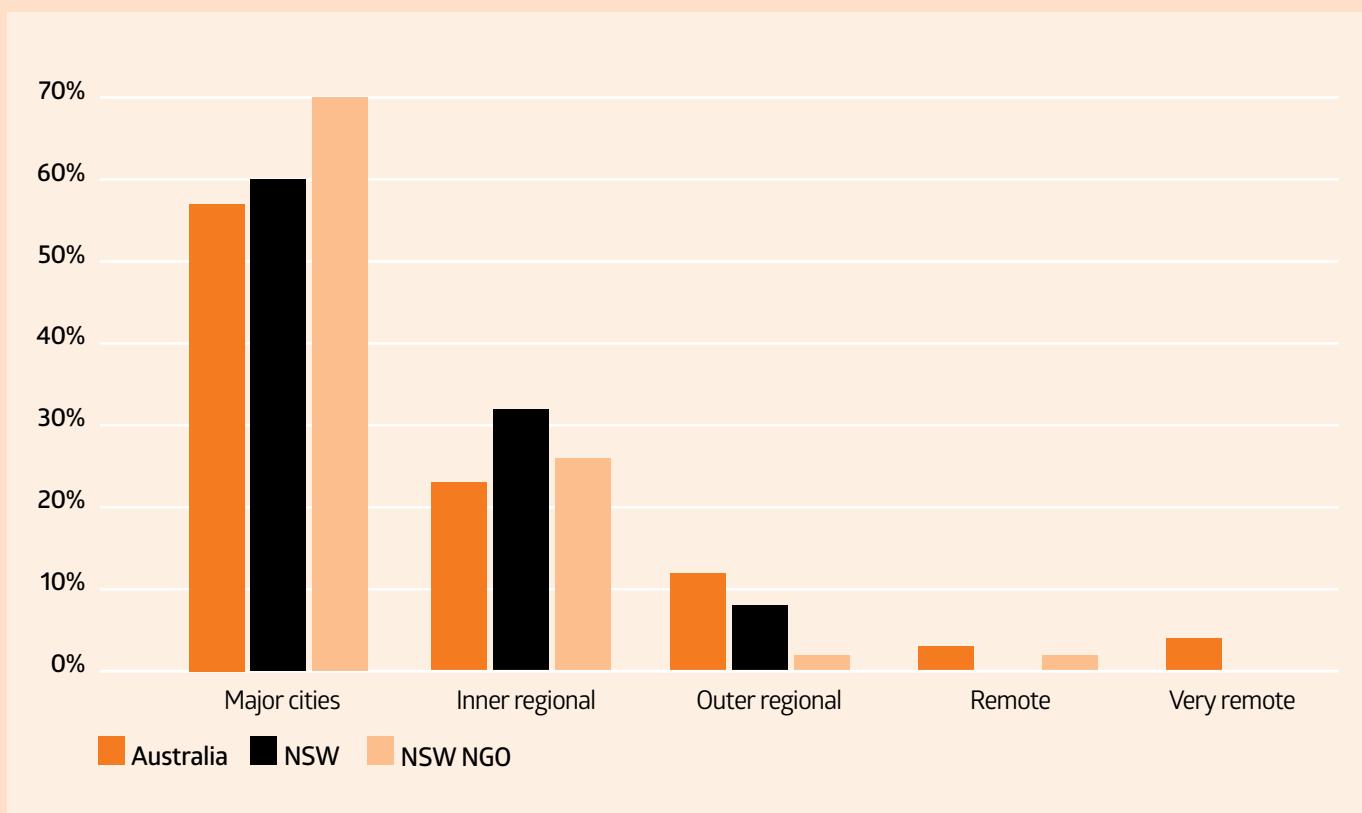


Figure 3: NSW Non Government Alcohol and Other Drug Service Delivery Taxonomy

Service level and intensity	Harm Reduction LOW → MEDIUM	Health Promotion and Harm Prevention MEDIUM → HIGH	Treatment HIGH → HIGH +	Treatment + HIGH + → MEDIUM	Extended and Continuing Care
Service type	Needle and syringe program Brief intervention - information and education	Health promotion and prevention - information and education Health promotion and prevention - community development	Case management Psychosocial counselling Withdrawal management Rehabilitation day program Residential rehabilitation Opioid treatment program	As for treatment plus: Specialist programs (ie residential family, residential women with dependent children, Indigenous, residential pharmacotherapy stabilisation or reduction)	Case management Psychosocial counselling Supported living/transitional housing program
Service setting	Needle and syringe centre Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events	Specialist drug and alcohol service – out-client Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events Social media	Specialist drug and alcohol service – out-client and out-reach Specialist drug and alcohol service – residential detox Specialist drug and alcohol service – residential	As for treatment	Specialist drug and alcohol service – out-client and out-reach Supported living/transitional housing
Workforce	- Health education officer - Community development officer - Welfare/youth worker - Drug and alcohol worker/counsellor - Aboriginal health worker - Peer worker	Drug and alcohol specialist knowledge and skills required. - Health education officer - Community development officer - Welfare/youth worker - Drug and alcohol worker/counsellor - Aboriginal health worker	Drug and alcohol specialist knowledge and skills required. - Drug and alcohol worker / counsellor - Aboriginal health worker - Mental health worker / counsellor - Psychologist - Social Worker - Nurse - General /medical practitioner	As for treatment	Drug and alcohol specialist knowledge and skills required. - Drug and alcohol worker/counsellor - Aboriginal health worker - Mental health worker /counsellor - Psychologist - Social Worker
Population & drug use focus	Individuals, families and communities Pre and contemplative, experimental and regular drug use Injecting drug use	As for harm reduction plus: Problematic drug use. At risk individuals and groups	Individuals and families. Problematic or dependent drug use. At risk individuals and groups	As for treatment plus: High complex health and social needs: - Women and parents with children - Coexisting mental health issues - Cognitive impairment - Acute physical health issues - Criminal justice connection - Trauma histories	Individuals and families Problematic or dependent drug use At risk individuals and groups

by NGOs, withdrawal management (detoxification) is provided by government. However, in the last 5-10 years this landscape has changed, with further shifts on the horizon. NGOs are now providing a significant portion of withdrawal management services, increasing their role in formal court diversion programs and opioid substitution therapies and programs.

Undoubtedly, client access and treatment outcomes are improved by providing continuity of care across service types and across service systems. Often being the first or only contact point for clients, the non government alcohol and other drugs sector plays a key role in facilitating care to other health, medical, social welfare, and support services, as well as reconnecting them with community and peer support. The majority of organisations across the sector provide case management services to support improved client experience and outcomes in the treatment sector. However, organisations highlight the need for greater interagency activity to enhance access to, and provision of, services, and to deliver a more integrated client-centred journey. Constraints on resources and the absence of shared understanding of the alcohol and other drugs system as a whole are barriers to achieving this.

3.2 INTERVENTION TYPES

The NSW non government AOD sector is diverse in its treatment approaches and philosophy, which is a strength of the sector. Approaches ranging from harm reduction to abstinence based programs are essential to meet the needs of NSW communities. The following are examples of the most common interventions provided in the sector.

Needle and syringe programs

Needle and syringe programs (NSP) aim to minimise the transmission of blood borne viruses among people who inject drugs through the distribution of sterile needles and syringes and safe sex equipment; promotion of safe disposal, including collection and disposal of used needles and syringes; development and delivery of relevant education programs; and the provision of information on and referrals to other health and welfare services. Several NGO AOD treatment providers act as a secondary NSP by distributing sterile needles and syringes alongside other interventions.⁷

Health promotion

The sector has a long history of developing prevention and health promotion programs for local communities. Health promotion activities can increase protective factors, reduce risk factors and build resilience which result in positive outcomes across a range of health and social problems including alcohol and other drug use, criminal activity and

⁷ New South Wales Department of Health (2006). Needle and syringe program policy and guidelines for NSW. NSW Department of Health, North Sydney.

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improve mental health.⁸ Strategies in the sector include targeted resource production, peer education, community development and school based education programs.

Screening and assessment

Screening is a brief method of determining the extent of a person's alcohol and drug use, and can assist in determining whether a service or program is appropriate. In response to the high level of co-existing mental health issues among people with problematic alcohol and drug use, screening for common mental health problems (such as depression and anxiety) is now considered part of routine intake and screening procedures across the AOD sector.

Following a screening process, an assessment is completed which may have both formal and informal elements. A comprehensive assessment informs the development and implementation of a treatment plan. A detailed assessment usually includes; the presenting issues; background and personal history; current and historical alcohol and drug use; readiness to change current issues, and screening for psychological problems.⁹

A range of reliable and validated screening, assessment and outcome measurement tools are used by the AOD sector.¹⁰

Brief interventions

Brief interventions are generally between 5-30 minutes in duration and are delivered across a range of AOD settings, as well other health settings. The benefit of brief interventions is they can be delivered opportunistically and can often be an effective first level of treatment offered to people with problematic alcohol and drug use. Brief interventions often consist of informal counselling and information on the harms and risks associated with increased use of alcohol and drugs.¹¹

Withdrawal management

There are a number of withdrawal management services delivered in the NGO AOD sector. These are delivered in hospital or community based settings, and can also support withdrawal management in the home if appropriate. Withdrawal is often medicated with the use of controlled sedatives, but can also be non-medicated in situations where analysis of alcohol and drug use and mental health screening indicate a mild withdrawal.¹²

⁸ World Health Organization (1986). Ottawa Charter for Health Promotion. WHO and Canadian Public Health Association, Ottawa.

⁹ New South Wales Department of Health (2008). NSW Health drug and alcohol psychosocial interventions: Professional practice guidelines, NSW Department of Health, North Sydney.

¹⁰ Deady M (2009). A review of screening, assessment and outcome measures for drug and alcohol settings. Network of Alcohol & other Drug Agencies, Sydney

¹¹ New South Wales Department of Health (2008). NSW Health drug and alcohol psychosocial interventions: Professional practice guidelines, NSW Department of Health, North Sydney.

¹² National Centre for Education and Training on Addiction (NCETA) Consortium. (2004). Alcohol and Other Drugs: A Handbook for Health Professionals. Australian Government Department of Health and Ageing.

Psychosocial counselling

The sector provides a range of short, medium and long term counselling, as well as therapeutic and psycho-educational groups to individuals and families. Common approaches include motivational interviewing, cognitive behavioural therapy, dialectical behaviour therapy, narrative therapy, acceptance and commitment therapy, and mindfulness.

Case management

A case management approach is employed by the NGO AOD sector for clients with complex needs, and those requiring ongoing care and support. The approach recognises that clients with complex and multiple needs access services from a range of service providers. The goal of case management is to provide seamless delivery across services, ensure communication between workers and providers, and to minimise duplication of services where overlap occurs. Case management should be delivered in partnership and collaboration with the client to deliver comprehensive assessment, individual care planning, service facilitation, outcome monitoring and advocacy.¹³

Residential rehabilitation

Residential rehabilitation is a general term for 24-hour, staffed, treatment programs that offer intensive, structured interventions after withdrawal from alcohol or drug dependence. Residential treatment is based on the principle that a residential setting free of non-prescribed alcohol and drugs provides an appropriate environment to address the underlying causes of problematic alcohol and drug use. Residential rehabilitation is usually 8 to 12 weeks, however some programs can go for up to 12 months. Most programs use group work as part of a structured program, and also includes relapse prevention, living skills training, parenting skills, case management and counselling.

A common approach used in the sector is the therapeutic community model - therapeutic communities emphasise a holistic approach to treatment and address the psychosocial and other issues behind substance abuse.

The “community” is thought of as both the context and method of the treatment model, where both staff and other residents assist the resident to deal with his or her drug dependence.¹⁴

There are also a few residential programs that provide methadone stabilisation, or methadone to abstinence programs.

Rehabilitation day programs

There are an increasing number of rehabilitation (or structured) day programs that are being delivered in the sector. Similar to residential rehabilitation, most programs use group work as part of a structured program, and also include relapse prevention, living skills training, parenting skills, case management and counselling. Programs are usually up to 8 weeks in duration and may sometimes be delivered in conjunction with clients from a residential program.

Extended and continuing care

Extended and continuing care following discharge from a withdrawal management or residential program is associated with improved substance use outcomes and lower rates of relapse. A standard program of continuing care has been described by NSW Health as having regular contact with a healthcare professional, along with access to a case manager for service coordination. Within a stepped care framework, these points of contact can then be used as a prompt to ‘step-up’ or ‘step-down’ treatment for the client.¹⁵ Reintegration into the community also requires access to appropriate housing, education/training and/or employment services, peer support and social networks.

3.3 MAJOR ACHIEVEMENTS OF THE SECTOR

The non government alcohol and other drugs sector has matured significantly over the last 15 years, and as a result of collective efforts by the sector, peak bodies, and government and philanthropic funders, broadly it has achieved:

- Increased capacity to identify and respond to complex client and population needs, particularly in the areas of mental health, trauma informed care and criminal justice.

¹⁴ New South Wales Department of Health (2007). Drug and alcohol treatment guidelines for residential settings, NSW Dept. of Health, North Sydney.

¹⁵ New South Wales Department of Health (2008). NSW Health drug and alcohol psychosocial interventions: Professional practice guidelines, NSW Department of Health, North Sydney.

13 New South Wales Department of Health (2008). NSW Health drug and alcohol psychosocial interventions: Professional practice guidelines, NSW Department of Health, North Sydney.

- Increased investment in infrastructure, quality improvement and organisational development.
- Contribution to evidence for informed practice, including involvement and leadership in clinical research and development of the research agenda.
- Diversity and specialty of service provision across the sector and within individual organisations, supporting continuum of care models and meeting needs of specific populations.
- Development of client and organisation data application, including outcome and impact monitoring and reporting.
- Reduced marginalisation and stigmatisation of treatment services and clients with alcohol and other drugs use issues, and increased acceptance of alcohol and other drugs treatment as an essential component of mainstream health approaches.
- Increased investment in workforce development and professionalisation, and greater comparability of qualifications with the public sector.
- A valued contribution to sector related policy and practice development, particularly in the areas of workforce and organisational development, and service guidelines for specific populations (for e.g. cognitive impairment, Aboriginal clients).

3.3.1 Workforce

Staff across the non government alcohol and other drugs sector report high levels of work satisfaction, reiterating NADA's 2008 research findings¹⁶. Putting aside known

substantial workforce issues in this and other community services sector, high satisfaction levels relate to the autonomy of NGOs, the ethical and philosophical nature of the work and organisations, and flexible work practices. The non government alcohol and other drugs sector staff are experienced and qualified. The average length of time of staff working in the alcohol and other drugs sector is 7.7 years, and 5.1 years with their current organisation. Almost half (48%) of respondents hold a university qualification (undergraduate degree, graduate certificate, graduate diploma, master's degree or PhD/doctorate), and 57% hold a specific alcohol and other drugs qualification.

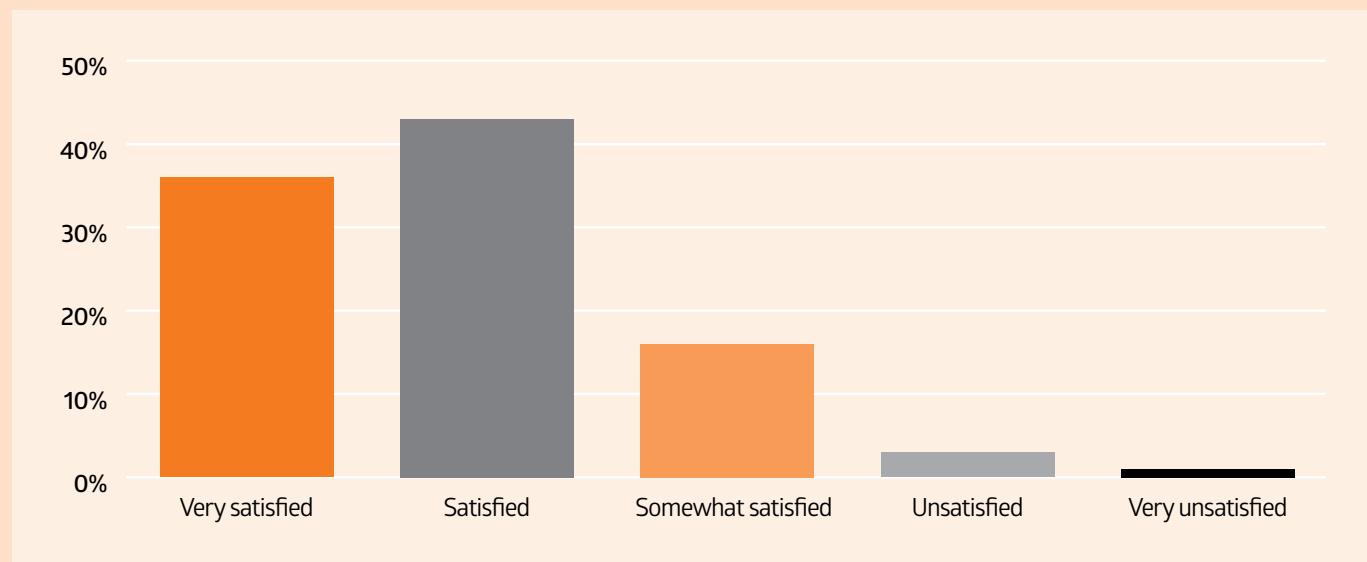
3.3.2 Quality improvement and accreditation

The sector is well engaged in organisational review and development through formal quality improvement programs. 90% of organisations are members of a quality improvement certifying body, with 67% of these having already attained formal accreditation. Whilst there are significant resource burdens carried by organisations in obtaining accreditation, benefits to operations and service delivery are recognised and have been experienced.

The main advantages have been improvements in strategic planning, better integration with the wider health service sector, improvements in organisational and operational policy and policy implementation at an organisational wide level, better data gathering, management and reporting, better workforce planning and stronger governance across the specialist alcohol and other drugs NGO sector.

¹⁶ Argyle Research (2008). NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues. Report prepared for NADA.

Figure 4: Work satisfaction levels of staff across NSW non government alcohol and other drugs sector



3.3.3 Responding to client need

Organisations have the capacity to work with clients presenting to AOD services with diverse, multiple and complex problems as a result of effective partnerships, skilled staff, and utilising evidence based approaches and appropriate tools. Many organisations have been able to demonstrate increased capacity to work with clients with co-existing mental health issues through results of the Dual Diagnosis Capability Audit Tool (DDCAT).

3.4 TRENDS AND EMERGING ISSUES

A 2009 ANCD research paper¹⁷ identified the following number of challenges faced by NGOs in the alcohol and other drugs sector and they are as pertinent today as ever:

- increased competition between NGOs for limited funding
- increased emphasis on business models that are sometimes in conflict with organisational values
- increased expectations around accountability, evaluation and organisational performance

- increased competition for skilled managers and other staff able to operate within the NGO sector
- evolution of large-scale consortia-based funding built on collaborative partnerships, and
- increased transference of risk management to NGOs from government.

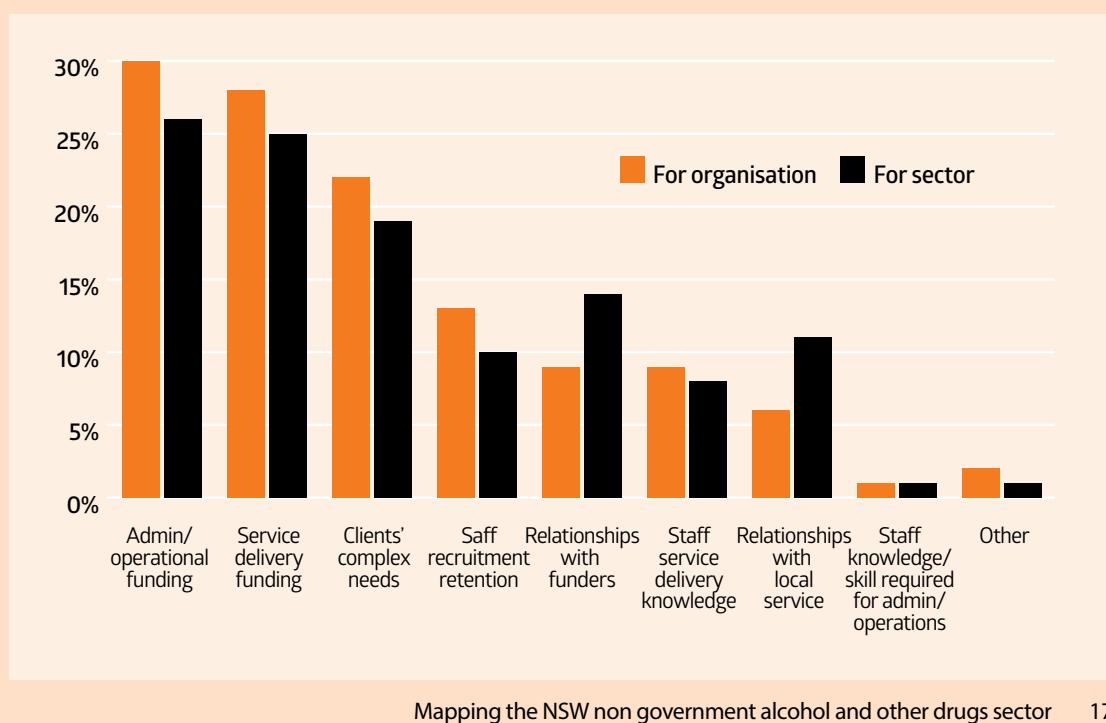
"In short, in order to remain viable all AOD services, regardless of size, need to operate in a competitive service-delivery model while maintaining the values that inform their practice." (page 1)

When asked to identify three main issues for their own organisation and the broader non government alcohol and other drugs sector over the next three years, organisations most commonly reported:

- 1 Adequate funding to meet administrative/operational costs
- 2 Adequate funding to meet client and community service delivery costs
- 3 Clients' complex needs.

