Training Needs Assessment: Alcohol and Drugs

Final

4 December 2018

Contents

1. Executive Summary

This report presents the findings from a training needs assessment (TNA) on alcohol and drugs. The TNA is aimed at better understanding and supporting the needs of a wide range of professionals who come into contact with substance misuse. It is anticipated that the outcomes from this TNA will help support and inform the development of a framework for the provision of alcohol and drugs related training for professionals across Northern Ireland.

The TNA was commissioned by PHA and involved focus groups with Drug and Alcohol Coordination Teams (DACTS) and depth interviews with CAMHS and DAMHS staff. A sample of health professionals was also surveyed. The TNA was conducted independently by Social Market Research between March and June 2018.

1.1 Key Findings from Focus Groups and Depth Interviews

Training Priorities

Poly drug misuse and comorbidity

Recognising and understanding the effects of combined drug use and the appropriate interventions and treatments.

Dual diagnosis

Clients sometimes present with both mental health issues and drug/alcohol issues. These co-existing issues often interact, for example high levels of depression and anxiety related to drug and alcohol use.

New psychoactive substances

The ever changing picture of psychoactive substances (legal highs) presents challenges to drug and alcohol teams. There is a need for training and regular updates on new and trending drugs.

Hidden harm

Recognising the signs of hidden harm. This is needed across the board, but particularly amongst those who might have frequent contact with children, for example, teachers and GPs.

Foetal Alcohol Syndrome

Foetal Alcohol Syndrome. Training is needed in particular for those professionals who are dealing with pregnancy or pregnancy advice so that intervention is made pre-conception or during term stage.

Alcohol Related Brain Damage (ARBD)

Training is needed on recognizing the symptoms of ARBD, avoiding misdiagnosis and implementing appropriate care and treatment.

Awareness Training for people who come into contact at early stages

GPs and general nursing staff need training on new drugs and on awareness of the services available. There was also a call for more training for social services, teachers and for volunteers.

Advanced training

Training needs to be progressive, not just offered at the basic or generic level, but also at the next level. Advanced training is needed for experienced practitioners.

Other Issues

Communication

Whilst information about training courses goes out through the system, training opportunities are not always communicated in a consistent or systematic way and training objectives need to be clearer so that staff can more readily see the relevance to their work.

Barriers to taking up training

The main barriers to training uptake are:

- Difficulties in releasing staff to attend, particularly blocks of staff;
- No cover for staff when they go on training;
- Courses are located too far away;
- The cost of people travelling from rural areas is high;
- The Integrated Elective Access Protocol (IEAP) places restrictions on planned leave/absence, and
- Some Trusts stop mileage being paid after a particular number of miles have been travelled or when budgets run out during a financial year.

Quality and value

- The general consensus was that the quality of workforce development training is high.
- Some commented that the longer courses could be compressed into a shorter timeframe.
- Stakeholders from CAMHS and DAMHS would prefer training to be given locally, responding to the needs of the moment and specifically targeted at their frontline staff.
- The majority of those who expressed an opinion thought that the workforce development training is being applied in the workplace.
- Focus group participants discussed the need to have better monitoring and feedback on the extent to which training was useful or applicable in the workplace. At the moment, such feedback is sporadic.

Accreditation

- Non-accredited training is not attractive to staff who want to move or seek promotion.
- Non-accredited courses are still attractive if they help with skills development
- Training needs to be mapped to accepted standards and competences
- Managers emphasized the value of training where it is relevant to the job, regardless of whether it is accredited or not.

1.2 Key Findings from Survey of Health Professionals

Attendance at Workplace Development Training on Alcohol and Drugs

- 69% had attended PHA funded workplace development training on alcohol and drugs, with 14% having delivered workplace development training;
- 46% had attended general awareness training, 40% training on motivational interviewing and 32% training on hidden harm;
- 62% had attended general awareness training at a basic level, whereas those attending motivational interviewing were more likely to have done so at an intermediate level (49%), with the same true for hidden harm (45%);
- 30% of those attending training on motivational interviewing took up the mentoring provided following this training *(note that the most common reason [53%] for not availing of mentoring was not being offered it or not being aware of it);*

