NATIONAL TELEPHONE SURVEY OF THE ADDICTION TREATMENT WORKFORCE

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Contents

1.0 Introduction

In 1998 the National Addiction Centre (NAC, which was then called the National Centre for Treatment Development; NCTD) conducted a national telephone survey of the dedicated alcohol and other drug (AOD) workforce[1-3]. This survey was designed to provide a picture of the state of the workforce at that time, and proved invaluable as a baseline measure from which we and others in the sector could plan initiatives for the further professionalisation of our field.

In 2004 this survey was repeated, at a time when the NAC had recently taken on the contract for the National Addiction Treatment Workforce Development Plan "Matua Raki". This second survey was used as part of the strategic plan published in the early stages of Matua Raki [4].

The current survey was commissioned by Matua Raki to update knowledge of the addiction treatment workforce for trend analysis seen as essential for future development of the workforce and services. For the first time the scope of the survey was to cover the gambling treatment workforce in addition to the alcohol and drug treatment workforce.

2.0 Method

2.1 Definition

Addiction treatment staff were defined as:

- Paid staff
- 70% or more of their clinical time is with patients affected by *their own* alcohol or other drug or gambling behaviour
- This includes undertaking brief or comprehensive assessments, counselling or other one-to-one treatment sessions, and facilitating groups
- This includes treatment delivered in person, on the telephone or via the internet
- This includes support workers (i.e. provision of one-on-one support) or facilitators of support groups primarily for people affected by *their own* AOD use or gambling
- This includes "dual diagnosis" workers in mental health settings whose work focus is on clients with dual addiction and other mental health diagnoses
- This includes managers who also have some regular clinical contact time which meets the above criteria

2.2 Randomisation Database

Addiction treatment workers were randomly selected as potential interviewees from a database maintained and updated by the NAC. This database had been originally created for the 1998 workforce survey and was updated on an ongoing basis when we were advised of staff changes. Major revisions occurred prior to the 2004 and 2008 surveys. For the latest survey this revision comprised of contacting all services on the database, the comprehensive *adanz* Addiction Treatment Directory, the membership register of the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) and any others we were made aware of. While the intention was to use the full list of DAPAANZ members, as had been the case in 2004, it was revealed after the survey was complete that only the registered competent practitioners list, making up 40% of DAPAANZ membership was in fact forwarded and therefore available to update the randomisation database.

Managers of all services were mailed letters in mid and late 2007 with active telephone follow-up of unresponsive services in early 2008, resulting in updated lists of staff meeting the above definition for 95.3% of known AOD services, 68.5% of known gambling services, and 82.4% of services which could not be easily categorized as either AOD or gambling. Where updated lists of staff details were not available, details from previous survey databases were retained. It should be noted that these percentages for service responses underestimate the percentage of workers for whom updated details were obtained, as particular effort was made to obtain worker details for larger services.

Services/workers were provisionally identified as AOD, gambling and combined AOD/gambling on the basis of details provided on the *adanz* Addiction Treatment Directory for the purpose of randomisation. The target recruitment number was 250 AOD workers (including combined workers) and up to 100 gambling workers (including combined workers).

2.3 Recruitment

Workers were telephoned by a research assistant who had their first name, initial of last name, and workplace details only. Once consent had been gained the first two questions clarified whether or not the worker was employed in an AOD or gambling service or described their service as being "AOD and gambling specialist". If the latter option, this was clarified by getting them to confirm

that they "personally routinely worked with people with both alcohol and drug and gambling problems in their current role". Interviews took on average 50 minutes to complete and were conducted between December 2007 and October 2008.

The achieved recruitment rate was 83.2% for AOD workers and 69.9% for gambling workers, with details of non-recruitment and ineligibility provided in Table 1. As a comparison, the recruitment rate for AOD workers in 2004 was 88.6%, with 5.8% refusing and 5.5% not contacted.

Table 1: Final Recruitment Status

	AOD workers	Combined AOD/Gambling workers	Gambling workers
Total randomised	303	47	59
Interviewed	208	24	34
Failed to recruit[i]	18	5	10
Refused	18	6	4
Had departed	31	2	5
Ineligible[ii]	19	8	4
Proved to be duplicate names	7	2	2
Number eligible	244	35	48
Recruitment rate including combined group	83.2%		69.9%
Refusal rate including combined group	8.6%		12.0%
Failed to recruit rate including combined group[i]	8.2%		18.1%

[i]not successfully recruited despite being confirmed as currently working clinically at the identified service – as a result of always being busy/unavailable at the times they were called
[ii]not clinical, or were unknown to the service

2.4 Recruitment Bias

Those declining to participate in the survey were asked to provide basic service and demographic details. Such information was not collated for randomly selected workers who were unable to be contacted. Once this latter group is excluded, the recruitment rate amongst contacted workers was 88.5%. Workers in residential settings were significantly less likely to participate in the survey (77.5%) than were exclusively outpatient workers (92.7%, χ^2=11.80, p<.001). There were no other systematic differences between those who were and weren't recruited for work setting (Island, DHB, service type, provincial) or patient characteristics (age, gender, ethnicity, professional identity). In contrast in 2004 there was no difference in recruitment rate between residential (94.7%) and exclusively outpatient workers (95.1%), with the only difference being that those who consented to participate were older (mean 46.7, SD 9.2) than those who did not consent (mean 40.2, SD 10.2, t=2.56, p=.011).

2.5 Follow-up interviews

At the conclusion of each interview, interviewers determined whether or not workers could be classified as nurses or youth workers based on several criteria which could be identified from the survey questions. Those eligible were invited to participate in a follow-up interview, described in greater detail in sections 5.0 and 6.0.

3.0 Alcohol and Drug Workers

3.1 Findings

This section summarises the profile of AOD workers, which includes the 208 workers identified in Table 1 as working in specialist AOD services or who had a specialist AOD role in broader services. Also included were the 24 "combined" workers who routinely worked with people with both alcohol and drug and gambling problems in their current role. Therefore the sample size for surveyed AOD workers in 2008 is 232. These workers are compared with AOD workers interviewed in 1998 (n=217) and 2004 (n=288).

Table 2: Demographic Profile

		Year of Interview		
		1998	2004	2008
Gender (Female)		59%	59%	59%
Ethnicity				
Pakeha/European		61%	64%	58%
NZ Māori		24%	22%	15% * ‡
Other European		11%	6%†	16% † +++
Pacific Nation		4%	4%	3%
Asian		1%	2%	5%*
Other		-	3%	3%
Age				
Mean:		41.8 (9.3)	46.6 (9.3)***	48.4 (10.3)*** +
Age Range	<35	24%	11%	11%
	35-49	53%	50%	41%
	50+	23%	39%	48%

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, +p<.05, ++p<.01, +++p<.001

As shown in Table 2, the demographic profile of the workforce has changed in several ways over the past ten years. While there has been no change in the gender balance, the ethnic make-up of workers has altered, with this change primarily occurring in the past four years. The proportion of Māori in the workforce has reduced from one quarter to 15% while at the same time there has have been increases in the number of Asian workers and those identified as Other European. The average age of a worker has continued to increase and is now 48.4 years.

In 2004 the increased mean number of years working in the AOD field was interpreted as showing an improved retention rate. This figure has remained stable between 2004 and 2008, despite the continued increase in the field size, which will inevitably involve workers with less experience joining the AOD field. Table 3 shows the distribution of workers experience underlying these mean scores, which have also remained essentially static between 2004 and 2008.

Table 3: Experience in AOD, Gambling and Mental Health

	Year of Interview		
	1998	2004	2008
Years in AOD field	5.7 (5.1)	8.0 (5.8)***	8.5 (6.9)***
Distribution of years in AOD field			
Less than one	4%	4%	3%
1-<5	50%	30%	30%
5-<10	28%	32%	29%
10+	18%	35%	37%
Any work in gambling field			25%
Years in gambling field, excluding those with none (n=57)			5.5 (6.9)
Any work in mental health field			60%
Years in mental health field, excluding those with none (n=139)			9.0 (7.6)

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, $^{+}$p<.05, $^{++}$p<.01, $^{+++}$p<.001

The 25% of the sample who had experience working in gambling included the 9% currently working in combined services and 16% with past gambling work experience. More common than gambling experience was mental health experience (60%). These data were not collected in 1998 or 2004.

Table 4: Self-selected Professional Identity

	Year of Interview		
	1998	2004	2008
Counsellor/Therapist	57%	53%	58%
Nursing	17%	16%	15%
Social Work	11%	11%	16%
Psychology	7%	5%	5%
Medicine	6%	3%	2%*
A & D/Addiction Clinician	0%	7%***	1% $^{++}$
Other	2%	6%*	3%

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, $^{+}$p<.05, $^{++}$p<.01, $^{+++}$p<.001

Table 4 shows that professional affiliations continue to be primarily divided between counsellor/therapist, nursing and social work. The apparent increase in social workers was not significant (e.g. 2004-2008 comparison, χ^2=1.84, p=.175). The emergence of a significant minority of workers identifying as AOD or addiction clinicians in 2004 has not been sustained, with a significant drop in the current survey period. Medical practitioners as a proportion of the workforce have shown a significant decline from 1998 to 2008.

Table 5 demonstrates that the formal tertiary qualification level of the workforce has continued to improve dramatically, with close to half holding postgraduate qualifications, triple the 1998 level, while those with no tertiary qualifications moves further towards zero, down from a quarter of the workforce in 1998. Postgraduate qualifications were most common for non-Māori (51% versus 23%, χ^2=9.30, p=.002), those not identifying as in recovery (54% versus 30%, χ^2=12.36, p=.000), those working in DHB services (56% versus 34%, χ^2=10.35, p=.001), and involved in the provision of methadone (61% versus 41%, χ^2=7.58, p=.006). Additional workers with postgraduate qualifications were younger on average (Mean (SD): 46.4 years (10.5) versus 50.1 years (9.8), t=2.81, p=.005). All workers identifying their profession as medicine or psychology had postgraduate qualifications, while nurses were significantly more likely than social workers and counsellor/therapists to have postgraduate qualifications (80% versus 35%, χ^2=23.95, p=.000).

Table 5: Qualifications

	Year of Interview		
	1998	2004	2008
Highest Qualification:		***	*** $^{++}$
Postgraduate	16%	34%	47%
Undergraduate	58%	60%	50%
Pre-tertiary/none	26%	6%	3%
AOD/gambling-specific Qualifications			
Completed (any tertiary)	45%	40%	63%*** $^{+++}$
Completed (postgraduate)	5%	13%**	27%*** $^{+++}$
Currently undertaking formal AOD/gambling education		17%	24%$^{+}$
Currently undertaking formal non-AOD education		26%	24%
Support by manager to undertake as much training as needed:			
Not at all		6.0%	2%
A little		7.0%	6%
Moderately		15.8%	18%
A lot		13.3%	17%
Very		57.5%	57%
Able to undertake as much clinical training as needed to do job well		69.1%	75%

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, $^{+}$p<.05, $^{++}$p<.01, $^{+++}$p<.001

While overall qualifications improved steadily over the three survey periods, the 2004 figure showed no significant change in the proportion of workers with an AOD/gambling specific qualification, which was 45% in 1998 and 40% in 2004. For the latest survey period however there has been a substantial increase to 63% of workers holding such a qualification. AOD/gambling specific qualifications were most likely amongst DAPAANZ members (75% versus 51%, χ^2=13.91, p=.000), counsellors/therapists (70% versus 52%, χ^2=8.53, p=.003), and those working in non-residential settings (67% versus 47%, χ^2=6.37, p=.012), while those with AOD/gambling qualifications had worked in the AOD field for longer on average (Mean (SD): 9.6 years (6.8) versus 6.6 years (6.8), t=3.17, p=.002).