¹⁷ Australian National Council on Drugs (ANCD) (2008). Non government organisations in the alcohol and other drugs sector: issues and options for sustainability. Canberra, ANCD.

Figure 5: Main issues for organisations and broader non government alcohol and other drugs sector over next three years



3.4.1 Funding

Since the inception of the National Campaign Against Drug Abuse in 1986 (now the National Drug Strategy), and the NSW Drug Summit in 1999, there have been large increases in funding to the alcohol and other drugs sector from the Australian and NSW Governments.

However, in the non government sector (and perhaps the public sector also) funding increases have not matched demand for services, increased costs of goods, services and utilities, reporting and compliance costs, and rising employee related expenses such salary, superannuation, and insurances. The 2009 Productivity Commission Report¹⁸ suggests government provides NGOs an average of 70% of the costs of contracted service delivery, leaving the organisation to make up the difference in any way possible, as well as meet overheads and staffing related costs.

Funding flows for alcohol and other drugs treatment services are highly complex, as demonstrated by the Drug Policy Modelling Program of NDARC¹⁹. Organisations unanimously report that funding has become complex in terms of the number of sources, how it is obtained, the administrative burden, varying contracting periods, and increased levels of performance reporting. Again the 2009 Productivity Commission Report pointed out:

"The efficiency and effectiveness of delivery of services by NFPs on behalf of governments is adversely affected by inadequate contracting processes. These include overly prescriptive requirements, increased micro management, requirements to return surplus funds, and inappropriately short-term contracts. Substantial reform of the ways in which governments' engage with and contract NFPs is urgently needed." (Page xxiv)

The majority of organisations across the NSW non government alcohol and other drugs sector report receiving grant funding from between one and three separate government agencies, often with several funding agreements/contracts with each one. In some cases, these separate funding arrangements are for the same service delivery (i.e. residential rehabilitation), but as the funds are from specific programs or 'buckets of money', a separate agreement/contract is implemented with varying time frames, performance indicators and reporting requirements. A number of organisations have contracts with between four and eight separate government agencies.

In recent years, government funding for the delivery of services to the community has been overshadowed by public sector and NGO funding reviews and reforms, both nationally and across states/territories. With over 80% of the NSW non government alcohol and other drugs sector in receipt of NSW Health funding, the two reviews of the NGO program since 2007 has created uncertainty at levels perhaps not previously experienced. These reviews, as well as a change in government, has NSW Health and NGOs in a cycle of short-term funding agreement/contracts whilst the reviews are completed and changes implemented; this is still the case at the time of writing this report.

There is no doubt that underfunding and inconsistent and poorly planned funding can impact on the quality and quantity of service delivery, capacity of organisations to plan and deliver needed services, and crucially, the ability to attract and retain already scarce appropriate staff.

3.4.2 Contracting and competition

Ironically, at a time of increasing need for collaboration between providers of health and social welfare services, government funders are moving away from NGO grant contribution and investment to market testing and competitive tendering. Whilst there are known benefits for competitive tendering in some areas of government purchasing, it is not appropriate for many health and social services as these require longer term funding commitments and certainty to bring about individual and community change.

The uncertainty of funding that comes with cyclical retendering is viewed as hindering the efficiency, effectiveness and development of the sector, and limits an organisation's ability to plan. In particular, it has an adverse effect on staff morale and the ability of organisations to attract and retain experienced professionals.

The NSW non government alcohol and other drugs sector argues that this specialist market is well known to government and does not need to be subjected to full scale contestability as it presents numerous risks for organisations, funders and clients. Significant investment by government over the past 15-20 years in infrastructure, organisational development and workforce may be lost through a competitive tendering process. Organisations express concern as to the potential 'splitting' of the sector that may come about from full scale contestable funding. Open market contestability allows for new service providers to compete for funding and there are potential benefits in this; however there are risks that providers without specialist skills and knowledge, and without connection to the clients/communities they are to serve, become providers

18 Productivity Commission 2010, Contribution of the Not-for-Profit Sector, Research Report, Canberra

19 Chalmers, J., Ritter, A. & Berends, L. (2013) Alcohol and other drug treatment financing in Australia – funding flows. Working Paper No 3 – Review of AOD prevention and treatment services. Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

of alcohol and other drugs services and clients receive substandard care. In addition there is the potential to homogenise the sector and reduce the diversity of service philosophy and approaches.

Many organisations cite recent negative experiences in responding to a specific Australian Government contestable tendering process for the delivery of alcohol and other drugs treatment services, where only those organisations with the best applications were awarded funding. For larger or otherwise fortunate organisations, they may have the capacity to employ skilled writers to submit funding applications. However, this does not take into account the demands and needs for a particular service and how individual organisations are providing effective services for highly disadvantaged and hard to reach communities/clients. There is clearly a need to support smaller and specialised services to undertake government tender processes.

Most of the non government alcohol and other drugs sector receives funding from multiple sources and need to do this to remain viable and sustainable. Likening the scenario to a house of cards, loss of one or two significant components of funding through a competitive tendering process equates to removing one of the bottom cards and the entire house collapsing.

3.4.3 Sector diversity and independence

"Besides delivering community services, not-for-profit organisations play a vital role in a healthy democracy by representing community interests."²⁰

Through the National Compact Working Together²¹, the Australian Government has acknowledged both the diversity of the not-for-profit as a strength and its independence as vital for a fair, inclusive society. It identifies a priority action to "protect the sector's right to advocacy irrespective of any funding relationship that might exist".

20 Whelan, J. (2012) Big Society and Australia. How the UK Government is dismantling the state and what it means for Australia. Centre for Policy Development. Accessed 25/02/2014 from <http://cpd.org.au>.

21 Commonwealth of Australia (2011) National Compact Working Together. ACT, Australia

An increasing number of factors have the potential to impinge on the broader non government sectors' independence. These factors are applicable to the NSW non government alcohol and other drugs sector:

- Decrease in 'untied' grant funds, increase in contracting for specific service delivery only, and increased compliance costs leaving little or no resources for representation and advocacy activity
- Competitive tendering environments can create reluctance in organisations to speak out or challenge public policy for fear of detrimental consequences
- Competitive tendering environments can inhibit collaboration and partnerships thus reducing organisations' collective capacity
- Contractual controls over advocacy and related activity, or 'gag clauses', as seen in some current Queensland funding agreements

The majority of health and welfare related NGOs have developed in response to community need; that is why they exist. However, increased 'contracting' or 'purchasing' of service delivery by government from the non government sector raises potential for independence to diminish, effecting a number of the sector's strengths such as flexibility, capacity to make decisions quickly, and adaptability.

3.4.4 Performance and accountability

Effective performance management between government funders and NGOs can be difficult; it appears there is some work yet to be done in getting the balance right between purposeful accountability and administrative burden, for both parties.

As registered not-for-profit organisations, the non government alcohol and other drugs sector adheres to its legislative requirements, recognising that overall this provides some level of surety for clients, community and funders. However, as reflected by the Productivity Commission in 2010²², organisations are frustrated that performance and accountability requirements placed on NGOs often do not appear to result in commensurate benefits, lack proportionality and do not necessarily improve

22 Productivity Commission 2010, Contribution of the Not-for-Profit Sector, Research Report, Canberra

outcomes for clients. Rather, the number and range of requirements can hinder service delivery due to time spent on administration instead of operations and service delivery. It has also been noted that the skills required for collating, analysing and reporting complex data may not always exist within organisations.

Broadly, organisations are supportive of a move away from inputs and outputs only reporting towards more outcome based performance reporting. As with many chronic health conditions, alcohol and other drugs service delivery outcomes are reliant on a number of factors, and caution must be applied when defining service delivery outcome expectations for the level of funding provided. Additionally, beneficial client outcomes are achieved from a range of interventions, multiple episodes, and even when a program is not completed, which must also be factored into the development of performance indicators. NADA has been actively supporting this through its work on the development of a standardised minimum set of outcome based key performance indicators (KPIs) and subsequent training package for specialist alcohol and other drugs NGOs that has been trialled and implemented with a number of NADA member organisations in late 2013 and early 2014. NADA has been advocating for streamlined and outcome based performance reporting with NSW Health since 2010²³. Working with MHDAO, a range of performance measures have been proposed for different alcohol and other drugs interventions, and it has been recommended that performance measures be used to evaluate grants over time and align to a broader goal or plan, such as a drug and alcohol strategy.

3.4.5 Working together

Organisations are generally well linked to other services in their local area; these relationships have developed over time to support shared clients. Challenges to maintaining these relationships include the geographic spread of NSW, particularly for rural and remote services, and little if any financial resources to support non clinical activities. All organisations across the sector indicate a critical need for resources that support them to further develop pathways for clients for continuing care and into other services as required. Initiatives such as the Commonwealths Improved Services Initiative which funded capacity building activity in the sector, including partnerships development has had a positive impact on the sectors ability to work together.

Relationships with Medicare Locals vary widely across the State, with the sector reporting some Medicare Locals prioritising engagement with community services, while others are not developed sufficiently to do so or clearly not interested in doing so. The previous entity GP NSW was seen as an effective mechanism to highlight alcohol and other drugs (and mental health) issues with GPs and to facilitate relationship development with General Practice. The loss of this state-based organisation is seen to have disrupted coordination of some programs and communications between GPs and the community service organisations. It is unclear at this stage what the impact of the change to Primary Health Networks will be.

Difficulty engaging with and accessing public mental health services, particularly psychiatry, remains an issue for non government alcohol and other drugs organisations and their clients, often having a detrimental impact on a client's ability to improve their health and wellbeing.

A small number of organisations reported they had extremely effective working relationships with the Local Health District in which they reside. This was more often than not due to the commitment of individuals and the LHD drug and alcohol team rather than any policy or systemic set-up.

3.4.6 Client complexities

Across the sector, client complexity has been identified as one of the main issues in the coming years for both individual organisations and the broader alcohol and other drugs sector. The main complexities reported are that clients present with are high levels of anxiety and/or depression, homelessness (or risk of), and recent release from prison. In addition, changing patterns of drug use, including increase in methamphetamine and new psychoactive substances, have been identified as areas of concern by some organisations.

3.4.7 Workforce

A supply of appropriately skilled, qualified, supervised and supported staff is an important prerequisite to providing quality care. The survey data collected and analysed for the Mapping Project indicated that the total NGO AOD workforce in NSW is approximately 1,000 staff. A third of all permanent full time staff surveyed employed as Alcohol and Other Drugs Workers earning less than \$50,000. Those consulted believed that funding level was the main barrier to increasing the proportion of the workforce with specialist tertiary qualifications.

23 NADA 2010, Discussion Paper: Performance Management between Drug and Alcohol NGOs and NSW Health, available at www.nada.org.au

3.5 PEAK BODIES – THE ROLE OF NADA

Peak bodies (also known as 'umbrella organisations' or 'intermediary bodies' internationally) have several definitions in Australia, including:

An organisation ... with other organisations as members formed to represent the collective views of its members to government, to the community and to other bodies. (Hamilton and Barwick 1993, p.17)

A peak council is a representative organisation that provides information dissemination services, membership support, coordination, advocacy and representation, and research and policy development services for its members and other interested groups. (Industry Commission, 1995, p.181)

A "peak body" is a non-government organisation whose membership consists of smaller organisations of allied interests. The peak body thus offers a strong voice for the specific community sector in the areas of lobbying government, community education and information sharing between member groups and interested parties. (Melville & Perkins 2003, p. ix)²⁴

Literature that discusses Australian peak bodies in the health and community services sector, generally describe core roles and responsibilities as:

- Policy development and advice
- Sector advocacy and representation
- Information dissemination
- Sector consultation and coordination
- Promoting and facilitating partnerships
- Sector capacity building
- Research.

The Productivity Commission Research Report 'Contribution of the Not-for-Profit Sector' (2010) highlights the role not-for-profits (NFPs) play in influencing public policy through advocacy. Peak bodies can facilitate contribution from a wide sector that has 'on the ground' knowledge and experience, thus providing analysis and expertise on what may or may not work, what the current

issues are and how to best implement policy change. Additionally, peak bodies support organisations to undertake activities and provide the services for which they are funded by government to do.

The Productivity Commission Report recommends governments review their support for sector development and strengthen strategic focus, including on:

- "developing the sustainable use of intermediaries providing support services to the sector, including in information technology
- improving knowledge of, and the capacity to meet, the governance requirements for not-for-profits organisations' boards and management
- building skills in evaluation and risk management, with a priority for those not-for-profit organisations engaged in delivery of government funded services". (Recommendation 9.2).

Capacity building may be described as actions that support organisations to become stronger, more responsive and effective service delivery organisations. Sustained capacity building requires an enduring relationship of trust, communication and united sense of purpose. Peak bodies are able to develop those relationships with members and are therefore ideally placed to deliver capacity building initiatives.

A Stanford Social Innovation Review²⁵, makes reference to 'backbone support organisations':

"Creating and managing collective impact requires a separate organisation and staff with a very specific set of skills to serve as the backbone for the entire initiative. Coordination takes time and none of the participating organisations has time to spare. The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails."

²⁴ Referenced in Strickland , M. and Goodes, K. (2008) Review of Tasmanian DHHS-Funded Peak Bodies and the Development of a Peak Body Strategic Framework, p. 26

²⁵ Kania, J. and Kramer, M. (2011) Collective Impact. Stanford Social Innovation Review, Winter 2011

Direct service delivery work is obviously of critical importance, however policy, expert advice, advocacy, information exchange and capacity building is also important in achieving good health and welfare outcomes with clients and communities. Peak bodies are ideally placed to undertake these roles, as direct service delivery organisations do not always have capacity to engage or lead policy, expert advice, advocacy, information exchange and capacity building work, particularly in drawing together the bigger picture or representative views. This work supports broader NSW Health endeavours by contributing to planning, communicating directions and practice, and developing partnerships with government and other service providers. In regard to funding, a review of a human service funded peak bodies in Tasmania²⁶ suggests minimum peak funding should be provided for core functions with negotiated additional funding for non-core functions. The funding of core functions should take into account staffing requirements, administration and operational expenses. Non-core function funding may be provided under separate agreements for specific projects which are focused on a particular need and time limited.

3.5.1 NADA: representing the NSW non government AOD sector

NADA has existed for over 30 years, providing a networking and representative function for the sector that has resulted in a well-defined, interconnected system of service delivery organisations. NADA has provided leadership for the sector in terms of organisation, service and workforce development, research, quality improvement, data management and client outcome related performance reporting. NADA has been central to NSW Health's role in planning and funding for the NGO specialty sector and for the integration of the NGO sector as a core component of the State's alcohol and other drugs service system.

In 2007, NADA developed specific NSW Health service guidelines for residential rehabilitation treatment that sit amongst the alcohol and other drugs treatment service guidelines of NSW Health, and are cited in national and international frameworks. NADA developed and implemented the AODTS-NMDS data base service for the specialist AOD treatment NGOs in NSW. NADA provides training, data collection and reporting assistance to NGOs and has recently added a client outcomes data base to assist NGOs to collect non mandatory client treatment outcomes data. Both these data base services have assisted members to increase their capacity for essential client data collection and reporting.

NADA's main activities are representing and advocating on behalf of the sector and developing partnerships with government, funding bodies, other community services sectors, quality improvement service providers, education and training and advisory bodies, research bodies and the media. NADA also manages a range of projects that strengthen agencies to be sustainable, appropriately resourced and able to deliver quality services to those affected by drugs and alcohol. Effectively, NADA acts as a specialist network of the professional NGO AOD sector.

"NADA continues to be a leader in sector development and advocacy! A great leader in lessening the impact of drugs and alcohol on our community!"

2014 Member Survey

"Good leadership and solid governance. Experienced. Very knowledgeable about the sector."

2014 Stakeholder Survey

3.5.3 NADA's current role in supporting the sector

The sector were overwhelmingly positive about the role of NADA in supporting their organisations and the AOD NGO sector as a whole. Consultation respondents frequently referred to the moral support and guidance provided by NADA in relation to organisations' issues, dilemmas and funding.

NADA's role in promoting the sector was seen favourably, and respondents often referred to the positive work NADA does in advocating on their behalf. NADA staff were perceived to be effective communicators who provided organisations with information and feedback about current activity and discussions at the political level.

NADA's role in the training and education of the sector was viewed as vital, particularly NADA's training grants and efforts towards up-skilling the workforce. The support provided by NADA around data and data systems, including the development of the Client Outcomes Management System (COMS), has been very useful for organisations.

The role of NADA in supporting organisations through accreditation was also rated highly. NADA's work assisting smaller organisations with managing financial agreements and providing a level of support and infrastructure was well received. NADA's Complex Needs Practice Enhancement Program was praised, as was its support for services conducting research on their activities and practices.

26 Strickland, M. & Goodes, K. (3p Consulting). (2008). Review of Tasmanian DHHS Funded Peak Bodies and the Development of a Peak Body Strategic Framework. Office for the Community Sector, Department of Health and Human Services.

3.5.2 NADA activity

Sector development

Develop sector knowledge:

- Information collation and dissemination (e.g. regular Member Email Update, quarterly newsletter - *The NADA Advocate*)
- Research capacity building activities
- Facilitate and host networking and knowledge sharing events
- Host an annual program of training, forums and conferences
- Develop and disseminate training tools and information resources
- Act as communication channel between organisations and funders

Develop organisational governance, management and service delivery:

- Support quality improvement practice and accreditation (e.g. partner with quality improvement program providers, develop information and practical resources)
- Develop and deliver information management and information technology programs to support organisation data collection and reporting (e.g. host on-line database for member's mandatory data collection)
- Targeted member support for service planning and performance reporting (individual training and workshops)
- Promote and support evaluation practices
- Develop governance and management knowledge and practice (e.g. NADA Governance Toolkit and NADA Policy Toolkit)

Develop workforce capacity:

- Workforce development analysis and reporting (e.g. workforce profiles, training needs)
- Develop resources and tools to support knowledge, skill and practice
- Run a workforce development training grants program for members
- Facilitate workforce training with specialist providers
- Develop and deliver issues specific training
- Develop and contribute to training and education packages

Policy, advocacy and representation

- Provide informed and expert advice to key government and stakeholder organisations regarding issues impacting on the sector, service delivery issues, the service system, health reform and the community
- Participate on formal reference groups, meetings, consultations and policy submissions
- Research and analysis of the sector to inform policy, program and project development
- Member and stakeholder consultation.

Organisations are pleased with the work done by NADA to create networks and collaborations between services, particularly amongst those that provide for similar client groups. A respondent from a youth service reflected on NADA's role in setting up a network for

youth-focused AOD NGOs, which has provided a voice in lobbying for youth issues that often get overshadowed by broader AOD issues. Similar comments were made about NADA's role in developing the network of women's organisations.

These networks facilitate the sharing of ideas between services, increase referrals, and can assist in reducing duplication. For example, discussion through the women's network led to a successful NADA funding proposal to pilot projects in identified areas of need in specialist Women's and women with children's organisations across NSW. The work being done by the women's network and the specialist pilot projects has been an important inroad in assisting the federal and state health departments to the resourcing issue and the need for support to develop specific residential services for Aboriginal women and their children, for day program and pre and post treatment support for women, and women with children.

3.5.4 NADA's role in the future

The sector believe that although it is already done to an extent, NADA could increase the level of conversation at the political level. NADA could assist with the new funding procedures and keep members updated, which will aid managers in answering the queries posed to them by their anxious staff. NADA could also provide further guidance for organisations about how to access funding.

Some in the sector believe that NADA could do more to lobby for funding, including lobbying to funding bodies to assist in covering the increases in wages to allow employees to be fitted at the appropriate award. They believed it would be beneficial if NADA consulted with organisations on a yearly basis to check how organisations are coping with wage/award increases.

Reporting compliance was also an issue that the sector felt that NADA could help by highlighting to government that the increased requirements for reporting and administration impacts on the provision of service, by taking away from services' time and resources that should be spent improving client outcomes.

NADA encourages organisations to work together, and members would like them to continue to assist the sector in working together as a community of services. They suggested that NADA might be well placed to help develop a Chief Executive Officer and manager forum to allow for confidential discussion around strategies and solutions to problems that organisations have found to help, such as what retains employees, what fringe benefits are offered and what supervision is provided to staff.

Discussions at consultation workshops suggested the possibility of having a liaison staffing position, perhaps situated at NADA, who could work with organisations. The liaison could conduct audits of organisations to ensure they are culturally appropriate, make links to services, and provide guidance on best practice. Respondents also thought NADA should conduct site visits to organisations to explain how new resources work and to provide assistance implementing them.

Respondents from rural and regional services noted that it is difficult for them and their staff to attend training sessions in Sydney due to the time and costs associated with travel and staff backfill. Additionally, organisations reported that they would like to receive professionalised training focused on the process of tendering.

The recent Grants Management Improvement Program Taskforce review of the NGO grants program had proposed a recommendation that a flexible approach to funding models in the new contracts administration system, including: "That NSW Health consider the option of contracting with a Peak/state-wide organisation(s) for the management of a whole program area which would be delivered by that Peak organisations constituent members". NADA members have supported the proposal for NADA to have an active role in the contract administration for the new grants system under the Partnerships for Health NGO Grant Program review. This initiative would see NADA manage the electronic performance reporting reporting system for the new contracts on behalf of MHDAO and the LHDs for AOD NGOs funded under the new grants scheme. NADA and its members believe that this approach will have a beneficial effect on the effective administration of NGO performance reporting and support good contract management by the NSW Ministry of Health.