Opinion of Current Workplace Development Training on Alcohol and Drugs

- 75% value the workplace development training provided by PHA *(just 3% don't)* with this view consistent across all respondent groups*;*
- 65% regularly apply the workplace development training to their jobs;
- 22% find it difficult to get released to go on alcohol / drug-related training courses *(61% don't have a problem getting released);*
- 47% said they would go on more training courses if training venues were outside Belfast;
- 44% are satisfied with the quality of current workplace development training, with 20% dissatisfied and 37% neither satisfied nor dissatisfied *(those who said they are experienced in the sector were more likely to be satisfied compared with those who said they are inexperienced [53% vs. 26%]);*
- 53% of those who had attended workplace development training were satisfied with quality, compared with 22% of those who had not attended training;
- The most common reasons for dissatisfaction with current training were: no training being made available or offered (28%); lack of advanced / higher level training (15%); more role specific training required (15%); and, training not being seen as a priority;

Current Training Needs

- 83% need skills-based training;
- 75% need awareness based training;
- 55% said they need training on prescription drugs, 53% on dual diagnosis and complex interventions, and 49% training on new psychoactive substances;
- Across all training requirements *(e.g. prescription drugs, hidden harm, engagement skills etc.)*, most needed training at either intermediate or advanced level;
- 22% identified other areas they need training in, with 81% needing this training at either intermediate or advanced level;
- 20% identified dual diagnosis and complex interventions as their top training priority;

- Using a ranking approach to current training needs found that the top 3 priorities in rank order to be: dual diagnosis and complex interventions; motivational interviewing; and, general awareness training;

- 18% said that training on dual diagnosis and complex interventions is the top training priority within their sector *(followed by general awareness training, 11%; and, engagement skills, 7%);*

Other Training Undertaken outside of PHA Commissioned Training

- 40% had undertaken other training on substance misuse outside of that provided by PHA, with this most likely to have been general awareness training (27%) and training on drugs and the law (25%);

Awareness, and Accessibility and Communication of Workplace Training Opportunities

- 33% rated their awareness of current workplace development training opportunities on alcohol and drugs as either 'excellent' or 'good' *[38% 'fair'; and, 27% 'poor' or 'very poor'];*

- 41% rated the quality of the information or communication they get on alcohol and drugs related training courses as either 'excellent' or 'good' *[38% 'fair'; and, 22% 'poor' or 'very poor'];*

- 66% normally find out about workplace development training courses via email, with 92% preferring this method;

- 54% find it easy to find out about current workplace development training on alcohol and drugs, with 29% finding it difficult;

- 49% would be prepared to travel at least 30 miles to avail of workplace development training on alcohol and drugs, with 33% prepared to travel between 30 and 40 miles;

- 39% said they need 4-5 weeks' notice to be able to avail of a training course, with 33% needing at least 6 weeks' notice;

1.3 Key Conclusions and Points for Consideration

Demand and need

- There is clearly a demand for the current PHA funded training and this report highlights areas where future training could be developed. Moreover, the training provided by PHA is valued and applied by those working across the alcohol and drugs sector;

- There are pressing training needs in relation to poly drug use, complex interventions and dual diagnosis;

- In relation to dual diagnosis, training should take account of the need for mental health professionals and drug and alcohol professionals to work together and understand each other's approaches to diagnosis and treatment pathways;

- There is an ongoing need for updates on new psychoactive substances and PHA may need to consider how best to deliver this in a flexible "fast response" manner that is not constrained by fixed training timetables;

- There is a need to develop advanced training in some areas, whilst still offering the basic levels for those who need it; and,

- More capacity is needed for training in motivational interviewing at both basic and advanced levels.

Finding out where PHA fits

- The training currently funded by PHA sits in a landscape that is populated by other training providers, including the Trusts, and by a multiplicity of training opportunities.

- In order to maximise the benefit of PHA funding, and to ensure that PHA funded training complements other training without duplication or displacement, a mapping exercise may need to be carried out to identify the totality of training available to those working in this area.

Awareness training or skills-based training?

- The distinction between awareness training and skills training was made repeatedly by respondents in this research. Some professions incidentally come into contact with drugs and alcohol whist others are focused entirely on these issues. PHA needs to decide on the balance of investment between awareness training and skills based training.