The worker and setting variables outlined above as being associated with different levels of postgraduate and AOD/gambling specific qualifications closely parallel those found in an analysis of 2004 data[4].

Furthermore the number of workers currently undertaking AOD/gambling education has also risen, while in contrast the rate of other study remains stable. In total 43% of workers described being currently enrolled in formal training (compared to 40% in 2004). Those currently enrolled in AOD/gambling training included several workers with no current AOD/gambling qualifications so that the total proportion with an AOD/gambling qualification *or* currently studying for such a qualification is 69%. The only worker/setting variables that were able to differentiate those who were currently studying were professional identity and professional body membership status. Counsellors/therapists had the highest rate of current study (52.6%), while nurses (20%) and social workers (31%) had the lowest rates (χ^2=15.2, p=.010). Workers who were not members of a professional body, but who had signalled their intention to join DAPAANZ in the next twelve months (accounting for 13% of the workforce) were more likely to be studying (63%) than the remainder of the workforce (40%, χ^2=5.75, p=.016). These workers were also more likely to be studying than workers not belonging to a professional body who said they did not intend to join DAPAANZ in the next 12 months (29%, χ^2=5.97, p=.015).

Workers continued to report high levels of support for training from managers, with a significant reduction in the proportion describing their manager as not at all or only a little supportive, from 13% in 2004 to 7% in 2008 (χ^2=17.3, p=.037). Workers were most likely to describe their manager as very supportive of training if they worked in a provincial location (70% versus 54%, χ^2=4.15, p=.042), or for a Kaupapa Māori service (76% versus 52.7%, χ^2=8.25, p=.004), while there was no difference for any other demographic, work setting, or qualification variables. Three-quarters of workers reported that they were able to undertake as much clinical training as needed to do their jobs well. As was the case in 2004 the main reasons given by those not able to undertake training were limited money and time/high workload. Unsupportive management was less of a feature than was the case in 2004, while travel distance required to study was more prominent.

Table 6: Work Setting

	Year of Interview		
	1998	2004	2008
DHB	61%	68%†	57%$^{+}$
Outpatient only	67%	76%*	76%*
Residential detox	7%	9%	7%
Residential post-detox	26%	16%**	22%‡
Primary treatment format:			
Face to face		95%	95%
Telephone/both equally		5%	5%
Kaupapa Māori		16%	20%
% clients Māori (past six months)	32.0 (28.6)	30.0 (29.1)	32.7 (27.6)
Service type:			
Youth			10%
All ages			18%
Adult			72%
% clients aged <18 (past six months)			12.4 (28.5)
North Island	72%	69%	70%
One of five main cities	66%	64%	54%** $^{+}$
Provincial/rural		19%	22%
Hours worked per week	34.3 (10.5)	35.5 (9.2)	34.2 (10.0)

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, $^{+}$p<.05, $^{++}$p<.01, $^{+++}$p<.001

Table 6 shows the spilt between outpatient and inpatient work settings has remained stable between 2004 and 2008, while the number of workers in post-detoxification residential settings shows a trend towards increasing, having fallen significantly between 1998 and 2004. Including the workers who were contacted but declined to participate (see section 2.4 Recruitment Bias) would reduce the "outpatient only" rate to 73%, while the detox and post-detox figures would be 8% and 24% respectively. There has also been a decrease in the portion of workers venued within one of New Zealand's five main cities.

Rates of telephone work, Kaupapa Māori service and estimated proportion of Māori clients remained stable since 2004. For the first time the age range of clients seen was inquired about, revealing that a quarter of workers were in services that routinely saw clients under the age of 18. The mean percentage of clients who were youth under 18 years was 12%, with 62% of workers seeing no youth clients and 17% reporting that youth constituted 20% or more of their clients.

DAPAANZ remains the organization with the highest membership rate by a very large margin (Table 7). As stated in the footnote to Table 7, the figures for DAPAANZ membership may under-estimate the true rate. Close to a quarter of the workforce stated that they intended to become members in the coming 12 months, including 59% of workers who were not currently members of any professional body.

Although the proportion of the workforce belonging to other professional bodies was stable between 2004 and 2008 there was a much wider range of overseas organizations named by 2008 workers, possibly mirroring the increase in workers identified as Other European or Asian.

Table 7: Professional Association Membership

	Year of Interview	
	2004	2008
Drug and Alcohol Practitioners Association of Aoteoroa New Zealand (DAPAANZ)	57%	49%[i]
Member		15%
Registered support worker		1%
Registered associate practitioner		5%
Registered competent practitioner		25%
Not sure		2%
Intending to upgrade membership in the next 12 months		13%
Intending to become a member in the next 12 months		23%
Other membership (including the following:)	50%	47%
New Zealand Association of Counsellors (NZAC)	17%	12%
New Zealand Nurses Organisation (NZNO)	12%	11%
Australia/NZ Association of Social Workers (ANZASW)	7%	11%
New Zealand Psychological Society (NZPsS)	2%	1%
Any professional affiliation	81%	78%

2004 comparison: $^{\ddagger}p<.10$, $^{+}p<.05$, $^{++}p<.01$, $^{+++}p<.001$

[i] While this figure represents a trend ($p<.10$) for reduced membership of DAPAANZ the fact that only competent practitioner details were used to update the randomization list, and not the full DAPAANZ membership, means that there was a bias which is likely to have led to under-recruitment of DAPAANZ members. This possibility is borne out by the observation that standard members (list as "Member" in the table) make up only 30% of DAPAANZ members in the surveyed sample but constitute 49% of total DAPAANZ membership.

The proportion of the workforce not belonging to any professional body remained constant at about one fifth of workers. Workers less likely to belong to a professional body were Māori (57% versus 82%, χ^2=10.47, p=.001), telephone workers (50% versus 80%, χ^2=5.79, p=.016), those in recovery (69% versus 82%, χ^2=5.25, p=.022), those with no more than an undergraduate certificate (57% versus 83%, χ^2=14.2, p=.000), and those with no AOD qualification (70% versus 83%, χ^2=5.07, p=.024). Workers with professional membership had more years experience in the AOD field (mean 9.0 years, SD 7.1 years) than those without (mean 6.6 years, SD 5.7).

Table 8: Clinical Supervision

	Year of Interview	
	2004	2008
Frequency		
Weekly	13%	7%
Fortnightly	50%	42%
Three-weekly	8%	6%
Monthly	23%	39%
Less than monthly	1%	3%
As required	3%	1%
Never	2%	3%
Format		
One on one	71%	72%
Group	6%	8%
Both	23%	20%
Setting		
Internal	33%	35%
External	60%	64%
Both	8%	1%$^{+++}$

2004 comparison: ‡p<.10, $^{+}$p<.05, $^{++}$p<.01, $^{+++}$p<.001

Frequency and type of clinical supervision is summarized in Table 8. The average frequency of supervision reduced significantly between surveys (linear-by-linear χ^2=13.26, p=.000), with monthly supervision now almost as common as fortnightly. There was no change in the ratio of one-to-one versus group or internal versus external supervision, but a marked decline was observed in the number of workers taking part in both internal and external supervision.

Receiving supervision fortnightly or more was more likely for counsellors/therapists (60% versus 34%, χ^2=15.24, p=.000), and less likely for part-time workers (less than 30 hours per week) (29% versus 55%, χ^2=10.98, p=.001), workers in provincial settings (32% versus 54%, χ^2=7.50, p=.006) and in all ages services (29% versus 54%, χ^2=8.68, p=.003). It should be noted that there is a strong overlap between these last two variables, with 45% of all ages services in provincial settings, compared to 23% of youth services and 16% of adult services.

The proportion of the workforce who are current smokers has continued to decline and is now well under half the level of ten years ago, as shown in Table 9. While there has been a small and non-significant increase in the proportion who are ex-smokers (now out-numbering current smokers three-to-one), the reduction in current smokers is primarily due to the increase in non-smokers (those who never smoked regularly), which has risen from one third to one half of the workforce.

Table 9: Substance Use and Recovery Status

	Year of Interview		
	1998	2004	2008
Nicotine status:			
Non-smoker	36%	42%	49%** ‡
Ex-smoker	34%	39%	38%
Current smoker	30%	20%**	13%*** +
Drinking status:			
Non-drinker	7%	5%	9%
Ex-drinker	36%	27%*	26%*
Current drinker	58%	68%*	65%
In recovery from:			
AOD problem			32%
Gambling problem			7%
Either			33%
Amongst those in recovery:			
Sought treatment			70%
Number of years in recovery			15.5 (8.0)

1998 comparison: †p<.10, *p<.05, **p<.01, ***p<.001
2004 comparison: ‡p<.10, +p<.05, ++p<.01, +++p<.001

Ex-drinker figures shown above have been interpreted in previous surveys as a proxy measure for the proportion of the workforce who are in recovery from their own substance use problem. For the 2008 survey we asked respondents directly if they considered themselves to be in recovery from a substance use problem, with 32% responding that they were. Recovery status was found to be highly correlated with "ex-drinker" status (χ^2=82.8, p<.00001), with 79% of ex-drinkers in recovery and 66% of those in recovery describing themselves as ex-drinkers. Amongst those in recovery, the most common substances were alcohol (80%), cannabis (53%), stimulants (37%), opioids (27%), and sedatives (22%). In addition 7% of respondents reported being in recovery from a gambling problem, almost all of whom were also in recovery from a substance use problem. Treatment had been sought by 70% of those in recovery, approximately one quarter (23%) of the total workforce. The average duration of being in recovery was 15.5 years. One respondent had been in recovery for less than two years and 92% had been in recovery for five or more years.

3.2 Summary

The validity of the data presented here rests on the question of representivity. In short, if there are significant biases in the recruited sample then any figures derived from the survey may be inaccurate. The very high response rate from AOD services (95%) to our request for updated lists of all current clinical staff helped to maximize the representivity of the list from which workers to be contacted were randomly selected. A high response rate (83%) was achieved for those randomly selected. Efforts were made to quantify any bias introduced through non-recruitment by seeking a minimal data set from all workers contacted who refused to participate in the survey. This identified a single factor – residential versus outpatient only services - as a systematic bias, and an adjusted figure has therefore been calculated and provided in the text following Table 6.

Overall the results of this survey show many areas of stability in the workforce profile, but with several areas of notable progress and concern. With respect to demographic variables, the workforce continues to age, but at a slower rate to that previously identified. The improved retention of staff within the sector, as measured by mean number of years in the field, has been maintained. The ethnic profile of the workforce is the most significant demographic change, with an increase in the proportion of Asian and Other European workers being matched by a reduction in Māori workers, so that the proportion of Māori in the workforce is only half the estimated proportion of clients (see Table 6).

Although the raw numbers are small and should therefore be treated with caution, it would appear that medical practitioners have become an even smaller part of the workforce over the past ten years, while the emergence of workers identifying their profession as "A&D or Addiction Clinician" in 2004 has substantially subsided. It is possible that this was a popular option in 2004 in the wake of the excitement generated by the establishment of DAPAANZ and that, although remaining members of DAPAANZ, workers have returned to preferring professional identifications that transcend a specific field.