4. ORGANISATIONAL PROFILE

4. ORGANISATIONAL PROFILE

The NSW non government alcohol and other drugs sector is a key player in reducing alcohol and drug related harms to individuals, families and communities.

This section presents an analysis of the data provided in June 2013 by 40 of the 57 NADA in-scope organisations, representing 70% of in-scope organisations.

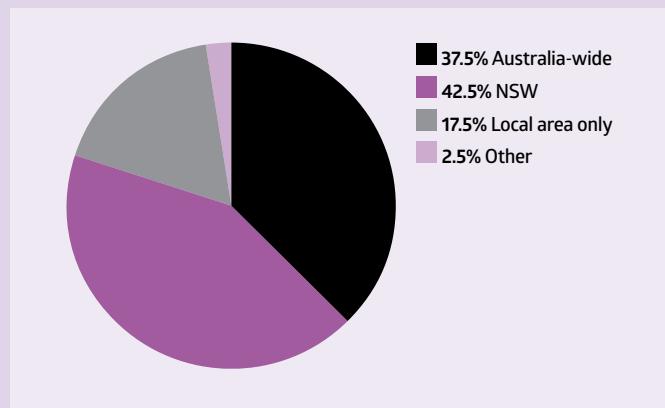
4.1 CLIENT AND COMMUNITY SERVICE DELIVERY

4.1.1 Service demand and access

The majority of organisations offer services to clients living or coming from anywhere in NSW or Australia (80%). Although 85% receive funding contribution from NSW Health and therefore have administrative ties to a specific NSW Health Local Health District (LHD), their service delivery reach is not constrained by those LHD boundaries.

80% of organisations report a changing pattern in demand for services over the past five years, most commonly that demand had increased. A small number indicated their client base had doubled over the past 5-7 years, with another organisation reporting an increase of 10-15% per year.

Figure 6: Organisations reported where clients live and/or come from to access services



One third of organisations provide services from three or more fixed sites, thereby increasing accessibility for a large number of clients. 60% operate from a single site, mainly those providing residential rehabilitation services.

Over 60% of organisations provide services through outreach.

Challenges to service access

Organisations report the three main difficulties clients experience in accessing their service/program as being:

- Wait time too long (47.5%)
- Distance and travel requirements (37.5%)
- Language and/or cultural barriers (32.5%)

85% of organisations manage a client waiting list with an average waiting period before entering the service being 2-4 weeks. On any given day, the average number of clients on an organisation's waiting list is 6 to 15 clients. Participants in sector and stakeholder consultations acknowledge that lengthy waiting lists make it difficult for clients to access a program, affecting their motivation and becoming despondent if they cannot see a counsellor or enter other treatment quickly.

There is some acknowledgement that the alcohol and other drugs sector broadly does not engage people from a culturally and linguistically diverse (CALD) background very well. There is currently only one specialist alcohol and other drugs services that is funded to work specifically with (CALD) populations. The Drug and Alcohol Multicultural Education Centre (DAMEC) has undertaken significant research that supports that there is poor engagement of CALD clients. Where clients are not accepted into a treatment program, the most common reason given by organisations was that the client requires drug and/or alcohol withdrawal (all but one of these organisations are primarily providing a residential rehabilitation service).

Table 1: Most common reasons clients are not accepted into a treatment program

Reason for not being accepted into service/program	%*
Client requires prior drug/alcohol withdrawal management	47.5
Poor program fit	42.5
Out of age range criteria	32.5
Other	22.5
Unable to complete waiting list requirements (i.e. maintain phone contact)	20
Cognitive impairment	17.5
Out of area with no transport available	15
Mental health issues	15
Physical health issues	10
Client coming directly from prison	10

Organisations were able to select more than one option

4.1.2 Services provided

NSW non government alcohol and other drugs specialist organisations are providing a full range of individual, family and community services, ranging from health promotion, community development, counselling, withdrawal management, residential rehabilitation and continuing care. A number of these organisations are providing innovative services; for example, methadone to abstinence and methadone stabilisation as part of a residential rehabilitation program, capacity building of Aboriginal controlled organisations in rural NSW, and services to people with cognitive impairment.

In addition to a noticeable increase in demand for services over the past 5 years, organisations report clients are presenting with increased complexity of issues, particularly coexisting mental health issues, and younger clients are requiring alcohol and other drugs specific services.

Over 75% of non government alcohol and other drugs specialist organisations primarily provide services to adult men and women, some of this service provision is for women only and some for men only.

Table 3 is not representative of the number of 'beds' available for men and women accessing residential treatment. Residential treatment options/beds for men far out weigh residential treatment options for women.

Table 3: Primary client group

Client group	% of organisations	
	#	%
Men and women over 18 years	47.5%	
Women only over 18 years	17.5%	
Young people and young adults	15%	
Men only over 18 years	12.5%	
Whole of community	5%	
Other	2.5%	

Table 2: Services provided by NSW non government alcohol and other drugs specialist organisations (n=40)

Sector taxonomy service intensity and level		Service type	Organisations providing the service	
#	%			
Low	Harm reduction	Needle and syringe program	3	7.5
		Information and education	25	62.5
Medium	Health promotion and harm prevention	Information and education	29	72.5
		Community development program	16	40
High	Treatment	Psychosocial – counselling	31	77.5
		Case management	33	82.5
		Withdrawal management – out client/out-patient – with medication	2	5
		Withdrawal management – residential – with medication	7	17.5
		Withdrawal management – residential – without medication	6	15
		Rehabilitation day program – 25 days	1	2.5
		Rehabilitation day program – 26 days or more	7	17.5
		Residential rehabilitation – 8 week stay	6	15
		Residential rehabilitation – 13 week stay	13	32.5
		Residential rehabilitation – 26 week stay	13	32.5
		Residential rehabilitation – therapeutic community	15	37.5
		Opioid maintenance treatment	5	12.5
High +	Treatment +	Residential rehabilitation – methadone to abstinence	4	10
		Residential rehabilitation – methadone stabilisation	5	12.5
Medium	Extended and continuing care	Supported living/transitional housing program	14	35
		Psychosocial – aftercare program / continuing care program	25	62.5

75% of organisations provide services to clients with mild to moderate mental health issues, with 40% reporting that they work with clients who have severe and persistent mental health issues.

Table 4: Specific client groups

Specific client groups	n	%*
Clients with mild to moderate mental health issues	30	75.0
Clients identifying as Aboriginal and/or Torres Strait Islander	26	65.0
Clients connected with the criminal justice system	25	62.5
Family groups and/or family members	23	57.5
Clients from culturally and linguistically diverse backgrounds	16	40.0
Clients with severe and persistent mental health issues	16	40.0
Clients aged 55 years and over	15	37.5
Women with dependent children	13	32.5
Other	11	27.5
Parents with dependent children	10	25.0

*Organisations were able to select more than one option

Health promotion and harm prevention

64% of organisations indicate they provide alcohol and other drugs health promotion and harm prevention through education and/or community development programs, with the most common activity being programs with school students, reaching an estimated number of 10,343 people per year.

Table 5: Estimated community reach for health promotion and harm prevention activities

Health promotion and harm prevention activity	Estimated community reach (no. people per year)
Programs with school students	10,343
Specified programs for young people, such as workshops, presentations, University visits	2,000
Specific community health promotion and education activities	2,400
Other activities: including open days or tours of services, program for drop-in clients	4,015

Opioid treatment programs

Just over 10% of organisations are currently providing opioid treatment (methadone or buprenorphine) as part of a broader treatment program, most commonly delivered by residential rehabilitation services.

Additionally, over half of all organisations provide services to clients already engaged in an opioid treatment program (methadone or buprenorphine) elsewhere. This indicated considerable and generally unfunded treatment activity to OTP clients across our sector.

Nicotine/tobacco cessation strategies

87% of organisations provide clients with specific nicotine/tobacco cessation strategies and programs; pharmacotherapy interventions being the most common type (55% of all organisations).

Table 6: Nicotine/tobacco cessation strategies and programs

Nicotine/tobacco cessation strategy/program	% organisations*
Pharmacotherapy, e.g. nicotine replacement or bupropion sustained release tablets	55%
Individual counselling	42.5%
Smoke-free environment	35%
Group program	25%
Other: including facilitating services from external providers, developing and distributing smoking cessation kits	15%
None provided	12.5%

*Organisations generally provide a combination of strategies and programs.

Gambling programs

Over 50% of organisations provide gambling programs for clients. Most commonly, this is provided through individual counselling and group programs.

Table 7: Gambling programs provided by organisations

Gambling program	% organisations*
Individual counselling	42.5%
Group program	27.5%
Other: including residential program, family support	20%
None provided	42.5%

*Organisations generally provide a combination of programs

Coordinated client care

Many organisations have established formal arrangements with other providers in order to better respond in a client related emergency / crisis situation, such as a client needing urgent medical or hospital care for a physical or mental health condition. These arrangements include memorandum of understandings (MOU) for client access to allied health and mental health services, emergency accommodation in unplanned client discharge situations, and agreed procedures for arranging client transport to hospital.

Service gaps

Organisations most frequently report the service type that is critically needed in their area is residential withdrawal management with medication (23%) and other withdrawal management types. Accessing existing withdrawal management is problematic for clients and referring organisations due to waiting times and distance required to travel to the service. Additionally, specific withdrawal management services for young people have been identified as a need. Many organisations not currently providing withdrawal management indicate this is a gap in their own service delivery; however they require additional resources to provide this service.

Supported living/transitional housing programs are also identified as a critical need (15%), as is additional methadone to abstinence residential services (10%) and aftercare/continuing care programs (10%).

Whilst there are approximately five targeted residential programs for women and their dependent children, fewer organisations are able to address alcohol and other drugs use and family dynamics with both parents and their children in a residential setting. This has an impact on a parent's access and retention in a drug/ alcohol treatment program. Often, resources are not available to organisations to cover costs of childcare services, a child friendly and safe environment, and much needed services for the child. It should be noted that there are no specific residential alcohol and other drugs services for Aboriginal women with or without children, and that this is a definite service gap.

Many organisations report it is difficult to facilitate access to GPs and psychologists willing to work with their clients with alcohol and other drugs issues, as well as limited availability of public psychiatry.

Table 8: Main external services facilitated for clients whilst in care/treatment

External service	% of organisations*
Mental health	72.5
Medical/physical health	67.5
Accommodation/housing	42.5
Legal	27.5
Child connection (Community Services)	27.5
Cognitive assessment/review	17.5
Employment	17.5
Family related	17.5
Other: including additional alcohol and other drugs treatment, welfare related services, education and training.	10.0
Parenting program/support	7.5

*Organisations identified the three main services facilitated

4.1.3 Client population

Client population accessing treatment

All non government organisations providing specialist alcohol and other drugs treatment are required to provide Alcohol and Other Drug Treatment Service Minimum Data Set (MDS) data as a government requirement. MDS data provides a descriptive snapshot of the client population accessing treatment, based around Service Episodes – defined as a treatment process, with defined dates of commencement and cessation.

In the 2012/13 financial year among those member organisations included in the NADA Sector Mapping Project, over 9600 episodes of treatment were provided to the NSW public – of which 96% was for those concerned about their own drug use. Interestingly, the proportion of episodes for those seeking treatment in relation to their own drug use captured for this sector mapping report

matches exactly with that reported at a national level (96%).²⁷ Overall, those accessing alcohol and other drug treatment were more likely to be male (67%), between 19 and 39 years of age (63%) and non-Indigenous (80%). Again, the client profile presented for those seeking treatment from the services involved in this Sector Mapping Project are representative of the same profile seen at a national level – that being male (68%), between 20-39 years of age (57%) and non-indigenous (79%). Referrals into treatment came from a range of sources, however, self-referrals made up 38% with a higher proportion of the main treatment provided being community based (63%) rather than residential (36%). In relation to source of referral and main treatment type the sector mapping data accords with data collected nationally in the same timeframe²⁷. A significant proportion of all treatment episodes occurring in 2012/13 related to concerns around alcohol use (37%), which is also in keeping with data available at a national level (41%). While, amphetamines (including methamphetamine) (22%) and cannabis (18%) were nominated as the second and third highest principle drugs of concern. Interestingly, alcohol also featured among the top most identified "Other drug of concern" along with nicotine, cannabis and amphetamines (including methamphetamine) – in both sector mapping and national data collections.

Figure 7: NSW NGO clients by sex (%), 2012-13

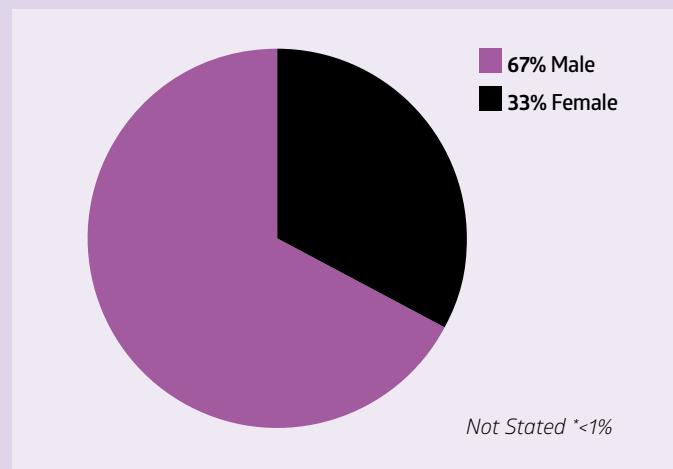
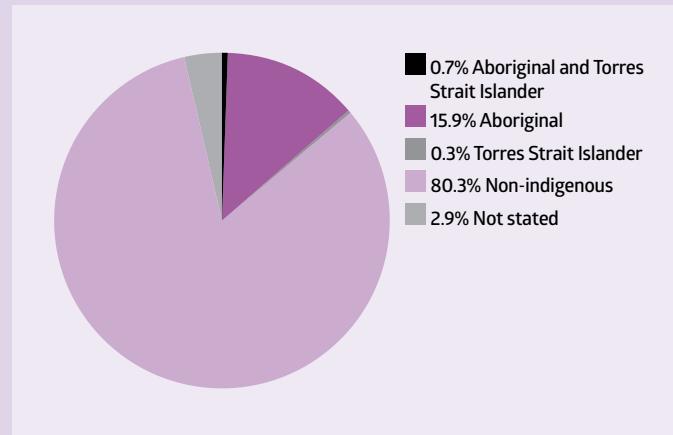


Figure 8: NSW NGO clients by Indigenous status (%), 2012-13



²⁷ Australian Institute of Health and Welfare 2014. Alcohol and other drug treatment services in Australia 2012–13. Drug treatment series 24. Cat. no. HSE 150. Canberra: AIHW

Figure 9: NSW NGO clients by age group (closed episodes), 2012-13



Client drug and alcohol use

According to member feedback, over three quarters of the sector report noticing a changing pattern in clients' drug use in the past five years. Namely an increase in meth/amphetamine use, and increase in alcohol use, and recently an increase in use of new and emerging psychoactive substances. The latter is difficult to quantify as the AODTS MDS does not routinely capture this data.

Generally heroin use is seen to be reducing, while organisations report seeing a greater number of clients using oxycodone (specifically OxyContin), in line with reports from the Illicit Drug Trends Reporting System.

Organisations also report clients are using multiple substances problematically, with one respondent noting this needs "a more integrated approach to treatment". A number of organisations indicate they are presented with issues relating to older people and drug/alcohol use, including interactions with medication, chronic physical health conditions, falls, long histories of prescribed drug misuse (particularly for women), and disabilities.

The sector and stakeholders indicate that over the last 10 years, organisations are responding to multigenerational effects of drug and alcohol use and dependence – grandparents, parents and their children.

Figure 10: NSW NGO closed episodes by principal and other drug of concern, 2012-13

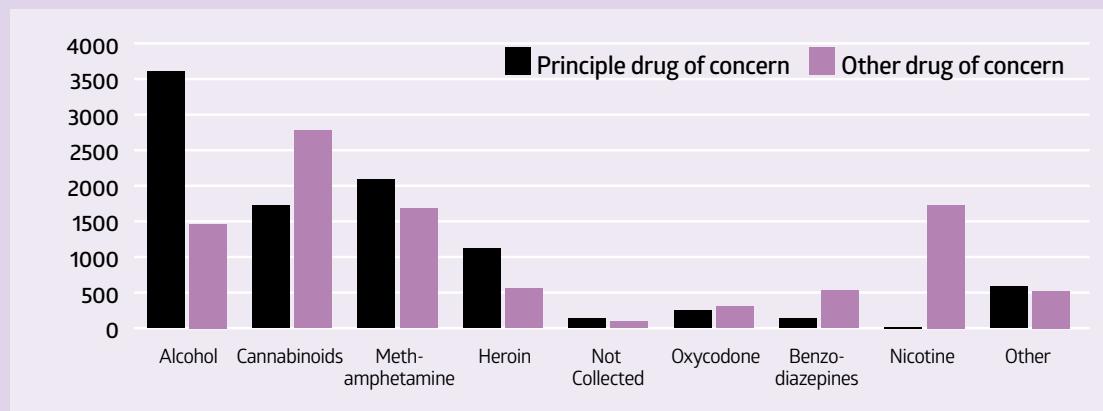


Table 9: NSW NGO closed episodes by main referral source, 2012–13

Source of Referral	Count	Percent
Self	3653	37.8
Other criminal justice setting	1073	
Family member/friend	918	9.5
Non-residential AOD treatment agency	840	8.7
Residential AOD treatment agency	745	7.7
Court diversion	598	6.2
Other	269	2.8
Other non-health service agency	202	2.09

**Those 1% or less have not been included*

Client complexities

Across the sector, 'client's complex needs' has been identified as one of the three main issues in the coming years for both individual organisations and the broader alcohol and other drugs sector (in addition to resourcing and costs issues).

In addition to drug and alcohol use, organisations indicated the three main complexities that their clients present with are anxiety and/or depression, homelessness (or risk of), and recent release from prison.

Whilst organisations report an increase in client numbers with coexisting mental health issues and a broader spectrum of mental health issues presented by clients, they also acknowledge an increased capacity across the sector to identify and respond to these issues. Overwhelmingly, organisations called for a greater recognition of the impact of trauma on drug and alcohol use and the additional complexity this adds to implementing treatment programs and the professional skills required across the sector.

Funding programs often do not recognise this aspect of service delivery.

Organisations report women with current or previous domestic violence are a highly vulnerable and difficult to engage client group - reluctant to access some alcohol and other drugs services where there might be issues around power, and fearful of their perpetrator knowing they are accessing a service.

Although ageing related health issues is not considered to be a complexity in a high number of presenting clients, organisations indicate this is an evolving issue. This client group, some of whom have not had previous contact with alcohol and other drugs services, are experiencing physical effects of ageing as well as mental illness, intellectual disability, chronic disease, and effects of often long term drug and alcohol use. Some organisations suggest that clients with mobility issues may not be accessing alcohol and other drugs treatment services as many buildings do not have adequate disability access.

In reference to clients with cognitive impairment, organisations are challenged to adapt their programs to ensure access and engagement. However, due to difficulties in facilitating services for this client group as part of a case management approach, some organisations and staff often work beyond their expertise to address client's needs.

4.1.4 Research activity

Almost half of the sector (46%) partners with research institutions for research activities and over half of the sector (54%) undertake independent research activities (in addition to service/program evaluation), providing a significant contribution to the evidence base of what works.

An example of such an investment is the Community Mental Health and Drug and Alcohol Research Network (CMHDARN) led by NADA and the Mental Health Coordinating Council (MHCC). NSW Health commenced fund this research sector development program in 2007, initially as a Research Grant Program that further developed research capacity in the

Table 10: Main complexities clients present with

Presenting complexity	%* of organisations reporting
Anxiety and/or depression	72.5%
Homelessness or risk of	42.5%
Recent release from prison	40%
Child risk of harm concerns/involvement with Community Services	22.5%
Child and/or adult sexual assault	22.5%
Personality spectrum disorder	22.5%
Domestic violence	17.5%
Bipolar or schizophrenia	17.5%
Other trauma: including loss and grief, recent suicide attempts, post-traumatic stress disorder	12.5%
Physical health	10%
Other: including other legal issues, entrenched poverty and family problems	10%
Low literacy skills	7.5%
Acquired brain injury	7.5%

*Organisations identified up to three main complexities

sector, fostered service provider and research institute partnerships, and resulted in a body of quality research relevant to community based organisations and the broader mental health and AOD sectors. The Research Network now aims to broaden involvement of alcohol and other drugs and mental health community organisations in practice-based research, to promote the value of research, and to increase the application of research evidence to everyday practice. Activities include reflective practice webinars, research forums, mentoring, and research practice resource development.

Summary of key achievements

- CMHDARN currently has 234 members, with over 2,500 people having accessed the website since September 2012.
- Sixteen research projects were funded through the CMHDARN Research Seeding Grants Program. Organisations reported achievements such as: the development of research capacity and knowledge; changes to service delivery; enhanced relationships with academics; and insight gained into the roles and benefits of consumer participation in research. The grants resulted in 5 published papers and 13 conference presentations reporting on outcomes of the projects.
- NADA, MHCC and the NHMRC Centre for Research Excellence in Mental Health and Substance Use (CREMs) have signed an MOU to offer research mentoring to workers based in NGOs through the CMHDARN Community Research Mentoring Project.
- Forty five academics from eleven universities have supported the CMHDARN activity over the last three years through a range of methods.
- CMHDARN received a Certificate of Commendation in the category of Cross Sector Collaboration at the Mental Health Matters Awards 2013, and more recently the Tom Trauer Research and Evaluation Award at the 2014 TheMHS Conference.



