
# NSW Alcohol and Other Drug Non Government Sector: Workforce Profile and Issues 2008

Funded by the Illicit Drug Diversion Initiative
through the NSW Health Department

# NSW Alcohol and Other Drug Non Government Sector:

## Workforce Profile and Issues

Prepared for: the Network of Alcohol and Other Drug Agencies (NADA)

Anni Gethin
Argyle Research and Training Pty Limited

## Acknowledgements

This report was completed with the assistance of NADA, and managers and staff from the non government alcohol and drug workforce. Argyle Research sincerely thanks all the people involved for their time and contributions.

# Table of Contents

# Tables and figures

## List of tables



## List of figures

# PART 1 – INTRODUCTION

# Introduction

## The NSW alcohol and other drug non government sector

The NSW alcohol and other drug non government (AOD NGO) sector is characterised by a highly diverse range of agencies, treatment models, and philosophical orientations. To date, the workforce of this sector has not been accurately profiled, nor has a systemic appraisal been made of the main issues affecting AOD workers employed in NGOs in NSW. This research aims to address these information gaps, and to assist agencies in better meeting the needs of their clients. It was commissioned by the peak body of the NSW AOD NGO sector, the Network of Alcohol and Drug Agencies (NADA).

This research provides the following information:

- a profile of the AOD NGO sector in NSW - including a count of the workforce, key demographic characteristics, levels of education, and training and job roles
- identification and analysis of key issues and trends that impact the workforce and their training and development needs. These include, the policy context, recruitment and retention of staff, changing trends of drug use, ex users as AOD workers and increasing complexity of client needs, and
- a map of the main skills required for the key roles in AOD work (including case worker, counsellor and team leader), and an assessment of the adequacy of existing education and training in preparing workers for the sector.

## The purpose of this research

This information is useful to NADA and NADA members in identifying specific challenges to AOD NGO agencies and workers within NSW. It is intended that NADA and its member agencies are able to use the information to help

- address skills and knowledge gaps in the sector
- inform grant applicants
- plan for the future of the sector
- find ways to improve training provision and quality
- address recruitment and retention issues, and
- improve referrals and information exchange.

The research findings also contribute to knowledge about AOD work in NSW and Australia. A survey of managers of AOD services across Australia found that "more information is required on the key characteristics of the AOD workforce and their workforce development needs. Such information can contribute to policies and strategies that develop the capacity of the AOD sector to manage and treat the increasingly complex needs of clients."[1]

This research is mainly drawn from the AOD NGO sector itself, using data from agency and worker surveys and interviews with managers and workers. It also builds on existing Australian AOD workforce research and refers to the policy context, including the NSW State Plan and the NSW Health Drug and Alcohol Plan 2006-2010. In addition, recent AOD research is used to examine issues such as trends in drug usage and coexisting disorders.

The research is part of NADA's Workforce Development program. It was conducted by consultants Dr Anni Gethin of Argyle Research in association with Edwina Deakin of EJD Consulting and Associates. The research took place between November 2007 and June 2008.

## Methodology

The workforce profile and issues analysis used a mix of research methods. These included

- a survey of NSW based NGO NADA member sites
- a survey of workers and managers in the sector
- individual and group interviews
- a workshop (skills mapping) and a focus group (psychology interns)
- ongoing consultation with NADA staff throughout the project
- consultation with the NADA Workforce Advisory Committee, and
- literature analysis (including workforce research, drug trends, policy and training documentation).

### Sampling frame: The NADA member list

The research aimed to obtain workforce data for every NADA member agency. NADA membership includes all NSW Health-funded AOD NGOs and approximately 90 percent of the total number of AOD NGO agencies in NSW. It also includes a number of additional human services NGOs that employ AOD workers. Thus, the NADA membership list can be considered as highly representative of the AOD NGO sector in NSW.

NADA lists its members by operational site or agency. A number of the larger, multi-site agencies such as The Salvation Army and Mission Australia have numerous membership listings, as these agencies list all their sites, including some that are not specifically AOD related. Other agencies, such as The Ted Noffs Foundation or Odyssey House, may operate from multiple sites but have only one listing. The list also contains sites that did not meet

[1] Roche,A., O'Neill,M., Wolinski, K. (2007). 'Alcohol and other drug specialist treatment services and their managers: Findings from a national survey.' *Australian and New Zealand Journal of Public Health.* (28)3. 252-258.

the criteria for this research. Accordingly, the membership list needed to be refined to ensure that all relevant member sites were included. Where agencies only had a single listing, but multiple sites, details were obtained for the unlisted sites. Excluded from the research were a small number of interstate sites, private clinics, duplicate contact points and defunded agencies. Also excluded were sites that are part of the membership list but do not employ any AOD workers (e.g. services for the homeless). After this process, there were 107 sites included in the research.

### Agency survey

The managers of member sites were asked to complete a data sheet for their workforce (Attachment 1). Response rates to email contact were modest (20%). However, follow-up phone calls and e-mail reminders, site visits by the researchers and data from the NADA training needs analysis ensured that workforce data was obtained for 85% of sites with, at minimum, a count of FTE staff, numbers of full and part-time workers and their main roles being provided for each site. All major NGO providers (The Salvation Army, The Ted Noffs Foundation, Odyssey House, Mission Australian and We Help Ourselves) provided data. Electronic research was used to make a best estimate of the staffing numbers of the remaining agencies.

The particular strength of the agency survey is that it enables data to be collected that cannot reliably be obtained through individual worker surveys. This includes data related to proportions of casuals and night staff (who may be less likely to complete surveys), fractional professionals (such as doctors and psychologists), and 'churn' (staff leaving) across the sector.

### Worker survey

An individual worker survey was used to obtain workforce information such as age, work history and career intentions (see Attachment 2).

These surveys were initially distributed in October 2007 to attendees at the NADA conference and subsequently distributed via e-mail to all member sites with a request to distribute to staff. The response rate on this survey was moderately low (111 – out of an estimated workforce of 1065).

### Interviews and focus group

Semi-structured interviews were held with 21 agency staff. (See Attachments 3 for interviewees). Interview questions covered the range of service models. New interviews continued until 'saturation point,' or the point that the same issues were being repeated by interviewees, was reached[2] A focus group was conducted with psychology interns in order to obtain the views of professionals entering the field. In addition, interviews were held with key NADA staff.

### AOD skills and knowledge mapping workshop

A workshop was held with 10 participants (primarily experienced service managers – see Attachment 3) to map the skills required of those in the main AOD worker roles. The main skills required for each role were identified. Key gaps in the knowledge and skills of workers entering the field were discussed, and assessments were made of the adequacy of the Certificate IV in AOD Work as preparation for working in the sector.

### Data analysis

The survey data (agency and worker) was analysed using Microsoft Office Excel and SPSS. The qualitative data was analysed according to the following themes:

- specific staff skills and knowledge required by services
- recruitment and retention issues
- impact of increasing professionalism and minimum qualifications on staff and services
- AOD education and training as preparation for work in the sector
- trends in client needs (e.g. complexity, coexisting disorders, new drug trends), and
- capacity of staff to address emerging trends.

[2] Kvale, S. (1996). *InterViews.* Thousand Oaks, CA.: Sage Publications.

# PART 2 - SECTOR AND WORKFORCE PROFILE

# Sector profile

## Overview

Diversity is a key characteristic of the AOD NGO sector. Philosophical orientation ranges from religiously based abstinence models to the sharp end of harm minimisation. Philosophical orientation can vary between staff or programs within one organisation. AOD-related work is undertaken by a wide range of agencies that use diverse service delivery methods and treatment models. A non-government AOD worker could be employed, for example, within a large residential rehabilitation centre operated by a charity, a remote Aboriginal controlled organisation, a hostel for intoxicated persons, a youth outreach team or a community development organisation. The workforce includes trained AOD workers, counsellors, support workers, nurses, psychologists, doctors, former and current drug users, researchers, drug educators and health promotion workers.

## Categories of NADA member sites

Within the NADA membership, AOD workers are employed in two broad categories of sites (see Table 1). These are

- specialist AOD sites, whose focus is AOD related (e.g. residential rehabilitation, counselling and referral), and
- social service agency sites with AOD programs or workers, which have another main focus. They may focus, for example, on homelessness, employment or youth services, but they operate an AOD program or employ AOD workers (e.g. an AOD counsellor or project worker).

**Table 1. NADA member sites by category**

| Member Sites[3] | No. | % |
|---|---|---|
| Specialised AOD sites | 77 | 72 |
| AOD programs/workers | 30 | 28 |
| **Total** | **107** | **100** |

Source: NADA Agency Data Survey, n=107.

[3] For the purposes of profiling the AOD workforce the focus is only on the 107 sites where AOD workers are employed, - the 13 member sites which had no specialised AOD workers or programs were not included).

## Service delivery models

AOD services can be delivered to clients in a number of ways. The most common service delivery model of NGO agencies is residential rehabilitation, followed by non-residential counselling and referral services. Table 2 lists the service models and the proportion of sites that offer each as defined by their main service. Some sites offer more than one main service.[4]

**Table 2. NADA member sites by main service model[5]**

| Service Type | No. | % |
|---|---|---|
| Residential rehabilitation | 41 | 38 |
| Outpatient counselling/referral | 35 | 33 |
| Detoxification | 9 | 8 |
| Information/education | 10 | 9 |
| Other 1 (frontline)[6] | 8 | 7 |
| Other 2 (support/allied)[7] | 8 | 7 |

Source: NADA Agency Survey, n=107.

## Philosophical orientation

Within the sector, the philosophical orientations of agencies are usually described as abstinence-based or harm minimisation. Most services are oriented to harm minimisation, but there is a substantial minority that are abstinence based.

**Table 3. NADA member sites by philosophical orientation**

| Orientation | No. | % |
|---|---|---|
| Harm minimisation | 85 | 79 |
| Abstinence based | 22 | 21 |
| **Total** | 107 | 100 |

Source: NADA Agency Survey, n=107.

[5] Some sites had more than one main service.
[6] Includes intoxicated person units, injecting centre, day program, crisis accommodation and half way houses.
[7] Includes research, training, family support and community development.

# Workforce Profile

## Overview

The workforce profile provides data for workers employed by NADA member agencies. All of these workers are employed in activities directly related to AOD services or in the management or support of these activities. Overall, there are an estimated 1065 AOD- related workers employed in NADA member sites. This profile identifies the demographics, work patterns, job roles, and qualifications of this workforce.

The estimated size of the NSW AOD NGO Workforce employed by NADA member agencies is 1065 workers – including frontline workers, managers, professionals and allied and support workers.

## Demographics

The workforce is predominantly female (61%) and the average age of workers is 44, with nearly half of workers over 45 (Tables 4 and 5). Aboriginal workers comprise approximately 4 percent of the workforce and culturally and linguistically diverse (CALD) identified workers comprise approximately 6 percent (Table 6).

These demographics are reflective of the general trends observed by other Australian AOD workforce studies[89] (including government and non government workers). That is, the AOD workforce is female-dominated and mature, with most workers over 40 and nearly half over 45. There are small percentages of Aboriginal and CALD workers.

[8] Duraisingam, V., Vidd, K., Roche, A., O'Connor, J. (2006*). Stress, satisfaction and retention among alcohol and other drug workers in Australia*. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.
[9] Macdonald, D. (2006). *A profile of the Australian Capital Territory alcohol and other drugs workforce*. Canberra: Social Research and Evaluation.