In 2004 the most exciting finding was the substantial increase in the qualification level for the field since the 1998 survey. This trend has continued with close to half of the field now holding a postgraduate qualification, while the proportion with a postgraduate AOD/gambling qualification has doubled from 13% to 27%. In 2004 there had been no increase in the proportion of the field holding an AOD/gambling specific qualification but by 2008 this has increased substantially. Close to two-thirds of the field now hold such a qualification, while at the same time the proportion of the field currently studying for an AOD/gambling qualification has increased significantly. In parallel with the increase in qualifications and current study this survey found that management support for study remains high and has in fact improved further since 2004. The predominant restraints on training are funding, time and distance from study locations.

For the first time the national workforce survey has sought to identify youth workers as a specific segment of the field. Dedicated youth services provide 10% of the workers, while a further 18% work in "all ages" services, with such services disproportionately situated in provincial settings. In total 17% of the workforce spend a significant amount of their clinical time (20% or more of their patients) working with youth under 18. The experience and needs of this sector are discussed in greater detail in Section 6.0.

DAPAANZ remains the professional organization with by far the greatest rate of membership amongst AOD workers. An area of concern identified in 2004 was the significant minority (19%) who were not members of any professional body. This figure remains essentially unchanged (22%). Of those not belonging to a professional body over half stated their intention to join DAPAANZ in the next 12 months. While this stated intention cannot simply be taken to indicate that this would in

fact occur, it is notable that this group (those with no professional membership who intend to join DAPAANZ) was the subgroup with the highest rate of current study (63%), a tangible measure of efforts to attain a more sound professional status.

Clinical supervision, although almost universally engaged in, has reduced in average frequency, with monthly supervision now almost as common as fortnightly. In 2004 the very low rate of workers engaged in both internal and external supervision was commented upon. Such arrangements have now all but disappeared.

Over the past ten years the rate of smoking has gone from being higher than for the general population to being substantially lower. Although there has been no reduction in the number of workers with the experience of nicotine addiction and cessation, the proportion of those who have never smoked has increased to half, something that perhaps should be reassuring to find amongst health professionals.

This survey marks the first time recovery status has been specifically enquired about. The figures reveal that one third of the workforce considers themselves to be in recovery from a substance or gambling problem. While equivalent figures are not available for preceding surveys, the proportion who are ex-drinkers suggests that this has remained stable since 2004, following a decline observed since 1998.

3.3 Workforce Development

Key implications of this research for future workforce development include the following:

1. A reduction in the proportion of Māori in the AOD workforce has been identified, with the greatest part of this reduction occurring during the past four years. Reasons behind this need to be further investigated. Given lower rates of qualifications and professional membership amongst Māori, it is possible that higher standards for recruiting new staff may be disproportionately affecting Māori. This issue would benefit from closer examination, as continuation of this trend has serious implications for the ability of the sector to respond to the needs of Māori clients.

2. Professionalisation of the field in terms of formal qualifications has continued to improve at an impressive rate. The continued high rates of study indicate that this process will be an ongoing one. Barriers of funding and time, whilst not surprising, must be considered if the workforce is to attain its potential. Whilst provincial workers enjoy the most supportive managers they would also be expected to be disproportionately effected by distance from training sites, which will exacerbate the impact of time and cost factors.

3. In 2004 the fact that one fifth of the workforce did not belong to any professional organization was identified as an issue of concern. This meant a sizeable portion of the workforce was practicing without a formal code of ethics to guide safe and professional practice. There has been no improvement in this figure in the past four years. DAPAANZ remains the professional body AOD workers are most commonly affiliated to, with half belonging, including 30% of the workforce belonging to DAPAANZ and no other professional body. As noted earlier, these figures might slightly under-represent the true rate of DAPAANZ membership. The importance of other organizations, such as NZAC, NZNO and ANZASW also have an important role to play. The promotion of professional membership to unaffiliated workers remains one of the most pressing areas for action. Targeting Māori, telephone workers, those who are less qualified, in recovery and have more recently joined the workforce would appear to be the areas where the greatest improvement can occur.

4. Over the past four years the frequency of clinical supervision has decreased, with monthly supervision now as common as fortnightly supervision. Clinical supervision is a key process for promoting professional practice, improving treatment delivery and maintaining worker wellbeing. Resourcing issues may have contributed to this decline but equally it may signal an undervaluing of supervision.

5. The AOD field has witnessed a remarkable reduction in the prevalence of smoking within the workforce over the past ten years. The challenge remains to translate this to a reduced prevalence amongst our clients. As being a current smoker may act as a barrier to raising the issue of smoking with clients, this is a development which would assist in any attempt to systematically promote smoking cessation as a routine activity with AOD clients.

6. Increasing numbers of Asian and Other European workers points to the potential for recruiting new staff from overseas or from amongst recent migrants. There may be benefit to this occurring in a planned rather than ad hoc manner. Issues to consider include identifying the strengths and challenges associated with different cultural groups, awareness of New Zealand cultural practices, qualification equivalency, adequacy of overseas professional association membership, and identifying which groups are most likely to remain within the New Zealand addiction workforce.

4.0 Gambling Workers

The following data represent the first time the gambling workforce has been included in this series of national workforce surveys. The primary intention of this research is to profile the gambling treatment workforce, not to compare it with the AOD workforce. The absence of earlier data means that trends analysis as undertaken above cannot be done for gambling. Instead these data provide the opportunity to establish a baseline.

The sample analysed here comprises workers in dedicated gambling settings as well as those who stated that they worked with both gambling and AOD clients (a group who were also included in the AOD worker profile in section 3.0 above). These "combined" workers make up such a large proportion of the sample described below (over 40%). Because they are likely to work with fewer gambling clients than will dedicated gambling workers, care has been taken to identify where these two groups may differ from one another, as the combined workers might otherwise obscure important characteristics of what might be considered the primary gambling workforce. Because of the small sample sizes involved, only fairly substantial differences will be reliable (i.e. statistically significant).

4.1 Finding

This section summarises the profile of gambling workers, which includes the 34 workers identified in Table 1 as working in specialist gambling services or who had a specialist gambling role in broader services. Also included were the 24 "combined" workers who routinely worked with people with both alcohol and drug and gambling problems in their current role. Therefore the sample size for surveyed gambling workers is 58.

Table 10: Demographic Profile

Gender (Female)			57%
Ethnicity			
	Pakeha/European		47%
	NZ Māori		17%
	Other European		10%
	Pacific Nation		0%
	Asian		17%
	Other		9%
Age			
	Mean:		48.9 (10.4)
	Age Range	<35	10%
		35-49	40%
		50+	50%

Combined and dedicated gambling workers did not differ on any of the demographic variables shown in Table 10.

Table 11: Experience in AOD, Gambling and Mental Health

Years in Gambling field	5.4 (6.8)
Distribution of years in gambling field	
Less than one	14%
1-<5	43%
5-<10	31%
10+	12%
Any work in AOD field	59%
Years in AOD field, excluding those with none (n=34)	10.7 (9.5)
Any work in mental health field	55%
Years in mental health field, excluding those with none (n=32)	7.4 (5.8

Combined and dedicated gambling workers had comparable mean (SD) years working in the gambling field of 4.9 (4.7) and 6.1 years (9.0) respectively. The figure in Table 11 for workers with experience in AOD (59%) includes all combined workers (by definition) and 29% of dedicated gambling workers.

Table 12: Self-selected Professional Identity

Counsellor/Therapist	69%
Nursing	3%
Social Work	17%
Psychology	7%
Medicine	0%
A & D Clinician	2%
Other	2%

Table 13 shows that 19% of the sample were currently studying for a gambling/AOD qualification and 24% for other qualifications. In total 36% of the sample were currently studying. Dedicated gambling workers were less likely to have a postgraduate gambling/AOD qualification than were combined workers (6% versus 25%, χ^2=4.32, p=.038). Gambling workers were also more likely to have completed a gambling/AOD qualification if they worked in a DHB service (73% versus 36%, Fisher's Exact p=.042), and identified as being in recovery from substance misuse (71% versus 34%, χ^2=6.04, p=.014). Workers with gambling/AOD qualifications reported working with a higher proportion of Māori clients (mean 39.1% (SD 27.5) versus 25.5% (21.4), t=2.13, p=.038), and had worked in AOD for longer (mean 9.1 years (SD 8.3) versus 4.1 years (8.9), t=2.18, p=.034).

Workers were more likely to have a postgraduate qualification if they worked in adult rather than all ages services (60% versus 23%, χ^2=5.51, p=.019) and if they were members of a professional body (61% versus 21%, χ^2=6.78, p=.009), but less likely to if they were social workers or counsellors/therapists (44% versus 100%, Fishers Exact p=.005).

Table 13: Qualifications

Highest Qualification:	
Postgraduate	52%
Undergraduate	43%
Pre-tertiary/none	5%
Gambling/AOD-specific Qualifications	
Completed (any tertiary)	43%
Completed (postgraduate)	14%
Formal training in population health methods/strategies	28%
Currently undertaking formal gambling/AOD education	19%
Currently undertaking formal non-gambling/AOD education	24%
Support by manager to undertake as much training as needed:	
Not at all	
A little	5%
Moderately	9%
A lot	16%
Very	14%
	57%
Able to undertake as much clinical training as needed to do job well	86%

Workers were more likely to be currently studying if they had formal training in population health (69% versus 24%, χ^2=10.13, p=.001), or currently held a gambling/AOD qualification (56% versus 21%, χ^2=7.45, p=.006).

Workers were more likely to describe their manager as being very supportive of ongoing training if the worker was male (76% versus 42%, χ^2=6.54, p=.011), or if they had a gambling/AOD qualification (72% versus 46%, χ^2=4.09, p=.043).

Table 14: Work Setting

DHB	19%
Primary treatment format:	
Face to face	97%
Telephone/both equally	3%
Kaupapa Māori	19%
% clients Māori (past six months)	31.3 (24.9)
Service type:	
Youth	0%
All ages	23%
Adult	77%
% clients aged <18 (past six months)	2.1 (5.0)
North Island	75%
One of five main cities	64%
Provincial/rural	10%
Hours worked per week	32.6 (9.7)

Table 14 shows 19% of gambling workers were employed in DHB services. Only 6% of dedicated gambling workers were employed in DHB services compared to 38% of combined workers

(χ^2=9.15, p=.002), and dedicated gambling workers also worked fewer hours on average (29.6 (9.9) versus 37.1 (7.6), t=3.09, p=.003), with 35% of dedicated gambling workers employed part time (defined as less than 30 hours per week) compared to 9% of combined workers (χ^2=5.24, p=.022).

Table 15: Professional Association Membership

Member of a professional association	76%
Drug and Alcohol Practitioners Association of Aoteoroa New Zealand (DAPAANZ)	33%
New Zealand Association of Counsellors (NZAC)	24%
Australia/NZ Association of Social Workers (ANZASW)	16%
New Zealand Psychological Society (NZPsS)	5%

Combined workers were more likely than dedicated gambling workers to be members of DAPAANZ (58% versus 15%, χ^2=12.16, p=.000), but less likely to be members of NZAC (13% versus 38%, χ^2=4.67, p=.031).

Workers were more likely to be members of a professional association if they held a postgraduate qualification (90% versus 61%, χ^2=6.78, p=.009).