The NSW Mental Health Commission is now a key partner of the research network, which is continuing to provide a much needed connection between both the mental health and alcohol and other drugs sectors in NSW. NADA, MHCC and the Commission are currently working together to fully embed research partnerships and practitioner led research as part of the core activity of both sectors.

It is clear that the non government alcohol and other drugs sector has much to contribute in the way of effective practice and responding to clients and communities with drug and alcohol problems. Organisations develop partnerships that enable the understanding and sharing of practice wisdom with the primary focus on reducing drug and alcohol related harms for individuals, families and communities.

4.2 GOVERNANCE AND OPERATIONS

4.2.1 Corporation / legal registration of organisations

Approximately half of the specialist NGO AOD sector is legally registered as an Incorporated Association.

Figure 11: Legal status of organisations



4.2.2 Income and expenditure

Annual operating costs

In the 2012/13 financial year, 50% of organisations indicate their operating budget is \$1M or less.

75% of the NGO sector have an overall operational budget of \$2M or less, highlighting that the sector is predominately made up of small to medium size organisations providing specific alcohol and other drug services. There are few organisations that are appropriately resourced to provide a range of interventions and treatment settings to holistically respond to meet client need across a continuum of care. Most organisations in the sector have established strong partnerships with other organisations to ensure appropriate support is provided.

Table 11: Organisation's operating costs for the 2012-13 financial year

Annual operating costs	% of organisations
Up to \$300,000	12.5%
\$300,000 to \$1M	37.5%
\$1M-\$2M	25%
\$2M-\$4M	15%
Over \$4M	10%

Annual expense allocation

In line with all human services industries, an organisation's main operating expense is staff salaries at an average of 68% of all costs.

Table 13: Organisation's expense allocation for the 2012-13 financial year

Funding allocation	Average %*
Staff salaries (wages and on-costs)	68
Facilities, equipment, infrastructure, vehicles, maintenance	9
Administration and compliance	8
Client and community service delivery: resource production, program delivery, client costs, etc.	8
Staff professional development: training, education, supervision, etc.	4
Other: including fundraising expenses, marketing	1

*Averages calculated across organisations per row, therefore do not add up to 100%

Income sources

Almost all organisations receive income from multiple sources. The most common income source is NSW Health, with 82.5% receiving funds from multiple budget codes from within the NSW Health alcohol and other drugs budget. The second and third most common income sources are the Commonwealth Department of Health and client contribution.

Table 12: Organisation's income sources for 2012-13 financial year

Source	% of organisations receiving funding	Average proportion of organisation's total funding (%)
NSW State Government – NSW Health	82.5	52
Commonwealth Department of Health	62.5	33
Client contribution	55	14
Other*	52.5	15
Fundraising and donations	42.5	21
NSW State Government – Family and Community Services	15.0	30
NSW State Government – Other**	10.0	31
Commonwealth Government – Other***	10.0	28
NSW State Government – Corrective Services	5.0	20
Local Government	2.5	5
Medicare payments	2.5	1

* Primarily private companies and clubs.

** Including Office of Liquor, Gaming and Racing, Department of Attorney General and Justice.

*** Including Department of Social Services

4.2.3 Infrastructure and equipment

A large part of the sector (over one third) report their buildings and facilities for organisation administration is currently inadequate.

Insufficient space for staff, and buildings in constant need of maintenance and repair without funds to undertake the work, are the most commonly cited issues.

40% of organisations report their current building and facilities for client and community service delivery to be inadequate. Again, a common issue is the need for maintenance, repair and upgrade without sufficient resources. Additional issues include the lack of suitable premises within budget, demand for service always outstrips availability, appropriate and respectful premises to deliver treatment such as individual or twin share client bedrooms for residential services, and sufficient space for varying client interventions such as individual and group counselling, family programs and child care.

As noted previously, organisations identify the three main issues over the next three years for both their own organisation and the broader non government alcohol and other drugs sector as:

- 1 Adequate funding to meet administrative/operational costs
- 2 Adequate funding to meet client and community service delivery costs
- 3 Clients' complex needs.

The majority of organisations indicate their anticipated infrastructure and resources over the next three years will be inadequate to meet operational and service delivery needs.

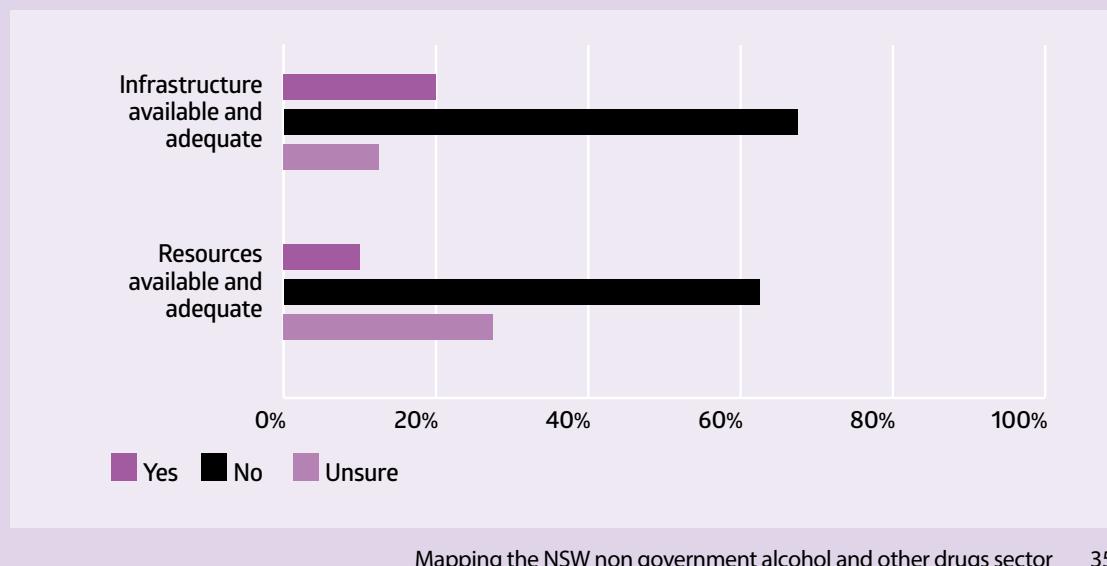
4.2.4 Quality improvement and accreditation

The majority (90%) of the NSW non government alcohol and other drugs sector are engaged in a formal quality improvement (QI) program with an external accrediting body. Two thirds (67%) of the sector currently hold accreditation against quality standards, with many in their second or third 3-4 year cycle, demonstrating an ongoing commitment to improvement and quality service provision.

Almost half of organisations are members of the Australian Council on Healthcare Standards (ACHS) undertaking the EQuIP Standards and almost half are members of Quality Innovation Performance (QIP) undertaking a range of standards – ASES, Health and Community Services Standards, ISO 9001. A small number of organisations are undertaking accreditation with other providers.

A significant issue for the sector is the requirement to comply with multiple sets of standards, up to four for some organisations, even though the standards all address the common themes of governance, management, operations and clinical service delivery.

Figure 12: Anticipated availability and adequacy of resources and infrastructure over next 3 years



Overall, organisations recognise and have experienced great benefits from undertaking formal quality improvement programs. However, the financial, human and time resources required is a significant burden that is not adequately recognised by government funders, although QI program engagement is a performance criteria in funding agreements. QI program provider membership fees of between \$3,000 and \$5,000, employing a staff member with relevant knowledge and skill to lead the QI process, and implementing changes to meet the standards (particularly work health and safety and human resources) are all costs that the organisation must meet annually, mostly without external funding to do so.

Many organisations also report that QI program administration and implementation has negatively impacted on clinical staff's available time with clients and clinical service delivery. These two priorities, along with program evaluation and research, needs to better recognised and resourced for organisations to maintain sustainability and continue in effectively addressing drug and alcohol harms across communities. This should be a priority for the new NGO contract system currently being developed by NSW Health.

4.2.5 Client information and data management

NADA provides a comprehensive system of support and infrastructure for the collection, collation and reporting of Alcohol and Other Drug Treatment Services Minimum Data Set (AODTS MDS) data. According to the Australian Institute of Health and Welfare (AIHW) 59 non government organisations provided MDS data from NSW – a break down is provided below:

Table 14: Publicly funded alcohol and other drug treatment agencies and closed episodes, by service sector, states and territories, 2012–13

AODTS MDS Data collection	NSW	National
Treatment Agencies		
Government	186	317
Non Government	59	397
Total	245	714
Closed Episodes		
Government	26,197	59,291
Non government	9,105	103,071
Total	35,302	162,362

Australian Institute of Health and Welfare (2014)²⁸.

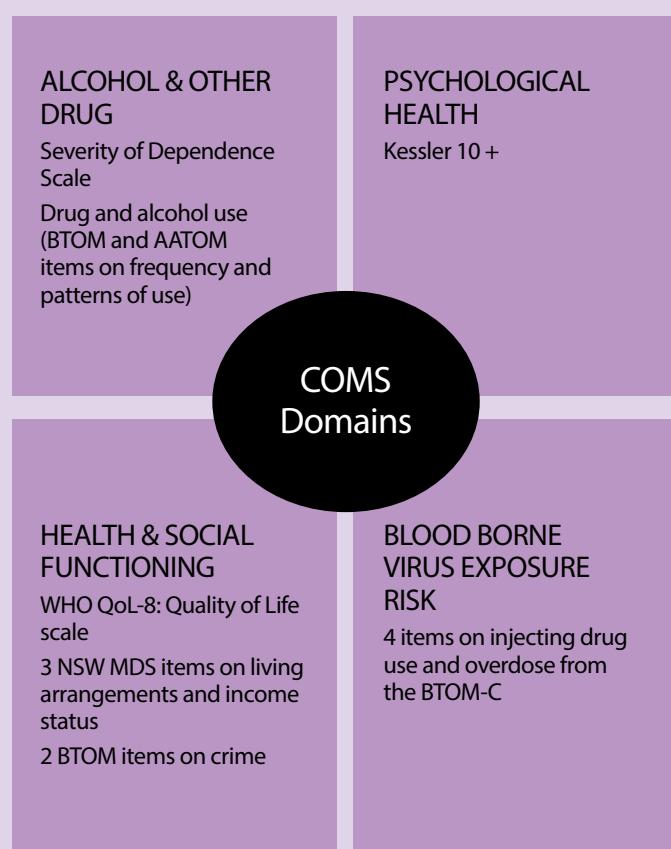
²⁸ Australian Institute of Health and Welfare 2014. Alcohol and other drug treatment services in Australia 2012–13. Drug treatment series 24. Cat. no. HSE 150. Canberra: AIHW.

Client Outcome Measure Data Collection

In the past 5 years, the number of organisations collecting client outcome data has grown dramatically. 95% of organisations reporting the use of outcome measures, with the most common tools the Severity of Dependence Scale (SDS) and the Kessler 10 or Kessler 10+.

The NADA data management system - NADAbase - also provides an online portal for the collection and reporting of Client Outcome Measures (COMS) data.

The NADAbase COMS data collection comprises of four domains in outcome measurement:



NADA member organisations are able to select the measures they wish to collect data on, at what stages of treatment (Intake, Progress 1, Progress 2 etc. Exit and Follow up) and in what time frames.

In the 2013/14 year almost half (47%) of NADA member services and/or organisations included in this Sector Mapping Report had entered client outcome measure (COMS) data into NADABase. A total of 5827 surveys had been entered into NADABase in 2013/14 with 49% of those surveys being completed at Intake, 22% at Progress 1, 10% at Progress 2 and 10% at exit. NADA have noted that these proportions have remained consistent from the previous financial year, which would indicate a continued commitment to client outcome data collection over time. However, NADA recognises that further development and support for members will be imperative to improve follow up data collection. Consistent collection of outcome data throughout treatment episodes and across the sector, is the only way to ensure that analysis of this data is meaningful.

When examining data from the 2013/14 year there are indications of some promising outcomes from treatment provided in the non government sector. It should be noted that data is limited to surveys completed at Intake, Progress 1, Progress 2 and Exit - where the survey data collected is a minimum of 10% of the overall number of surveys completed for 2013/14. Figure 13 provides an indication of changes in severity of alcohol and other drug dependence over time using the average Severity of Dependence Scale (SDS) from those organisations engaged in this mapping report who have adopted COMS as their treatment outcome reporting system.

The general trend is a reduction in severity of dependence over time. Also important to note is that the average severity of dependence on entry into treatment is high, (any score of 5 or above is considered dependent).

Figure 13: NSW NGO COMS data, average Severity of Dependence Scale score (across all substances), 2013-14

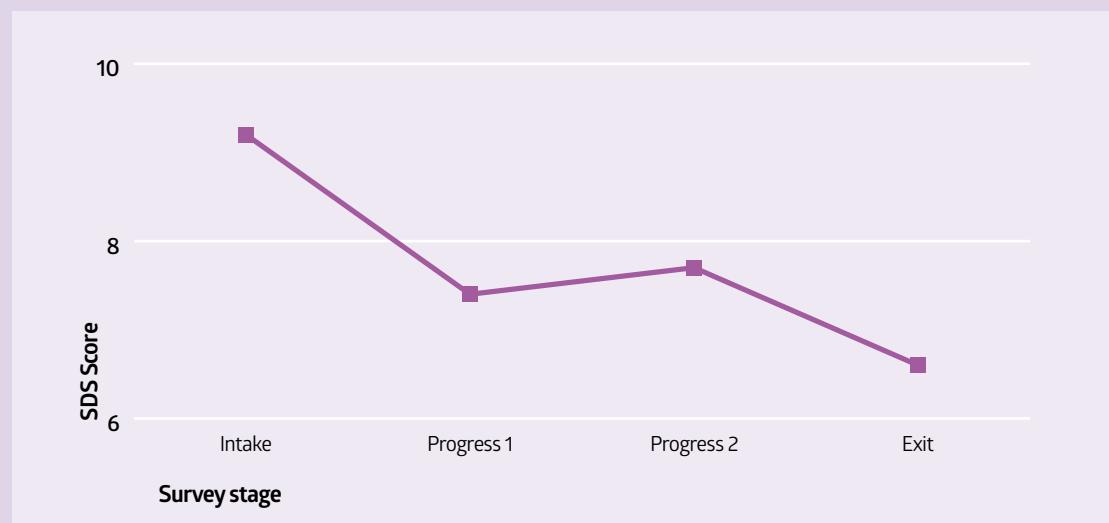
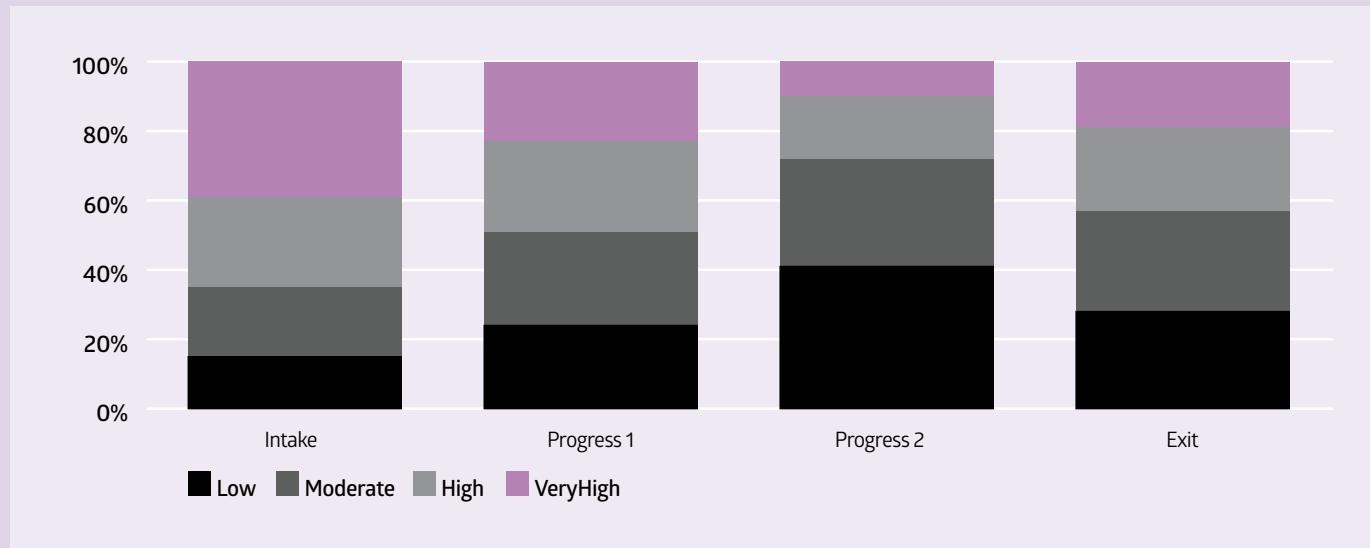


Figure 14: NSW NGO COMS data, distribution of average Kessler 10 scores, 2013-14



The complexity of clients who present to treatment with mental health issues is accurately depicted in Figure 14 depicting Kessler 10 (K10) scores and the proportion of low to very high measures of anxiety and depression, and change over time while accessing treatment.

Another useful outcome measure incorporated in NADAbase COMS that explores general health and wellbeing is the well validated WHO Quality of Life 8 Scale. Figures: 15 and 16 give a snapshot of improvements in overall wellbeing and then a breakdown in terms of physical, psychological, social and environment domains.

Figure 15: NSW NGO COMS data, overall WHO Quality of Life 8 Scale (mean scores), 2013-14

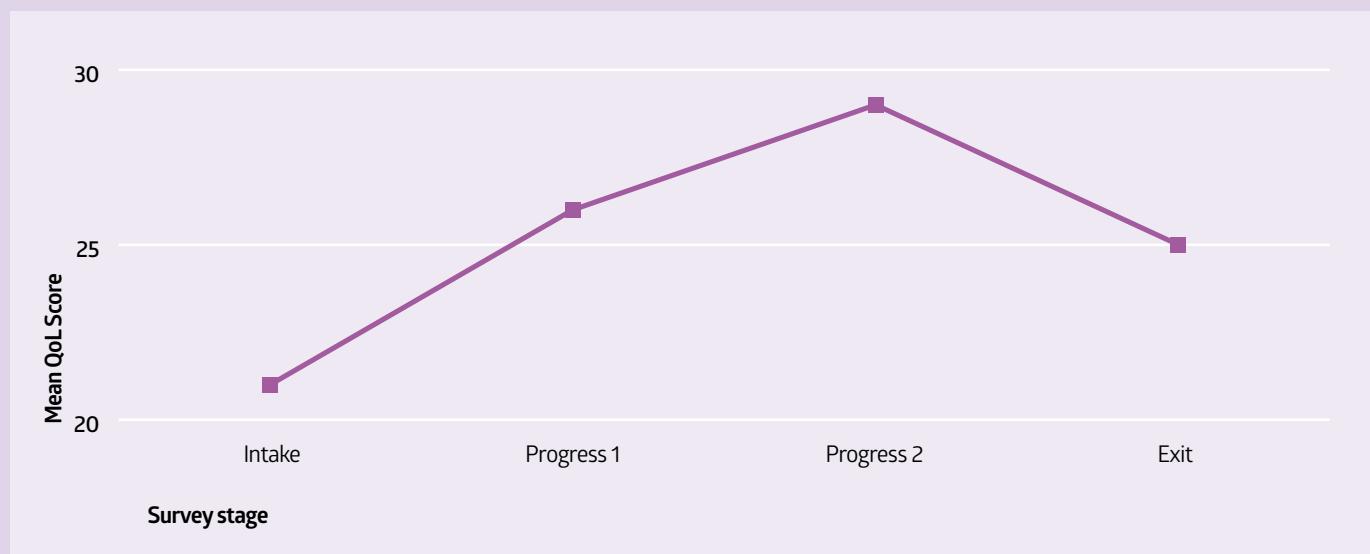
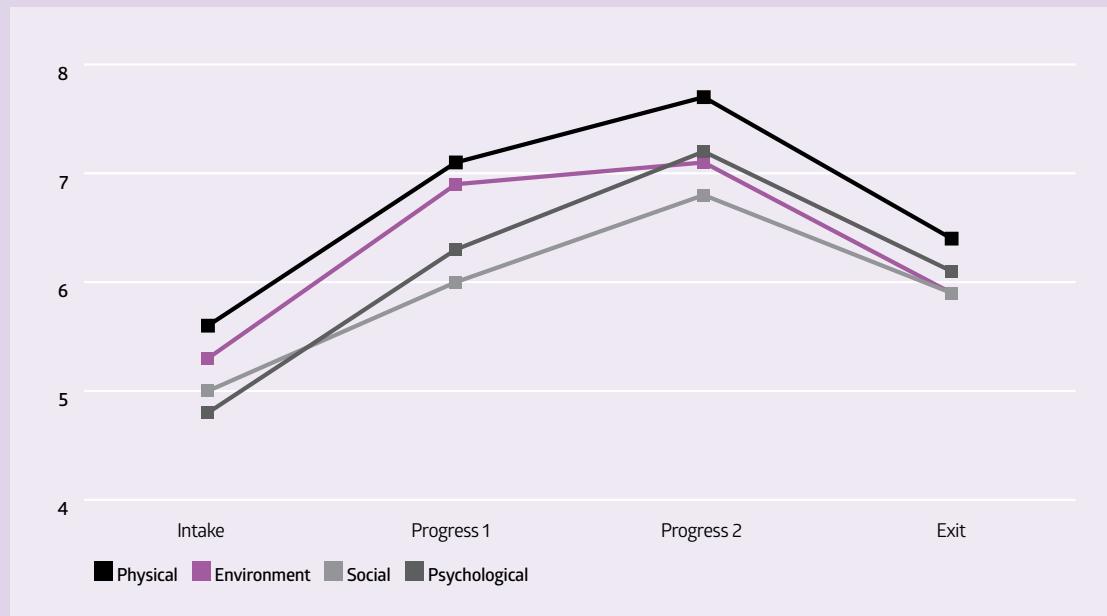


Figure 16: NSW NGO COMS data, overall WHO Quality of Life Scale 8 (domain scores), 2013-14



It is useful to note that any organisation using NADAbase COMS can export these figures in relation to their own client outcome data at any time – to be used in review, annual reports and other presentations.