**Table 4. Workforce by gender**

| Gender | Freq. | % |
|---|---|---|
| Female | 454 | 61 |
| Male | 291 | 39 |
| **Total** | 745 | 100 |

Source: NADA Agency Survey Data, n=745.

**Figure 1. Workforce by Gender**

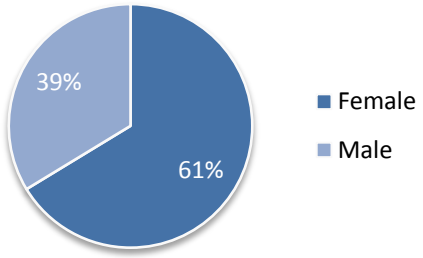



**Table 5. Workforce by age**

| Category | Data |
|---|---|
| Average | 43.8 |
| Range | 22-67 |
| 45+ | 48% |

Source: NADA Worker Survey, n=111.

**Table 6. Aboriginal and CALD**

| Identity | Freq. | % |
|---|---|---|
| Aboriginal | 32 | 4 |
| CALD | 48 | 6 |

Source: NADA Agency Survey data, n=745.

## Work patterns

Most workers (54%) are employed full-time, with 27 percent employed part time. Very few workers (3%) are on fixed contracts, and 15 percent are casuals. The proportion of part-time and casual staff (42%) is higher than that recorded in other AOD workforce studies,[11,12] with NCETA (2006) observing a 70%/30% split between full time and part time staff and Macdonald (2006) a 75%/25% split for the ACT AOD workforce. This difference is most likely a reflection of two factors. First, it indicates that more part time and casual workers are employed in NGOs than government AOD agencies; and second, it may reflect that the methodology used in this research accounted more accurately for part-time and casual staff (i.e. data was recorded by agency managers rather than individual employees).

**Table 7. Workforce by work pattern**

| Work Pattern | Freq. | % |
|---|---|---|
| Full time | 405 | 54 |
| Part Time | 202 | 27 |
| Fixed contract | 26 | 3 |
| Casual | 112 | 15 |
| **Total** | 745 | 100 |

Source: NADA Agency Survey, n=745

[11] Duraisingam, V., Vidd, K., Roche, A., O'Connor, J. (2006). *Stress, satisfaction and retention among alcohol and other drug workers in Australia*. National Centre for Education and Training on Addiction (NCETA). Adelaide: Flinders University.
[12] Macdonald, D. (2006). *A profile of the Australian Capital Territory alcohol and other drugs workforce*. Canberra: Social Research and Evaluation.

Work patterns by gender are generally consistent with the gender division in the sector, or quite close to the gender split of 61% female, 39% male. Using these proportions, there are not significant differences in patterns of work by gender.

**Table 8. Work pattern by gender**

| Work Pattern | Female | % | Male | % | Total |
|---|---|---|---|---|---|
| Full time | 241 | 59 | 164 | 41 | 405 |
| Part Time | 125 | 62 | 77 | 38 | 202 |
| Fixed contract | 17 | 65 | 9 | 35 | 26 |
| Casual | 71 | 63 | 41 | 37 | 112 |

Source: NADA Agency Survey, n=745

## Qualifications

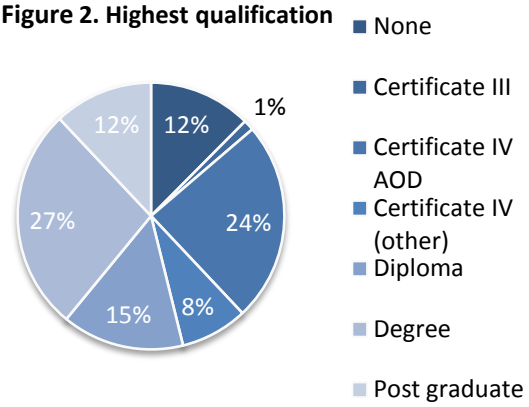
The workforce is generally well qualified with 87 percent having a Certificate IV or above; nearly 40 percent have an undergraduate degree and/or a post-graduate qualification. A high proportion of workers (24%) hold the Certificate IV in AOD Work specialist qualification. This reflects the trend reported by managers of agencies to have all or most of their staff obtain the Certificate IV in AOD Work qualification. Also, some larger agencies reported that they put their staff through their own registered training organisations. Overall, approximately one third of the workforce has a specialist AOD qualification, including other AOD-focused courses such as Masters of Addiction Studies.

**Table 9. Workforce by highest qualification**

| Qualification | Freq | % |
|---|---|---|
| None | 58 | 12 |
| Certificate III | 6 | 1 |
| Certificate IV AOD | 113 | 24 |
| Certificate IV | 38 | 8 |
| Diploma | 69 | 15 |
| Degree | 126 | 27 |
| Post graduate | 56 | 12 |
| **Total** | 466 | 100 |

Source: NADA Agency Survey, n=466

**Figure 2. Highest qualification**



## Job roles

Frontline AOD workers form the bulk of job roles in the in the sector, with 48 percent of workers employed as AOD caseworkers, AOD counsellors, support workers, intake officers and welfare workers. Management and administration roles form the next highest proportion at 23 percent, with the remainder of the workforce fairly evenly divided between the professional roles of psychologists, doctors and nurses, and the health promotion, research and community development roles (Table 10). There were also an additional 2 percent of workers in other roles.

The distribution of job roles in the AOD NGO sector differs markedly from the Government sector where the highest proportion of workers are nurses (47%)[13] as compared to 8 percent in the NGO sector; and workers employed as frontline AOD workers (27%)[14] as compared to 49 percent in the NGO sector. These differences in job role distribution can be seen primarily as a reflection of the different distribution of service models of the NGO sector: residential rehabilitation and counselling services predominate as opposed to clinical and community health settings. It can also be noted that non-professional staff are more affordable for NGOs to employ — even if they would like to employ more professional staff, there are significant cost restraints in doing so.

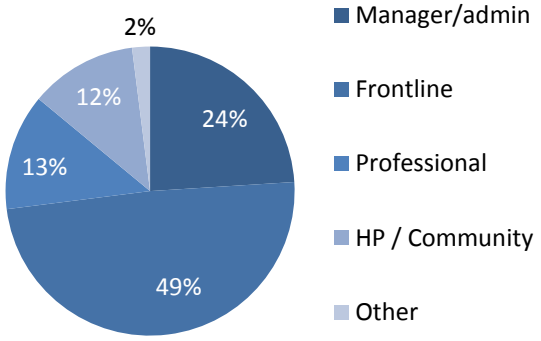
[13] Duraisingam, V., Vidd, K., Roche, A., O'Connor, J. (2006). Stress, satisfaction and retention among alcohol and other drug workers in Australia. National Centre for Education and Training on Addiction (NCETA). Adelaide: Flinders University.
[14] *ibid*

**Table 10. Workforce roles**

| Role | Freq. | %* |
|---|---|---|
| Manager | 58 | 8 |
| Clinical coordinator | 15 | 2 |
| Team leader | 32 | 4 |
| Administration | 64 | 9 |
| **Total manager/admin** | **169** | **24** |
| AOD case worker | 128 | 18 |
| Counsellor | 89 | 13 |
| Residential support worker | 87 | 12 |
| Intake officer | 17 | 2 |
| Welfare worker | 23 | 3 |
| **Total front line** | **344** | **49** |
| Nurse | 57 | 8 |
| GP | 11 | 2 |
| Psychologist | 17 | 2 |
| Social worker | 4 | 1 |
| **Total professional** | **89** | **13** |
| Health promotion worker | 50 | 7 |
| Comm. development worker | 10 | 1 |
| Project worker | 16 | 2 |
| Policy/research | 5 | 1 |
| **Total HP/Community** | **81** | **12** |
| **Other** | **15** | **2** |

Source: NADA Agency Data Survey 2008, n=698
*Small variations due to rounding.

**Figure 3. Workforce Roles**



# Recruitment, retention and staff movement

## The issues

Recruiting and retaining staff can be an issue for the AOD NGO sector, largely because the sector's typical salaries are not comparable with those offered by government agencies. However, on the positive side, working in NGOs is seen to offer a range of benefits — such as greater flexibility and autonomy — when compared to work in the government AOD sector. Those who participated in this study generally expressed a high level of satisfaction with their work, although burnout and salary dissatisfaction were significant issues. In terms of staff movement within the AOD sector as a whole, managers and staff would like to see a reduction of the barriers to staff movement between government and non-government agencies as well as improved ease of staff movement between NGOs.

*"When AIDS first hit it was easy to find staff – drugs were sexy – it was all sex and drugs and death. Now it is a lot harder. And at the end of a funding cycle we can't find anyone to work here."* Clinical coordinator

*"We used to get twelve applications for job ads and interview eight, now it's more like four with two to interview."* Program director

*"We have tried everything to get a new caseworker – newspapers, internet – and for months no response."* Coordinator

*"The salaries will never be comparable. If the government could run AOD services as cheaply as the NGO sector – they'd do it themselves."* Service Manager

## Recruitment

Filling staff positions is increasingly becoming a problem for most agencies. Managers reported observing a clear drop in responses to job advertisements. The main reasons cited for recruitment difficulties were

- lower salaries as compared to the government AOD sector
- a tight employment market (The Australian work force, with a 4% unemployment rate, is close to full employment)[15]
- particular difficulties recruiting nurses
- decreased appeal of working in the alcohol and drug sector
- lack of opportunity for career progression for non-professional staff
- disincentives for potential staff from the government AOD sector, such as loss of pay, benefits and superannuation, and
- difficulties in moving between NGOs, which also raises the issues of potential loss of benefits and superannuation.

[15] Australian Bureau of Statistics (2008). 6202.0 - Labour Force, Australia, Feb 2008. Canberra: ABS.

A minority of agencies reported having fewer or no difficulties in finding staff. These agencies differed from others in the following respects:

- offered wages comparable to the government sector for professional positions
- offered a high level of training and staff development opportunities that were understood to increase the career and employment prospects of staff, and
- consistent ability to recruit from staff that had done a placement at the agency.

### Recruitment sources

The main sources of recruitment are other AOD NGO agencies and other NGOS. This is followed by new graduate, former client and 'other sector' recruits. Government AOD agencies and government agencies in general ranked as the lowest sources of recruitment. These rankings are entirely consistent with the comments of staff and managers, which indicated that recruitment from the government sector is difficult due to that sector's higher wages and better conditions for employees. Once a worker is employed in a government agency, they are unlikely to shift or return to the NGO sector. The rankings also suggest a fair degree of staff movement between NADA member agencies and between NGO welfare agencies in general.

**Table 11. Sector recruitment sources - Ranked**

| Recruitment Source | Rank |
|---|---|
| Other NGO AOD | 1 |
| Other NGO | 2 |
| New graduates | 3 |
| Former clients | 4 |
| Other sector | 5 |
| Government AOD | 6 |
| Other Government | 7 |

Source: NADA Agency Data Survey 2008

*"We find it difficult to recruit and retain frontline staff due to the challenging nature of the work, demands of rotating roster and the inability to match salaries with government agencies, e.g. DoCS."* Manager, residential rehabilitation facility.

## Retention

Staff retention is quite stable across the sector, with a reported 36 percent turnover in a three year period, and an average of around 12 percent staff churn each year.[16] Although some agencies had higher than average levels of staff departures, these levels were surprisingly low given the reported dissatisfaction with pay levels. However, the low churn is consistent with the comments of managers that retaining existing staff is much less of a

[16] Agency Data Survey 2007, n=426

problem for agencies than recruitment, and that permanent full- time and part-time staff are quite stable. Some agencies had formal staff retention programs, but the majority of survey respondents and interviewees cited other workplace factors that contributed to staff satisfaction and commitment to their agency.