Table 16: Clinical Supervision

Frequency	
Weekly	12%
Fortnightly	55%
Three-weekly	3%
Monthly	28%
Less than monthly	2%
As required	0%
Never	0%
Format	
One on one	65%
Group	14%
Both	21%
Setting	
Internal	16%
External	84%
Both	0%

Table 16 shows that clinical supervision was most commonly undertaken fortnightly (55%) , in one on one format (65%) and was provided by a supervisor external to the worker's service (86%). Dedicated gambling workers were significantly less likely to have internal supervision than were combined workers (3% versus 33%, χ^2=9.91, p=.002). Workers were more likely to receive supervision of at least fortnightly frequency if they did not work in a provincial setting (73% versus 17%, Fishers Exact p=.012), if they did not hold a gambling/AOD qualification (82% versus 48%, χ^2=7.39, p=.007), but if they held a postgraduate qualification (80% versus 54%, χ^2=4.59, p=.032).

Table 17: Recovery Status

Nicotine status:	
Non-smoker	59%
Ex-smoker	34%
Current smoker	7%
Drinking status:	
Non-drinker	17%
Ex-drinker	21%
Current drinker	62%
In recovery from:	
Alcohol or other drug	24%
Gambling	9%
Either	28%
Amongst those in recovery:	
Sought treatment	87%
Number of years in recovery	16.7 (9.5)

Dedicated gambling workers were less likely to be ex-drinkers than were combined workers (9% versus 38%, χ^2=7.05, p=.008). They were also less likely to identify as being in recovery from a substance use problem (9% versus 46%, χ^2=10.52, p=.001), while there was a non-significant trend to also be less likely to identify as being in recovery from a gambling problem (3% versus 17%, χ^2=3.37, p=.067).

4.2 Summary

The sample described above can be less reliably considered to be representative than is the case for the AOD sample. This is the result of a poorer response rate (69%) by gambling services to the request for staff details used to populate the worker database (from which workers were randomly selected for recruitment) and a lower recruitment rate (70%) for those selected workers. In particular, the timing of the survey coincided with significant management challenges within the Gambling Helpline, a major employer in the sector and one which chose not to take part in the survey. Compounding these sources of potential recruitment bias is the comparatively small sample size which means that figures presented must be considered to be more approximate than is the case for the AOD workforce profile, therefore reducing the ability to detect differences in statistical analysis. With these issues in mind, key elements of the findings can be cautiously summarized.

The surveyed gambling worker sample is highly qualified, with half holding post-graduate qualifications and almost none without any qualifications. A substantial proportion (43%) had gambling/AOD specific qualifications, but only a small proportion of these were post graduate, approximately half the rate found for AOD workers, with dedicated gambling workers less likely to have such qualifications than were combined gambling/AOD workers. Over a third of gambling workers were currently studying and overall management support for study was highly rated.

Although formal comparisons were not carried out between gambling and AOD workers, some observations can reasonably be made. As with AOD workers, the proportion of the gambling workforce who identified as Māori (17%) was substantially lower than the proportion of Māori clients (31%). A quarter to the surveyed workforce did not belong to any professional association. This would appear to be an area of equal concern within both the gambling and AOD sectors. Unfortunately the small sample size allowed for the identification of only one variable associated with the absence of professional membership among gambling workers and that was the absence of a postgraduate qualification

Years of experience in their respective field appears shorter than for AOD workers (on average 5.4 years for gambling workers and 8.5 for AOD workers), but this is perhaps not surprising given that gambling is a comparatively small and emerging field.

A substantial proportion of gambling workers were Asian, an encouraging finding given that 7-8% of gambling service users are Asian[5], and that this figure is widely considered to under-represent the true extent of problem gambling in New Zealand's Asian communities.. The absence of any Pacific workers in this sample should not be interpreted as showing there are no Pacific workers in the sector, as this is not the case. Given the proportion of Pacific workers in AOD was only 3%, a similar figure for the gambling sector could easily produce the figure presented in Table 10 (0%) by chance, even if the true population prevalence were somewhat higher.

Supervision appeared to be more regular and was less often internal than was the case for AOD services.

The gambling workforce sample surveyed here comprises two distinct groups: those who work in dedicated gambling services and those in work settings where they routinely work with both gambling and AOD clients. Differences between these two groups were found in terms of qualifications, work setting, work hours, professional association membership, clinical supervision, and recovery status. Future attempts to examine the gambling workforce would benefit from being aware of this distinction.

5.0 Sector Subgroup: AOD/Addiction Nursing

5.1 Introduction

The 2004 national telephone survey of a representative sample of AOD treatment workers (n=288)[6] found that 16% identified as nurses, comprising the largest professional group next to counsellors. Forty Two (93%) of the 45 nurses who consented to a follow-up survey completed the follow-up telephone interview[7]. Survey results informed the Matua Raki workforce development project focused on advanced practice nursing. In 2008 two major activities in this project were: 1) the development of a strategy discussion document to facilitate the recognition of advanced practice nurses working in the sector and to assist with the establishment of advanced practice clinical roles including Nurse Practitioner and; 2) a further follow-up survey of nurses who completed the NTS.

As in 2004, the purpose of the 2008 survey was to provide information on current and potential nursing roles within the AOD/addictions treatment field and professional development needs, thereby identifying workforce related issues and informing workforce planning and development. Repeating the survey allows for the identification of changes since 2004.

5.2 Method

The survey was developed from a review of the 2004 questionnaire in consultation with advanced practice nurses. Nurses who met criteria for a follow-up interview from the NTS AOD, combined AOD/gambling or gambling only samples were informed by the NTS interviewers about the follow-up nursing survey and asked if they would consent to being contacted for this survey. Criteria included: identifies nursing as main professional group or; member of a professional nursing body or; has a formal nursing qualification. Forty nurses met criteria.

A research nurse with extensive experience in working with people with addiction and co-existing mental health disorders received contact details from the NTS co-ordinator and individually contacted the nurses by telephone. She re-iterated the purpose and nature of the follow-up survey and assured the nurses of confidentiality and anonymity in respect to their individual responses prior to gaining consent for the telephone interview of approximately 30 - 40 minutes. Interviews were arranged to suit each participant and were conducted between the end of April 2008 and beginning of December 2008.

Of the 40 eligible nurse participants who completed the NTS survey, four were unavailable to the nurse researcher due to their details not being passed on in time. Of the 36 available participants, one nurse was unable to be contacted despite numerous attempts and another did not complete the survey due to work pressures. Therefore, 34 of the available 36 nurses (94.4%) completed the telephone interview.

5.3 Findings

5.3.1 Profile

5.3.1.1 Work setting

Table 18 provides a summary of the work settings of the 34 nurse respondents. Over three quarters (77%) worked in a city location and 47% worked in one of the main five cities. Over half (56%) worked in the North Island. Nearly three quarters (74%) described their workplace as AOD specialist, 18% as dual diagnosis, 6% as mental health and 3% as AOD and gambling. Similar to the 2004 survey findings, the nurse respondents in the present survey were predominantly employed by DHBs, and worked primarily in outpatient settings with adult clients. Just over half (53%) were directly involved in providing Opioid Substitution Treatment. The median percentage of Māori clients worked therapeutically with in the past 6 months was 17.5 (range 1-90).

Table 18: Nurses work setting

DHB	85%
Outpatient	82%
Residential	15%
Both Outpatient/Residential	3%
Service type:	
Youth	6%
All ages	29%
Adult	65%
Directly involved in provision of Opioid Substitution Treatment	53%

Eighty-five percent were employed in a designated nursing position (76% in 2004). The other 15% included the nurse who had recently moved out of the AOD field and 12% with generic position titles that reflected the specific nature of their role, i.e. educator, counsellor, co-ordinator and addictions clinician. Similar to the 2004 survey finding of 74%, 73% of the nurse respondents in the present survey considered their job description reflected their day to day work. The remaining quarter commented that their job description was either too generic (not nursing specific), too broad or, conversely, too narrow.

5.3.1.2 Nurses demographic characteristics and duration of working in AOD

Table 19 provides a summary of the demographic profile of the 34 nurse respondents together with the average number of years worked in the field and in their current position. Similar to the findings from 2004 (82%) the nurse respondents were primarily women and their average age was mid-forties (45 years, sd 8.4 in 2004). In the present survey 47% were aged 50 years or older. Only one nurse identified as Māori, no nurses as Pacific and only one nurse as Asian. Twenty-nine percent identified as other European (principally United Kingdom). Similar to the 2004 survey findings, the nurse respondents in the present survey had spent nearly a decade working in the AOD field (9.9, sd 8.5 (2004).

Table 19: Nurses demographic characteristics and duration of working in AOD field

Gender (Female)		79%
Ethnicity		
Pakeha/European		62%
NZ Māori		3%
Other European		29%
Pacific Nation		0%
Asian		3%
Other		3%
Age		
Mean:		47.8 (9.8)
Age Range	<35	12%
	35-49	41%
	50+	47%
Years in AOD field (mean, sd)		8.8 (6.5)
Years in current position (mean, sd)		4.7 (5.7) *

* One nurse had recently moved out of the AOD field into a senior health management position

5.3.1.3 Professional identity, nursing registration and scope of practice

Nurses (self-selected professional identity) comprised 15% of the total NTS sample, similar to the 1998 (17%), and 2004 (15%) findings. Four nurses self-identified as counsellor/therapist, reflecting their particular focus or role. Fifteen (44%) nurses had a comprehensive nursing registration, 26% had a psychiatric/mental health registration reflecting the position of addiction services within the mental health and addiction treatment sector and 12% had a general or general and midwifery or general and obstetric registration. Two nurses had a New Zealand Nursing Council scope of practice based on education preparation that restricted them to working in their present position/AOD service.

5.3.1.4 Qualifications and training

As can be seen from Table 20, 50% of the nurse respondents had completed an AOD postgraduate certificate or diploma (45% had a postgraduate qualification in 2004) and four (12%) were currently enrolled in study towards an AOD/addictions related qualification. Qualifications/papers enrolled in included: Postgraduate Certificate in Health Sciences (Addiction and Co-existing Disorders), Otago

Table 20: Postgraduate qualifications, current study and management support

Qualification	
Any Postgraduate	80%
AOD/addictions related Postgraduate (cert/dip)	50%
Currently studying for AOD/addictions qualification	12%
Supported by manager to improve knowledge and skills:	
Not at all/a little	12%
Moderately	23%
A lot/very	65%
Able to undertake as much clinical training as needed to do job well	71%

University; Dual Diagnosis paper, Massey University and; Postgraduate Certificate in Alcohol and Drug Studies, Auckland University. Five (15%) nurses were enrolled in other training/education which included a clinical nursing master's programme, psychodrama, Rational Emotive Behavioural Therapy, and a clinical supervision certificate.

Nearly two thirds of the nurse respondents considered that they were supported a lot or very much by their service manager to improve their knowledge and skills and over 70% felt that they were able to undertake as much clinical training as needed to do the job well.