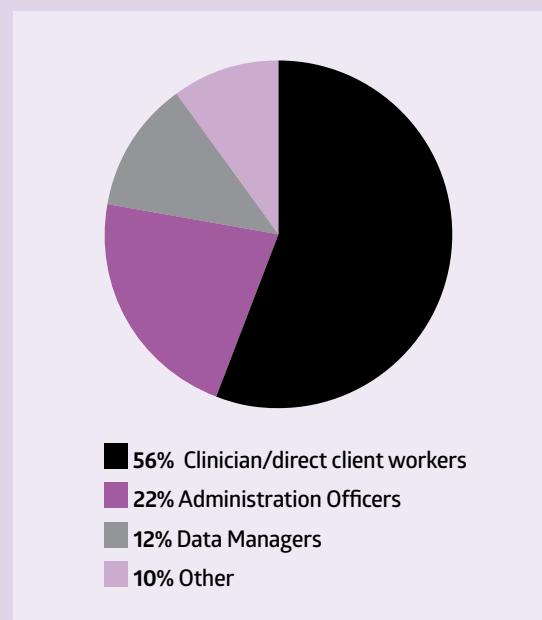
Collection and collation

The majority of organisations across the sector are utilising validated clinical screening and assessment tools to assess clients and measure outcomes as a part of the treatment program provided; half of which use the data set incorporated in NADAbase (NADA's on-line client information system available to all members).

Outside of those using NADAbase as a mechanism for collecting, collating and reporting client outcome data, most organisations use in-house developed systems (spreadsheets and databases) or purchased systems (e.g. Communicare). However there is still a small minority using paper based systems. Whilst organisations report varying levels of functionality with the latter two options, high costs, time invested in developing and sourcing systems, and internal expertise required to lead and operationalise the systems are long standing issues for the sector. NADA's development and provision of NADAbase for members has gone some way to addressing these issues, however there are limitations with what can currently be achieved due to NADA's financial constraints and the diversity of service provision and requirements across the sector.

Increasingly, organisations make reference to the administrative burden being placed on them to meet funding and legislative requirements. This is also reflected in how client data is collated, with 75% of organisations with an electronic system reporting it is clinicians/direct client workers who are collecting and entering data.

Figure 17: Responsibility for client data entry

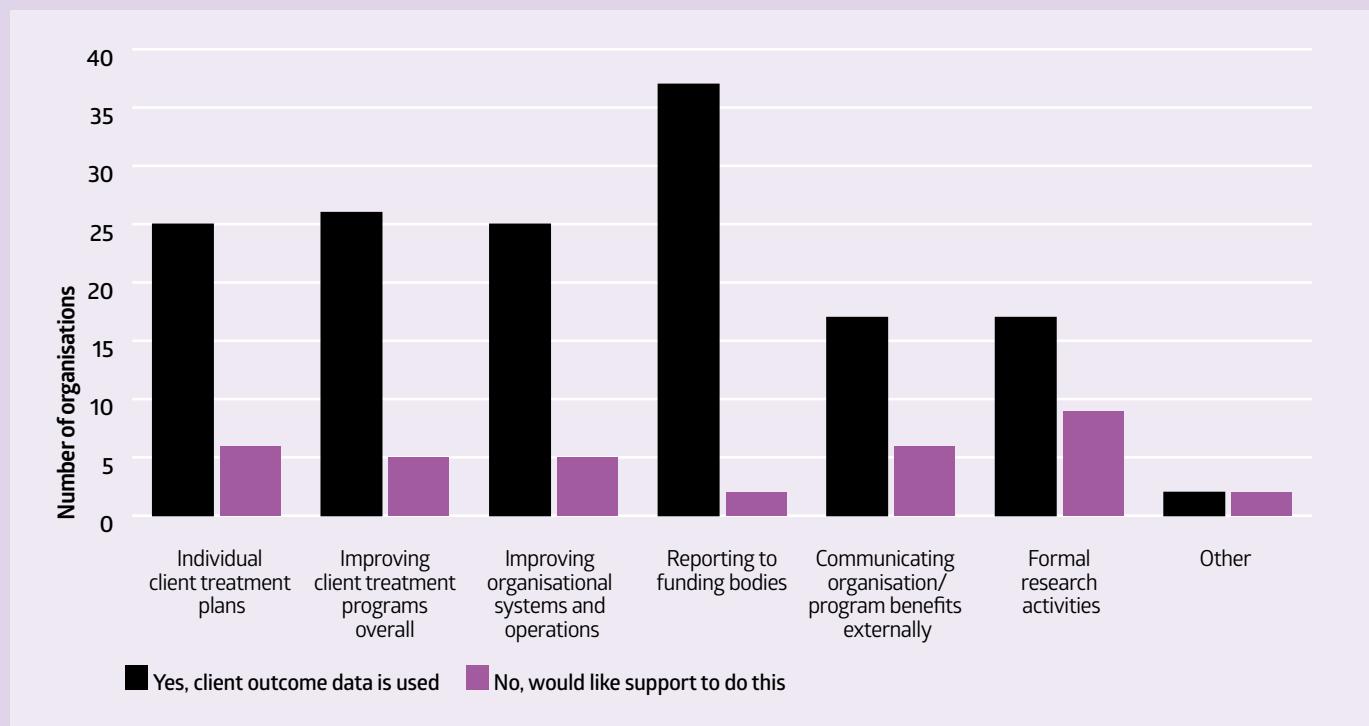


It is noted that there is no standard electronic system for collating data relating to non-treatment alcohol and other drugs service delivery, such as information and education, and community development.

Data application

Organisations have been asked how they use the client outcome data that is collected and if they would like support across a range of data applications. Most organisations – over 90% - indicate they are reporting client outcome data to funding bodies. The most frequently reported area which organisations would like support in is using client data for formal research activities (23%).

Figure 18: Application of client outcome data



5. WORKFORCE PROFILE

5. WORKFORCE PROFILE

The NSW non government alcohol and other drugs sector has a diverse, capable and skilled workforce and employs approximately 1,000 people.

In June 2013, NADA disseminated an individual staff survey to the 57 NADA member specialist NSW AOD organisations and received 339 staff responses across 42 organisations (73.7%). Some information presented in this section is data from sector responses to the NADA Organisational Survey, also disseminated to the sector in June 2013.

Sector staff reported high levels of work satisfaction, reiterating NADA's 2008 research findings²⁹. These high satisfaction levels relate to the autonomy of non for profits, the ethical and philosophical nature of the work and the organisations, and the flexible work practices offered by the sector.

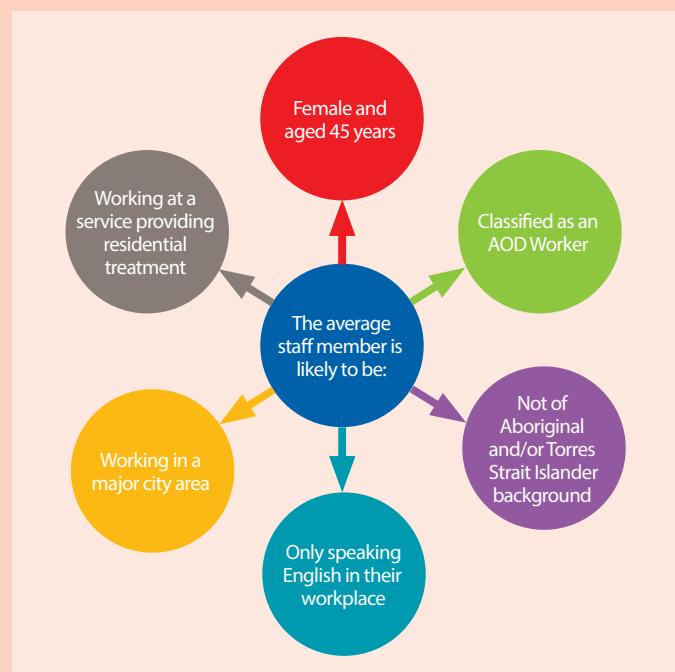
The staff in the alcohol and other drugs non government sector are experienced and qualified. The workforce is made up of staff with a mix of roles, skills and qualifications. The average length of time of staff working in the sector is 7.7 years, and 5.1 years with their current organisation. Almost half (48%) of survey respondents hold a university qualification (undergraduate degree, graduate certificate, graduate diploma, master's degree or PhD/doctorate), and 57% of staff hold a specific alcohol and other drugs qualification. Of those staff with qualifications that are not AOD specific, their qualifications are largely in the areas of community services/community welfare, psychology, social work and counselling.

5.1 DEMOGRAPHICS OF THE NSW AOD NGO SECTOR

There are slightly more female staff in the sector than male staff. Of those who responded to the Staff Survey, 58.7% were female and 40.4% were male (0.9% did not provide their gender). Characteristics of the workforce can be seen in Figure: 19.

The average age of respondents was 44.8 years, ranging from 19 to 70 years. These demographics are similar to the data obtained in the 2008 profile of the NADA member agency workforce, *NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues* (2008), where the workforce was found to be mostly female (61%), and the average age of staff was 43.8 years (1 year younger on average than data found in the current 2013 survey).³⁰ Similar demographics in the AOD sector have also been seen in surveys from other states and territories (eg the 2009 Victorian Alcohol and Other Drugs Workforce Census³¹). The 2011 Australian Capital Territory Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile (informed by the workforce from both government and non-government services) noted the average age of respondents was 40 years of age.³²

Figure 19: Characteristics of the NSW NGO alcohol and other drugs sector workforce



²⁹ Argyle Research (2008), *NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues*. Report prepared for NADA.

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³⁰ Argyle Research (2008). *NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues*. 2008. Report prepared for NADA.

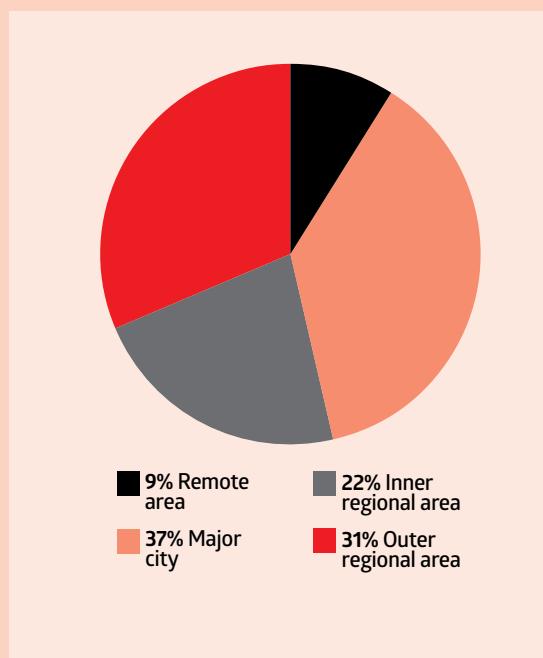
³¹ Victorian Department of Health (2009). *2009 Victorian Alcohol and Other Drug Workforce Census*. Melbourne: Mental Health, Drugs and Regions Division, Victorian Government, Department of Health

³² Alcohol Tobacco and Other Drug Association ACT (2011). *ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2011*. Canberra: Alcohol Tobacco and Other Drug Association ACT

5.1.1 Regional location of workplace

Most respondents (37%) indicated their workplace was located in a major city with no staff located in very remote areas. These remoteness categories are from the Australian Standard Geographical Classification (ASGC) remoteness categories.³³

Figure 20: Regional location of workplace



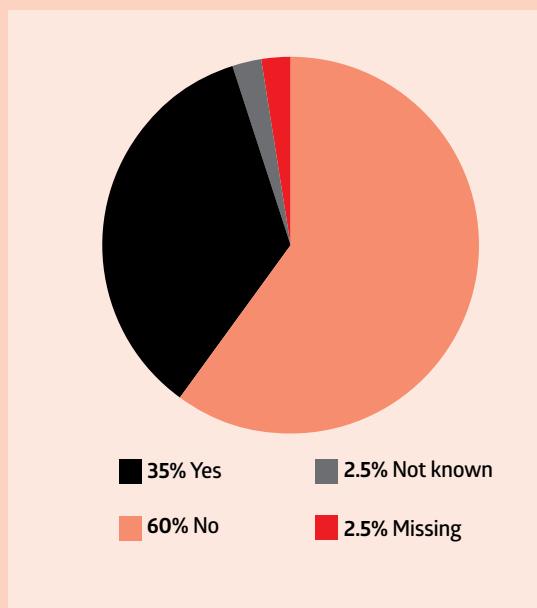
5.1.2 Staff diversity

6.8% of respondents to the staff survey identified as being of Aboriginal background, and 0.6% as Aboriginal and Torres Strait Islander background. However, across surveyed organisations, a third (35%) of organisations reported having staff that identified as of Aboriginal and/or Torres Strait Islander background.

13.3% of staff identified as being from a culturally and linguistically diverse (CALD) background. These backgrounds included Asian, Australian Aboriginal and Torres Strait Islander, British, European, Middle Eastern, Maori, North American and Samoan. A small number (2.4%) of staff spoke a second language in their workplace including Croatian, Gaelic, German, Hindi, New Zealand Maori, Papua New Guinea Pidgin English, Samoan and Spanish.

³³ ASGC remoteness categories are a statistical geography structure which allows quantitative comparisons between 'city' and 'country' Australia. Five categories exist: Major Cities (RA1), Inner Regional (RA2), Outer Regional (RA3), Remote (RA4) and Very Remote (RA5).

Figure 21: Staff identifying as of Aboriginal and Torres Strait Islander background



5.1.3 Ageing workforce

The average age of respondents to the staff survey was 44.8 years, ranging from 19 years to 70 years (n=2 missing). Slightly over half (55.8%) were aged 45 years or over, and 25.1% of staff were aged 55 years or over.

Comparing this to data found in the *NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues (2008)*, staff are now slightly older, and a higher proportion are aged 45 years or over, as seen in Table: 15.

Table 15: Comparison of staff ages from 2008 to 2013

	Workforce Profile and Issues (2008)	Current Staff Survey (2013)
Average age	43.8	44.8
Age range	22-67	19-70
% aged 45 years and over	48%	56%

These data can also be compared to the ageing of the community services and health workforce in Australia as a whole; where, in 2011, 21.2% of the workforce was aged 55 years and over.³⁴ One of the challenges facing the AOD sector is the ageing nature of the workforce, which Roche and Pidd (2010)³⁵ say is an issue that is

"particularly important for the AOD sector and the wider community services and health industry".

5.1.4 Services types provided by surveyed staff

Services provided by organisations were diverse, as seen in Table: 16 (noting that respondents could choose more than one option). Residential rehabilitation was the service selected by the largest number of staff respondents. Survey respondents were from organisations that represent each of the four levels of the Sector Taxonomy.

Table 16: Types of services provided by organisations

Service type	Service type mapped to Sector Taxonomy levels	n	%*
Residential rehabilitation	Treatment	277	81.7
AOD health promotion and prevention - information and education	Health promotion and harm prevention	206	60.8
Psychosocial counselling	Treatment	156	46.0
Psychosocial aftercare/ continuing care program	Extended and continuing care	142	41.9
AOD health promotion and prevention - community development	Health promotion and harm prevention	117	34.5
Withdrawal management	Treatment	104	30.7
Supported living/transitional housing program	Extended and continuing care	101	29.8
Other (e.g. education/training, support for family/children/ parents, acquired brain injury specific assessment/case management/intervention)	N/A	38	11.2

*Respondents could choose more than one option. Percentages represent the proportion of respondents for each response option.

³⁴ Community Services & Health Industry Skills Council (2013). The Care Industry: A Time for Action. Environmental Scan. Sydney: Community Services & Health Industry Skills Council. Accessed 27 September, 2013 at: <http://www.cshisc.com.au/learn/cshisc-environmental-scan/escan-2013/>

³⁵ Roche A M, Pidd K (2010). Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide

5.1.5 Positions of surveyed staff

Respondents to the Staff Survey held many different position types. The most common position title selected was Alcohol and Other Drugs Worker. There were no Addiction Medicine Specialists or Psychiatrists among the survey respondents.

Table 17: Primary position titles of staff

Position title	N	%
Alcohol and Other Drugs Worker	67	19.8
Other (Counsellor, Case Manager, Case Worker, Teacher, Educator, Family Support Worker, Program Coordinator, Program Development, Team Leader)	59	17.4
Residential Support Worker	41	12.1
Alcohol and Other Drugs Counsellor	30	8.8
Administration Officer/Receptionist	25	7.4
Team Leader/Manager (with client/clinical duties)	23	6.8
CEO/Executive Officer/Organisation Manager	17	5.0
Team Leader/Manager (coordination role without client/clinical duties)	12	3.5
Finance/Business Officer	10	2.9
Outreach/Aftercare Worker	8	2.4
Registered Nurse	8	2.4
Aboriginal Alcohol and Other Drugs Worker	7	2.1
Intern Psychologist	6	1.8
Project Officer	5	1.5
Health Promotion Worker	4	1.2
Quality Improvement Coordinator	4	1.2
Psychologist	3	0.9
Community Development Worker	2	0.6
Social Worker	2	0.6
Allied Health Professional other	1	0.3
CALD Alcohol and Other Drugs Worker	1	0.3
Enrolled Nurse	1	0.3
Medical Officer	1	0.3
Policy Officer	1	0.3
Research Officer	1	0.3
Addiction Medicine Specialist	0	0.0
Psychiatrist	0	0.0

The NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues (2008) reported that in 2008, 48% of job roles were filled by frontline AOD workers (e.g. Alcohol and Other Drug [AOD] Caseworker, AOD Counsellor, Support Worker, Intake Officer, or Welfare Worker). In the 2008 profile, 23% were found to be in management and administration roles (such as Manager, Clinical Coordinator, Team Leader and Administration Officer).³⁶

Summary of key staff demographic characteristics in NSW alcohol and other drugs sector:

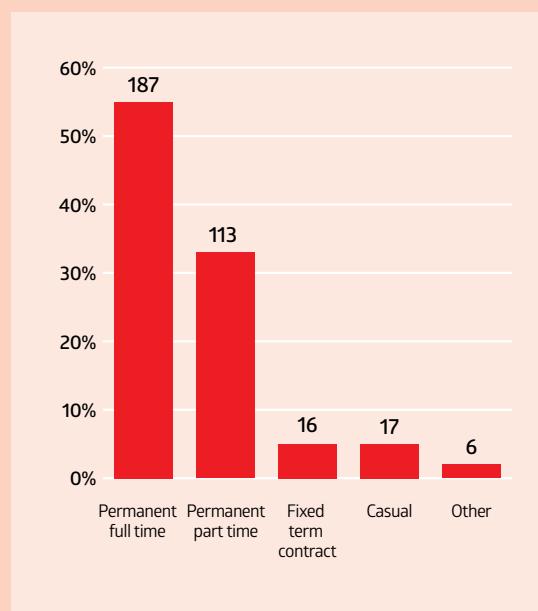
- Just over half of staff are female
- Average age of staff - 45 years
- Less than 10% identify as of Aboriginal or Torres Strait Islander background
- 13% of staff are from a CALD background
- 2% of staff speak a second language in the workplace
- 82% of staff are from an organisation that provides residential rehabilitation
- The most common position title selected was AOD Worker.

5.2 EMPLOYMENT ARRANGEMENTS

5.2.1 Contract type

Most staff members were employed on a permanent full time basis, as shown in table: 22, followed by a permanent part time basis. These are similar to the findings of the NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues (2008), where 54% of the workforce were employed full time, and 3% on fixed contracts.³⁷

Figure 22: Employment contract type



5.2.2 Designated Aboriginal and Torres Strait Islander positions

Eight organisations (20%) indicated that they have designated Aboriginal and Torres Strait Islander positions. 31 organisations (77.5%) indicated they did not have designated Aboriginal and Torres Strait Islander positions (n=1 missing; 2.5%).

5.2.3 Volunteers

Of the surveyed organisations, almost two thirds (62.5%) utilised volunteers. Most commonly volunteers were being used for functions such as recreational activities, client transport and general support, or were students and interns.