## Formal retention programs

Approximately 20 percent of agencies/sites had formal staff retention programs. These programs included the following elements:

- professional development programs
- training plans and reviews
- support for external training
- practice and development days
- executive coaching
- talent mapping
- support for career goals
- part-time work
- clinical supervision
- internal transfers
- career opportunities and progression
- time in lieu
- flexibility
- supportive management
- self rostering
- succession management
- staff housing, and
- staff outings.

*"I just love my job, and I love working here. If I had to work for the government, with all the pointless processes and rules: well, I think I would find it very frustrating."*
Psychologist

*"We retain 60% of our staff long term, another 30% medium term (2-4 years), with 10% moving on more quickly."*

Operations manager – large multi site agency.

### Factors in retaining staff

Although most agencies did not have formal retention programs, there are a number of factors that clearly assist AOD NGO agencies in retaining staff. These include both features to induce staff loyalty and specific activities and programs undertaken by management which assist in staff retention. Such factors include

- packaging salaries to reduce the disparity between NGO and government salaries
- commitment to the organisational ethos (e.g. "Staff are committed to the Army.")
- commitment to a particular treatment model (e.g. "Staff are passionate about the 12-step model.")
- support for training and development (e.g. "We give staff paid time off to study.")
- professional supervision
- active prevention of stress and burn out (e.g. time off from particular roles or duties, supporting strong supervisory relationships, ensuring time in lieu is taken)
- high level of flexibility in working hours (e.g. "We fit in with them.")
- having all staff part-time (e.g. "It protects against burnout.")
- staff autonomy (e.g. "We have a very flat management structure and encourage staff to make their own decisions and use their imagination."), and
- social events and team building.

## Staff movement and intentions

Staff were asked where they had last worked prior to their current position (Table 12). The largest proportion (44%) had worked within the AOD NGO sector, 25 percent in the same organisation and 19 percent in another AOD NGO agency. The next-largest proportion (36%) had previously worked in another sector, of which the highest category (12%) was social service-related positions (see Table 13). The movement from Government AOD agencies into the AOD NGO sector (6%) was relatively small.

**Table 12.Last position worked**

| Last Position | % |
|---|---|
| In same organization | 25 |
| Other AOD NGO agency | 19 |
| Subtotal AOD NGO | 44 |
| Government AOD agency | 6 |
| Other sector | 36 |
| Returning to workforce | 3 |
| None (i.e. first position) | 4 |
| Other | 2 |

Source: NADA Staff Survey 2007, n=111

**Table 13. Last position if 'other sector'**

| Sector | %* |
|---|---|
| Youth | 1 |
| Mental Health | 2 |
| Medical | 3 |
| Health | 4 |
| Social services | 12 |
| Education | 3 |
| Community | 1 |
| Other Government | 4 |
| Private Sector | 6 |
| Own business | 1 |

Source: Worker Survey, n=40

*As a percentage of all staff surveyed

Workers were asked about their movement intentions for the next two years — if they were intending a change in role, whether they intended to move within their current agency, to another agency or to undertake other activities (see Table 14). The largest proportion (43%) expressed no clear intention of moving from their current role. For those selecting options, 'within agency movement' formed the largest proportion of intentions, with 19 percent planning to seek a promotion within their current agency and 13 percent planning to seek a different position within their current agency. Smaller numbers (8% each) expressed the intention of shifting either to another AOD NGO organisation or the government AOD sector.

**Table 14. Staff movement intentions – next two years**

| Intentions | %* |
|---|---|
| No stated intention to move | 43 |
| Promotion within current agency | 19 |
| Different position in current agency | 13 |
| Position in another AOD NGO agency | 8 |
| Position in a government AOD agency | 8 |
| Leave the AOD sector | 7 |
| Full time study | 7 |
| Maternity leave | 0 |
| Retire | 4 |

*More than one option could be selected.

## Barriers to inter- and intra-sectoral movement

The issue of barriers to staff movement was explored in the qualitative elements of this research. There is a clear preference to improve the ease of movement for staff between government and non government sectors and between NGO agencies. Staff would like to be able to work freely in a range of AOD agencies during their careers. In general, it was felt that there was very little movement into the NGO sector from government agencies because of lower salaries, except at the most senior levels. Essentially, most of the barriers to both inter- and intra- sectoral movement would be removed by offering comparable salaries for similar work roles and ensuring that staff can retain benefits and seniority when they move. However, any such move would need to be facilitated by

- salary increases in the NGO sector, and
- professional progression in roles such as AOD counsellor, caseworker, coordinator and team leader (e.g. workers with three years' command the same salary across the board).

In terms of staff movement within the AOD NGO sector, it was reported that the divergent treatment models in the sector may create a barrier to movement, for example, a different skill and knowledge set is required for working with an abstinence model or harm minimisation model. Also, for some staff, working with a particular model is a reflection of their philosophical or spiritual values, so they would only choose to work in agencies which reflected this personal commitment. For example:

*"The staff here have been through the abstinence model and it has worked well for them – so that's the approach they want to use with clients."*

*"I have nothing against 12 step, but I wouldn't want to work with that model."*

One interviewee commented that it would be advantageous to the development of a complete skill set if there was ease of movement across the sector:

*"It would be great if people could move from agency to agency, say learn about therapeutic communities, do some time in a detox, spend time outpatient counselling etc."*

## An aging workforce

The AOD workforce has a larger proportion of mature age workers than most other industries. NCETA's study involving 1345 AOD workers across Australia found that nearly half were over 45 years of age.[17] A very similar age distribution was found in the NSW AOD NGO sector (see Table 1, above), with an average age of around 44 years.

> *"Unless younger workers can be recruited into AOD work, the AOD sector may face a severe lack of experienced and qualified workers over the next 10-20 years, when large numbers of the current workforce reach retirement age."* (NCETA, 2006)

Given the mature and aging workforce, it can be expected that difficulties finding replacements for retiring staff may occur in the next couple of decades. Although addressing this issue could include recruiting younger workers, it could also involve recruiting people 40 and older. That is, managers prefer workers with life experience and maturity. People looking for a career change or to re-enter the workforce after child rearing were identified by managers as an ideal source of ongoing new recruits to the sector.

[17] Duraisingham, V., Pidd, K., Roche, A., O'Connor, J. (2006). *Satisfaction, stress and retention among alcohol and other drug workers in Australia.* National Centre for Research and Training on Addiction (NCETA). Adelaide: Flinders University.

# PART 3 - SECTOR SKILLS, KNOWLEDGE AND TRAINING

# Skills and knowledge for AOD work

## The issues

Within AOD work, certain common skills and knowledge are required of all workers in addition to the skills and knowledge specific to different job roles. Experienced managers and workers were asked to define the key common skills and knowledge for AOD workers and also to define the specific skills and knowledge required for key roles in the sector.

This skills mapping provides useful information for managers, workers, AOD students, training providers and also for agencies advertising positions.

## Common skills and knowledge

For workers entering the AOD sector, a number of basic skills and knowledge were identified as necessary for effectively working with people with substance dependence problems. These included

- drug knowledge
- basic understanding of dependence and addiction
- boundary setting, and
- harm minimisation and the policy context.

### Drug knowledge

A knowledge of illicit and licit drugs and their effects was seen as essential for working in the sector. Specifically, workers need to be able to be able to name the main drugs being used in Australia, including their street names. They also need to understand the major classes of drugs (i.e. opioids, stimulants, alcohol, sedatives and cannabis), and the differing actions and harms associated with each — both short and long term. In addition, some knowledge of polydrug use and the interactions between illicit and licit drugs (including common prescription drugs such as sleeping tablets and antidepressants) is seen as desirable.

### Basic understanding of dependence and addiction

'Why don't they just stop using?' is one of the questions often asked in relation to drug use by people unfamiliar with the nature of drug dependence and addiction. People can also believe that education and treatment can usually rapidly reform problematic drug use. These attitudes were seen as unhelpful for workers in the sector. Thus, it was seen as essential that new workers have at least a basic understanding of the reasons why some people are compelled to keep using drugs, even despite severe adverse consequences. Following from this, workers also need to understand the immense difficulties that addicts commonly face during recovery, the process of recovery and knowledge of the high rates of relapse.

### Boundary setting

Workers need to be clear about the boundaries between themselves and the clients with whom they work. This is particularly important in AOD work given the sensitive issues that often arise with clients, and also the significant proportion of former users who work in the sector. Care needs to be taken with certain issues, including over-identification with clients, self-disclosure and social interaction with clients outside the work setting.

Although boundaries are necessary in AOD work, a difficulty can arise for new workers in that there is not a uniform set of 'professional boundaries' common to the sector; what is appropriate in one agency may not be in another. In this sense new workers should be guided by the code of conduct of the facility in which they are working or where their placement is undertaken. However, it was agreed by the research participants that part of the training for AOD work must include an understanding of professional boundaries, including definitions of boundaries, behaviours that are never acceptable and possible situations where a worker's professional boundaries may be at risk.

### Harm minimisation and the policy context

Harm minimisation is the key principle underlying drug policy and AOD agency funding in Australia. This is discussed at some length in the next section. Knowledge of harm minimisation principles and the policy context of the sector were seen as necessary for all workers, including those working within drug free and abstinence-based agencies.

## Knowledge and skills for key AOD roles

There are a number of key work roles in the AOD NGO sector, namely

- AOD caseworker
- AOD counsellor
- Team leader
- Residential support worker, and
- Health promotion worker.

This section outlines the skills and knowledge viewed as essential and desirable for each of these roles.

### *AOD caseworker*

- Other names: AOD case manager (Also, AOD counsellors' work often includes components of casework)
- Proportion of AOD NGO workforce in this role: 18%.

AOD caseworkers work with individual clients to assist them as they participate in a particular therapeutic program, to support them in their recovery from addiction and/or minimise the harm caused by drug use. Caseworkers also provide support and referrals relating to other aspects of their clients' lives, such as health and well-being, education, training and work, and legal and family issues. Caseworkers are employed in both residential and outpatient settings.

#### Skills and knowledge for the AOD caseworker

Client related

- A non-judgmental approach to clients to show empathy with their situation
- Initial assessment skills — ability to assess the nature of the client's issues, their motivation to seek treatment, their commitment to recovery, and whether the agency provides appropriate services
- Ability to engage and develop a rapport with clients
- Ability to establish and maintain appropriate boundaries
- Communication and listening skills
- Advocacy skills (the ability to promote the best interests of a client with other agencies and parties)
- Able to effectively impart harm minimisation knowledge (e.g. needle syringe programs, condom use, usefulness of health checks, etc.)

Case management

- Assessing the needs and goals of clients
- Motivational interviewing — utilising effective, non judgemental methods of enabling clients to make changes in their lives and behaviour.
- Supporting and motivating clients with progress through a therapeutic intervention
- Knowledge of referral networks and ability to appropriately refer clients
- Relapse monitoring and prevention

Individual

- Knowledge of drugs and drug effects
- Ability to work independently, particularly one-on-one with clients
- Awareness of own limitations in skill and knowledge — able to seek assistance
- Willingness to learn, both through ongoing training and on-the-job learning
- Time and workload management skills

Organisational

- Knowledge of the philosophical orientation of the agency
- Teamwork and liaison with management and other workers
- Report writing
- Quality assurance (applying quality assurance guidelines in practice)
- Computer skills — relevant software, e-mail, data entry
- Record keeping

Desirable

A number of other skills and knowledge were identified as desirable for a case worker, an indication of the increasing depth of what they could offer clients and the organisation in which they worked. It was recognised that these skills and knowledge would be developed through experience working with clients and/or additional training.