Table 21 provides a summary of reported training/workshops attended by the nurse respondents in the past two years. As shown in this table, over half had attended "other workshops". These included a wide range of topics as listed below:

- Psychological interventions and strategies (Cognitive Behavioural Therapy, Dialectical Behaviour Therapy, Solutions Focussed Therapy; mindfulness, self esteem)
- Working with groups, families
- Strengths based therapeutic approaches
- Dual diagnosis
- Trauma
- Violence, domestic violence
- Medications
- Hepatitis C
- Management supervision
- Ethics and privacy
- Risk management
- Evidence based practice

Table 21: Training/workshops attended by nurses in the past two years

Training/workshop	
AOD	91%
Cultural	85%
Mental Health	82%
Gambling	35%
Gender Specific	24%
Other	52%

5.3.1.5 Professional affiliations and networks

The nurse respondents belonged to a range of professional bodies, with 88% belonging to a professional nursing organisation. Of these, the majority specified the New Zealand Nurses Organisation (NZNO) (80%) which is both a union and a professional body. Four nurses belonged to the Drug and Alcohol Nurses of Australasia (DANA) (two in combination with DAPAANZ and NZNO respectively), 21% belonged to DAPAANZ (two in combination with DANA and the Australia/New Zealand Psychodrama Association respectively), one specified a "psychiatric nursing organisation" and one the Royal College of Nurses and Midwives (Scotland). In comparison to 2004, fewer nurses reported belonging to an AOD or mental health nursing organization (2004: DANA 30%, NZ/Aust College Mental Health Nursing 14%). Given that membership of DAPAANZ was similar this may perhaps reflect a lower New Zealand profile of DANA and the prominence of NZNO as a union for all nurses as well as a professional body. In regard to DANA, 71% had heard about DANA and 39% were interested in being contacted about DANA. Over three

quarters were interested in being part of a national nurses' email for nurses working in AOD/addictions.

5.3.2 Recruitment and Retention

Of note, is that 21% of the nurses surveyed were UK nurses, reflecting a broader nursing workforce recruitment issue of difficulty in recruiting adequate numbers of New Zealand nurses. The nurse respondents were asked if they thought 15% of the AOD workforce was an optimal nursing proportion. Thirty one of the 32 nurses who responded to this question said it was not. The most common explanation for indicating a higher proportion (range of suggestions between 20% and 60% as optimal) was that nurses are able to provide comprehensive or holistic care (50% of responses). Several comments referred to the broad focus of nursing on health incorporating an understanding of physical and mental health and medical (including medication) knowledge. Two nurses provided a caveat commenting that an increased proportion would be contingent on nurses employed having the required AOD related therapeutic skills. Other comments highlighted the importance of interdisciplinary input and one of the two nurses who did not provide an estimate stated it would depend on what area of the workforce was requiring staff.

Table 22 provides a summary of how long the nurse respondents considered that they would continue to work in the field. Three nurses did not provide an estimate having left the field (one nurse) or in the process of leaving (two nurses). The two nurses in the process of leaving cited work related stress as their reasons for leaving. Of the nurses who said they would remain working in the field for more than five years, one commented "*I have a passion for this work"* and another said "*…believe I will be in it forever – the AOD/mental health area*".

Table 22: Nurses perception of how long they will continue to work in the addiction treatment field (n =31)

1-2 years	18%
2-5 years	21%
More than 5 years	44%
Don't know	9%
Left/in process of leaving	9%

Table 23 provides a summary of perceived barriers to nurses wanting a career in the AOD treatment field. All 34 nurses provided responses to this question and most specified more than one barrier. In respect to responses related to nurses *not being interested* and *lack of knowledge and skills,* several comments referred to the lack of promotion within nursing generally about nursing in the AOD field and lack of exposure to AOD/addictions theory and placement experience during undergraduate nursing education programmes. Limited undergraduate preparation and exposure to AOD treatment were also identified by 19% of nurse respondents in the 2004 survey.

Table 23: Perceived barriers to nurses wanting a career in the addiction treatment field

Barriers	*% of responses*
Lack of knowledge, skills, attitudes	71%
Nurses not interested	71%
Stigma	59%
Lack of understanding/awareness of roles	44%
Pay and conditions	38%
Under-resourced field	21%

Other barriers cited included a perceived difficult client group (three responses), competition from other areas (two responses), a lack of career pathway/vacancies in local areas (three responses) and a lack of training opportunities (one response).

5.3.3 Nursing Role

5.3.3.1 Skills nurses bring to the AOD field

The nurse respondents identified a range of skills that nurses bring to the AOD field. In summary, these were consistent with the skills identified in the 2004 survey and referred to a range of skills along the continuum from health promotion and education, to working with clients with complex treatment needs. The nurse respondents in the current survey similarly referred to a foundation of a broad understanding of physical and mental health, human development and medical knowledge reflected in a comprehensive or holistic approach. More specifically these skills included:

- Health education
- Assessment and treatment planning;
- Co-ordination of care from assessment to discharge
- Monitoring including of physical health e.g. blood tests, blood pressure etc
- Pharmacotherapy
- Withdrawal management
- Crisis intervention
- Risk management
- Ability to establish good relationships with clients
- Counselling
- Consultation/liaison
- Documentation
- Flexibility to work with a variety of people in a range of settings;
- Teamwork
- Advocacy
- Understanding of health care systems

One nurse respondent made the point, consistent with other comments made in respect to undergraduate education limitations, that it was important not to assume nurses had the required AOD skills based on a three year nursing education, thereby highlighting the need for postgraduate training and education.

5.3.3.2 Routine activities

Table 24 provides a summary of activities that the nurse respondents reported they were routinely involved in. These activities are consistent with the role of nurses who are primarily employed in DHB services providing outpatient treatment.

Table 24: Routine activities within day to day work

Activity	
Individual therapy	88%
Comprehensive assessment	82%
Education or other community work	82%
Brief initial assessment/triage	79%
Clinical case-management	79%
Facilitate groups or meetings for patients or their families	56%
Report writing	94%
Supervision of other staff	71%
Administration	71%
Management	41%

5.3.3.3 Ongoing treatment/interventions

The nurse respondents estimated that they spent an average of 21% (sd 21) of their time in conducting assessments and 51% (sd 24) of their time involved in ongoing treatment interventions. Table 25 presents the components of ongoing treatment interventions and the proportion of nurses typically involved in each activity. Again reflecting the dominant work setting of an outpatient DHB setting, over three quarters were typically involved in individual client work, monitoring risk and risk management, consultation/liaison, clinical case-management, health promotion and education, monitoring health status, managing emergencies and withdrawal management and detoxification. To a lesser extent they were involved in working with significant others, family and whanau, cultural interventions and group work.

Clarifying comments reflected possible underlying reasons for less involvement with significant others, families and whanau, cultural interventions and group work. Five comments referred to a perception that clients did not want significant other or family and whanau involvement and/or not having a significant other. Eleven comments suggested referral was made for input from culture specific services for specific clients as required and working collaboratively. The main reason provided for lack of involvement in group work was that the service did not provide this and four comments alluded to lack of resources. Three other nurses noted that their service did provide groups but that they were not involved.

In comparison with the 2004 survey findings, a much higher percentage of nurses were involved in consultation liaison activities (91% compared with 33%) suggesting a greater emphasis on this role within DHB specialist services. Reported consultation/liaison activities included regional consultation and general practitioner consultation/liaison, e.g. roles related to opioid substitution treatment (53% of nurses were directly involved with opioid substitution treatment). It is of interest that 71% of nurse respondents in the present survey endorsed family inclusive practice/working with significant others and whanau compared to 40% in the 2004 survey perhaps reflecting a higher emphasis within services on family inclusive practice as promoted by the Kina Trust. However, in response to a follow-up question directly asking nurses as to whether they routinely included client's significant other's, families and whanau in their day to day work, a lower proportion (58%) said they did so (consistent with the response to the item in Table 24 in respect to facilitating groups or meetings for patients or their families). This finding needs further investigation and suggests the

need for a continuing focus on family inclusive practice as well as continuing professional development in this area. A similar low proportion (29%) of nurse respondents in the present survey as in 2004 (26%) endorsed working with groups.

Table 25: Ongoing treatment/interventions

Activity	
Individual client work	97%
Monitoring risk and risk management	94%
Consultation/Liaison	91%
Clinical case/care management	88%
Health promotion, education	85%
Monitoring health status	85%
Managing emergencies	85%
Withdrawal management/detox	79%
Medication administration/management	73%
Family inclusive practice/working with significant other's family/whānau	71%
Cultural interventions	44%
Group work	29%

The nurse respondents who reported utilising psychological models/talking therapies in their day to day work (88%) were asked to identify the three main models or approaches used and to estimate their competence in these on a scale of 0-10 (0 being not at all competent and 10 being highly competent). The models or approaches cited most frequently were cognitive behavioural including relapse prevention (82%) and motivational enhancement/motivational interviewing (56%). Other reported approaches included Dialectal Behaviour Therapy (three responses), solutions based approaches (three responses), Person Centred/Rogerian (three responses); strengths based/clinical case-management (three responses) and; family approaches, psychodrama, psychodynamic; 12 Step, Rational Recovery, Te Whare Tapa Wha, therapeutic community, harm reduction, recovery approach, goal setting and behaviour modification (one response each).

Respondents who subjectively estimated that they were low in competence in their specified models or approaches (less than 5/10) provided clarifying comments. Comments referred to:

- A lack of training and/or experience
- Not working often with clients and using the specified approach
- Not having much time working with clients in therapy
- A lack of engagement/interest by clients
- Still learning
- Opioid Substitution Treatment role does not allow opportunity

The nurse respondents were then asked to rate their competence in respect to specific interventions on a scale of 0 – 10 (0 being not competent and 10 being highly competent). Table 26 provides a summary of the proportion of nurses who rated themselves as 8/10 or higher in both the 2004 and 2008 surveys. As can be seen from this table the nurse respondents in both surveys reported that they felt most competent in screening/brief assessment, managing emergencies and clinical case-management. Further investigation is needed in respect to the apparent reduction in subjective competence in respect to mental health assessment. Reviewing responses in respect to mental health assessment, 27% of nurse respondents in the 2008 survey estimated their competence as 7/10. In addition to mental health assessment, areas in which nurses feel relatively less competent indicating specific areas for professional development continue to be health promotion/education including pre-post HIV/hepatitis counselling, smoking reduction/cessation and physical health assessment; although the findings from the present survey suggest that these nurse respondents feel relatively

competent in physical health assessment and that training in smoking cessation is having a positive impact.

Table 26: Proportion of nurses who estimated competence in interventions eight or above on a scale of 0 – 10 (not at all confident to extremely competent) (2004 and 2008).

	Year of Interview	
Intervention	2004 (n=42)	2008 (n=34)
Screening/Brief Assessment	95%	88%
Mental health assessment	91%	59%
Brief Interventions	85%	68%
Managing emergencies	83%	82%
Clinical case management	73%	85%
Health promotion/education	59%	68%
Physical health assessment	55%	67%
Smoking reduction	38%	53%
Pre-post HIV/Hepatitis counselling	19%	26%

The nurse respondents in the 2008 survey were also asked to similarly rate their competence in respect to the interventions listed in Table 27. In regard to competence in working with youth, as described above, the nurse respondents were primarily engaged in working with adults. The results presented in Table 27 suggest areas for skill enhancement that target specific individual psychological and broader psychosocial interventions.

Table 27: Proportion of nurses who subjectively estimated competence in interventions as eight or above on scale of 0 – 10 (not at all confident to extremely competent)

Intervention	
Opioid Substitution Treatment	74%
Withdrawal management	71%
De-escalation of potentially volatile situations	76%
Working with clients with co-existing disorder	62%
Motivational interviewing/enhancement	56%
Conflict resolution	47%
Groups	41%
Cognitive behavioural strategies	26%
Working with youth	23%
12 Step Facilitation	18%
Social Behaviour Network Therapy	18%
Couple/family interventions	12%

5.3.4 Professional Development

5.3.4.1 Professional development priorities

The nurse respondents were asked to identify their three top professional development priorities over the next one to two years. Six nurses (18%) referred to changing jobs or planning travel and did not identify professional development priorities. Seven nurses (21%) referred to post-graduate qualifications and similar to the 2004 survey findings, the nurse respondents in the present survey specified a range of other priorities. More specifically, professional development priorities are listed below under the following five categories: postgraduate qualifications; therapeutic skill enhancement; leadership and management; career/role development and keeping up to date.