- Whilst the target professions for skills based training are evident, the potential targets for awareness training need to be mapped.

Barriers to be addressed

- The location of training events can be problematic to those who live some distance away and it should be recognised that this incurs costs, both financial and human. These can create barriers and, potentially, inequalities;

- Organisations find it difficult to release blocks of staff for training and, often, only one member of a team can attend when all of the team would benefit from attendance;

- Pressures on clinical capacity, the introduction of the Integrated Elective Access Protocol (IEAP), and the general difficulty in balancing work and training pressures means that managers often say "no" to training;

- To address the issues of training location, releasing blocks of staff and the balancing of work and training commitments, consideration should be given to increasing the availability of on-site training and distance learning; and,

- The IEAP and other workplace rules often mean that staff are required to give 6 weeks' notice of absence. This needs to be taken into account when publicising training events, particularly as it can take a further 2 to 3 weeks for information about training to filter down to the relevant staff.

Accreditation and competences

- Whilst staff themselves prefer accredited courses, their managers highlight the importance of skills based training for frontline staff. It is clear, however, that staff are much more attracted to courses that offer accreditation and accredited courses fill up quickly. Consideration should be given to the value of accrediting more courses so as to attract greater take-up.

- Thought will need to be given as to which type of accreditation is most appropriate, given the diverse set of professions that work in drugs and alcohol. Alternatively, course outcomes could be linked to key professional competences. Again, consideration would need to be given as to which set of competences would be most appropriate.

2. Background to the Training Needs Analysis (TNA)

In January 2018, the Public Health Agency (PHA) commissioned Social Market Research (SMR) to undertake a training needs assessment (TNA) on alcohol and drugs. The TNA is aimed at better understanding and supporting the needs of the wide range of professionals who come into contact with substance misuse. PHA intends to develop a framework of alcohol and drug training against which it will commission future training programmes and services. The framework will also provide guidance for those who take their own training decisions. It is anticipated that the outcomes from this TNA will help inform and support the development of the framework.

2.1 Alcohol and drug use in Northern Ireland

Substance misuse remains a significant public health problem in Northern Ireland, and PHA with other key stakeholders, are committed to addressing the problem in a strategic way. In terms of the prevalence of alcohol and drug use in Northern Ireland, and the ever changing context, it is worth reflecting on the following:

Prevalence of alcohol and drug use

- Around three-quarters of the NI population drink alcohol, mostly within sensible weekly limits. However, a significant proportion engage in riskier/harmful drinking behaviour resulting in a range of problems with health, mortality, family life, etc.
- Cannabis is the most frequently used illegal drug in Northern Ireland and the misuse of prescription drugs is relatively high.
- In March 2017, 5,969 people in Northern Ireland were in drug and alcohol treatment services in Northern Ireland.
- Patterns of substance misuse vary across different societal groups, with a higher prevalence amongst the LGBT community, families where a child is on the child protection register and people in the criminal justice system.

The changing picture of alcohol and drug use

- The numbers of those in treatment for alcohol only has declined since 2007, whilst those in treatment for drugs only and combined drugs and alcohol misuse have gone up over the same period.
- Notwithstanding the fact that alcohol only treatment has gone down, alcohol related hospital admissions have been steadily increasing in the last 10 years and drug related deaths have gone up in the last 10 years.
- There are also changes in substance use, for example, an increase in the use of New Psychoactive Substances, some prescription drugs and injecting drug use.
- Changes in drug use are more evident within high-risk and at-risk populations.

2.2 The necessity for a training needs assessment

Given current prevalence, and the ever changing context, it was of some concern that the programme for workforce development, 2013-16, was not based on an extensive training needs assessment. Nevertheless, in 2015 PHA commissioned the development and delivery of three 'lots' of workforce development programmes:

- ✓ Staff working with adults;
- ✓ Staff working with children and young people; and,

- ✓ Motivational interviewing.

Current courses on offer vary from awareness-raising to skills development. Some courses are open to a wide range of professionals and non-professionals, others are restricted to certain professionals or groups.

Although there is a wide range of training available, a recent NI study showed a lack of training on NPS use, gaps in knowledge on drug interaction effects, and transfer of existing skills.