- Knowledge of comorbidity
- Understanding the different philosophical orientations that guide AOD work
- Group facilitation skills
- Cultural awareness
- Knowledge of a referral network and capacity to refer appropriately
- Deeper knowledge of issues of dependence and pharmacology, including interactions between licit and illicit drugs
- Familiarity with Australian drug policy, especially the tenets of harm minimisation and how this applies to the AOD NGO sector

- Sexual health, STIs and promoting safe sexual behaviours
- Program evaluation skills
- Theoretical knowledge of different therapeutic approaches

### *AOD counsellor*

- Other names: none, but AOD counselling is commonly undertaken by psychologists and workers in other roles, including caseworkers, clinical coordinators and team leaders
- Proportion of AOD NGO Workforce in this role: 13%.

AOD counsellors work with individual clients and groups in a therapeutic setting. Their role is to use recognised therapeutic approaches to support clients and help them to make desired changes in their lives. Counsellors typically assist clients through the process of recovery and/or harm reduction. They also assist in helping clients develop coping methods, life skills and stress management skills. There is a degree of overlap in the skills and knowledge required of AOD workers and counsellors, although counsellors are usually expected to have tertiary qualifications in counselling or psychology.

#### AOD counsellor skills and knowledge

Client (as for AOD worker)

- A non judgemental approach to clients / empathy for their situation
- Initial assessment skills — Ability to assess the nature of the client's issues, their motivation, and to determine whether the agency provides appropriate services
- Ability to engage and establish rapport with clients
- Ability to establish and maintain appropriate boundaries
- Communication and listening skills
- Advocacy skills (ability to promote the best interests of a client with other agencies and parties)
- Ability to effectively impart harm minimisation knowledge (e.g. needle syringe programs, condom use, usefulness of health checks etc)

Counselling

- Advanced counselling skills (tertiary training in counselling or psychology) — note that there a wide variety of recognised therapies
- One-on-one counselling using recognised therapeutic approaches
- Group facilitation skills — being able to effectively lead a group in a therapeutic process and ensure that group rules are maintained.

Individual

- Knowledge of drugs and their effects
- Ability to work one-on-one with clients
- Awareness of own limitations in skill and knowledge — able to seek assistance
- Willingness to learn, both through ongoing training and 'on the job')
- Time and caseload management skills

Organisational

- Knowledge of the philosophical orientation of the agency
- Teamwork and liaison with management and other workers
- Report writing
- Quality assurance (applying quality assurance guidelines in practice)
- Computer skills

Desirable

- As for an AOD Caseworker (see above)
- Knowledge of range of therapeutic counselling methods
- Ability to effectively work with clients regarding comorbidity

### *Team leader*

- Other names: Assistant manager, coordinator (team leader is a distinct role from case coordinators and managers)
- Proportion of workforce in team leader role: 4%

Team leaders are the 'middle management' of the sector. They comprise a relatively small proportion of the total workforce — a reflection of the flat management structures and small size of most NGOs. Their role largely involves the day-to-day management of staff and service delivery. They also usually undertake casework and/or counselling with individual clients.

#### Team leader skills and knowledge

Client

- As for AOD caseworker (see above)
- As for counsellor (if undertaking counselling)
- Superior clinical skills (as compared to caseworker)
- Managing challenging behaviours (in clients) — serving as a role model to other staff when dealing with difficult situations

Management

- Communication and negotiation skills
- Leadership skills — demonstration of good practice and leadership in the philosophy of the agency
- Ability to manage day-to-day services
- Ability to provide day-to-day supervision and management of staff
- Performance management
- Making 'best practice' advice available to for staff
- Managing challenging staff behaviours
- Maintaining roster and time sheets
- Coordinating training /backfill

Individual

- Maturity/experience/even temperament

Organisational

- Research and evaluation
- Budgeting
- Writing grant applications
- Occupational health and safety awareness

### *Residential support workers*

- Other names: Client support worker
- Proportion of workforce in residential support worker role: 12%.

Residential support workers (RSW) are employed in residential rehabilitation services. Tertiary qualifications are not necessarily required, although a Certificate III or IV in AOD Work or welfare is viewed favourably. The RSW role is to support clients during their rehabilitation and to work closely with the staff who are providing therapeutic interventions. RSWs may undertake a wide range of support services including monitoring the well being of clients, supervising client activities (such as work, shopping), night duty and looking after the practical day to day running of the service.

#### Residential support worker skills and knowledge

Client

- Orient clients with the residential program, providing to them a good understanding of the rules of the facility and how the program runs.
- Take a non judgmental approach to clients and show empathy for their situation
- Engage and build a rapport with clients
- Establish and maintain appropriate boundaries
- Possess communication and listening skills

Individual

- Understand of when to seek assistance
- Common sense
- Practical domestic / gardening skills

Organisational

- Maintain records

### *Health promotion /community worker*

- Other names: health educator
- Proportion of workforce in health promotion / community worker roles: 8%.

Health promotion and community workers focus on drug education and prevention rather than treatment (although they sometimes undertake counselling). They usually work with other agencies and groups, such as community organisations, schools and youth organisations. Health promotion workers (and educators) provide information about drugs and alcohol, their effects and avoiding and/or reducing harm. They can operate from a harm minimisation or abstinence philosophy. Community workers engage community members at an organisational level to raise awareness and educate; they work to increase the capacity of other organisations and community members to address drug issues.

#### Health promotion/community worker skills and knowledge

Drug related

- A wide knowledge of community drug usage patterns, characteristics of user groups
- Excellent knowledge of the names and the effects of drugs (including street names for drugs)
- Awareness of drug trends and changes in drug usage in the community
- Harm-reduction methods

Client

- Ability to engage and work effectively with a cross-section of clients, including school children, youth or particular CLD communities
- Ability to engage and work effectively with workers from a wide variety of agencies including schools, police and youth organisations
- Excellent communication skills

Community

- Networking skills
- Good understanding of how the community operates, including different allegiances and conflicts

# Training and staff development issues

## The issues

This research identified a number of specific education, training and staff development issues for the sector. These included

- certificate IV in AOD Work and its adequacy as preparation for working in the sector
- psychology degrees and their adequacy as preparation for working in the AOD field
- ex-users and their training, support and professional development needs, and
- AOD workers in non-AOD specialist agencies, including training, support and professional development needs.

The information presented in this section is derived from the skills mapping workshop, a focus group with psychology interns, and interviews with workers and managers.

## Certificate IV in AOD Work

The Certificate IV in AOD Work is a commonly held qualification in the sector, with around a quarter of workers reporting it as their highest qualification (see Table 9 - above). It is promoted by TAFE and other training providers as covering the necessary skills and knowledge to prepare people for work as AOD caseworkers, support workers, outreach workers or needle syringe program workers. Managers were asked for their views on the qualification as preparation for working in the sector.

### Skills and knowledge coverage of the Certificate IV in AOD Work

First, it was agreed by the managers interviewed, that the Certificate IV in AOD Work should provide

- an understanding of the AOD sector and work involved
- an understanding of drugs, dependence and addiction
- a grounding in professional boundaries and ethics
- basic assessment and interviewing skills
- basic case management and referral skills, and
- knowledge of health promotion and preventative strategies.

In terms of actual content, the competencies of the Certificate IV primarily cover these key elements. Managers of AOD agencies have found that people with the qualification are generally more rounded and confident and have demonstrated, through their completion of the course, a clear motivation to work in the sector.

In practical terms, workers entering the sector with the Certificate IV in AOD Work qualification

- understand the broader context of the sector
- are better placed to work in an organisation, with an understanding of:
    - administration
    - how organisations operate
    - accountability
- understand how referrals operate
- have a capacity to understand complex issues
- have 'professional language,' an advantage in liaison with other agencies and referrals, and
- possess knowledge of language of the mental health sector and improved liaison with NGOs.

## Skills and knowledge gaps in Certificate IV in AOD Work graduates

The managers also identified a range of shortcomings in the preparation provided by undertaking the Certificate IV. These included:

- *Knowledge gaps*
    - pharmacology — insufficient understanding of the effects of drugs and the basics of pharmacology
    - overdose and injecting drug use
    - harm reduction — the principles and practice (this is can be found by students to be 'dry and boring')
    - street names for drugs
    - complexity of polydrug use
    - the policy continuum in which the sector operates, including harm minimisation and federal and state drug policies
    - being able to locate relevant information
    - knowledge of referral pathways, such as
        - other rehabilitation services
        - other social services
    - case managing across services
    - working with children and families

- *Procedural skills and knowledge deficits*
  - general administration and office skills
  - data sets
    - understanding of software
    - knowledge of how to enter data appropriately, and understanding of importance of data and why it is collected
  - report writing
  - internal organisational policies

- *Mental health and AOD*
  - comorbidity knowledge
  - knowledge of the pharmacological interactions and effects in relation to mental health, of both legal and illicit drugs
  - effects and interactions of mental health medications
  - delineating what they have learned
  - knowledge of causal relationships between mental illness/substance abuse

- *Attitudes and understanding*
  - understanding of dependency (i.e. an unfounded belief that drug dependency and addiction can easily be cured)
  - harm reduction — the importance of keeping people alive and the palliative nature of some treatments
  - realising that it is acceptable to 'not know' — 'bluffing' can create dangerous situations
  - understanding of professional boundaries and how to maintain them
  - service specific knowledge

### Other observations

It was also observed that the delivery mode of the Certificate IV in AOD Work is important. Interacting with tutors and other students was seen as very beneficial for students. Learning from a tutor with a range of life skills and understandings was seen as a better way of learning than online and in isolation.

Mangers noted that quality of teaching can vary markedly, and that Certificate IV in AOD Work graduates could differ in the skills and knowledge they acquired from studying for the qualification.

## Psychology degrees

Psychologists comprise two percent of the AOD NGO workforce — and managers of agencies would like to employ more professionals from this discipline if they could afford to do so. An experienced psychologist is viewed as an asset to a treatment service, particularly in assisting in working effectively with comorbidity clients. In regard to new graduate psychologists, this research found that issues exist concerning adequate preparation for working in the sector.

### New graduates

The APS (2002) discussion paper, *Psychology and substance use: Potential contributions and professional training needs*, recommended that all psychologists have adequate AOD related knowledge and skills. Even so, it is apparent that new graduate psychologists in NSW can lack knowledge and skills in the area of AOD. The psychologists interviewed indicated that there is little coverage within the degree of treatments for addiction, dependence or comorbidity. They also observed a lack of clinical training, either in AOD or other areas of practice; they were not provided with sufficient practical training in assessment, interviewing or counselling.

In essence, unless a psychology degree curriculum provides experience in working with clients, a new psychology graduate is ill-equipped for work in the AOD sector. Treating addiction requires specialised skills. And, as has been shown, the clients of AOD services have particularly complex needs. To illustrate, one psychologist commented “I just had no idea what I was doing.”

One means of providing the necessary skills and knowledge is the psychology internship. In this model, structured training in the treatment of AOD issues is provided. These training positions also provide a way of attracting psychology graduates into the AOD workforce — and the theoretical knowledge of psychology training and the expertise contained by workers in the particular agency can compliment each other. For interns, engaging and challenging work combined with quality of training outweigh the fact that they are paid less than they would be in the government sector.