Postgraduate Qualifications

- Completing/continuing Masters qualifications
- Continuing or exploring pathway to Nurse Practitioner
- Completing postgraduate AOD Diploma
- Undertaking specific papers/certificate e.g. pharmacotherapy, mental health related, management

Therapeutic skill enhancement

- Motivational Interviewing
- Working with couples
- Group work
- Working with people with co-existing mental health disorders
- Training in supervision and providing supervision to others
- HIV/Hepatitis pre-post counselling
- Physical health assessment
- Developing presentation skills
- Detoxification

Leadership and management

- Develop staff management skills
- Develop leadership skills
- Grow in clinical leadership role

Career/role development

- Role development to meet needs of current/new position
- Apply for PDRP
- Explore professional pathway
- Apply for clinical leadership role
- Apply for management/leadership role in broader health care system

Keeping up to date

- New developments in the field
- Current addiction understanding
- Increase mental health knowledge
- Therapies – pharmacological including for detoxification, and psycho-social
- Liaison with other services

5.3.4.3 Perceived barriers to undertaking postgraduate education

The nurse respondents were asked about perceived barriers to nurses undertaking postgraduate education based on barriers identified by nurse respondents in the 2004 survey. At least half considered each of these barriers, as well as a perceived lack of confidence, as contributing to the overall challenge for nurses undertaking postgraduate education

- Family reasons 79%
- Lack of workplace support 74%
- Lack funding 65%
- Lack of confidence 65%
- Lack of organisation support 50%

Comments relating to workplace support referred to the difficulty of managing study and work without being supported to have a reduced client caseload "*…management's unrealistic expectation of nurses doing study and not reducing their workload or arranging for caseload support*" and "*getting time off work"* as well as lack of salary recognition for postgraduate courses completed.

The following options were differentially endorsed in respect to provision of postgraduate education courses and delivery mechanisms (video conferencing was not included). All nurses endorsed interdisciplinary training as well as a combination of delivery mechanisms. One nurse commented *"…combination of all should be available to meet the differing needs (of nurses) and attendance availability*".

- Interdisciplinary training 100%
- Nursing delivered 35%
- Block courses on site 79%
- Distance learning 62%
- Weekly onsite courses 50%
- Audio conferencing 44%

5.3.4.3 Professional supervision

A high proportion of the nurse respondents (85%) in the present survey, similar to the 2004 survey (93%), reported participating in professional supervision. Four (12%) nurses said they did not participate in supervision and one nurse was not currently working in a clinical role. Comments in regard to not participating in professional supervision included reference to working in small teams and having access to peers and clinical nursing leaders. The supervision foci were similar to those in the 2004 survey and included:

- Clinical work
- Ethical issues
- Support
- Team/work issues
- Role development
- Education/training
- Administration
- Career development

Of those receiving supervision, 90% rated their satisfaction with their supervision arrangements as three or higher on a scale of 0 – 5 (0 being not at all satisfied and 5 being extremely satisfied). Themes identified in respect to the benefits of supervision included:

- Reflective practice
- Safe and ethical practice
- Role development
- Safe and supportive environment
- Feedback, guidance and an independent perspective
- Workload management
- Managing stress

A similar proportion of respondents in the 2008 and 2004 surveys had undertaken supervision training (50% and 55% respectively) involving a range of approaches. Training undertaken included: part of a formal education qualification (UK); internal DHB training, and; qualification via an external provider. In the present survey only 30% of respondents said they provided supervision for other workers (64% in 2004). The reasons for not providing supervision commonly included: lack of time due to workload commitments; lack of confidence or experience in the field and; lack of training opportunities. The average number of supervisees was 2.5 (sd 3.1). Supervisees included nurses and other staff working internal and external (primarily mental health) to addiction treatment services.

5.3.5 Leadership and Delegation

5.3.5.1 Leadership

Almost three quarters (74%) of the nurse respondents said they undertook leadership tasks which would involve a median of about 10% (range 2 – 70%) of their time. These included the following tasks:

- Activities associated with nursing student placements
- Liaison with nursing educators
- Mentoring new graduate nurses
- Mentoring undergraduate and postgraduate students across disciplines
- Performance appraisals of nursing staff
- Orientation and training of staff across disciplines
- Delegation of client related work
- Clinical supervision
- Consultation/liaison role with NGO service providers
- Supervision, consultation and training on dual diagnosis
- Administration supervision
- Second in charge to clinical nurse leader
- Presentations at leadership meetings
- Committee membership and representing nurses at forums
- PDRP assessor

Eighty-two percent of the nurse respondents said they had a role with student nurses (64% in the 2004 survey). This involved being a "buddy" or preceptor, co-ordinating student placements, involving students in sessions when on placement and presenting sessions in nursing undergraduate education programmes. Reasons provided for lack of involvement included: being a "specialised unit"; lack of resources; concerns about confidentiality; lack of familiarity with New Zealand nursing; lack of office space or small service and; lack of interest from undergraduate education

nursing providers. However, it was notable that less than half of the nurse respondents (41%) said they were familiar with the undergraduate mental health and addictions curricula of their local programme and associated comments suggested, in general, a lack of communication between the undergraduate programmes and addiction treatment service nurses.

Forty-one percent said they worked with staff to whom they delegated tasks or aspects of client treatment plans, taking on average 20% (sd 15.0) of their time. Concerns in respect to this role identified by five nurses centred on workload, issues of boundaries and complexity of clients needs.

5.3.6 Clinical Career Pathway

5.3.6.1 Professional development and recognition programmes

Consistent with the majority of nurse respondents working within DHB settings, 71% said that their organisation had a Professional Development and Recognition Programme (PDRP) in place. This finding is congruent with the 2004 survey findings whereby 57.1% of the nurse respondents said that their organization had a PDRP programme in place and 14.3% were developing one. However, this finding also highlights differential access to such programmes across DHB and NGO sectors.

5.3.6.2 Advanced practice roles

Just over half of the nurse respondents (51%) indicated that they intended to work towards an advanced practice role (30% Nurse Practitioner and 21% another advanced practice role). Other specified advanced practice roles included clinical nurse leader, clinical nurse specialist e.g. dual diagnosis and a more specialised counselling role.

For nurses not working in advanced practice roles, the themes that emerged from consideration of comments from the nurse respondents who stated that they did not intend to work towards an advanced practice role included:

- Left the field/moving out of the field or nursing
- Satisfied with current role/experience
- Age and phase of life
- Lack of workplace support or high workload/stressful role
- Wanting a life/work balance
- Issues and uncertainty about the Nurse Practitioner role

Of interest was the continuing unfamiliarity with the Nurse Practitioner role and pathway. Only 21% of the nurse respondents in the current survey were familiar with the Nurse Practitioner pathway. This probably reflects that there are no established Nurse Practitioner roles to date within the AOD field, although a small number of nurses are on this pathway, supported by their service. The Nurse Practitioner pathway for nurses in the AOD field is still being developed on a nurse by nurse basis.

Similar to 2004 survey responses, the 2008 nurse respondents identified benefits of the Nurse Practitioner role for clients and for the nursing profession. These included:

- Improve access and reduce barriers, including to opioid substitution treatment
- Improve continuity, co-ordination and consistency of care ("one stop shop"*)* and for clients with complex needs (e.g. complex co-existing mental health and other issues)… "*stop them falling down the crack*"
- Improve quality of care and outcomes
- Increase choice

- More comprehensive/holistic treatment that includes health promotion and education
- Add value - prescribing rights
- Input to treatment policy development and protocols
- Increased client advocacy

In respect to benefits of the Nurse Practitioner role for the nursing profession, responses were also similar to those in the 2004 survey. These included:

- Advanced practice role
- Leadership role
- Provide greater credibility with other professions
- Role in education and training
- Increase in scope and autonomy, including in primary care
- Extends the clinical career pathway
- Will assist recruitment by increasing the profile of AOD nurses
- Role model

One nurse respondent commented that *"…the role would take pressure off medical staff and assist with supporting general practitioners"*. Another envisaged the role as *"…working in collaboration with medical staff and other team members*". However, some nurses were more cautious and unsure of the role as it had yet to be established and highlighted that the role needs to be well resourced to be effective. One nurse raised the issue of being known to be a prescriber in a small rural community.

5.3.7 Future Directions

Finally, nurses were asked about the role that nursing could play in the future to meet the needs of people with AOD problems/addictions and to identify three things that could markedly improve nursing in the AOD/addiction field that would benefit clients.

5.3.7.1 Future role nursing could play

Many of the themes that were identified from responses were similar to those identified in the 2004 survey but there were also some additional themes, reflecting the trends in mental health and addiction services towards closer linkages with primary care and other sectors, an increasing emphasis on assisting people with complex AOD and mental health issues, the need to focus on health and wellbeing more holistically, including supporting people with their recovery journeys as well as an increasing focus on the provision of consultation/liaison and the potential of advanced practice nursing. Key themes identified were:

- Increase in range of advanced practice roles including consultation and liaison roles, nurse led clinics, mobile detoxification roles and Nurse Practitioner with prescribing rights;
- Continuing expansion of roles into other service areas including primary care, justice;
- Nurse led clinics in a range of setting/sectors including primary care;
- More holistic health/wellbeing focus;
- Increased role with clients with complex needs, including co-existing mental health and physical health issues;
- Leadership roles in clinical practice, policy development, treatment development and integration, advocacy and challenging stigma and discrimination;
- Increasing input to nursing undergraduate and postgraduate programmes;

5.3.7.2 Three things that could markedly improve nursing

The nurse respondents provided a range of suggestions in respect to the following categories.

Education and training

- Training in engagement and counselling approaches
- Accessible postgraduate education for all nurses working in AOD/addictions
- Ensuring adequate undergraduate knowledge and skills and attitudes as well as exposure to AOD/addictions treatment for all nursing students
- Ensuring inclusion of AOD/addictions competencies in postgraduate nursing programmes

Recruitment and retention

- Clear career pathways and structures
- Development of a range of advanced practice roles, including Nurse Practitioner
- Recognition of AOD nurses within professional bodies

Organisation infrastructure

- Adequate resources
- Manageable workloads
- Support for advanced practice roles
- Ability to reduce workload when undertaking study
- Actively supportive nursing leaders across mental health and addictions services

Professional Bodies

- Recognition of AOD nurses

5.3.8 Summary and Workforce Development Implications

In summary, nurses continue to comprise a significant proportion of the AOD workforce. Most of the nurse respondents in the present survey were employed in a designated nursing position and most worked in a city location in an AOD specialist DHB service, predominantly with adult clients. Half of the nurse respondents were involved in the provision of opioid substitution treatment. The continuing predominance of nurses working in DHB settings raises issues about AOD nursing within the NGO and other sectors and may well relate to continuing salary inequities. If so this is an area for further investigation. Half of the nurse respondents had completed an AOD postgraduate qualification and 12% were currently enrolled in postgraduate study. Almost all had attended an AOD related workshop/training in the past two years, 82% a workshop/training related to mental health, and 35% a gambling related workshop/training.

In respect to recruitment and retention, broader workforce related issues were evident in regard to an increasing number of UK nurses employed, an aging workforce and a lack of Māori, Pacific and Asian nurses. Perceived barriers to nurses wanting a career in the AOD field included inadequate preparation within undergraduate nursing programmes and lack of promotion of AOD nursing more generally; issues that require urgent attention.