Why a training needs assessment is now required

Moving forward, PHA wishes to develop a comprehensive Framework of alcohol and drug training which will provide the basis for future commissioning by the PHA as well as an advisory tool for other relevant services to inform their own training decisions.

The changing patterns of alcohol and drug misuse and the increasing level of hospital admission and death would, alone, necessitate an examination of whether training is adequate and appropriate to deal with current and changing needs.

The lack of a comprehensive assessment of training needs and the evidence that there are gaps in the current arrangements add further weight to the need for such an assessment.

A comprehensive assessment of workforce training needs for those who have contact with substance users is, therefore, a necessity.

3 Terms of Reference and Methodology

3.1 Research Requirement

To support the needs of professionals who come into contact with substance misuse, PHA intends to develop a framework of alcohol and drug training against which it will commission future training programmes and services. The framework will also provide guidance for those who take their own training decisions.

Phase 1 of this two-phased approach will review the current programme of training and consult with those workforce groups targeted in the PHA and HSCB *'Joint Commissioning Framework 2013-16'* on their further training needs and those that took up the provided training.

It is anticipated that the outcomes from this research will support phase 1 by providing a comprehensive training needs assessment of those who were targeted and/or took up training commissioned as part of the three "Lots" by the PHA in 2015, referred to above.

3.2 Research Aim and Objectives

In support of phase 1 of the training framework development, the PHA commissioned SMR to undertake a workforce needs assessment to assess training needs among a diverse range of professionals and staff.

- **Research Aim**

  The overall research aim was to conduct a training needs assessment to:

  a) review the PHA commissioned training provision of the last two years; and,

  b) inform the development of further workforce training for those individuals and organisations that work with people who misuse alcohol and/or drugs.

Within this overall aim, a number of attendant objectives were set:

- **Research Objective 1**

  To establish what training was taken up by specific, identified staff groups in terms of training courses commissioned by PHA (period 2015/16, 2016/17, Q1-Q3 2017/18) as well as those offered by different providers;

- **Research Objective 2**

  To establish how useful training *(including any offered mentoring)* provided in the last two years has been among those who took it up;

- **Research Objective 3**

  To ascertain what courses/issues were most relevant to those who took up training;

- **Research Objective 4**

  To identify, in detail, further training needs/gaps in training provision among those that had been targeted within the Commissioning Framework 2013-16.

3.3 Methodology

Based on the Terms of Reference, SMR conducted the research in two complementary stages:

- ***Qualitative:*** Focus groups with Drug and Alcohol Coordination Teams (DACTS) and depth interviews with CAMHS and DAMHS staff;
- ***Quantitative:*** An online survey of health professionals working in the alcohol and drugs sector across Northern Ireland.

3.3.1 Focus Groups with DACTS

A total of four focus groups were undertaken, including 54 participants overall (Table 3.1). A copy of the discussion guide is attached as Appendix A.

Table 3.1 Details of focus groups

TRUST AREA	DATE	LOCATION	NUMBER ATTENDING
WDACT	1 March 2018	Grangewood Hospital, Derry, and by videolink[1] with WHSCT offices, Enniskillen	17
NDACT	5 March 2018	County Hall Ballymena	9
SDACT	7 March 2018	Tower Hill Hospital, Armagh	9
BDACT / SEDACT	8 March 2018	Linum Chambers, Belfast	19

3.3.2 Depth Interviews

A total of 4 telephone interviews were undertaken with leaders in CAMHS and DAMHS (Table 3.2) A copy of the discussion guide is attached as Appendix B.

Table 3.2 Details of telephone interviews with CAMHS / DAMHS

NAME	DATE	ORGANISATION
Participant 1	28 February 2018	NHSCT / DAMHS
Participant 2	6 March 2018	WHSCT CAMHS
Participant 3	6 March 2018	SHSCT CAMHS
Participant 4	29 March 2018	BHSCT CAMHS

3.3.3 Online Survey

Staff from a diverse range of sectors targeted by the commissioned training were invited to take part in an online survey to elicit their views and experience around training needs. PHA emailed the survey link to lead contacts in a range of service providers to distribute among their staff:

- PHA commissioned providers of substance misuse services;
- HSCT Community Addiction Teams, DAMHS/CAMHS;
- Drug and Alcohol Coordination Teams in each Trust area (DACTs; N=5);
- Social Services (Dir. of Social Services in each HSCT) – primarily children's services;
- Family support hubs;
- Homeless hostels and support services;
- Needle and Syringe Exchange pharmacies[2].