## Ex-users as AOD workers

Ex-users are a significant component of the AOD NGO workforce. For privacy and other reasons it is not possible to accurately determine the number of ex-users employed in the sector, although numbers are substantial, according to people interviewed in this research. Data collected in this research also showed that ex-clients rank as the fourth-highest source of recruitment for agencies. Understandably too, one of the key motivations behind AOD work is successful recovery from addiction. A range of views were expressed about the training and professional development needs of ex- users.

Some managers thought that ex-users were well-managed within the sector. For most rehabilitation services, former clients need to have spent at least two years in recovery and be employed in another occupation before they can be employed in the agency. A view was expressed that the experience of successfully recovering from addiction could enhance a person's professional practice, or at the very least, have no negative impact. Other managers identified a range of issues surrounding the work of ex-users, including

- poor retention in AOD tertiary training
- over-identifying with clients
- poorly maintained professional boundaries
- belief that their personal experience is the same as others (of use and recovery)
- a singular view of treatment ('what worked for me, should work for you.')
- shifting too soon post recovery into AOD work
- insufficient professional supervision, and
- unclear guidelines about managing a relapse.

Addressing these issues requires a thoughtful response by course trainers and agency managers. Ex-users clearly can require a high level of support to successfully make the transition to AOD frontline work. Sufficient time in recovery may also be required before ex-users should be eligible to undertaking formal training in AOD, given poor retention. Former clients may do well working in the service where they were treated. However, further training and support may be required to work effectively in agencies using other treatment models.

### The AOD worker in a non-specialist agency

Nearly a third of specialist AOD workers are employed in welfare agencies without a specific AOD focus. That is, they work in agencies that service populations such as youth, homeless people, women, culturally and linguistically diverse people and others. As such, they are usually part of a multidisciplinary team working with clients with complex needs.

There are challenges for AOD workers in this type of setting. Co-workers may not understand the nature of drug and alcohol addiction and the reality of client relapse. They may see that the job of the AOD worker is to 'fix up the alcohol or drug problem' rather than recovery usually being a lengthy process. One way of helping to overcome this lack of understanding would be to provide an overview of drug and alcohol work to other agency workers, showing, for example, information about harm minimisation, statistics about treatment outcomes and outlining the professional practice of an AOD worker.

# PART 4 – WORKFORCE ISSUES

# The policy and funding context

## Overview

The AOD NGO sector exists firmly within a wider policy context. At a general level, core funding for non-government agencies is largely determined by Federal and State policies; policy also influences priorities for program and service delivery, data collection and reporting requirements, and support for workforce development.

This section outlines the major policy influences on the sector, including harm minimisation, specific national and state policies, and policy trends towards promoting evidence-based treatment. Knowledge of these influences is useful in helping to understand the wider context in which non-government AOD work occurs and in identifying policy related workforce skills and knowledge. Gaps and emerging demand in policy related workforce skills and knowledge are also discussed.

## Harm minimisation

Harm minimisation is the main underlying principle of Australian AOD policy. Its tenets are evident in all federal and state government AOD policy documents. There are three core elements to harm minimisation: the reduction of supply, the reduction of demand and the reduction of harm caused by drugs.[18] For NGO alcohol and other drug agencies, most focus on reducing drug related harm. There are also a small number of agencies which aim to reduce demand through drug education and prevention.

Where confusion can arise is that within the AOD NGO sector, harm minimisation is frequently used as a term to describe non-abstinence services and to distinguish them from abstinence-based treatment services. However, abstinence-based services are funded as part of the harm minimisation strategies of government.[19] Consequently, a clearer distinction can be made if we consider that, whilst all AOD NGO agencies are concerned with reducing drug related harm, the primary aim of some services is to assist people addicted to drugs and/or alcohol to abstain from use, whilst for other services, the primary aim is to minimise harm to the user.

[18] Ministerial Council on Drug Strategy (2004). The National Drug Strategy: Australia's integrated framework 2004-2009. Canberra: Commonwealth of Australia.
[19] *ibid*

## Policies and plans that influence the AOD NGO sector

There are a wide range of policies and plans that potentially influence AOD NGO activities in NSW (see sidebar). Most of these documents are readily available on the Internet or from NSW Health. They are useful (and sometimes essential) for agencies to refer to when applying for funding for new programs or services – to show, for example, that the proposed program or service is in alignment with stated government policy. In addition, service guidelines provide information on best practice in particular aspects of service delivery.

**Some national and state polices that affect the NGO AOD sector.**

- The National Drug Strategy: Australia's Integrated Framework 2004-2009
- National Drug Strategy Aboriginal and Torres Strait Islanders Peoples Complementary Action Plan 2003-2009
- National Alcohol Strategy: Towards Safer Drinking Cultures 2006-2009
- The State Plan 2006: A New Direction for NSW
- The State Health Plan- Towards 2010
- NSW Health Drug and Alcohol Plan 2006-2010
- NSW Health Youth Alcohol Action Plan 2001-2005
- The Management of People with a Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines
- Needle and Syringe Program Policy and Guidelines for NSW 2006 16
- Amphetamine, Ecstasy and Cocaine: A Prevention and Treatment Plan 2005-2009
- NSW Withdrawal Management Guidelines

The NSW State Plan is a major policy driver in setting government policy agendas until 2010.[20] There is not a major emphasis on AOD in this document, but there are a few policy statements that are of interest and can be referred to in funding applications to show a broad consistency between an agency proposal and state policy.[21] These include a general commitment to prevention and to following the outcomes of the NSW Alcohol Summit (2003) and NSW Drug Summit (1999). There are also goals that address the reduction of risk drinking to 25 percent down 25% by 2012 and holding the proportion of people using illicit drugs steady and less than 25 percent. Crime prevention is a strong focus, with a specific commitment to fund AOD treatment for those at risk of reoffending through therapeutic treatment and diversion programs such as the 'Magistrates Early Referral into Treatment' (MERIT).

The NSW Drug and Alcohol Plan 2006-2010 is directly focused on giving policy direction to AOD services. Its main aims are to improve service delivery, promote evidence-based

[20] NSW Government. The State Plan: A New Direction for NSW.
[21] For example, the Federal NGO Treatment Grants Program required reference to the NSW State Plan

treatment and improve workforce capacity. The AOD NGO sector is featured prominently in this document and partnered in its development. The clear intent is that the policy framework guides the development of better integration and consistency between government and non government services. There are also commitments to providing new services, enhancing existing services (especially for identified population groups) and workforce development. Although the plan does not detail the financial commitment to these actions, it clearly is essential for agencies seeking state government funding or to work collaboratively with government agencies to refer to the statements in this document.

*"The non government sector will be a significant provider of drug and alcohol services. Public, private and non-government programs will be well integrated."*
NSW Health. Drug and Alcohol Plan 2006-2010

## Evidence-based treatment

There has been a strong trend towards evidence-based treatment and policies within the AOD sector overall and within health and social services generally. In essence, governments are only interested in funding interventions that 'work,' and evidence needs to be provided that proposed interventions will be effective. Agencies are already required to collect data on treatment episodes, and for AOD NGO services and workforce, the demand for an 'evidence base' has a number of other implications.

Proposals for new services or interventions need to draw from research demonstrating their likely effectiveness. This requires both access to alcohol and drug research and the ability to research, locate, and present relevant evidence. It also creates challenges for new treatment areas where there is an undeveloped evidence base, such as the treatment of coexisting disorders.

Existing funded interventions need to be routinely evaluated and a component of funding is often allocated to this purpose. For NGOs, frequently neither the time nor expertise to conduct an evaluation is available. One of the main problems that can occur is that evaluations are conducted *post hoc* and the base line data is not collected properly.

Reports from managers of NGOs suggest that funding body requirements to demonstrate effectiveness are not particularly rigorous. That is, the evidence provided (e.g. references to studies) is unlikely to be rigorously assessed and evaluation methodologies are unlikely to be challenged. However, a greater demand for rigor could be expected in coming years. More importantly, agencies themselves have a clear interest in determining whether their treatments and activities are effective.

## Policy related skills and knowledge needs

'Workers do not understand the policy context' was a concern expressed by a number of managers involved in this research. Their observation was that workers in the sector,

including some more experienced workers, had little understanding of the concepts of harm minimisation and the way treatment services are funded in NSW. As a consequence, they did not understand how their work and agency fit within the approaches to address addiction and reduce drug-related harm across the Australian population. Other policy related skills and knowledge gaps included

- preparation of grant applications, including understanding the premise that government usually only funds proposals that are clearly consistent with their own policies and funding guidelines.
- collection of data on treatment episodes and program outcomes and understanding the importance of these activities, and
- evaluating interventions and programs.

# Comorbidity

## The issues

Dealing with mental illness in clients is one of the main challenges facing staff in AOD agencies. Clients presenting with substance abuse disorders will also commonly have a mental illness. There is a consensus across the AOD and mental health sectors that comorbidity has become the 'expectation rather than the exception.'[22] As such, AOD workers can expect to encounter the full range of mental health problems in clients. Most often this will be higher prevalence, lower severity disorders such as anxiety and depression, but can also include acute episodes in clients such as post traumatic flashback or drug induced psychosis, and higher severity disorders including bipolar disorder and schizophrenia.

**Comorbidity in AOD work**

*For AOD workers, the issue is of clients whose primary presenting issue is substance abuse and who also have a mental illness or mental disturbance.*

The main challenges for AOD workers in regard to dealing with comorbidity are a lack of

- confidence and knowledge about mental illness
- training in identifying and treating clients with mental illnesses
- integration and co-operation between the mental health and AOD sectors generally,[23] inhibiting a collaborative approach to addressing comorbidity, and
- knowledge about effective treatment for comorbidity.

## Staff knowledge and training needs

The NADA training needs analysis (2007) identified comorbidity as the foremost training need for frontline treatment staff.[24] In the 2007 staff survey (Appendix 2), comorbidity again emerged as a key issue, with nearly 40 percent of respondents specifically identifying comorbidity as one of the key new client needs to emerge in recent years.

[22] The Senate, Select Committee on Mental Health (2006) *A national approach to mental health – from crisis to community. First report.* Commonwealth of Australia.
[23] Druginfo Clearinghouse (2007). "Creating synergy between mental health and drug and alcohol sectors: can we really work together?" Seminar Notes. http://www.druginfo.adf.org.au/downloads/Seminar_notes/mental_health_SeminarNotes_4Dec07.pdf
[24] Deakin, E. And Gethin, A. (2007). *Training needs assessment of NGO Alcohol and other drugs agencies in NSW.*

Interviews undertaken for this current study have more specifically identified the comorbidity skills and knowledge that are required by AOD staff:

At intake/assessment

- confidence with mental health issues, such as the ability to recognise the symptoms of mental illness; understand typical behaviours of mentally ill clients; recognise whether client behaviour is an acute reaction (e.g. drug -induced psychosis), or relates to a longer-term mental illness
- referral knowledge: knowing when and where to refer clients to specialist mental health services and when to call on mental health crisis services, and
- risk management: understanding what to do when clients are at risk of suicide or of harming themselves or others.