While the majority of nurses belonged to a professional nursing organisation, only a very small minority belonged to DANA and no nurse specified Te Ao Maramatanga (NZ College of Mental Health Nurses), highlighting the need to address AOD nursing within professional nursing bodies. Just over 20% belonged to DAPAANZ. Of note, over three quarters endorsed being part of a national nurses' email for nurses working in the AOD/addictions sector (also supported in the 2004 survey) suggesting an important workforce initiative that would build on smaller networks in place and further support linkages and the building of leadership amongst nurses in the sector.

The nurse respondents identified a range of clinical and counselling skills that nursing brings to the AOD field along the continuum from health promotion to working with clients with chronic and complex substance use and co-existing physical and mental health treatment needs. In general, the nature of routine tasks that were highly endorsed were those consistent with a predominantly DHB specialist service work setting. In comparison with the 2004 survey findings, there was a notable increase in consultation/liaison activities which may reflect the nature of the roles of nurses in this survey as well as an increasing focus on specialist services providing consultation and liaison to a broad range of providers and other sectors.

Another finding was the continuing low involvement in group work amongst the nurse respondents, perhaps reflecting the lack of group-work within many outpatient specialist AOD agencies. The relatively low proportion of nurses who said they routinely included significant others, family and whanau in their day to day work was concerning, perhaps reflecting a combination of pervasive beliefs, work practices and lower levels of competence in family work as evidenced by the relatively low proportion of nurses who rated their competence in couple/family interventions as high. Also of concern was that less than 70% of the nurse respondents rated themselves as highly competent in mental health assessment which suggests the need for further investigation and a continuing priority focus for professional development. Similar to the 2004 findings, as a group the nurse respondents felt they were relatively less highly competent in physical health assessment and health promotion and in the present survey in providing psycho-social interventions.

These findings are generally congruent with the professional development priorities identified by the nurse respondents in the present survey. They point to a need for targeted professional development to ensure all nurses are highly competent in "routine" clinical competencies and in psycho-social interventions shown to be effective in working with individuals with substance use

related issues and their significant others, families and whanau. These include brief interventions, motivational interviewing, cognitive behavioural strategies, involving and working with significant others, family and whanau and group work. Also of high importance is the ability to individualise these interventions for a range of individuals with varying levels and complexity of treatment needs.

In line with the increasing expectation for experienced nurses to take on leadership and delegation roles almost three quarters of the nurse respondents said they undertook a range of leadership tasks and a significant minority worked with staff to whom they delegated tasks or aspects of client treatment plans. Developing leadership skills is another identified priority area for professional development.

While the majority of nurse respondents felt supported by their managers to improve their knowledge and skills and to undertake needed clinical training, they affirmed a number of perceived barriers to undertaking postgraduate education. These included difficulty in managing study and work without the support of a reduced workload, suggesting staffing resource issues or a lack of acknowledgement of the importance of postgraduate education and the challenges this provides in juggling workload and family and other commitments. Also of note was the 100% endorsement for interdisciplinary postgraduate training and a variety of delivery mechanisms to meet the varying work situations of nurses, including block courses on site and distance learning.

The findings from the present survey confirmed that the majority of nurses participate in professional clinical supervision. However, only 30% of nurse respondents in the present study provided supervision to others pointing to a need for supervision training. Professional supervision for nursing is being addressed by Te Pou, the National Centre for Mental Health Research and Workforce Development. Continuing to work collaboratively across workforce centres will be of critical importance.

The Matua Raki workforce development emphasis on advanced practice and developing nurse leaders within the addiction treatment sector is further endorsed by the findings from this survey, with just over half of the respondents indicating their intent to work towards a range of advanced practice roles, including Nurse Practitioner. While responses confirmed an understanding of the benefits of Nurse Practitioner roles, the lack of familiarity with the Nurse Practitioner pathway probably reflects the pioneering nature of the role within the AOD field. The nurse respondents in this survey also clearly endorsed a range of potential future roles for nursing in the AOD/addiction field which is consistent with trends in service delivery and a greater emphasis on health and wellbeing, supporting clients with behaviour and lifestyle change and meeting the needs of clients with chronic and complex substance use and co-existing mental and physical health problems.

Lastly, the nurse respondents provided a range of suggestions for improving nursing in the AOD field. These included a focus on education and training, recruitment and retention, organisation infrastructure and professional bodies.

6.0 Sector Subgroup: Working with Youth

6.1 Introduction

For the first time in the National Telephone Survey, all respondents who were identified as working with youth were asked if they would like to participate in a confidential and anonymous follow up survey of treatment workers who work with youth.

6.2 Method

Youth are defined as service clients aged under eighteen, while "working with youth" was defined as working primarily in a youth service or working 20% or more of the time with clients aged <18 years. In total 35 respondents to the main survey met these criteria. Of these 29 (83%) agreed to participate in a follow-up interview.

Contact details of two of the consenting workers were not forwarded in time for the completion of the survey. Of the remaining 27, 22 were interviewed by an experienced research assistant, who is also a qualified social worker and experienced AOD clinician, and four interviews were conducted by Dr Ria Schroder (youth survey principal investigator). One person who had initially consented to be involved in the youth follow-up declined to participate when contacted (due to time constraints), making the total number of respondents 26.

The interview was a structured telephone interview that took approximately 40 minutes to complete. The interview covered five main areas: demographic details, training and professional development, clinical practice, service structure and working with family/whanau.

6.3 Results

6.3.1 Demographic profile of all youth workers

Using the demographic data collected as part of the main survey it was possible to obtain a general profile of people who were currently working with youth in the AOD/gambling treatment field. Of

Table 28: Demographic profile

Age (years)	
Mean	41.1
Range	27-60
Gender (female)	60%
Ethnicity (%)	
Pakeha/European	49%
NZ Māori	23%
Other European	23%
Pacific Nation	3%
Other	3%
Nicotine status:	
Ex Smoker	40%
Non Smoker	46%
Smoker	14%
Currently in recovery:	
Substance Use (%)	29%
Gambling (%)	3%

the 266 respondents in the main survey, 35 (13%) met the criteria set by this study of working with youth.

Table 28 presents a demographic profile of the 35 treatment workers identified as working with youth. The majority of workers were female (60%) and identified as being of Pakeha/European ethnicity (49%). Regarding their own substance use 86% were currently not smoking (ex smoker 40%, non smoker 46%) and 29% identified as being in recovery from some other form of substance use. Only one person identified as being in recovery from gambling. The average age of youth workers was 41.1 years, with 26% aged less than 35 years of age (compared to 11% and 10% for the AOD and gambling fields respectively). When comparing youth workers who agreed to be involved in the youth follow-up study with those who did not, the only difference between the two groups was gender. While 100% of the identified male youth workers agreed to take part in the follow-up study, only 71% of female youth workers consented ($\chi 2 = 4.83$, $p = .033$).

Tables 29 and 30 provide an overview of the professional profile of the 35 youth workers and a description of the services they worked in.

Table 29: Professional profile

Self-selected professional identity:	
Counsellor/Therapist	66%
Social Work	14%
Nursing	14%
Psychology	6%
DAPAANZ member	37%
Member of other professional body	41%
Level of AOD or gambling qualification	
No qualification	34%
Undergraduate	49%
Postgraduate	17%
Currently enrolled in AOD or gambling training	29%
Years worked in AOD treatment field	
Mean	6.1
Range	0-20
Years worked in mental health services	
Mean	4.8
Range	0-22
Ever worked in gambling field	17%

Three main professional groups were represented among treatment workers who work with youth. While the majority identified as counsellors/therapists (66%), a small group identified as social workers or nurses. In addition 49% of youth workers had completed AOD or gambling training to an undergraduate level and 17% to a postgraduate level. Twenty nine percent of youth workers were currently enrolled in such training.

Youth workers had worked on average for 6.1 years in the AOD treatment field and 4.8 years in mental health services. Only 17% of youth workers had ever worked in the gambling field and had done so for an average of 1.8 years (range 6 months-4 years).

Table 30: Service characteristics

Organisational status	
DHB	43%
Non-DHB	57%
Workplace description	
AOD Specialist	63%
Dual Diagnosis	14%
AOD and Gambling Specialist	9%
Social Service	3%
Mental Health	3%
Broader Health	3%
Gambling Specialist	0%
Other	5%
Treatment modality	
Non-Residential	89%
Residential	6%
Both Equally	6%
Type of service worked in	
Youth	60%
All ages	40%
Interaction type	
Face-to-face	94%
Telephone	6%
Service located in a city	69%
Service located in the North Island	74%

In terms of work place, fewer youth workers worked in DHB (43%) than non DHB (57%) organisations, the majority were working in non-residential treatment settings (89%) with clients on a face-to-face basis (94%). The majority of services where located within a city setting (69%), were in the North Island (74%) and were classified as being youth specific services (60%). Comparisons between people working in youth specific services and those working in all age services indicated that there were no differences between these groups on a range of demographic, service structure or professional development variables.

6.3.2 Youth follow-up data

The remaining sections of this report explore in more detail the working and training profiles of people working with youth in AOD and gambling treatment and are therefore based on the data of the 26 youth workers who took part in the follow-up interview. Respondents in the youth follow-up study were asked a number of additional questions about their experiences of working with youth.

Table 31 presents an overview of respondents' experiences of working with youth. In terms of treatment modality, 50% of youth workers were working in outpatient treatment settings. Community services (described as working within schools or in mobile services) and day treatment settings were the second most common settings for working with youth (19% and 15% respectively). Only one youth worker (3%) identified working in a solely residential setting but two youth workers (7%) identified working in a combined day and residential setting.

On average workers had worked in their current position with youth for 2.7 years; had worked with youth in general in the AOD/gambling field for 4.3 years, and had worked with youth in general for 6.0 years.

Table 31: Experience working with youth

Current service type	
Outpatient	50%
Community	19%
Day	15%
Combined	7%
Residential	3%
Years worked in current position	
Mean	2.7
Range	0.1-11
Years worked with youth in general (outside AOD/gambling)	
Mean	9.0
Range	0.8-20
Years in AOD/gambling (general)	
Mean	6.0
Range	0-19
Years worked with youth in AOD/gambling	
Mean	4.3
Range	0.8-15.

A profile of the respondents' training needs and workforce development experiences is presented in Table 32. Only one person working with youth in the AOD/gambling field identified as having no academic qualifications, while 65% had completed an undergraduate tertiary level qualification and 31% a postgraduate qualification. When asked to rate how adequate they perceived this training to be in assisting them in their work with youth, very few (8%) rated their previous training as 'excellent', with the majority (81%) rating it as 'good' or 'very good'.

Training at polytechnics, inservice training and workshops/short courses were identified as the three most common sources of current training. However, when asked what their preferred sources of training would be, respondents rated courses from tertiary institutions and workshops/short courses as the most preferred source of ongoing training. Other preferred options included mentoring/supervision, block courses and learning from interactions with young people. Inservice training was rated as the least preferred source of training.