The survey link was also disseminated by training providers with existing contracts with PHA to those that had attended any of their alcohol and drug training (over the period of November 2015 to December 2017). The survey ran from 8 May 2018 to 4 June 2018 and

[1] Due to adverse weather conditions
[2] NSE pharmacies were not part commissioned training but will be included in Phase 1 due to their close working with drug users.

was completed by 267 respondents. A copy of the survey questionnaire is included as Appendix C.

4. Findings from Focus Groups and Stakeholder Interviews

4.1 Introduction

Four focus groups were carried out with the Drug and Alcohol Coordination Teams, one each with:

- WDACT
- NDACT
- SDACT
- BDACT/SEDACT (combined)[3]

The focus groups were well attended with people from 30 different organisations taking part. The following organisations were represented in the focus groups:

- Ards and North Down Borough Council
- Ascert
- Barnardo's
- Belfast City Council
- BDACT Service User rep
- Belfast Health and Social Care Trust
- Council for the Homeless Northern Ireland
- Causeway Rural and Urban Network
- Derry & Strabane District Council
- Derry & Strabane Policing and Community Safety Partnership
- Derry Healthy Cities
- Education Authority
- Extern
- Extern / BDACT Connections
- Fermanagh Drugs & Alcohol Forum
- Future Foyle
- Lisburn YMCA
- Northern Health and Social Care Trust
- Omagh & Fermanagh District Council
- Probation Board for Northern Ireland
- Public Health Agency
- Police Service of Northern Ireland
- Regional Service Users Network
- Regional Service Users Network
- SEDACT Connections
- South Eastern Health and Social Care Trust
- Start 360
- Western Connections
- Western Health and Social Care Trust
- Youth Justice Agency

Stakeholder interviews were also carried out with senior staff from

- NHSCT CAMHS
- SHSCT CAMHS
- WHSCT CAMHS and
- BHSCT & SEHSCT Drug and Alcohol Mental Health Service (DAMHS)

The findings from the focus groups and the stakeholder interviews are presented below. In each case, we present the results from electronic voting (where applicable) followed by

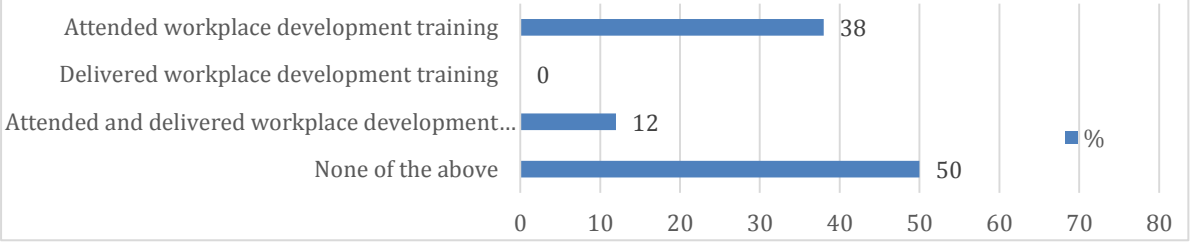
[3] Due to extensive overlap of membership organisations

the key points made by participants in relation to each of the specific topics.

4.2 Attendance and Satisfaction with Workplace Development Training

Half of the focus group participants had either attended training, with 12% having also delivered training (Figure 4.1).

Figure 4.1: Have you ever attended or delivered workplace development training (base=50)



The fact that half had not attended or delivered any of the training, is reflected in the 53% who said that they are neutral when it comes to satisfaction with workforce development training (Figure 4.2). The bulk of those who had attended were satisfied (40% of focus group attendees) and just 8% said they were dissatisfied.