During Treatment

- causality and prevalence of comorbidity, and what types of mental illnesses to expect as associated with particular patterns of alcohol or drug usage (e.g. alcohol dependence and depression, amphetamine use and anxiety and affective disorders)
- mental illnesses, such as anxiety or depression, that can result from or be uncovered during withdrawal
- progression of mental illness (e.g. prognosis for depression, schizophrenia)
- how mental illness affect a client's responsiveness to treatment (e.g. personality disorder), and
- effective counselling techniques — knowledge of current best practice in treating comorbidity.

## Characteristics of agencies who are dealing effectively with comorbidity

Managers of several agencies stated that their staff dealt effectively with comorbidity. This was accredited to a number of factors, including

- staff who had a good knowledge of mental illness (e.g. psychiatric nurses, or were highly experienced at dealing with complex clients)
- good collaborative relationships with local mental health services — e.g. confidence that the mental health service(s) will accept referrals, and/or reassure staff if client was 'ok to stay in the AOD facility'
- good referral relationships with mental health professionals (e.g. a consulting psychiatrist or psychologist with experience in AOD issues), and
- structured training program in assessing and treating comorbid clients.

**Case Study. Kedesh Rehabilitation Services comorbidity internship program**

Kedesh Rehabilitation Services is a residential rehabilitation facility with about 70% of their clients presenting with comorbidity. Clinical staff have developed a highly structured professional program to enable their psychology interns to effectively work with comorbid clients. This program involves 580 hours of placement and 100 hours of training. It ensures that interns are competent in basic skills before moving onto more complex skills – for example, they must show competency in group facilitation and case management before moving onto assessment and counselling. Interns also develop knowledge in AOD issues, various types of mental disorder, utilising evidence of best practice and mental health services. Practical experience is provided in dealing with a client group who are often challenging and confronting.

Under the Council of Australian Governments Grants program Kedesh House, in conjunction with NADA will be providing comorbidity training to other NGO agencies staring in 2008.

## How the sector is dealing with comorbidity

There is a very high level of awareness about the issue of comorbidity within the sector. In terms of workforce capacity, the consensus is that there is a need to

- provide further training to staff in effectively dealing with comorbid disorders, and
- develop cooperative relationships between AOD and mental health services.

These issues are currently being addressed. Grant funding has been made available to improve capacity to address comorbidity and the sector is undertaking a wide range of comorbidity related initiatives. These grants/initiatives include

- under the 'Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative,' NSW AOD NGOs will receive approximately $9 million over a 3 year period
- AOD NGOs contributing to comorbidity research — NADA is running a two-year research grants program in which grants were awarded to AOD NGOs to undertake research specifically relating to comorbidity.
- screening and intervention tools being developed for AOD NGO use (such as Psycheck — developed by the Victorian AOD service, Turning Point)
- instances where good relationships have been established between AOD NGO agencies and mental health services. (see Case Study - Kedesh)
- increasing provision of vocational training in comorbidity, and
- systematic well developed and conceptualised training in comorbidity to be delivered to 12 agencies in the sector (see Case Study – Two inner city agencies).

**Case study. Two inner city agencies – two different experiences.**
The contrasting experience of two inner city agencies illustrates the value of a good collaborative relationship with mental health services. Both agencies dealt with complex clients and employed staff who were very experienced in identifying mental illness.
The first agency had a 25 year relationship with local mental health service, and staff were confident that referrals would either be accepted or that reassurance would be given that the client was sufficiently stable to remain in rehabilitation. The agency had recently established an MOU with this mental health service to ensure continuity of the relationship if locum or new staff were present. The agency also had good referral relationships with a local doctor and psychiatric facility.

By contrast the second agency found that none of their referrals were accepted by the nearby mental health service, even in cases where the client was apparently suffering from a serious psychiatric illness (the majority of staff of this agency are nurses with psychiatric training). Managers of this agency had formed the view that any of their clients would be viewed as drug users and not provided with specific mental health services. Also, if the mental health crisis team were called – they would 'never come'.

There are a number of areas in which action could improve the capacity of the AOD NGO sector to effectively deal with comorbidity. These include

- systematic training of staff across the sector in the identification of mental illness, including training in the use and application of screening tools.
- incorporating key skills and knowledge relating to comorbidity into the Certificate IV in AOD Work
- an intersectoral strategy to enhance collaborative relationships with mental health services (i.e. not depending on agreements brokered by individuals or individual agencies)
- systematic data collection on clients presenting with comorbidity
- the development of an improved evidence base for effective treatments for comorbidity, and
- continuing contribution of AOD NGOs in research into best practice in treatment of comorbidity.

# Complexity of client needs

## The issues

Increasing complexity of client needs has been observed by agencies across the sector. Clients typically have mental health and welfare issues in addition to substance dependence. Changing patterns of drug use can also potentially alter demands on workers. Specific population groups have particular needs that create demands for specialised knowledge and skills in the AOD workforce — including, in particular, Aboriginal clients, CALD, young people, ex-prisoners, women with children and marginalised men. Comorbidity was discussed earlier in this report. This section discusses the demands on the workforce created by working with clients with increasingly complex needs.

## Working with clients with complex welfare needs

Clients rarely present with just a substance problem. Complex welfare and other needs also commonly occur. The issues identified by interviewees included

- homelessness or risk of homelessness
- poverty
- unemployment
- family breakdown
- child protection (e.g. where the children of a client are at risk of abuse or neglect)
- DoCS referrals (e.g. regaining access to children)
- gambling addiction
- cognitive damage
- justice system involvement (e.g. MERIT or community service orders)
- physical impairment and sickness, and
- poor dental health.

## How the sector is dealing with complex needs

The range and complexity of issues facing clients presents challenges to AOD workers – in addition to treating substance issues, new knowledge, skills and referral networks are required. Agencies within the sector are responding to the demands made upon them in a number of ways:

- specialist skills/knowledge within agencies — some agencies deal regularly with particular client groups and issues (e.g. justice system referrals, or women with DoCS involvement) and have developed specific strategies and referral networks to deal with the needs of their clients
- adapting existing treatment models to better meet the needs of clients. Some agencies have recognised that clients with impaired cognitive capacity are not coping with traditional treatment methods. They have adapted their case management,

counselling and group work methods (for example, simplifying language, recognising limited attention spans, breaking down instructions into very simple steps), and

- referral and case management with other welfare agencies. Agencies routinely refer clients to other services. However, the complexity of welfare needs is creating a need for integrated case management. This has led to the development of long-term relationships with other health, welfare and educational services, including medical services, TAFE, psychologists, social workers and dentists.

The skills and knowledge required for dealing with greater complexity are quite varied, as the range of issues faced by clients is so diverse. They include

- good referral networks and a clear understanding of when and where to refer clients
- networking skills — the ability to work effectively with agencies such as DoCS and also other NGOS
- 'seeking information when in doubt' — recognising when one's skills or knowledge are sometimes limited and being prepared to seek advice, and
- being 'up to-date' with best practice in treating complex client needs.

## Changing patterns of drug use — Is this an issue for AOD workers?

Within the Australian community patterns of problematic drug and alcohol usage are not static. Attention has recently been drawn to the rise in usage of crystal methamphetamine, or 'ice', as it is commonly known. The focus has been on the alarming psychotic behaviours associated with ice usage and the unknown long term mental health impacts of use of this drug.[25] Interviewees were asked if they had observed changes in their client groups' drug use and, if so, whether this was creating any new demands for knowledge and skills of their workers.

### The sector response

The responses to these questions were mixed. Some agencies had found little change in the drugs clients used. Alcohol and cannabis were still the main drugs of concern, followed by heroin, with polydrug use relatively common: "They use whatever they can get their hands on." Other agencies, particularly those working with youth, had seen a clear change in drug use patterns. They had observed a rise in the proportion of amphetamine type substance users (e.g. speed, ecstasy): "it used to be about 20 percent amphetamine users, now it's more like 40 percent."

*"It's nearly all alcohol and cannabis that we see here – the same as it has been for a long time."*

[25] Fulde, G. and Wodak, A. (2007). 'Ice: cool drug or real problem?' *Medical Journal of Australia*. 186 (7): 334-335.

As far as the drug ice is concerned, it has yet to make a significant impact on drug treatment services: ice users are not presenting in substantial numbers. This observation reflects research that found "in contrast to heroin, only a small proportion of these dependent methamphetamine users have contact with drug treatment services."[26]

In terms of demands for workforce skills and knowledge, issues specifically related to the effective treatment of amphetamine users were identified. These include

- understanding the impact of long term use of 'party drugs'
- addressing the mental health issues and degradation of social ties associated with long term amphetamine use, and
- determining effective treatment methods, including the use of pharmacotherapies.

The increase in ice usage and a host of associated long-term problems related to mental health and cognitive functioning of users can be expected to test the skills of AOD workers in coming years.

### Working with Aboriginal clients

Aboriginal clients are overrepresented amongst people seeking in AOD treatment, with 10 percent of treatment episodes being provided for Aboriginal clients in Australia[27], despite that population comprising only 2.1 percent of the total Australian population. Within the NADA membership, seven agencies offer Aboriginal-specific services, and approximately four percent of the sector workforce is Aboriginal .

This client group presents challenges to agencies and the workforce. Working effectively with Aboriginal clients ranked the second highest of needed client group skills in NADA's 2007 Training Needs Analysis. Specifically noted were needs for skills in

- cultural understanding
- impacts of incarceration
- engaging with family members, and
- modifying case management for Aboriginal clients.

[26] McKetin, R. & Kelly, E. (2007) 'Socio-demographic factors associated with methamphetamine treatment contact among dependent methamphetamine users in Sydney, Australia. *Drug and Alcohol Review*. 26, 161-168

[27] Australian Institute of Health and Welfare (AIHW) (2007) *Alcohol and other drug treatment services in Australia 2005–06 Report on the National Minimum Data Set.* Canberra: AIHW.

These issues are still current. A number of additional issues were noted in this research. Most of the services offered to Aboriginal people are Aboriginal controlled abstinence-based residential rehabilitation centres. Whilst this service model is certainly effective for some people, offering a wider range of AOD services appropriate to Aboriginal clients was observed by interviewees as a legitimate demand on the NGO sector. It was also determined that community-based drug and alcohol interventions are required in addition to individual treatment.

These demands on the sector workforce are complicated by a number of factors:

- Aboriginal clients often prefer to work with Aboriginal workers
- there are insufficient numbers of trained Aboriginal AOD workers, and
- the Aboriginal population is concentrated in remote NSW.

For the sector to respond adequately to the needs of Aboriginal clients there is a need to determine effective ways of recruiting, training and supporting Aboriginal AOD workers. In addition, non Aboriginal workers and services see the need for further training and assistance in working well with Aboriginal clients.

### Working with special-needs population groups

All population groups have particular needs in addition to their requirements for treatment. This is largely reflected and addressed by the range of targeted services and programs offered by AOD NGO agencies. In addition to Aboriginal controlled centres (discussed above) there are specialist services and programs available for

- youth
- men
- women
- mothers
- culturally and linguistically diverse people
- ex-prisoners, and
- injecting drug users.

Difficulties can arise for workers when they work with clients and do not have a depth of knowledge or experience of the client's particular needs, for example, such as in understanding the needs of ex-prisoners or a person who does not speak English. In some instances, clearly it is best to refer these clients to other agencies. For example, a mother with children is best served by an agency that accommodates families. Also, it was suggested by interviewees that when workers are dealing with unfamiliar client groups, an option they have is to seek advice from an agency with relevant expertise.