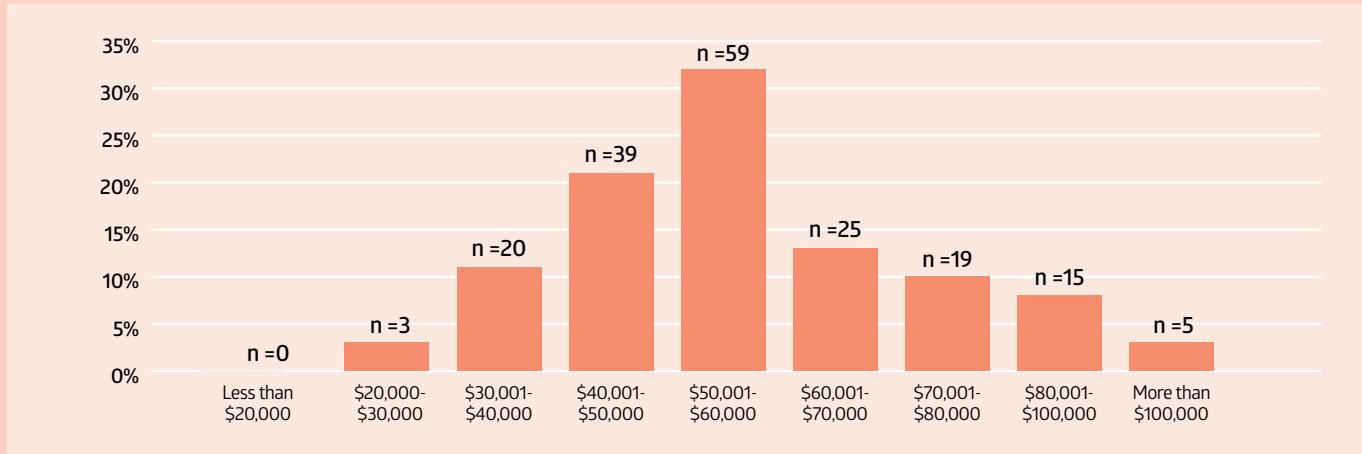
5.2.4 Visiting or private providers

65% of organisations indicated utilising visiting or private providers who work as part of their team but are not employed by the organisation (n=1 missing, 2.5%). General practitioners were utilised in 18 organisations, psychiatrists in 12 organisations, mental health nurses/workers in four organisations, and 14 organisations utilise 'other' types of visiting or private providers (mainly relating to health).

³⁶ Gethin A (2008). NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues 2008. Accessed 25 February, 2013 at: <http://www.nada.org.au/media/6040/2008workforceprofile.pdf>

³⁷ Ibid

Figure 23: Annual gross salary for permanent full time staff only (n=187)



5.3 STAFF WAGES AND AWARDS

5.3.1 Annual salary

Half of all staff respondents (51%) indicated an annual gross (before tax) salary of less than \$50,001 with the most common salary range being \$50,001-\$60,000 (23.3%). Five staff members (1.5%) identified as volunteers and seven respondents (2.1%) did not answer the question.

Of all permanent full time staff (n=187), a third (n=62, 33.2%) earn a gross salary of less than \$50,001. The most common salary band for permanent full time staff was \$50,001-\$60,000, as seen in figure: 40 (n=2, 1.1% missing).

5.3.2 Award classifications

62.5% of staff respondents were employed under the SCHADS/SACS Award. Others indicated they were employed under another award classification (18.3%) (for example an enterprise agreement), or were on an individual contract (15%). 14 respondents (4.1%) did not answer the question.

5.3.3 Additional unpaid hours

Just under half (n=143, 42.2%) of staff survey respondents indicated they did not work any additional unpaid hours (n=4 missing, 1.2%). 192 respondents (56.6%) worked additional unpaid hours. The average number of additional unpaid hours worked was 4.8 hours per week.

5.3.4 Main tasks performed by staff

Staff respondents were asked to list the three main tasks involved in their job. The most cited tasks included client case work, group therapy/facilitation and counselling. The most common combination of tasks was client case work, group therapy/facilitation and counselling. Also of note were administration, case management, and managing staff.

Table 18: The three main tasks involved in job

Task	No. cited
Client case work	113
Group therapy/facilitation	96
Counselling	95
Administration	56
Case management	52
Managing staff (e.g. rostering, volunteer program)	50
Program implementation/coordination/management	47
Education within program (including mental health, development of workshops)	38
Assessment	30
Provide client support (e.g. culturally, assisting with accommodation, Centrelink)	28
Data collection/management	26
Intake/admissions (including managing residents who assist in the admissions office)	19
Staff/clinical supervision	19
Quality assurance/improvement/ management	17
Financial management (including budgeting)	16
Accounting	15
Medications	13
Research	13
Community engagement/development	11
Referral management	11
Funding (e.g. grant applications, reporting, submission writing)	10
General/building maintenance/tasks (e.g. cooking, security)	10
Liaise/report to stakeholders and key agencies/services (e.g. mental health, prisons)	10
Phone enquires/answering and providing support over the phone	10

5.3.5 Employment related incentives/conditions

Staff responses show that various employment related incentives/conditions are provided by organisations, as seen in Table: 19. Time in Lieu was the most commonly selected (n=238, 70.2%) incentive/condition provided by organisations. Less than 5% of staff said their organisation did not provide any employment related incentives or conditions. The most commonly mentioned 'other' incentive/condition was salary packaging/salary sacrifice, selected by 31 respondents. Five respondents (1.5%) did not answer the question, and one respondent was unsure.

Table 19: Employment related incentives/conditions provided by organisation

Incentive/Condition	n	%*
Time in Lieu (TIL)	238	70.2
Flexible work practices (e.g. changing start times, attending personal appointments outside of lunch hour)	214	63.1
Employee Assistance Program (EAP)	151	44.5
Annual salary increments	114	33.6
Conference leave	100	29.5
Flexi leave / rostered day off (RDO)	99	29.2
Study leave – unpaid	79	23.3
Study leave – paid	78	23.0
Unpaid leave	78	23.0
Indexation (CPI)	69	20.4
Other	49	14.5
Additional paid leave (e.g. service closure of Christmas/New Year period)	48	14.2
Superannuation matching (employer contributes the same amount that you do)	34	10.0
No employment related incentives/conditions provided	10	3.0

*Respondents could choose more than one option.
Percentages represent the proportion of respondents for each response option

5.4 EXPERIENCE AND QUALIFICATIONS

Sector staff are experienced and qualified. The average length of time of staff working in the alcohol and other drugs sector is 7.7 years, and 5.1 years with their current organisation. Almost half (48%) of respondents hold a university qualification (undergraduate degree, graduate certificate, graduate diploma, master's degree or PhD/doctorate), and 57% hold a specific alcohol and other drugs qualification.

The workforce is made up of staff with a mix of roles, skills and qualifications. Of those staff with qualifications that are not AOD specific, their qualifications are largely in the areas of community services/community welfare, psychology, social work and counselling.

5.4.1 Years in position, organisation, sector and workforce

Staff survey respondents reported working in their current position for an average of 3.9 years. While some respondents have been in the AOD sector for less than a year, others have been in the sector for 35 years.

5.4.2 Last employment position

Around 20% of staff survey respondents (n=66) indicated their last employment position was in their current organisation. Of those respondents that said their last employment position was in 'another sector' or 'other', the most common sectors were community services/welfare, health and mental health, and hospitality. Two respondents (0.6%) did not answer the question.

Table 20: Last employment position

Position	n	%
Another sector/other	182	53.7
Current organisation	66	19.5
Another NGO AOD organisation	52	15.3
None – new graduate	13	3.8
Government AOD organisation	12	3.5
None – returning to workforce after lengthy break	12	3.5

5.4.3 Qualifications

40.4% of respondents (n=137) indicated that they hold a specific alcohol and other drugs qualification. The most commonly reported specific qualification was the Certificate IV in AOD (n=85, 25.1%). A small number of respondents (n=8, 2.4%) had completed postgraduate studies in alcohol and other drugs. One respondent did not answer the question (0.3%). 59.3% of respondents (n=201) indicated that they did not hold a specific alcohol and other drugs qualification.

Table 21: Alcohol and other drugs qualifications held

Qualification	n	% *
No specific AOD qualification	201	59.3
Certificate IV AOD	85	25.1
Diploma in AOD and Mental Health	30	8.8
Diploma in AOD	26	7.7
Other	11	3.2
Postgraduate studies	8	2.4
Undergraduate Degree in AOD	1	0.3

*Respondents could choose more than one option. Percentages represent proportion of responses for each option.

Data from the NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues (2008) suggest that a greater proportion of the workforce in 2013 have a specialist AOD qualification than in 2008, when around a third were found to have a specialist AOD qualification.³⁸

Figure 24: Competence working with AOD clients who also experience other complexities (averages score on scale from 1-5)



³⁸ Argyle Research (2008), NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues. Report prepared for NADA.

5.4.4 Highest qualification

Staff survey respondents were asked what the highest qualification they had obtained was, noting that it did not have to be AOD specific. Almost half of respondents (45.7%) hold an undergraduate degree, graduate certificate, graduate diploma, Masters degree or PhD/doctorate, as seen in Table: 22.

Table 22: Highest qualification obtained

Qualification	n	%
Undergraduate degree	70	20.6
Diploma	63	18.6
Certificate IV	46	13.6
Graduate diploma	40	11.8
Masters degree	28	8.3
Advanced diploma	20	5.9
Up to and including Year 10/School Certificate	18	5.3
Graduate certificate	16	4.7
Year 12 or equivalent college certificate	15	4.4
Other (Eg Psychology Honours, Registered Nurse, Accountant)	14	4.1
Certificate III	6	1.8
Certificate II	2	0.6
PhD/Doctorate	1	0.3

There is currently no AOD specific undergraduate level degree available in NSW and limited education and training specific to AOD at university level.

For each qualification above high school level, respondents were asked to specify the area/name of their highest qualification. The most common responses to other levels of qualifications were as follows:

- Certificate III: business administration
- Certificate IV: alcohol and other drugs, community services/community welfare, mental health/alcohol and other drugs and mental health
- Diploma: community services/community welfare, alcohol and other drugs and mental health, alcohol and other drugs
- Advanced diploma: accounting, community services management, counselling, counselling and family therapy
- Undergraduate degree: psychology, social work, social science/social welfare
- Graduate certificate: counselling, drug and alcohol, education, health/social health
- Graduate diploma: psychology, counselling, education, Gestalt therapy
- Masters degree: health service management, social health, social work
- PhD/Doctorate: genetics.

5.4.5 Minimum qualifications

The Organisation Survey indicated that 23 organisations (57.5%) have positions (other than allied health professions) that require a minimum qualification. These included certificate level (e.g. for support workers), diploma level (e.g. for counsellors) and tertiary level qualifications (e.g. for a CEO). 40% (n=16) did not have positions requiring a minimum qualification (n=1 missing, 2.5%).

5.5 COMPETENCY WORKING WITH CLIENTS WHO HAVE COMPLEX NEEDS

Staff survey respondents were asked how competent they felt working with AOD clients with complex needs who also experience other complexities. They could select from a five point scale, from 1 (*I am not competent*), to 5 (*I have advanced competence*) and the option of not applicable/not relevant to my role.

Overall, respondents indicated that they felt competent working with clients across the spectrum of complex needs, with an average for all items of 3.4 out of a possible 5. Fewer respondents felt competent working with clients with foetal alcohol spectrum disorder (an average of 2.6 out of a possible 5). Averages for all complexities are presented in Figure: 24.

The highest proportion of respondents who selected "I have advanced competence" cited:

- Anxiety and/or depression (15% responded "I have advanced competence")
- Community Services involvement (14.5% responded "I have advanced competence")
- Bail or parole conditions (13.6% responded "I have advanced competence").

The greatest proportion of respondents who selected "I am not competent" cited:

- Foetal alcohol spectrum disorder (13% responded "I am not competent")
- Receiving Opioid Substitution Therapy (OST) (11.5% responded "I am not competent")
- Pregnancy (7.7% responded "I am not competent").

Please note there was some missing data for this survey question; not all respondents answered all of the questions, and the number of missing responses ranged from 1 to 6 for each question.

The proportion of staff who responded not applicable/not relevant to my role also varied across questions, ranging from 13.6% (for "clients identifying as Aboriginal and/or Torres Strait Islander"), to 26.3% (for "receiving opioid substitution therapy").

5.6 STAFF RECRUITMENT, RETENTION AND SATISFACTION

Organisations in the AOD specialist sector have more difficulty recruiting staff than retaining staff. Around two thirds of organisations reported having difficulty recruiting staff (n=27, 67.5%), whereas only a third of organisations (n=13, 32.5%) reported having difficulty retaining staff (n=1 missing, 2.5%).

Those organisations that had experienced difficulties recruiting or retaining staff were asked why they thought they had experienced these difficulties. The most commonly selected responses were:

- difficulty finding staff with appropriate knowledge, skill and/or qualifications (n=22)
- lower wages in comparison to other sectors (n=19)
- lower wages in comparison to government drug and alcohol/health/welfare sector (n=18).

Successes in retaining staff were attributed to positive organisational factors. In the Organisation Survey, 29 organisations identified internal or external factors that had contributed to successful recruitment and retention of staff within their organisation. Flexibility in the workplace was the success factor cited by the largest number of organisations. Also of note were:

- good organisational culture
- professional development/training opportunities provided
- good working conditions (e.g. creative environment, physical environment, family friendly, well resourced).

5.6.1 Recruitment

There can be difficulties finding staff with appropriate qualifications and fit for organisations. Difficulties recruiting staff was a commonly reported issue amongst rural and remote participants, citing the limited expertise around AOD in the available workforce in these areas. Attracting employees to rural locations was also reported as a barrier to recruitment.

The lack of portability of entitlements from other sectors, such as long service leave and superannuation entitlements, may also pose difficulties in recruiting staff from other sectors. The percentage of organisations experiencing difficulties in recruiting and retaining staff are indicated right.

Figure 25: Difficulties in recruiting and retaining staff



5.6.2 Recruitment sources

Organisation Survey respondents were asked to indicate the three main sources of newly recruited staff. As seen in Table 23, 'other non government community/health/welfare organisation' was the recruitment source for the largest number of organisations (n=26).

Table 23: Recruitment sources

Recruitment sources	n	%*
Other non government community/health/welfare organisation	26	65
Other non government AOD organisation	25	62.5
Government community/health/welfare organisation	19	47.5
New graduates	18	45
Government AOD organisation	8	20
Other	6	15
Returning to workforce after a period of absence	4	10
School leavers	1	2.5

*Respondents could choose more than one option. Percentages represent the proportion of organisations for each recruitment source

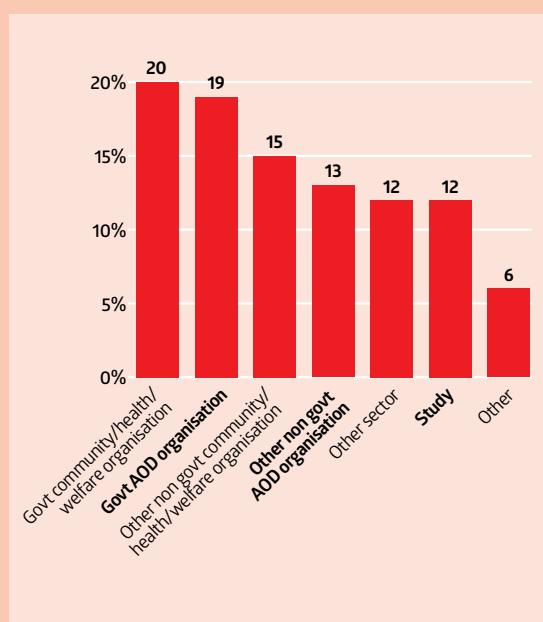
5.6.3 Retention

While organisations have less difficulty retaining staff than they do recruiting staff, importance still needs to be placed on retention, as recruiting and training new staff is costly and time consuming. Lower wages in the NGO sector compared to the public sector was cited by participants as a barrier to retention; staff will want to look for work where there is more chance for a greater income. Some respondents reported that their organisations are paying above the award rate in order to ensure they retain their staff. 70.5% of Staff Survey respondents intend to be working at their same organisation in two years' time (1.8%, did not answer the question).

5.6.4 Destinations of staff who leave their organisation

Organisations were asked to identify the three main employment destinations of staff who leave the organisation. 20 (50%) of the organisations cited 'government community/health/welfare organisation' as one of the three main employment destinations of staff who leave the organisation (n=1 missing, 2.5%). 19 organisations (47.5%) selected 'government drug and alcohol organisation' as one of the destinations, as seen in Figure: 26.

Figure 26: Destinations of staff who leave organisation

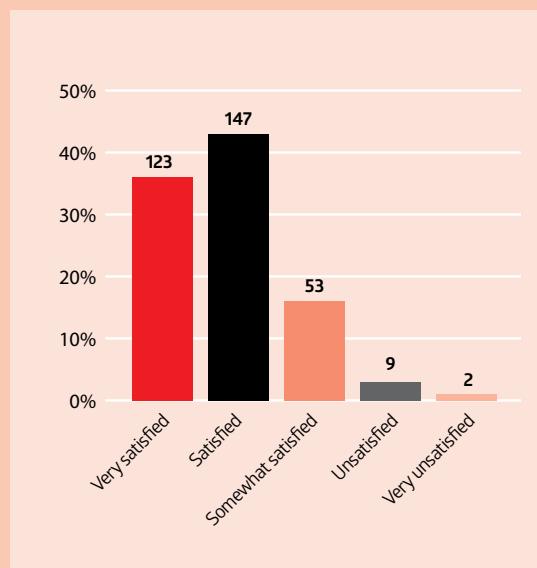


**Respondents could choose more than one option.
Percentages represent the proportion of organisations for each employment destination.*

5.6.5 Staff satisfaction working in the drug and alcohol sector

Overall, respondents of the Staff Survey reported feeling satisfied working in the NGO AOD sector. 79.6% of staff said they felt "very satisfied" or "satisfied" (n=270) and only a very small number indicated dissatisfaction; 3.2% (n=11) reported being "unsatisfied" or "very unsatisfied". Five people (1.5%) did not answer the question.

Figure 27: How satisfied are you working in the NGO drug and alcohol sector?



5.7 WORKFORCE DEVELOPMENT

5.7.1 Preferred learning method

Staff respondents prefer short courses/workshops (77.3%) and on-the-job training (72.3%) as methods to gain new skills and knowledge.

5.7.2 Funding for training

Organisations expressed the difficulty in providing training with limited resources. The NADA Workforce Development grant program was perceived as having a large impact on the sector. Some organisations rely solely on the NADA grants for their training and workforce development.

5.7.3 Professional development opportunities

All organisations who completed the survey indicated providing professional development opportunities for staff. Almost all (n=36, 90%) organisations provide 'financial contributions for alcohol and other drugs and related short courses/workshops'. Induction and training programs, structured performance review and development, and internal training/workshops were also provided by over 80% of organisations.

5.7.4 Future staff development needs

Organisations were asked to select the three main issues or subjects that their organisation and staff needed development support in over the next three years. 'Responding to client complexity' was selected by almost half (n=18, 45%) of organisations (n=2 missing, 5%).

Table 24: Future staff development needs

Development issues/subjects	n	%*
Responding to client complexity	18	45
Quality improvement programs	15	37.5
Client data management	15	37.5
Program/service evaluation	14	35
Strategic planning	13	32.5
Tender submissions/writing	11	27.5
Research	8	20
Consumer participation	8	20
Organisation performance reporting	6	15
Other	1	2.5

*Respondents could choose more than one option. Percentages represent the proportion of organisations for each development issue/subject

Similar results were seen when staff were asked to consider the three main issues or subjects they would need development support in over the next three years. The most common response was "responding to client complexity", selected by 36.6% of respondents. This client complexity related mainly to mental health, comorbidity, and dual diagnosis. "Program/service evaluation" was also commonly selected (34.8%), as was "quality improvement programs" (30.4%) and "client data management" (30.1%). Nine staff members (2.7%) did not answer the question.

5.7.5 Workforce development issues for NGO AOD sector

Respondents of the Staff Survey were asked what they thought were the three main workforce development issues for the NGO AOD sector more broadly. Overall, staff responded that retention and recruitment and lower wages in comparison to the Government sector were key workforce development issues for the NGO AOD sector over the next three years. Eight respondents (2.4%) did not answer the question.

Table 25: Workforce development issues for NGO AOD sector

Issues	n	%*
Retention of staff with appropriate knowledge, skill and/or qualifications	176	51.9
Recruitment of staff with appropriate knowledge, skill and/or qualifications	157	46.3
Lower wages compared to government alcohol and other drugs / health / welfare sector	149	44.0
Resources and access to professional development	134	39.5
Lower wages in comparison to other sectors	115	33.9
Recognition and profile of the sector	114	33.6
Strategic direction for workforce development	87	25.7
Other	10	3.0

*Respondents could choose more than one option. Percentages represent the proportion of respondents for each response option

6. SUCCESSES AND CHALLENGES

6. SUCCESSES AND CHALLENGES

Investment in the NSW non government alcohol and other drugs sector is essential to reduce alcohol and drug related harms to NSW communities.

6.1 KEY ACHIEVEMENTS

The 1999 Drug Summit and subsequent State and Commonwealth service enhancement funding has led to an increase in the array of evidence-based treatment options for people affected by drug and alcohol problems.

As a result of the collective efforts of the sector, consumers and their families, NADA, governments and philanthropic funders, the AOD sector in NSW has achieved the following:

Society and health system

- reduced marginalisation and stigmatisation of treatment services and clients with addiction, and greater acceptance of AOD treatment as a core component of mainstream health and wellbeing approaches
- improvements in drug and alcohol use reduction and cessation
- improvements in health and psychosocial functioning
- reduced involvement in crime and the criminal justice system
- change in service delivery in response to the change in the evidence base (pharmacotherapies and psychotherapies and who is best placed to deliver them).

Service delivery

- greater understanding of the interdependencies between services for people with AOD problems (prevention and treatment linking to housing, trauma, sexual health, education, employment, domestic violence, women's and children's services)
- some NGOs providing services for methadone
- examples of LHD and Medicare Local networked continuums of care and support across public, private and NGO sectors
- a greater emphasis in services on the evidence for what works, primarily through client matching to services and intersectoral case management underpinned by provision of networked services across the continuum of care
- new orientation to outcomes rather than outputs, and mechanisms for judging outcomes.