The main reason for dissatisfaction was the location of training courses. This opinion was mostly expressed in WDACT and became a recurring theme in that focus group. Other reasons given by focus group participants for dissatisfaction were that:

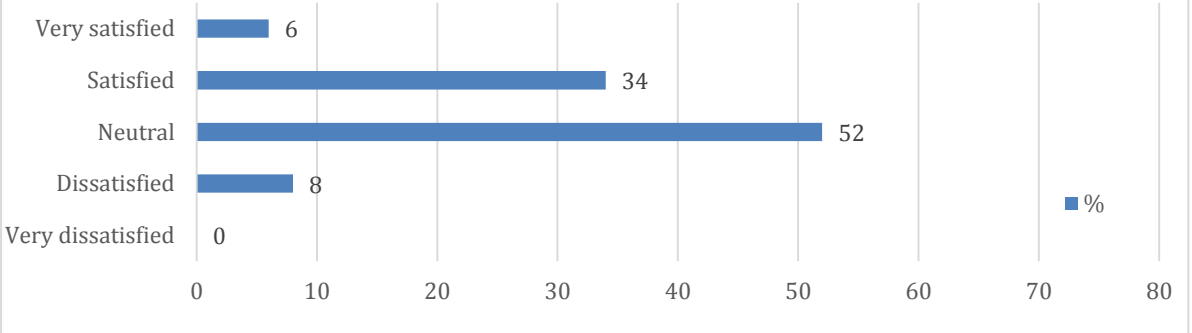
- much of the training is too generic and not focused on specific issues;
- there is little provision for building on the training at a more advanced level; and,
- there is no "fast react" provision for updates or training on fast emerging issues, such as new forms of psychoactive substances.

One of the 5 stakeholder interviewees had attended a workplace development training course and was very satisfied with the training. The remaining 4 interviewees had not attended any of the training.

On stakeholder commented that the courses on offer are too generic, probably suited to a basic level introduction for teachers, paramedics, etc., but not suitable for staff dealing with complex tier 3 issues.

Stakeholders also raised the question of where PHA sourced training fits into the overall picture and stressed the need for a more strategic approach that identifies training needs and offers appropriate training solutions. This was to be a recurring theme in the focus groups and interviews.

Figure 4.2 What is your general satisfaction level with current workforce development training? (base=50)



4.3 Training Needs

A flip chart session followed the initial focus group questions. Participants were invited to reflect on three themes:

- Broad Areas of Training Need;
- Specific Needs in Own Sector; and,
- Main Gaps in Provision.

Once the flip charts had been populated, the groups were invited to discuss what they had written. The groups populated the charts on broad needs and specific needs in a similar fashion, so these are taken together in the description, below. Stakeholder interviewees were asked about training needs under the same headings.

4.3.1 Broad Areas of Training Need and Specific Needs in Own Sector

A number of themes arose repeatedly across all the focus groups and interviews. These are described, below.

Defining Workforce

All of the focus groups raised the need to define the workforce as did a number of stakeholders. These discussions centred on the need to recognise that different teams and professions come into contact with drugs and alcohol at different points in the patient/client journey. The different professions have different training needs, therefore, depending on their role when it comes to recognising, diagnosing and referring clients and patients onwards for specific interventions. Some groups of staff just need awareness training, some need brief intervention training, whilst frontline staff need specific skills training. Training, therefore, needs to be targeted at the appropriate level for each sector.

One stakeholder commented that PHA should identify the map of those working in the sector, decide who the training is being targeted at and where it fits with other training on offer.

Poly drug misuse and comorbidity

All of the focus groups and interviewees gave high priority to training on poly drug misuse, to help in recognising and understanding the effects of combined drug use and the appropriate interventions and treatments. Discussion on poly drug misuse was often embedded in the wider issue of comorbidity and the need for training on interventions with young people who increasingly have complex needs and significant dependency problems. Comorbidity is also an issue in adult age groups.

Stakeholders stressed the need for staff training on how young people present with different combinations of prescription drugs and alcohol.

Dual diagnosis

Focus group conversations on comorbidity led to specific discussion about patients and clients who present with both mental health issues and drug/alcohol issues. These co-existing issues often interact, for example high levels of depression and anxiety related to drug and alcohol use.

A number of participants reported that this is increasingly common and emphasised the importance of recognising the different signs and symptoms so that interventions and treatment pathways are developed appropriately. There was also a call for training on the

impacts that drugs and alcohol have upon mental health and for training that would enable closer working between mental health and drug teams.