# PART 5 - SUMMARY, CONCLUSIONS AND FUTURE DIRECTIONS

# The AOD NGO sector and workforce: Summary of key issues

## The sector

The sector itself contains a diverse range of agencies, sites and programs. Most NADA members (72%) are AOD specialist sites, with 28 percent represented by AOD programs or workers in other welfare agencies. The dominant forms of service types are residential rehabilitation or referral and counselling, which comprise 71 percent of services. Philosophically, most services (79%) work from a harm minimisation perspective, with abstinence-based services (21%) forming a substantial minority.

## The workforce

The workforce employed in AOD NGO agencies and sites has the following characteristics:

- mostly female (61%)
- maturity (average age 44)
- a relatively high proportion of part time workers (27%)
- highly qualified (78% tertiary qualified/39% degree or above)
- high take-up of the Certificate IV in AOD Work (24%)
- frontline workers comprise the largest proportion of workers (49%), and
- professional roles are in a minority (13% — nurses, psychologists, GPs and social workers).

The AOD NGO workforce differs from the government AOD workforce primarily in the distribution of work roles (e.g. nurses comprise 47 percent of the Government AOD workforce and frontline AOD workers 27 percent). There are also fewer full-time workers in the NGO sector — 54 percent as compared to 70 percent.

## Recruitment, retention and staff movement

Recruitment is a key issue for NGO agencies, with numerous agencies reporting problems recruiting new staff. A general decline in both the number and quality of applicants has been reported. Agencies who did not have difficulties recruiting staff were either able to offer higher salaries than normal for the sector or had particularly interesting positions that attracted candidates

Retention is far less of an issue, with a number of factors keeping staff engaged in particular agencies. These factors include

- salary packing
- loyalty and commitment to an agency ethos
- training and staff development, and
- high level of flexibility and autonomy.

Those agencies who did find retention an issue cited an inability to compete with the government sector as a major factor in their difficulties.

As a reflection of the high level of retention, 75 percent of staff intended to remain in their current agency, either in their current or another role. Staff movement is primarily occurring within agencies and across the sector itself. The main source of recruitment is other AOD NGO agencies. This is followed by other NGOs and new graduates. Ex-clients are the fourth-highest source of recruitment.

Barriers to staff movement were observed, particularly when moving between government and non government sectors. Government AOD workers face a drop in salary if they move to the NGO sector, and staff can lose superannuation and other benefits when they leave an NGO agency, even for another NGO. This suggests that an industry agreement regarding retention of benefits would ease movement between sectors.

Like most of the human services workforce, the AOD NGO workforce is aging. With an average age of 44, a retirement exodus can be expected within the next 10 to 20 years. The main concern is that when older staff start leaving there will be staff shortages. Although recruiting younger workers— assuming they stay in the sector — is one way of addressing this issue, ongoing recruitment of more mature staff (forties upward) is also a useful strategy. Maturity and life experience are highly desirable characteristics in AOD workers.

### Skills and knowledge

A number of common essential skills and knowledge for AOD work were identified:

- drug knowledge
- understanding of addiction and dependence
- boundary setting, and
- harm minimisation.

A concern was expressed that workers were entering the sector without adequate skills and knowledge in these areas, exposing their clients and themselves to risks. Ideally, these skills and knowledge areas would be adequately covered in the Certificate IV in AOD Work.

Skills and knowledge for key roles in the sector were delineated. These were the skills and knowledge identified by managers as essential for undertaking the roles of

- AOD Caseworker,
- AOD Counsellor
- Team Leader
- Residential support worker, and
- Health promotion worker.

These skills and knowledge sets included the common skills and knowledge (identified above) and a range of more specialised attributes depending on the role.

### Training and staff development

The Certificate IV in AOD Work is viewed as a reasonable general preparation for working in the sector, with graduates of the course considered to be more 'job ready' than those without the qualification. However, a wide range of shortcomings were also observed in the preparation provided by the qualification. In particular, there was concern that the course did not provide sufficient grounding in the essential common skills and knowledge identified above.

Psychologists are sought after by agencies, and experienced psychologists are an asset in AOD treatment. New graduates can lack essential AOD related skills and knowledge and may enter the workforce with minimal clinical skills. As such, new psychology graduates usually require structured 'on the job' training and supervision before treating clients.

Ex-users form a significant part of the sector. Specific training needs were observed for this group. In particular, ex-users may need support and supervision regarding professional boundaries, and may need to be assessed for readiness before beginning tertiary training in AOD.

A number of NADA member sites are other human services agencies that offer AOD programs (28%). The individual worker in a non-specialist AOD agency may find that other workers have a limited understanding of their work. Briefing colleagues in these agencies about AOD work could prove useful.

### Policy and funding context

The AOD NGO sector exists within a policy and funding context, with ongoing resourcing of the sector and program funding strongly influenced by federal and state policies. Harm minimisation is the core principle underlying drug policy in Australia, and all agencies are funded under harm minimisation strategies. There are numerous individual policies, plans and guidelines that affect AOD work range from the high level of the NSW State Plan to individual service type guidelines.

Within health and human services there has been a strong trend toward evidence-based treatment polices. This affects workers in AOD NGOs in two main ways: It increases the requirements for evaluation, and requires demonstration of program effectiveness in applications for grant funding.

The policy and funding context and agency responses to policy and funding requirements are not well understood by some workers in the sector. There is a need for training in

- the policy context
- preparing grant applications
- evaluation, and
- compulsory data and records.

### Comorbidity

Comorbidity is a major issue for the sector, with increasing awareness of the problem creating a strong demand for new skills and knowledge. The sector is responding well to these demands by successfully obtaining grant money to increase capacity in relation to comorbidity. A range of new training and initiatives emerged in 2008. Key skills and knowledge needs include

- understanding comorbidity and typical presentations
- helping staff deal confidently with comorbidity clients
- referral knowledge
- reliable assessment tools and their use
- risk management, and
- best treatment practice.

It was also observed that the capacity of AOD NGOs to address comorbidity is enhanced by strong relationships with mental health services.

### Complexity of client needs

In addition to comorbidity, clients are presenting with increasingly complex needs. These include a host of welfare-related issues, the needs associated with target population groups and cognitive problems amongst clients. Aboriginal clients place unique demands on services and are disproportionately represented amongst those seeking treatment. Increasing amphetamine use can also be expected to change and add complexity to client treatment needs.

Many agencies have been able to establish highly effective ways of dealing with welfare issues and working with specific population groups. There is also a clear trend in agencies to adapt existing therapeutic forms to cope with the changing cognitive and attention deficit needs of clients. It can be seen that the expertise required to work effectively with clients with complex needs and from particular target groups is largely contained within the NGO sector. The key issue is determining effective means of sharing this knowledge.

New drug trends do present a challenge to some agencies in the sector and can be expected to create demand for new skills and knowledge. Knowledge about effective treatments for amphetamine abuse is being sought. The methamphetamine 'ice' has yet to impact on workers in AOD NGOs; users are not currently seeking treatment in great numbers. This trend could be expected to change in the future.

REFERENCES

Australian Bureau of Statistics (2008). 6202.0 - Labour Force, Australia, Feb 2008. Canberra: ABS

Australian Institute of Health and Welfare (AIHW) (2007) *Alcohol and other drug treatment services in Australia 2005–06. Report on the National Minimum Data Set*. Canberra: AIHW.

Deakin, E. and Gethin, A. (2007). *Training needs assessment of NGO Alcohol and other drugs agencies in NSW.* Sydney: NADA.

Druginfo Clearinghouse (2007). "Creating synergy between mental health and drug and alcohol sectors: can we really work together?" Seminar Notes. http://www.druginfo.adf.org.au/downloads/Seminar_notes/mental_health_SeminarNotes_4Dec07.pdf.

Duraisingam, V., Vidd, K., Roche, A., and O'Connor, J. (2006). *Stress, satisfaction and retention among alcohol and other drug workers in Australia.* National Centre for Education and Training on Addiction (NCETA). Adelaide: Flinders University.

Fulde, G. and Wodak, A. (2007). 'Ice: cool drug or real problem?' *Medical Journal of Australia*. 186 (7): 334-335.

Kvale, S. (1996). *InterViews.* Thousand Oaks, CA.: Sage Publications.

Macdonald, D. (2006). *A profile of the Australian Capital Territory alcohol and other drugs workforce*. Canberra: Social Research and Evaluation.

McKetin, R., and Kelly, E. (2007).'Socio-demographic factors associated with methamphetamine treatment contact among dependent methamphetamine users in Sydney, Australia. *Drug and Alcohol Review.* 26, 161-168.

Ministerial Council on Drug Strategy (2004). *The National Drug Strategy: Australia's integrated framework 2004-2009*. Canberra: Commonwealth of Australia.

Roche,A., O'Neill,M., and Wolinski, K. (2007). 'Alcohol and other drug specialist treatment services and their managers: findings from a national survey.' *Australian and New Zealand Journal of Public Health.* (28)3. 252-258.

The Senate, Select Committee on Mental Health (2006) *A national approach to mental health – from crisis to community. First report.* Canberra: Commonwealth of Australia.

# NSW Alcohol and Other Drug Non Government Sector:

## Workforce profile and issues

Prepared for: the Network of Alcohol and Other Drug Agencies (NADA)

# REPORT ATTACHMENTS

Attachment 1. Agency data collection form

Attachment 2. Staff survey

Attachment 3. Research participants

ARGYLE RESEARCH AND TRAINING PTY LIMITED

# NETWORK OF ALCOHOL AND OTHER DRUG AGENCIES

## NON GOVERNMENT ALCOHOL AND OTHER DRUG WORKFORCE

## AGENCY DATA COLLECTION FORM

This form: Workforce data

The attached form is being used to collect data from NADA member agencies about the profile of their workforce. The aim is to obtain data from all agencies to give an accurate profile of the sector.

Background: Workforce profile

NADA has engaged consultants to profile the workforce of the AOD NGO sector in NSW. The purpose is to clearly determine the demographics, qualifications and future development needs of this workforce. This information is essential for effective advocacy for the sector, planning for future workforce development, and targeting existing and emerging skills and knowledge gaps. The research involves agency and staff surveys, interviews, focus groups and workshops.

Filling in the data form

Please complete one form per agency.

If you don't have certain data – please leave that section blank.

The form can be filled in by hand, electronically, or over the phone.

1) Written – print, fill in, and:

FAX: 9251 4737

or

POST: 608/129 Harrington Street,
THE ROCKS, NSW 2000

2) Electronically – open in WORD, complete and:

EMAIL: anni@argyleresearch.com.au or
jo@nada.org.au

3) In person –

PHONE: Anni Gethin on 9251 4737 or 0422 415 469.