Workforce

- reduced reliance on personal experience of addiction and treatment services as the main criterion for staff selection
- greater comparability of qualifications and remuneration of staff in the public and NGO sector, and the beginning of efforts to integrate training across the public and NGO sectors
- volunteers and visiting/private providers make important contributions to the workforce
- staff have been working in the AOD sector for 8 years on average
- increased investment in workforce qualifications and professionalism (minimum qualifications, formal training and supervision of staff, continued upskilling) - almost half (46%) of staff hold an undergraduate degree or above (undergraduate degree, graduate certificate, graduate diploma, Masters degree or PhD/doctorate). 40% hold a AOD specific qualification, of which 25.1% (85 of all 339 staff who answered the survey) had Vocational Education and Training (VET) Certificate IV
- flexibility in the workplace, good organisational culture, providing professional developing/training opportunities, and good working conditions were seen as recruitment and retention success factors.

Quality improvement

- improved data collection and analysis
- development and use of standardised outcome oriented assessment and treatment tools
- NGO leadership, including NADA's role in sector advocacy and development
- 90% of AOD NGOs surveyed for this Project were involved in Quality Improvement (QI) programs and 67% currently hold QI program accreditation services
- Partnering and leading research and evaluation to support service improvement
- NSW Health's work to retain, build and foster the improvements to the sector which have been achieved over the last 15 years of investment.

6.2 KEY CHALLENGES

The main challenges for the NSW AOD NGO sector over the next three years include:

- adequate funding to meet administrative/operational costs (resources for organisations to upgrade their equipment, systems and facilities to accommodate new clients or improve their service delivery)
- adequate funding to meet client and community service delivery costs (infrastructure, staff for reporting functions, staff remuneration in line with or better than award)
- Adequate funding to support recruitment and retention of staff in the sector
- clients' complex needs (ageing population, issues of alcohol, new psychoactive substances and prescription drug use and increasing complexity of client needs were the main reasons for the change in demand for services)
- problematic alcohol attitudes and use as a widespread community concern and increasing media coverage (with demand for alcohol treatment reported as the biggest demand for services across NSW)
- emerging drug use trends (synthetic or "designer" drugs among young people, increased meth/amphetamine, and increased use of "harder" drugs other than heroin in older people).

Uncertainty about future funding also contributes to these problems. In addition, some organisations narrow their client entry criteria to clients with less complex and less intensive need because they cannot afford salary levels of appropriately skilled and qualified staff.

Despite funding not being increased in relation to service cost drivers in recent years, service demand has increased and funding bodies are expecting more from organisations. For example: performance reporting, accreditation and quality improvement activities, capacity to provide services for clients in the context of their family and other significant relationships (including infrastructure and flexibility to provide child care, family counselling and transport), education and job preparation programs, and navigation of a complex mental health system. Only a small

number of organisations are able to cater for parents, in particular women, with dependent children, and there is a complete absence of specific residential treatment for Aboriginal women. The importance of providing flexible service delivery to families was highlighted, including ensuring that services are easy to access and attend by families regardless of the type of treatment provided.

Other areas for development in the AOD program as a whole in NSW:

- availability of withdrawal management services (to address appropriate services for young people, geographical access in NSW, and the reduction of inpatient withdrawal services in LHDs)
- availability of residential rehabilitation services for women only and young people
- availability of culturally appropriate services and links to Aboriginal Community Controlled Health Services
- links to multicultural support services
- increased access to treatment for lesbian, gay, bisexual, transgender and intersex people
- capacity to deliver additional counselling, continuing care (aftercare) programs, outreach, community engagement and strengthening partnerships with other providers involved in the client journey
- capacity to provide staff with sufficient training and development
- capacity to employ administrative and management staff
- capacity to increase clinical staff and their professional development and supervision arrangements
- capacity for after hours staffing systems in residential services
- portability of conditions, shared professional development activities and parity remuneration across sectors.

7. CONCLUSIONS AND RECOMMENDATIONS

7. CONCLUSIONS AND RECOMMENDATIONS

The NSW Ministry of Health currently funds public sector community and hospital based AOD services. For the last 15 years, NSW Ministry of Health through MHDAD and the LHDs has made its investment in the NSW NGO AOD prevention and treatment services sector infrastructure, and partially funded the majority of the NADA member organisations in NSW to deliver specialist AOD services. Most of the AOD NGO sector receives funding from multiple sources (e.g. NSW Government, Commonwealth Government and charitable donations).

The funding of the AOD NGO sector is highly complex due to a number of factors including differing sources of funding. NGOs are currently funded by a combination of grants by NSW Health. The old core NGO grant contribution is used by most as a contribution to basic running costs. It is based on no real defined portion of service delivery or costed part of service outcomes. Many are also significantly funded through the Commonwealth Department of Health substance misuse funding streams.

NADA endorses the funding principles for non government organisations providing alcohol and other drug treatments set out by the Australian National Council on Drugs and urges the NSW Ministry of Health and Commonwealth Department of Health to incorporate these principles in the development of future funding approaches.

Funding principles for non government organisations providing alcohol and other drug treatments

1. Recognition and utilisation of the particular strengths of NGOs:
 - a. Recognise the important role of AOD NGOs and the benefits they bring to the wider AOD sector.
 - b. Recognise that NGOs provide more resources to service provision than governments fund.
 - c. AOD NGOs need to be free to advocate and participate in public debate.
2. Processes that are cooperative and transparent:
 - a. Cooperation and partnership between government, AOD NGOs, and service users/consumers are to be promoted and pursued.
 - b. The basis for government decisions surrounding funding models for the AOD sector and funding decisions must be transparent.
3. A funding model and processes that best support provision of best quality services to people affected by drug problems:
 - a. Funding models need to be those which best support efficiency, value-for-money, stability and sustainability, without compromising equity, innovation and diversity.
4. Funds provided at levels adequate to cover the real costs of service provision:
 - a. Levels of funding provided to AOD NGOs must be adequate to enable provision of quality services that meet demand, and all the costs associated with its delivery.
5. Compliance requirements that will support efficient, quality, evidence-based services:
 - a. Efforts to streamline reporting and reduce red tape for AOD NGOs must continue.
 - b. Services must engage in quality improvement and/or undertake accreditation, with appropriate support.
 - c. Evaluation of service effectiveness should be undertaken wherever possible and appropriate, to support continued efforts to provide services that are evidence-based.

Australian National Council on Drugs (ANCD) (2014). *Funding principles for non government organisations providing alcohol and other drug treatments*. Canberra, ANCD.

Overall, this mixture of grants and other income, some specific service purchasing and some ‘contributions’ to service provision, make up the global budgets that enable these organisations to provide high quality AOD services. Another factor in the complexity of funding is the differing types of drug health services funded or provided with a contribution towards service (i.e. Medicare entitlements, out-of-pocket contributions etc.); these include residential and outpatient treatment, day programs, aftercare, detoxification and non-treatment services (education and health promotion).

7.1 NSW NGO AOD SPECIALIST SERVICE PROVIDERS

The taxonomy developed for this project indicates the types of services across the continuum for harm reduction, health promotion and harm prevention, treatment, and extended and continuing care; service types; service settings; and the staff types to deliver the services. The NGO sector have in place processes and protocols for client matching to service type and level. Staffing of services is diverse in order to best meet client needs.

The organisations surveyed for this project are providing more than one level of service (harm reduction, health promotion and harm prevention, treatment, extended and continuing care) and for multiple drug types (in NSW the most commonly used drugs were, alcohol, cannabis, meth/amphetamine, tobacco, MDMA, pain killers, cocaine). Clients most commonly seeking services are those with problematic alcohol use in combination with other drugs.

Organisations have the capacity to work with clients presenting to AOD services with diverse, multiple and complex problems through consortia or networked models of local and state-wide service delivery. Many Project consultation respondents commented on the gaps in their service delivery in catering for clients with mental health and physical comorbidities and complex needs.

Many believed that the sector as a whole has improved its capacity to support people with coexisting mental health conditions through training, increasing staff qualifications, state and Commonwealth funding, and networking between the AOD and the mental health sector. Organisations have been able to demonstrate this increased capacity through results of the Dual Diagnosis Capability Audit Tool (DDCAT). Despite these advances, respondents reported that it was still difficult to support people with complex mental health issues, and the sector as a whole needed to be better equipped to provide ongoing care for people with chronic issues, particularly mental health issues.

7.2 PEAK SUPPORT

NADA is highly regarded by its specialist prevention and treatment organisation members for its contribution to building the NSW NGO AOD sector’s capacity to provide the community with contemporary evidence-based services across harm reduction, acute care, treatment and continuing care. NADA’s role in advocating for and contributing to an alcohol and other drugs service system approach to workforce development has been highly valued by MHDAD and the sector.

An established and effective approach to workforce, organisation and sector development is in place, including NADA’s work with the sector on:

- Quality improvement and organisation accreditation
- Service delivery networks and partnerships, and providing opportunity to address shared issues as well as sector specific matters
- Cross sector collaboration with Government, primary health care, research institutes and other speciality sectors
- Client and organisational data management (through MDS, COMS and other electronic systems and projects)
- Knowledge, skill and capacity development of the sector’s workforce, particularly in working with clients with complex health and social needs.
- Identifying, promoting and utilising expertise within the sector for workforce development programs and activities
- Demonstrating and promoting the sector’s good practice, innovation, achievements and research findings
- Developing and supporting implementation of resources for frontline services, including clinical and best practice guidelines
- Service delivery performance monitoring and reporting.

This Mapping Project represents the continuation of NADA’s work with the sector and MHDAD to identify the capacity, strengths and cost drivers for a range of the sector’s services. It positions NADA and the sector to provide input into work with MHDAD to develop the current and future alcohol and other drugs service delivery procurement plan for NSW. In addition the taxonomy could be further detailed with MHDAD and become a tool for mapping the components for which the government and non government sectors have responsibility, and the development of costings for the staffing levels required.

7.3 RECOMMENDATIONS

Recommendation 1 – Collaboration with Government

NADA and the sector to work with government in strategic and service level planning to develop and fund a whole of system approach to AOD prevention and treatment services in NSW.

Recommendation 2 – Use the sector mapping data

Government to use the sector mapping data to assist in planning and purchasing services. NADA to use the data to inform participation in reviews, consultations and sector development activity. The sector to use the data at the local level to further develop local partnerships, networks and referral pathways.

Recommendation 3 – Apply funding principles that consider infrastructure and operational costs

Government should apply the funding principles for non government organisations providing alcohol and other drug treatments outlined by the Australian National Council on Drugs (ANCD). These principles consider key areas such as service delivery needs, administrative and incorporation costs, infrastructure and operational resource needs, and workforce and organisational development needs as described in the mapping report.

Recommendation 4 – Outsource contract administration

MHDAO should explore options to outsource contract administration to NADA for the new contract system under the Partnerships for Health reform proposals.

Recommendation 5 – Develop sector leaders

NADA to explore the development of sector leadership groups or communities of practices that focus on i) governance and leadership ii) clinical practice processes to improve quality, share practices and identify priorities.

Recommendation 6 – Increase and maintain sector capacity

Maintain NADA's effective workforce, organisation and sector development priority activities as the key enablers of change and a more integrated and evidence based AOD service system.

Recommendation 7 – Improve data systems

Appropriately resource NADA and the sector to enhance quality client data collection and performance reporting, with a particular focus on improving client outcome data collection and utilisation.

Recommendation 8 – Embed research and evidence

NADA and the sector to work with research centres, government and key players to increase the research capacity of the sector, apply evidence based approaches and inform future research priorities.



6. APPENDICES

6. APPENDICES

APPENDIX 1: IN-SCOPE NADA MEMBER ORGANISATIONS

Number	Organisation Name	Program Name
1	Adele Dundas Inc.	Adele House
2	Calvary Mater Newcastle	Alcohol and Drug Service
3	Salvation Army	Alf Dawkins Detoxification Unit
4	Arbias Ltd	Arbias Specialist Services NSW
5	Benelong Haven Family Rehabilitation Centre	Benelong Haven Family Rehabilitation Centre
6	Salvation Army	Blue Mountains Recovery Services
7	Bridges	Bridges
8	Salvation Army	Central Coast Recovery Services
9	Mission Australia	Centre for Youth Well Being: Junaa Buwa
10	Detour House	Detour House
11	Blue Mountains Drug and Alcohol Recovery Services Inc.	Dianella Cottage
12	Drug and Alcohol Multicultural Education Centre (DAMEC)	Drug and Alcohol Multicultural Education Centre (DAMEC)
13	Youth Off The Streets	Dunlea AOD Youth Service
14	Family Drug Support	Family Drug Support
15	Construction Industry Drug and Alcohol Foundation	Foundation House
16	St Vincent de Paul Society	Freeman House
17	Ngaimpe Aboriginal Corporation	Glen Centre
18	St Vincent's Drug and Alcohol Service	Gorman House
19	GROW Community NSW	GROW Community
20	Guthrie House	Guthrie House
21	Holyoake Family AOD Program	Holyoake Family AOD Program
22	Women's Alcohol and Drug Advisory Centre	Jarrahdale House
23	Kamira	Kamira
24	Alcohol and Drug Foundation NSW	Kathleen York House
25	Kedesh Rehabilitation Services	Kedesh Rehabilitation Services
26	Salvation Army	Lake Macquarie Recovery Centre
27	The Lyndon Community	The Lyndon Community
28	Mission Australia	MA Centre - Drug and Alcohol Program
29	Manly Drug Education and Counselling Centre (MDECC)	Manly Drug Education and Counselling Centre (MDECC)
30	St Vincent de Paul Society	Maryfields Day Recovery Centre
31	Mercy Community Services	McAuley Outreach Service
32	Namatjira Haven Drug and Alcohol Healing Centre	Namatjira Haven Drug and Alcohol Healing Centre
33	Alcohol and Drug Service, Calvary Health Care Riverina	O'Connor House
34	Odyssey House McGrath Foundation	Odyssey House
35	Teen Challenge	One80TC
36	Oolong House	Oolong House
37	Orana Haven Aboriginal Corporation	Orana Haven Aboriginal Corporation

Continued over page

Appendix 1: In-Scope NADA member organisations *continued*

Number	Organisation Name	Program Name
38	Alcohol and Drug Service, Calvary Health Care Riverina	The Peppers
39	Phoebe House	Phoebe House
40	Ted Noffs Foundation	Program for Adolescent Life Management (PALM)
41	St George Youth Services	Resources & Education on Alcohol and Drugs for Youth (READY)
42	Salvation Army	Shoalhaven Bridge Program
43	SMART Recovery Australia	SMART Recovery
44	Mission Australia	South West Youth Services - Drug and Alcohol Awareness Program
45	Western Sydney Drug and Alcohol Resource Centre (WESDARC)	Substance.org
46	Uniting Care	Sydney Medically Supervised Injecting Centre(MSIC)
47	The Butterly	The Butterly
48	Mission Australia	Triple Care Farm
49	Upper Hunter Drug and Alcohol Service (UHDAS)	Upper Hunter Drug and Alcohol Service (UHDAS)
50	Watershed Drug and Alcohol Recovery and Education Centre	Watershed Drug and Alcohol Recovery and Education Centre
51	Waverley Drug and Alcohol Centre	Waverley Drug and Alcohol Centre
52	Wayback Committee	Wayback Committee
53	Weigelli Centre Aboriginal Corporation	Weigelli Centre
54	WHOS - We help Ourselves	WHOS Hunter
55	WHOS - We help Ourselves	WHOS Sydney
56	Salvation Army	William Booth House
57	Macarthur Drug and Alcohol Services Committee Incorporated	Youth Solutions

APPENDIX 2: PROJECT BACKGROUND, SCOPE AND METHODOLOGY

Mapping the New South Wales Non government Alcohol and other Drugs Sector Project (the Project) is intended to support the work of the Network of Alcohol and Other Drugs Agencies (NADA) by mapping and analysing the current provision of non government organisation (NGO) alcohol and other drugs (AOD) services across a number of domains. The mapping gathered information to describe the sector's role and breadth in the delivery of health and community services, the sector's history and current policy environment, profiled the sector's organisations, and profiled the sector's workforce.

Community based non government, private and public sector AOD providers all contribute significantly to the delivery of AOD treatment services in NSW. Their work is complemented by services provided by the public and private hospital systems.

Better articulating the sector's current capacity and opportunities for development will support activities for an improved interface between the government and NGO sectors. Such changes may include opportunities for NGOs and community-based service providers to deliver out-of-hospital care, which will allow those NGOs and community-based services to have new roles in providing treatment and care to their community. Policy and program considerations at the NSW State Government level (including realignment of the NGO grant arrangements, outsourcing from the public sector to the NGO sector and return to contract management by program areas in government) also provide the rationale for this Project.

People who use AOD treatment services and who benefit from the expertise of the specialist AOD sector are often among the most vulnerable people in society. AOD NGOs in NSW have a long history with communities and other government funded health and human services organisations encouraging and enabling individual and family wellbeing, recovery and participation in society. In order to make it easier for people to access the services they need when they need them, the AOD NGO providers strive to deliver services that are tailored to people's individual needs and preferences, that are consistently high quality, and of the right intensity and duration. They also participate in education and research activities, quality improvement and service delivery and outcomes data collection and reporting to the community and funders.

NADA is the peak organisation for the NGO AOD sector in NSW. NADA's main activities are advocacy, representing the sector and developing partnerships with government, funding bodies, other community services sectors, quality improvement service providers, education and training and advisory bodies, research bodies and the media. NADA also manage a range of projects that strengthen agencies to be sustainable, appropriately resourced and able to deliver quality services to those affected by drugs and alcohol.

The Project was led by NADA but is a collaborative project with the NSW Ministry of Health Mental Health Drug and Alcohol Office (MHDAO), and reflects NADA and MHDAO's longstanding working relationship. Better articulating the sector's current capacity and opportunities for development will support activities for an improved interface between the government and NGO sectors, particularly with the recent moves by governments away from big centralised planning processes.

Terms of reference

Project aim

The aim of the project was to provide a comprehensive description against an agreed way of classifying (taxonomy) the AOD services of the NSW NGO AOD sector that will inform NADA's advocacy and sector development activity.

Project scope

The Project considered the NSW based NADA member organisations (and one NADA member who is ACT based) that are funded to and/or provide specialist AOD services in NSW.

The Project focused on NSW based AOD 'specialist' members, whose sole or primary focus was AOD prevention, community development and/or treatment service delivery. This grouping makes up just over half of the full NADA membership. Whilst organisations whose primary focus was other than AOD service delivery were not the focus of this Project, data gathered will be used to inform NADA activities and services for all NADA members.

Project considerations

- AOD 'specialist' organisations
- State and Commonwealth policy and program development
- NSW Government outsourcing agenda
- NSW Health NGO Program reforms
- Drug and Alcohol Clinical Care and Prevention (DA-CCP) Project
- Commonwealth AOD program reviews.

Project Team

Siggins Miller was accountable to the NADA Project team for completing the Project deliverables within the agreed timeframe. NADA was responsible for ongoing management and monitoring of the Project, and for reporting to the NADA Board of Directors.

The NADA Project team was made up of:

- Larry Pierce, CEO
- Tanya Merinda, Director Planning and Strategy
- Heidi Becker, Program Manager.

Tanya Merinda was the NADA Project Lead responsible for coordinating and leading communication and activities. Individual NADA staff provided specific Project related guidance as required. The NADA team was responsible for announcing the Project to stakeholders.

The Siggins Miller Project Team was led by Professor Mel Miller, and Ms Geraldine Cleary was the project manager responsible for coordinating Siggins Miller's activities and being the consistent first contact person for the Project.

Expert Reference Group

NADA convened an Expert Reference Group (ERG) consisting of nominated members to provide broad guidance for the Project. NADA prepared the draft ERG Terms of Reference (ToRs) and correspondence for announcing the Project, introducing the consultants and inviting the proposed ERG members to participate in the Project.

NADA provided the secretariat for the ERG, including organising and chairing the three face-to-face meetings, designing and drafting the agenda, and drafting and circulating the minutes.

The Expert Reference Group included:

- Larry Pierce - CEO NADA (Chairperson)
- Tanya Merinda - Director Planning and Strategy NADA (Secretariat)
- Heidi Becker - Program Manager NADA
- Liz Junck Manager - Prevention and Community Based Programs, Mental Health Drug and Alcohol Office NSW Ministry of Health
- Garth Popple - CEO We Help Ourselves (WHOS); NADA Board Treasurer
- Gerard Byrne - Program Consultant, Recovery Services Salvation Army; NADA Ordinary Board Member
- A/Prof Nic Lintzeris - Director Drug and Alcohol Services South Eastern Sydney Local Health District
- Prof Mel Miller - Director Siggins Miller
- Geraldine Cleary - Associate Director Siggins Miller.

Methodology

Siggins Miller systematically reviewed relevant literature and reports to inform the deliverables, including the reports listed in the ToRs for this Project. The mapping entailed collation and review of program documentation; a preliminary literature review; design and implementation of surveys of services and workforce. We developed a sector taxonomy based on our review of evidence for systems of effective AOD harm reduction and care and AOD frameworks and classification systems. The taxonomy is presented earlier in this Report.

Our preliminary scan of the literature and reports also informed the design of the surveys and workshop protocols. The scan included a review of classification of services by service types or elements (i.e. medical research, training/ education, clinical care) based on client complexity, need and organisational capacity (similar to how public hospitals classify their patients and their 'illness') and aligned with the categorisation of the Drug and Alcohol Clinical Care and Prevention (DA-CCP) Project.

Some organisations that finished the survey did not provide responses to all survey questions. Where this is the case, it is noted in the analyses. Data were not included from survey respondents who started but did not complete the survey.

Sector mapping

Siggins Miller and NADA designed the consultation tools using the nomenclature and definitions for service types from the draft sector taxonomy agreed by the ERG and NADA, as well as the NADA 2008 workforce survey. Tools were drafted in consultation with NADA, seeking feedback out-of-session from the members of the ERG if needed.