Stakeholders also talked about the problems of dual diagnosis. Training is needed, they said, for frontline staff who have to make mental health assessments with young people who are under the influence of alcohol or drugs.

New psychoactive substances

The ever changing picture of psychoactive substances ('legal highs') presents challenges to those working with substance users/in substance misuse services. Some focus group participants needed training with a specific focus on the impacts of psychoactive substances on young people. There is also a need for regular updates on new and trending drugs.

Stakeholders also stressed the diversity of drug use. Trends in psychoactive substances and their combinations with other drugs change all the time and staff need access to training and information that is right up to date for the areas and populations that they work with.

Misuse of prescription and over the counter drugs

Poly drug users often mix prescription, over the counter and other drugs with new psychoactive substances. There is a need for more training on the interactions between these different forms of drug misuse and a need for training on treatments and interventions.

Hidden harm

The children of those who misuse alcohol and drugs were frequently mentioned in the focus groups. There was consensus in the groups of a need for training on recognising the signs of hidden harm. This is needed across the board, but particularly amongst those who might have frequent contact with children, for example, teachers and GPs. Interventions with the whole family can be appropriate in such circumstances and training on such interventions is needed. The link between sexual abuse and drugs and alcohol was emphasised as a training need.

Foetal Alcohol Syndrome

Foetal Alcohol Syndrome was mentioned in two of the four focus groups. Training is needed in particular for those professionals who are dealing with pregnancy or pregnancy advice so that intervention is made pre-conception or during pregnancy.

Alcohol Related Brain Damage (ARBD)

Alcohol Related Brain Damage was discussed at some length in WDACT. The behaviours of those suffering ARBD often resemble dementia and patients are often inappropriately placed in custodial care. With the right treatment patients can recover from ARBD. Training is needed, therefore, on recognizing the symptoms of ARBD, avoiding misdiagnosis and implementing appropriate care and treatment.

Other areas of training need

Other areas of training need mentioned in focus groups were as follows:

- Recognising the signs of psychosis;
- Safer needle exchange;
- The use and misuse of counterfeit drugs;
- The use of Naloxone;
- Training and support for carers and siblings;
- Coping with chronic drug dependency;

- Suicide awareness;
- Skills in engaging young people and drug/alcohol misusers;
- Brief intervention training for GPs;
- Understanding the issues in BME and new communities; and
- Advanced motivational interviewing.

Differences between DACTS

Generally speaking, similar issues arose throughout the focus groups. However, in relation to these two questions (general and specific training needs) there were some differences in emphasis.

The location of training was a feature of the discussions with WDACT where it was argued that training is too Belfast-centric. WDACT also argued that the patterns of drug misuse vary geographically and emphasised the need for training to be specific to local needs. SDACT emphasised the high levels of alcohol problems in rural areas.

The discussions at the combined BDACT and SEDACT focus group were more strategic than with the other groups. For example, this focus group strongly emphasised the need for evidence based interventions and interventions that are age and topic appropriate. They also stressed the need to promote evidence based interventions with non-specialist workers and organisations.

Differences between stakeholder interviewees and DACTS

Stakeholder interviewees from CAMHS and DAMHS were largely in agreement with each other on training needs and stakeholders had similar training needs to report. Stakeholders differed from DACT focus group participants on the balance between career development and on the job skills. Stakeholders were more likely to favour any training that enhances job skills, regardless of the impact that training might have on an individual's career development.

4.3.2 Main Gaps in Training Provision

Much of the discussion on gaps in training provision mirrored the training needs already identified, above. The repetition of these areas implies that they are of high priority to the DACTS and to stakeholders from CAMHS and DAMHS. In order of the most mentioned they are:

- Dual diagnosis;
- Poly drug use;
- Hidden harm; and
- Misuse of prescription medication.

The discussions on main gaps also ranged across the following areas.

Age groups

Training on alcohol and drugs is mostly targeted towards teens and young adults but there are also issues in older age groups who may present with negative cognitive functions due to drugs and alcohol. Training could be focused on awareness raising and recognising the role of alcohol and drugs in certain behaviours.