Agency Name

_____

Branch _____

Contact Officer (for this form)

_____

Telephone _____ email

_____

# NADA WORKFORCE PROFILE
# AGENCY DATA FORM

**1) Staffing profile (total and by gender)**

| Category | Male | Female | Total |
|---|---|---|---|
| Total FTE | **N/A** | **N/A** | |
| Permanent full time | | | |
| Permanent part time | | | |
| Fixed term contract | | | |
| Casual | | | |
| Volunteers | | | |

**2) Staff cultural diversity (total and by gender)**

| Category | Male | Female | Total |
|---|---|---|---|
| Aboriginal and Torres Strait Islander (ATSI) | | | |
| Culturally and Linguistically Diverse (CALD) | | | |

**3) Job roles in agency**

*Please state the number of full time equivalent staff currently employed in each job role*

| Role | FTE staff |
|---|---|
| **Management and administration** | |
| Administrative staff | |
| Clinical coordinator | |
| Manager | |
| Team leader | |
| Other *(please specify)* _____ | |
| **Frontline treatment** | |
| AOD case worker | |
| Counsellor | |
| Intake officer | |
| Medical practitioner | |
| Nurse | |
| Psychologist | |
| Residential support worker | |
| Social worker | |
| Other *(please specify)* _____ | |
| **Policy / health promotion / community development** | |
| Community development worker | |
| Health promotion worker | |
| Policy worker | |
| Project officer | |
| Researcher | |
| Other *(please specify)* _____ | |
| **Client support workers** | |
| Child care worker | |
| Vocational education worker | |
| Other *(please specify)* _____ | |
| Other position *(please specify)* _____ | |
| Other position *(please specify)* _____ | |

**4) Staff qualifications**

*Please state how many staff have the following qualifications, counting only the highest level of qualification for each staff member.*

| **Qualification** | **Highest qual-ification** |
|---|---|
| No qualification | |
| Cert III | |
| Cert IV AOD | |
| Cert IV (other) | |
| Diploma – non post graduate | |
| Degree | |
| Post graduate qualifications | |
| Other qualification | |

**4a)** How many of your staff (total) have a specialist qualification in AOD?
(e.g. Cert IV AOD, major in addiction studies, specialist qualification in AOD counseling etc)____

**5) Professional associations**

Which professional associations are represented among your staff (e.g. APS, AASW, APSAD, nursing, and/or medical associations)

_____
_____
_____

**6) Recruitment sources**

*Please rank the top 3 source categories for staff recruitment for your agency*

| **Category** | **Ranking** |
|---|---|
| School leavers | |
| New graduates | |
| Returning to workforce (e.g. from childrearing) | |
| Former clients | |
| Other AOD NGO agency | |
| Government AOD agency | |
| Other NGO | |
| Other government agency | |
| Other sector | |

**7) Staff movement and retention**

*Please rank the top 3 destinations of staff who leave your agency*

| **Destination** | **Ranking** |
|---|---|
| Other AOD NGO agency | |
| Government AOD agency | |
| Other NGO | |
| Other government agency | |
| Other sector | |
| Childrearing | |
| Further study | |
| Retire | |
| Other (*please specify*)_____ | |

**7a)** How many permanent staff have left your agency in the last 3 years?____

**7b)** Do you have a staff retention program?

Yes/no

If yes, what does this program involve?

_____

_____

_____

_____

# NETWORK OF ALCOHOL AND OTHER DRUG AGENCIES

## NON-GOVERNMENT ALCOHOL AND OTHER DRUG WORKFORCE
# STAFF SURVEY

This survey is part of research into the workforce profile and staff development needs of NGOs providing alcohol and other drug (AOD) services in NSW. This research will assist the sector in planning for the future and to better meet the needs of its workers and clients.

The survey is only for employees of **NADA member organisations**, including managers.

The survey should take about 10 minutes to complete.

All responses will be processed anonymously; it will not be possible to identify individuals or agencies from the reported survey data. The results will be published later this year as part of a full research report and will be available for use by all NADA member organisations.

Independent consultants have been engaged by NADA to undertake this research. Should you have any queries regarding the survey, please contact Anni Gethin of Argyle Research on

**0422 415 469**, or on email: anni@argyleresearch.com.au. Alternatively, Jo Khoo, Manager Workforce Development at NADA can be contacted on **9698 8669** or email: jo@nada.org.au

---

PLEASE **RETURN** BY **MAY 16 2008**:

1) Fax: 9251 4737

2) Post: Argyle Research

608/129 Harrington Street,

THE ROCKS NSW 2000

| | |
|---|---|
| | **YOUR BACKGROUND** |
| **1** | **Age** _____ |
| **2** | **Gender**<br>☐Male<br>☐Female |
| **3** | **Aboriginal or Torres Strait Islander**<br>☐Yes<br>☐No |
| **4** | **Culturally and Linguistically Diverse Background**<br>☐Yes (*please specify*) _____<br>☐No |
| | **CURRENT JOB ROLE** |
| **5** | **Current position (title)**<br>_____ |
| **6** | **Main tasks involved in your job (e.g. counseling, casework, managing staff, research etc)**_____ |
| **7** | **Work patterns:**<br>☐Full time (average hours per week) _____<br>☐Part time (average hours per week)_____<br>☐Casual (average hours per week)_____ |
| **8** | **Size of the agency where you work (approx. number of FTE employees)**<br>_____ |
| **9** | **Agency Location**<br>☐ Sydney metro<br>☐ Other metropolitan area (Newcastle or Wollongong)<br>☐ Regional centre<br>☐ Rural town<br>☐ Remote<br>☐ Other(*please specify*) _____ |
| **10** | **Type of service(s) your agency offers**<br>☐ Outpatient care (e.g. outreach, aftercare, counseling etc)<br>☐ Residential (e.g. residential rehabilitation, therapeutic communities etc)<br>☐ Supported assisted accommodation<br>☐ Health promotion<br>☐ Community development<br>☐ Policy/advocacy/research<br>☐ Other *(please specify)* _____ |
| | **WORK HISTORY** |
| **11** | **Last position**<br>Where was your last position? (*please tick one only*)<br>☐In same organisation<br>☐Other NGO AOD agency<br>☐Government AOD agency<br>☐Other sector (*please specify sector*) _____<br>☐Returning to workforce<br>☐None – this was first position (go to question 12)<br>☐Other (*please specify*) _____ |
| **12** | **If first paid job**<br>If this position was your first paid job, which best describes your previous situation?<br>☐New graduate<br>☐School leaver<br>☐Volunteer (*please specify*)_____<br>☐Other (*please specify*)_____ |
| **13** | **Years worked**<br>Please fill in number of years you have worked for each:<br>Current role: _____years<br>Current agency: _____years<br>Workforce total: _____years |

## Work History (cont.)

**14** **Organisations**

In your working life, approximately how many different organisations have you worked for?

____

**15** **Sectors**

Apart from AOD, which different sectors have you worked in (please tick as many as appropriate)?

☐Youth
☐Mental health
☐Medical (hospital/other clinical)
☐Health
☐Social services
☐Education
☐Community
☐Other government (*please specify*)_____
☐Private enterprise (*please specify*)_____
☐Own business(*please specify*)_____
☐Other (*please specify*)_____

## QUALIFICATIONS, STUDY AND TRAINING

**16** **Qualifications**

Tick as many as appropriate. Please state what area your qualifications are in, e.g. welfare, AOD, psychology etc. If you have post graduate qualifications, please provide details, e.g. Masters, Grad Dip etc and the area of your qualification.

☐None
☐Cert III (*please specify*)_____
☐Cert IV (*please specify*)_____
☐Diploma – non post graduate (*please specify*)_____
☐Degree (*please specify*)_____
☐Post Graduate Qualifications (*please specify*) _____
☐Other (*please specify*)_____

**17** **Current study and training**

Are you currently undertaking any study or training?

☐Yes (*please specify*)_____
☐No

**18** **Recent study and training**

In the past 12 months what types of study or training have you completed? Please state what you studied or trained in, and if applicable, type of Post Graduate course.

☐None
☐Short course(s) (*please specify*)_____
☐Supervised workplace training (*please specify*)_____
☐Self directed learning (*please specify*)_____
☐Cert III (*please specify*)_____
☐Cert IV (*please specify*)_____
☐Diploma -non post graduate (*please specify*)_____
☐Degree (*please specify*)_____
☐Post Graduate (*please specify*)_____
☐Other (*please specify*) _____

**19** **Intended study and training**

Are you intending to undertake any study or training in the next 12 months?

☐Yes (*please specify*)_____
☐No

**20** **Certificate IV AOD**

If you do not already have a Cert IV AOD, is this a qualification you would consider acquiring?

☐Already have Cert IV AOD
☐Yes
☐No

If yes or no, please explain why this is the case (e.g. will provide useful skills, already have higher qualifications etc):

_____
_____

## SKILLS AND KNOWLEDGE NEEDS

**21**

**Changing client needs**
In recent years, have you observed any changes in the needs of your clients?
☐Yes
☐No
If yes, please describe how client needs have changed:_____
_____
_____

**22**

**Organisational and workplace changes**
In recent years, have you observed any organisational or workplace changes?
☐Yes
☐No
If yes, please describe the changes:_____
_____
_____

**23**

**Skills and knowledge needs**
Are there any particular skills or knowledge that you would find useful to acquire in the next 2 years? (e.g. in relation to: specific therapies, complex needs clients, co-morbidity, management, clinical supervision etc)
☐Yes
☐No
If yes, please provide details:_____
_____
_____

**24**

**Learning methods**
What learning method do you prefer to gain the skills and knowledge you need?
☐On the job training
☐Short courses
☐Self directed learning (e.g. online, manuals, texts etc)
☐External conferences, seminars and events
☐Longer formal course (e.g. Certificate, Grad Cert etc)
☐Other (*please specify*)_____

## FUTURE INTENTIONS

**25**

**Next two years**
Over the next two years do you intend to do any of the following? (*please tick*)
☐Seek a promotion within your current agency
☐Seek a different position in your current agency
☐Seek a position in another NGO AOD agency
☐Seek a position in a government AOD agency
☐Leave the AOD sector (*please specify the sector to which you might move*)_____
☐Undertake full time study
☐Take maternity leave
☐Retire
☐Other (*please specify*)_____

## FURTHER COMMENTS

**26**

Please add any further comments you wish to make about workforce development issues and/or challenges facing the AOD NGO sector:
_____
_____
_____
_____
_____

**Thank you for filling in this survey**

## *AOD NGO workforce profile and issues: Research participants*

| Participant | Agency | Position |
|---|---|---|
| **Julaine Allan** | The Lyndon Community | Post doctoral fellow |
| **Deb Allen** | Guthrie House | Manager |
| **Anna Brusuker** | Wollongong Crisis Centre | Manager |
| **Mark Buckingham** | Kedesh House | CEO |
| **Gerard Byrne** | Salvation Army – Recovery Services Command | Social Programme Secretary |
| **David Calder** | Salvation Army FYRST Parramatta | Psychologist |
| **Alison Churchill** | Community Restorative Justice Centre | Manager |
| **Fiona Craig** | Kedesh House | Psychologist/service manager |
| **Amanda Davies** | Kathleen York House | Manager |
| **Kristina Devlin** | Manly Drug Education and Counselling Centre | Peer support worker |
| **Jonathan Furness** | Salvation Army – FYRST Parramatta | Manager |
| **Jennifer Locke** | Hillsong Emerge | Manager |
| **Noel Hackett** | Turning Point Case Management | Manager |
| **Jo Khoo** | NADA | Senior Project Officer |
| **Collette McGrath** | Medically Supervised Injecting Centre | Clinical Manager |
| **Matt McSevney** | CHESS Employment Service | AOD Worker |
| **Francesco Mendolicchio** | CoAsIt | AOD Worker |
| **Larry Pierce** | NADA | CEO |
| **Rodney Robbins** | Orana Community Haven | Manager |
| **Tirrania Suhood** | Blacktown Alcohol and Other Drugs Family Services | Manager |
| **Kyron Tari** | Mission Australia Referral and Support Services | Manager |
| **Tony Trimingham** | Family Drug Support | CEO |
| **Des Walsh** | We Help Ourselves – Metro | Manager |
| **Anonymous** | Various | AOD Worker x 2<br>Counsellor x 2<br>Family Support Coordinator<br>GP<br>Manager x4<br>Psychologist intern x 5 |