The design of the consultation protocols (survey instruments, follow-up interview and workshop questions) was also guided by the framework for mapping capacity in the health sector. In addition to its focus on capacity at a variety of different levels (system, organisational, community and personnel), the framework also ensures that attention is paid to a variety of factors within the external environment, such as broader labour force issues and health worker capacity.

Stakeholder analysis

A total of 78 stakeholders were in scope for the consultations. They were categorised into three (3) groups: ERG members; representatives of NADA member organisations in scope (managers of the 57 services in scope); and non-provider stakeholders.

Consultation strategy

The consultation activities included:

- ERG meetings
- NADA Board consultation
- Organisation and staff surveys with member organisations in scope
- Follow-up telephone interviews with representatives of NADA organisations based on their organisation survey response
- Interviews with 16 nominated key informants
- Four consultation workshops (Western Sydney, Sydney, Lismore and Newcastle) with representatives of NADA organisation in scope (refer Appendix 6 for the workshop agenda and Appendix 7 for the workshop evaluation form).
- Some stakeholders participated in more than one consultation activity.

Survey and telephone interviews with representatives of NADA member organisations in scope

Two surveys were utilised for this Project: an organisation survey completed by managers, and a staff survey completed by the workforce. The surveys were presented with joint badging (NADA and Siggins Miller logos) and circulated by NADA to all managers of member organisations in scope. Managers were asked to circulate the staff survey to their staff and support them to complete it. NADA also advertised the survey to its members via the NADA website.

In addition to online completion of the surveys using the links provided, respondents had the option to complete the survey using a word version and submit it to Siggins Miller by email, post or fax depending on services' preferences. NADA sent three reminder emails during the three week period from when the survey went live. An additional week was incorporated into the project schedule to accommodate late submissions.

Siggins Miller reported weekly to NADA on the response rates, and NADA decided on strategies to prompt those organisations who had not yet provided a completed survey. The NADA Board Members also worked to generate responses to the survey. Siggins Miller agreed to extend the survey deadline by two weeks to the end of July so that additional responses could be added to the data after the preliminary analysis had been completed and discussed by the ERG on 16 August 2013.

Respondents to the organisation survey were given an option to nominate for a follow-up 15 minute phone interview to discuss issues. 28 of the 40 respondents nominated to be interviewed and 21 of these were available to be interviewed. The sample included a range of stakeholders across service types, population sub-groups and geographies.

Together, survey and follow-up interview data provide information on factors affecting current and future service capacity, and sector performance.

Telephone interviews with non-provider stakeholders

Siggins Miller conducted 16 telephone interviews with key informants in the NSW AOD sector nominated by NADA. Respondents represented the Government and non government sector, as well as other jurisdictions and related peak bodies in NSW.

Workshops

Using the findings from the literature and document reviews, the surveys and interviews with key informants we developed agendas for and facilitated four half-day workshops (two in Sydney and two in the regional locations of Newcastle and Lismore) with NADA members. These workshops were titled "Future of the sector: What are our funding and other needs". Feedback provided by workshop participants can be found at Appendix 8.

In addition, we designed and facilitated a 1.5 hour consultation workshop with the NADA Board at its meeting on 17 June 2013 in Sydney.

The consultation activities engaged the following stakeholders, with some people participating in more than one consultation:

- 12 participants in the NADA Board consultation meeting
- 310 participants in the staff survey
- 40 participants in the organisation survey
- 21 participants in the service provider follow-up interviews
- 16 participants in the key informant interviews
- 35 participants across four workshops (senior staff and managers in both clinical and non clinical positions from NADA in-scope organisations).

Siggins Miller accepted additional organisation and staff surveys received in the two week period after the survey close date. In total 339 staff were surveyed and their data were analysed and presented in the Workforce Profile. Additional data on funding sources were sought from the 40 organisations who completed the organisation survey, and 33 provided these data.

Data analysis activities

The Sector Taxonomy, presented in this report, was informed by a review of the literature and documentation on AOD service classification systems, taxonomies and frameworks used at the international, national and state and territory levels. It was also informed by review of the evidence for effective AOD interventions developed for the Project, and by ERG feedback (received May 2013).

The preliminary analyses of the consultation data informed preliminary findings about the nature and capacity of existing services, including needs addressed, current availability and access issues, service gaps and emerging issues. These findings were considered by the ERG and used in conjunction with the data from the document and literature reviews to develop the products for this Project.

The draft components of the Sector Mapping Report including the draft Sector Taxonomy, Contextual Profile, the Organisational Profile, and the Workforce Profile were developed and reviewed collaboratively by Siggins Miller and NADA..

Based on NADA's advice, Siggins Miller compiled all the amended material in separate sections in a single document. A presentation including key data from this report and points for discussion was prepared and presented to the ERG at its meeting in Sydney on Friday 11 October 2013. Based on feedback from the ERG, NADA undertook to redraft the recommendations. Siggins Miller and NADA also revised the taxonomy in line with ERG advice.



SIGGINS MILLER



NADA
network of alcohol & other drugs agencies

Mapping the NSW Non Government Drug and Alcohol Sector Project

Survey for drug and alcohol specialist organisations

Individual Staff Survey

Background information

The NADA *Mapping the NSW Non Government Drug and Alcohol Sector Project* will undertake an analysis of the NSW non government drug and alcohol sector in order to better describe the sector's role, breadth and outcomes in the delivery of health and community services. Siggins Miller has been engaged by NADA in partnership with the NSW Ministry of Health to conduct the Project. This Project will provide NADA and member organisations with information to guide advocacy and sector development initiatives.

As a staff member of a **drug and alcohol specialist organisation whose sole or primary focus is drug and alcohol prevention, community development and/or treatment service delivery**, you are invited to participate in this **staff survey** component of the Project. This staff survey is designed to gather information from **all staff** in these organisations, including, but not limited to, direct client workers, administration and managers.

We are also gathering sector information through an organisational survey. Your participation will help develop an understanding of the issues faced by staff and organisations in the non government drug and alcohol sector.

Thank you for participating in this consultation activity, your time and input is greatly appreciated. For further Project information, contact [REDACTED]

How to complete the survey

The survey can be completed by one of the following ways:

A large black rectangular box that obscures the survey questions and responses.

If you are printing the survey and filling it out on paper, please tick the appropriate box for your response. If you are completing this survey in a Word document on the computer, type X next to the appropriate box for your response, or highlight your response.



Survey questions

The survey will take approximately 10 – 15 minutes to complete, with many of the answers requiring a tick box response only. Please provide a response for each question.

Please complete the survey by Friday 21 June 2013.

Further information

Siggins Miller requests that you indicate the organisation you work for to assist in gathering a good response rate for data analysis. Your survey responses **will not** be linked to your organisation or provided to your organisation. Only de-identified data (without the name of your organisation) will be provided to NADA to contribute to the deliverables of this Project.

Your participation in this survey is voluntary and you may withdraw your participation at any time.



Your organisation

Q1: This is a list of organisations in scope for the Project. Please select your organisation (one only).

	<i>Program/Organisation</i>	<i>Organisation</i>
<input type="checkbox"/>	Adele House	Adele Dundas Inc
<input type="checkbox"/>	Alcohol and Drug Service	Calvary Mater Newcastle
<input type="checkbox"/>	Alf Dawkins Detoxification Unit	Salvation Army
<input type="checkbox"/>	Arbias Specialist Services NSW	Arbias Ltd (Victoria)
<input type="checkbox"/>	Benelong's Haven Family Rehabilitation Centre	Benelong's Haven Family Rehabilitation Centre
<input type="checkbox"/>	Blue Mountains Recovery Services	Salvation Army
<input type="checkbox"/>	Bridges	Bridges
<input type="checkbox"/>	Central Coast Recovery Services	Salvation Army
<input type="checkbox"/>	Centre for Youth Well Being; Junaa Buwa	Mission Australia
<input type="checkbox"/>	Detour House	Detour House
<input type="checkbox"/>	Dianella Cottage	Blue Mountains Drug and Alcohol Recovery Services Inc
<input type="checkbox"/>	Drug and Alcohol Multicultural Education Centre (DAMEC)	Drug and Alcohol Multicultural Education Centre (DAMEC)
<input type="checkbox"/>	Dunlea Alcohol and other Drug Youth Service	Youth Off The Streets
<input type="checkbox"/>	Family Drug Support	Family Drug Support
<input type="checkbox"/>	Foundation House	Construction Industry Drug and Alcohol Foundation
<input type="checkbox"/>	Freeman House	St Vincent de Paul Society
<input type="checkbox"/>	Glen Centre	Ngaimpe Aboriginal Corporation
<input type="checkbox"/>	Gorman House	St Vincents Drug and Alcohol Service
<input type="checkbox"/>	GROW Community	GROW Community NSW
<input type="checkbox"/>	Guthrie House	Guthrie House
<input type="checkbox"/>	Holyoake Family AOD Program	Holyoake Family AOD Program
<input type="checkbox"/>	Jarrahdale House	Women's Alcohol and Drug Advisory Centre
<input type="checkbox"/>	Kamira	Kamira
<input type="checkbox"/>	Kathleen York House	Alcohol and Drug Foundation NSW
<input type="checkbox"/>	Kedesh Rehabilitation Services	Kedesh Rehabilitation Services
<input type="checkbox"/>	Lake Macquarie Recovery Centre	Salvation Army
<input type="checkbox"/>	Lyndon Community	Lyndon Community
<input type="checkbox"/>	MA Centre - Drug and Alcohol Program	Mission Australia
<input type="checkbox"/>	Manly Drug Education and Counselling Centre (MDECC)	Manly Drug Education and Counselling Centre (MDECC)
<input type="checkbox"/>	Maryfields Day Recovery Centre	St Vincent de Paul Society
<input type="checkbox"/>	McAuley Outreach Service	Mercy Community Services
<input type="checkbox"/>	Namatjira Haven Drug and Alcohol Healing Centre	Namatjira Haven Drug and Alcohol Healing Centre



	<i>Program/Organisation</i>	<i>Organisation</i>
<input type="checkbox"/>	O'Connor House	Alcohol and Drug Service, Calvary Health Care Riverina
<input type="checkbox"/>	Odyssey House	Odyssey House McGrath Foundation
<input type="checkbox"/>	One80TC	Teen Challenge
<input type="checkbox"/>	Oolong House	Oolong House
<input type="checkbox"/>	Orana Haven Aboriginal Corporation	Orana Haven Aboriginal Corporation
<input type="checkbox"/>	Peppers	Alcohol and Drug Service, Calvary Health Care Riverina
<input type="checkbox"/>	Phoebe House	Phoebe House
<input type="checkbox"/>	Program for Adolescent Life Management (PALM)	Ted Noffs Foundation
<input type="checkbox"/>	Resources & Education on Alcohol and Drugs for Youth (READY)	St George Youth Services
<input type="checkbox"/>	Shoalhaven Bridge Program	Salvation Army
<input type="checkbox"/>	SMART Recovery	SMART Recovery Australia
<input type="checkbox"/>	South West Youth Services - Drug and Alcohol Awareness Program	Mission Australia
<input type="checkbox"/>	Substance.org	Western Sydney Drug and Alcohol Resource Centre (WESDARC)
<input type="checkbox"/>	Sydney Medically Supervised Injecting Centre(MSIC)	Uniting Care
<input type="checkbox"/>	The Buttery	The Buttery
<input type="checkbox"/>	Triple Care Farm	Mission Australia
<input type="checkbox"/>	Upper Hunter Drug and Alcohol Service (UHDAS)	Upper Hunter Drug and Alcohol Service (UHDAS)
<input type="checkbox"/>	Watershed Drug and Alcohol Recovery and Education Centre	Watershed Drug and Alcohol Recovery and Education Centre
<input type="checkbox"/>	Waverley Drug and Alcohol Centre	Waverley Drug and Alcohol Centre
<input type="checkbox"/>	Wayback Committee	Wayback Committee
<input type="checkbox"/>	Weigelli Centre	Weigelli Centre Aboriginal Corporation
<input type="checkbox"/>	WHOS Hunter	WHOS
<input type="checkbox"/>	WHOS Sydney	WHOS
<input type="checkbox"/>	William Booth House	Salvation Army
<input type="checkbox"/>	Youth Solutions	Macarthur Drug and Alcohol Services Committee Incorporated



- Q2: Where is your workplace located (*select one only*)?
- Major city
 Inner regional area
 Outer regional area
 Remote area
 Very remote area
- Q3: Indicate the type/s of services your organisation provides (*select all that apply*):
- Psychosocial counselling
 Psychosocial aftercare/continuing care program
 Withdrawal management
 Residential rehabilitation
 Drug and alcohol health promotion and prevention - information and education
 Drug and alcohol health promotion and prevention - community development
 Supported living/transitional housing program
 Other (specify): _____

About you

- Q4: What is your age?
_____ years
- Q5: What is your gender (*select one only*)?
- Male
 Female
 Other
- Q6: Do you identify as Aboriginal or Torres Strait Islander (*select one only*)?
- No
 Yes, Aboriginal
 Yes, Torres Strait Islander
 Yes, Aboriginal and Torres Strait Islander
- Q7: Do you identify as from a culturally and linguistically diverse background (*select one only*)?
- No
 Yes (specify): _____
- Q8: Do you speak a second language in your workplace (*select one only*)?
- No
 Yes (specify): _____



Your employment

Q9: Which best describes your employment contract type (*select one only*)?

- Permanent full time
- Permanent part time (specify average weekly hours): _____
- Fixed term contract (specify length and weekly hours of contract): _____
- Casual (specify average weekly hours): _____
- Other (specify): _____

Q10: What primary position title are you employed under (*select one only*)?

- Drug and Alcohol Worker
- Drug and Alcohol Counsellor
- Aboriginal Drug and Alcohol Worker
- CALD Drug and Alcohol Worker
- Residential Support Worker
- Outreach/Aftercare Worker
- Psychologist
- Intern Psychologist
- Social Worker
- Registered Nurse
- Enrolled Nurse
- Allied Health Professional other (specify: _____)
- Medical Officer
- Addiction Medicine Specialist
- Psychiatrist
- Health Promotion Worker
- Community Development Worker
- Team Leader/Manager (with client/clinical duties)
- Team Leader/Manager (with coordination role without client/clinical duties)
- Project Officer
- Administration Officer/Receptionist
- Finance / Business Officer
- Quality Improvement Coordinator
- Policy Officer
- Research Officer
- CEO/Executive Officer/Organisation Manager
- Other (specify): _____

Q11: What are the three main tasks involved in your job (e.g. counselling, client casework, research, managing staff)? (*List 3 only*).

Q12: In an average week, how many additional unpaid hours would you work?

- No additional unpaid hours worked
- _____ hours



Q13: Which Award classification level and year are you employed under (*select one only*)?

- SCHADS SACS Level 1 Year _____
- SCHADS SACS Level 2 Year _____
- SCHADS SACS Level 3 Year _____
- SCHADS SACS Level 4 Year _____
- SCHADS SACS Level 5 Year _____
- SCHADS SACS Level 6 Year _____
- SCHADS SACS Level 7 Year _____
- SCHADS SACS Level 8 Year _____
- Other Award classification (specify): _____
- No award, individual contract

Q14: Indicate your annual gross (before tax) salary range (*select one only*).

- Less than \$20,000
- \$20,001-\$30,000
- \$30,001-\$40,000
- \$40,001-\$50,000
- \$50,001-\$60,000
- \$60,001-\$70,000
- \$70,001-\$80,000
- \$80,001 - \$100,000
- More than \$100,000
- No salary, I am a volunteer

Q15: What employment related incentives/conditions does your organisation provide (*select all that apply*)?

- Time in Lieu (TIL)
- Additional paid leave (e.g. service closure of Christmas / New Year period)
- Flexible work practices (e.g. changing start times, attending personal appointments outside of lunch hours)
- Flexi leave / rostered day off (RDO)
- Annual salary increments
- Indexation (CPI)
- Study leave - paid
- Study leave - unpaid
- Conference leave
- Superannuation matching (employer contributes the same amount that you do)
- Employee Assistance Program (EAP)
- Unpaid leave (specify): _____
- No employment related incentives / conditions provided
- Other (specify): _____
- Other (specify): _____

Q16: On average per year, how much time does your organisation provide for you to undertake training?

_____ days per year



Q17: Provide a response for each of the following statements about clinical supervision:

	Yes	No	Don't know	Not applicable to me
Clinical supervision is important for my work with clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My organisation facilitates/provides for clinical supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I receive clinical supervision at least monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical supervision is provided by someone within my organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical supervision is provided by someone external to my organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical supervision is provided via video conferencing/tele-health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The clinical supervision I receive provides adequate support for working with clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your experience and qualifications

Q18: How many years have you worked in:

Your current position: _____ years

Your current organisation: _____ years

The drug and alcohol sector: _____ years

Workforce in total: _____ years

Q19: Where was your last employment position (*select one only*)?

- Current organisation
- Another non government drug and alcohol organisation
- Government drug and alcohol organisation
- Another sector (specify): _____
- None - new graduate
- None – returning to workforce after lengthy break
- Other (specify): _____

Q20: Apart from drug and alcohol, what other sectors have you worked in (*select all that apply*)?

- Youth
- Mental health
- Disability
- Education
- Community services
- Medical (hospital/other clinical)
- Government
- Private/own business
- Have not worked in another sector
- Other (specify): _____



Q21: What specific drug and alcohol qualification do you hold (*select all that apply*)?

- No specific drug and alcohol qualification
- Certificate IV AOD
- Diploma in AOD
- Diploma in AOD and Mental Health
- Undergraduate Degree in AOD (specify): _____
- Postgraduate studies (specify): _____
- Other: _____
- Other: _____

Q22: What is the highest qualification you have obtained (does not need to be drug and alcohol specific) (*select one only*)?

- Up to and including Year 10/School Certificate
- Year 12 or equivalent College Certificate
- Certificate II (specify): _____
- Certificate III (specify): _____
- Certificate IV (specify): _____
- Diploma (specify): _____
- Advanced Diploma (specify): _____
- Undergraduate Degree (specify): _____
- Graduate Certificate (specify): _____
- Graduate Diploma (specify): _____
- Masters Degree (specify): _____
- PhD/Doctorate (specify): _____
- Other (specify): _____

Q22a: Did you obtain your highest qualification in the past 12 months?

- Yes
- No

Q23: In the past 12 months, what training have you completed (*select all that apply*)?

- No training
- Short course/s (specify course name): _____
- Supervised workplace training (specify): _____
- Self directed learning (specify): _____
- Other (specify): _____

Q24: Are you currently studying a formal qualification?

- No
- Yes (specify): _____



Q25: How competent are you working with drug and alcohol clients who also experience the following: (select the statement that best applies to you):

	<i>Not applicable/ not relevant to my role</i>	<i>I am not competent</i>	<i>I have minimum competence</i>	<i>I am mostly competent</i>	<i>I am competent</i>	<i>I have advanced competence</i>
Anxiety and/or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar or schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality spectrum disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clients identifying as Aboriginal and/or Torres Strait Islander	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness or risk of homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired brain injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coming direct from prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bail or parole conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other connection with criminal justice system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal alcohol spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Services involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving Opioid Substitution Therapy (OST)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child and/or adult sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current or previous domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culturally and linguistically diverse backgrounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low literacy skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Future workforce development

Q26: What learning method do you prefer to gain new skills and knowledge (*select all that apply*)?

- On-the-job training
- Short courses/workshops
- Self directed learning (e.g. online)
- Conferences, seminars, forums, etc
- Formal qualification courses (VET, university)
- Other (specify): _____

Q27: Are you intending to undertake formal study or training in the next 12 months?

- No
- Yes (specify): _____

Q28: Have you noticed a changing pattern in clients' drug use in the past 5 years?

- No
- Yes. Describe the change: _____

Q29: Have you noticed a changing pattern in demand for services in the past 5 years?

- No
- Yes. Describe the change: _____

Q30: If you have noticed a change in the pattern of clients' drug use or in the demand for services, what impact has this had on you and your work?

Q31: Thinking about the next three years, what are the three main issues/subjects **you** need development support in (*Please select only 3*)?

- Strategic planning
- Organisation performance reporting
- Tender submissions/writing
- Quality improvement programs
- Client data management
- Program/service evaluation
- Research
- Consumer participation
- Responding to client complexity (specify): _____
- Other client/clinical (specify): _____
- Other: (specify): _____
- Other: (specify): _____



Q32: Thinking about the next three years, what are the three main workforce development issues for the non government drug and alcohol sector (*Please select only 3*)?

- Recruitment of staff with appropriate knowledge, skill and/or qualifications
- Retention staff with appropriate knowledge, skill and/or qualifications
- Strategic direction for workforce development
- Resources and access to professional development
- Lower wages in comparison to government drug and alcohol / health / welfare sector
- Lower wages in comparison to other sectors
- Recognition and profile of the sector
- Other (specify): _____
- Other (specify): _____

Q33: How satisfied are you working in the non government drug and alcohol sector (*select one only*)?

- Very satisfied
- Satisfied
- Somewhat satisfied
- Unsatisfied
- Very unsatisfied

Q34: Where do you plan to be working in two years time (*select one only*)?

- In current position
- Different position in current organisation
- Position in another drug and alcohol NGO
- Position in a government drug and alcohol service
- Leaving the drug and alcohol sector - moving to _____ sector
- Studying full time
- Retiring
- Other (specify): _____

Additional comments

Do you have any other comments?

For example, issues impacting on your organisation, workforce, or drug and alcohol sector.

Thank you for completing this survey.

Contact NADA if you would like a copy of the Organisational Survey





NADA

network of alcohol & other drugs agencies