Table 32: Training and professional development

Highest completed academic qualification	
No academic qualifications	4%
Undergraduate	65%
Postgraduate	31%
Adequacy of general training for work with youth	
Not very good	12%
Good	46%
Very Good	35%
Excellent	8%
Most common current source of training	
Polytechnic	23%
Inservice	19%
Workshops/Short courses	19%
Preferred source of training	
University	39%
Polytechnic	15%
Workshops/Short courses	15%
Number of youth related training courses attended (last 12 months)	
Mean	1.7
Range	0-6
How well youth training courses fitted needs for working with youth	
All needs	4%
Most needs	27%
Some needs	42%
A few needs	19%
No needs	4%
N/A	4%
Most common barriers to training	
Time constraints	69%
Geographical distance	65%
Financial constraints	58%
Lack of relevant courses	53%
Lack of support	35%
Desired areas for future training	
Specific therapies	39%
Mental health and dual diagnosis	31%
Communicating with/engaging youth	27%
Best dissemination method for research	
Workshops/Short courses	42%
Emailing information	15%
Hui/Conferences	12%
Email discussion groups	12%
Attributes required to work with youth	
AOD and mental health knowledge	42%
Ability to engage, relate and listen to youth	39%
Ability to use a range of treatment approaches	31%
Knowledge of youth development	23%

The number of youth related training courses respondents had attended in the last 12 months ranged from 0-6 with a mean of 1.7. While almost one third felt these courses had met ‘all’ or ‘most’ of their needs, the majority of workers identified some gaps, with almost two-thirds indicating that

these courses only met 'some' or 'a few' of their needs. In particular, when asked about the areas they would like training to further facilitate their work with youth, three main areas were identified. Most frequently mentioned was training in specific therapies such as Motivational Interviewing (MI), Cognitive Behaviour Therapy (CBT), music and art therapy and youth specific approaches. Youth workers also indicated a desire for training in mental health and dual diagnosis issues in youth and wanted to learn ways to improve communication and to more effectively engage youth.

A number of barriers preventing youth workers engaging in further training were identified. These included time constraints, geographical distance, financial constraints, and lack of relevant courses. Despite these constraints, respondents still identified that the best mechanism for disseminating research information to youth workers was through group forums such as workshops or short courses. Email was also acknowledged as a useful medium either through directly emailing findings of research to youth workers (15%) or through email discussion groups (12%).

Respondents were also asked to identify what they thought were the main attributes a person needed in order to be able to work effectively with youth in the addiction treatment field. Four key assets were identified: a good knowledge of AOD and mental health; ability to engage, relate and listen to youth; sound knowledge and practical application of a range of treatment approaches (including youth specific approaches) and a sound knowledge of youth development.

Table 33: Clinical Practice

Most common clinical models used with youth	
Motivational Interviewing	96%
Cognitive Behavioural Therapy	92%
Solution Focussed	81%
Clinical Management	73%
Supportive Counselling/Psychotherapy	58%
Most common assessment tools used with youth	
Comprehensive Assessment	81%
Substances and Choices Scale (SACS)	62%
Cultural Assessment Tool	54%
Common problems youth present with	
AOD	77%
Family functioning	73%
Trauma/Abuse	54%
AOD and Mental Health	46%
Self-rated areas of competence[i]	
Most competent (mean)	
Brief Interventions	8.5
Assessing Strengths	8.3
Screening and Brief Assessments	8.3
Least competent	
Pre-Post HIV Test	1.7
Hepatitis Counselling	2.3
Pharmacotherapy	4.2
Clinical supervision received	100%
Supervision suits needs	
Completely	27%
Mostly	39%
Somewhat	27%
A little	8%

[i]Competence rating scale, zero = not at all competent, 10=extremely competent

As indicated in Table 33, respondents identified that they used a number of clinical models with youth. MI (96%), CBT (92%) and Solution Focussed Therapy (81%) were the most commonly used clinical models. A range of assessment tools were also used and apart from the comprehensive and cultural assessment tools, it appears that the recently developed Substance and Choices Scale is already being utilised by a number of youth workers.

Treatment workers who work with youth also identified a range of problems that youth presented to treatment with. These included AOD issues, family functioning, trauma/abuse and co-morbid AOD and mental health issues.

Respondents were asked to rate their competence on a scale of zero to ten (0=not at all competent, 10=extremely competent) on a number of clinical skills. These included screening and brief assessments, physical and mental health assessment, health promotion, pre-post HIV test, hepatitis counselling, smoking cessation, managing emergency situations and threats of violence, pharmacotherapy, clinical case management, brief interventions and assessing strengths and weaknesses. Youth workers rated themselves as most competent in conducting brief interventions (mean 8.5, range 6-10), assessing strengths and beneficial activities (mean 8.3, range 5-10) and screening and brief assessments (mean 8.3, range 5-10). Pre-post HIV tests (mean 1.7, range 0-10), hepatitis counselling (mean 2.3, range 0-10) and pharmacotherapy (mean 4.8, range 0-10) were the areas youth workers felt least competent in.

Although all 26 youth workers (100%) confirmed that they received clinical supervision, only 27% felt that this supervision completely suited their needs. Identified gaps in supervision included: supervisors lacking knowledge about youth (19%); internal rather than external supervision (12%); not receiving enough supervision (23%) and supervisors lack of knowledge about addiction (23%).

In order to increase knowledge about the types of services youth attend, youth workers were asked what they thought were the key characteristics of an effective youth service and enquired about the extent of youth involvement in the services they were currently working in with youth. As indicated in Table 34, the three key characteristics respondents identified as being associated with a youth friendly AOD/gambling service included the need for a service to have youth friendly knowledgeable staff (77%); to be youth focussed (73%) (set up as an environment that appealed to youth and involved youth); and to be accessible to youth (50%). This meant that services were in areas that youth could easily get to, were open hours when youth were likely to use them and, if need be, were mobile.

Table 34: Service structure

Perceived key characteristics of a youth friendly service	
Staff – youth friendly and knowledgeable	77%
Youth Focussed	73%
Accessible	50%
Youth involved inservice	35%
Youth involvement paid position	56%
How youth friendly is your service?	
Extremely	31%
Very	23%
Somewhat	27%
A little	12%
Not at all	8%

When asked to rate how 'youth friendly' their current service was, the majority of respondents (54%) rated their service as 'very' or 'extremely' youth friendly. However, when it came to having youth involved in their service only 35% of respondents reported that their service had any youth involved in the development, management or running of their service. Of these, 56% had youth involved in a paid position.

Finally, with regard to service structure, respondents were asked about any changes they had noticed in the treatment that is provided for youth in their workplace or the wider treatment sector, since they had been working with youth. Although a small minority of respondents had not noticed any changes in their workplace, 73% of respondents stated they had. These included: using new assessments, particularly more youth focussed assessments; development of professional standards; more family inclusive practice; increase in staff numbers; increase in youth clients; memorandums of understanding with other key youth agencies; more cultural involvement; more youth friendly approaches; move from abstinence to harm reduction focused treatment; and development of youth treatment models and assessment tools.

Fewer respondents (46%) reported they had noticed changes in the wider treatment sector but the changes they had observed included: the sector being more accepting of youth involvement; changes in legislation such as the anti-smacking bill; more youth specific services being developed; more AOD workers in non AOD agencies; more cultural involvement; more consumer involvement; more transparency aided by development and publicity of complaints procedures; development of youth appropriate models; more training for youth clinicians and concerns about dominance of youth justice work impacting on clinical work.

The final section of this report focuses on the involvement of family/whanau in treatment. Table 35 indicates that family involvement was rated as 'extremely' or 'very' important by 73% of the youth workers, with only one respondent rating it as only 'mildly' important.

Table 35: Working with family/whanau

Space available to meet with whanau	
Yes	92%
Frequency included family in treatment (last 6 months)	
Never	8%
Hardly Ever	15%
Sometimes	35%
Almost Always	23%
Always	19%
Importance of involving family	
Extremely	42%
Very	31%
Somewhat	23%
Mildly	4%
Interaction type	
Depends on family/whanau	54%
Face-to-face with client	31%
Telephone	15%

The majority of respondents (92%) reported that the treatment service they worked in with youth had a space available for meeting with family/whanau and 77% of respondents reported they had included family/whanau at least sometimes in their work with youth in the last six months. For over half of the treatment workers, the type of interaction with family/whanau depended on the

family/whanau they were working with, but 31% reported interacting face-to-face with families with the youth client present and 15% reported to having telephone contact with whanau.

6.4 Summary

These data provide the first snapshot of the AOD/gambling workforce who work with youth in Aotearoa, New Zealand. People who work with youth at least 20% of the time (referred to as youth workers in this study) make up approximately 13% of the AOD/gambling workforce. The youth workforce appears to be slightly younger than the general AOD/gambling workforce with a greater proportion of youth workers aged younger than 35 years. Despite the younger age of this workforce, approximately one half had completed an undergraduate AOD/gambling specific qualification, and only one person working with youth held no formal academic qualifications.

The majority of people working with youth were doing so in youth specific services (60%) but no differences were found between those working in youth specific services or all age services. The three main groups of professionals working with youth were counsellors/therapists, social workers and nurses.

Although the majority of the youth workforce is female, proportionally more males than females agreed to be part of this youth follow up study. However, despite this difference, those who participated in the youth follow study (n=26) were found to be representative of the identified youth workforce on all other variables examined. This follow up study enabled a more in-depth focus on the youth workforce and identified a number of important issues with regards to training and professional development.

Of particular concern for ongoing training and development, is the relatively low number of youth related courses attended by youth workers in the last 12 months and the inability of these courses to adequately meet the needs of people working with youth. Respondents identified that the areas where they required further training were in specific therapies such as CBT and MI and how to use them with youth, communicating with and engaging youth, updating knowledge on youth mental health and working with youth with comorbid mental health and AOD issues. They also identified a discrepancy between their current source of training and their preferred source of training. In particular, inservice training, which was identified as the second most common source of training for youth workers, was listed as their least preferred source of training. Additionally, youth workers also identified a number of barriers that could prevent them from undertaking ongoing training. Establishing ways of reducing these barriers is essential.

While it was extremely pleasing to note that all people in the youth workforce were receiving clinical supervision, some concern was raised at the number of youth workers who perceived that this supervision did not completely meet their needs. In particular, concerns about the lack of knowledge that supervisors were perceived to hold about youth and AOD related issues indicates the need for a particular focus in this area. A useful step might be to provide training for current supervisors to allow them to up skill in these areas and to identify more supervisors already knowledgeable in these areas.

Despite evidence to suggest the importance of youth involvement in the development, management and running of health services attended by youth, only about one third of services that worked with youth had youth involved in some capacity in their services. A greater commitment from treatment services to formally promote youth participation in their services in an active, meaningful and supported way is encouraged as an important way forward to improving treatment services for youth.

Youth workers comments on the number of changes in their own workplace and the AOD/gambling treatment sector in general in relation to youth indicated that a variety of changes had been noticed at both levels. Although it is beyond the scope of this current study to explore this issue in greater

detail, it is interesting to note that the majority of changes that were mentioned were viewed as positive. This perhaps highlights the growing acceptance by the treatment sector of the importance of, and need for, youth appropriate AOD treatment.

A final comment must be made about the definition of youth used in this study. Increasingly, it is accepted that the term 'youth' encompasses a wider age group than the 13-18 year old age group defined in this study. Advances in developmental research, especially with regard to brain development, suggest that young people are not fully developed by aged 18 and in fact, brain development to allow full 'adult' functioning, may not occur in some young people until 23-25[8]. For this reason, debate has emerged about the appropriateness of youth services that only cater to those aged between 13-18 years and calls have been made to extend youth services to include those aged up to 25 years. With this extended definition in mind, it is important to remember that this survey of the youth workforce relates primarily to younger youth. It would be useful in future surveys to extend this definition of youth to the 13-25 year old age group.

7.0 References

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