Training for people who come into contact at early stages

There was discussion on the level of training required for professionals who come into contact with patients/clients at an early stage. GPs and general nursing staff need training on new drugs and on awareness of the services available. There was also a call for more training for social services, teachers and for volunteers. Better training, it was argued, could lead to better signposting and earlier intervention. Some suggested that training at source

of qualification needs to be improved, for example with GPs, nurses, teachers, social workers etc.

Advanced training

The level of training was discussed frequently in the focus groups. Training, it was argued, needs to be progressive, not just offered at the basic or generic level, but also at the next level. Advanced training is needed for experienced practitioners. Once training is provided there should be mechanisms to support its use to avoid training dilution and to maximise efficacy. Ongoing competency coaching might help in this regard.

System of alerts

Stakeholders also reiterated the need for a system of alerts [*note that DAMIS was not mentioned in any of the groups],* by which staff can be quickly updated on the changing pattern of drug misuse in the area. Training needs to be as immediate as possible in order for drug teams to be able to respond effectively.

Older adolescents with chaotic behaviours

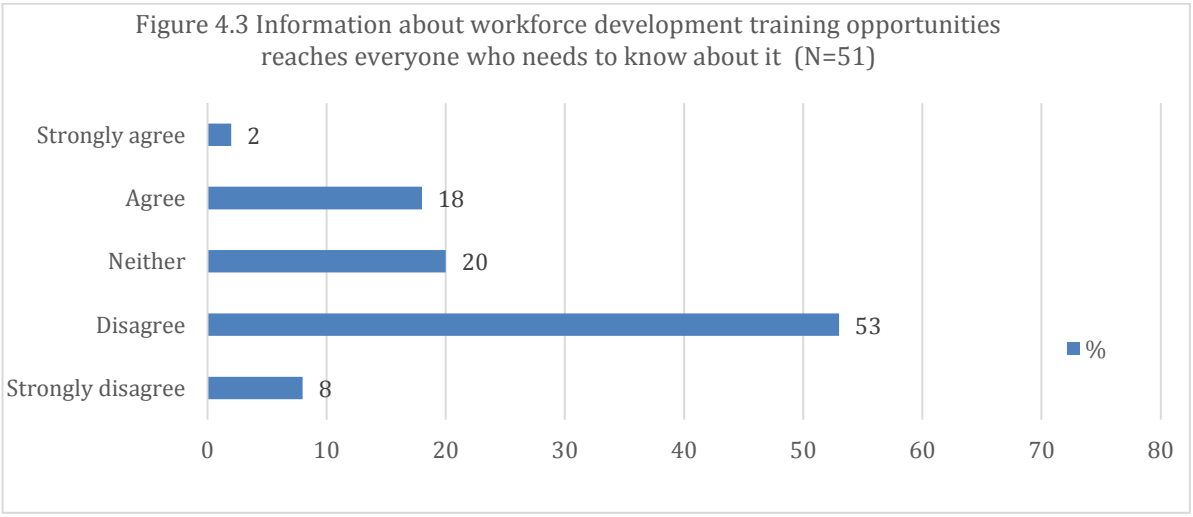
Stakeholders also mentioned that frontline staff often have to deal with older adolescents whose behaviours and lifestyles are chaotic. These complex cases can involve, for example, poly drug use and mental health issues combined with chaotic home life and poor parental support. Training could be aimed at how to assess the complex needs with which these young people present and how best to plan interventions that need to be managed at different levels and include a range of professions and services.

4.4 Communication of Information on Training

There was also discussion around the communication of information about workplace development training opportunities.

Figure 4.3 shows that 61% of focus group attendees disagreed with the statement that information about workforce development opportunities reaches everyone who needs to know about it, with one in five agreeing.

Figure 4.3 Information about workforce development training opportunities reaches everyone who needs to know about it (N=51)



Following the above question discussion then focused on the following themes.

Communication

Whilst information about training courses goes out through the system, focus group participants thought that there were areas for improvement. Training opportunities are not

communicated in a consistent or systematic way and training objectives need to be clearer so that staff can more readily see the relevance to their work.

Communication may reach around 6,000 people but that doesn't mean that it gets to the right people. When information is sent out generally, without guidance or comment, staff might not appreciate its relevance to their work. It was suggested that greater targeting at specific professions or individuals may help in this regard.

Training needs are different in different organisations. Front line staff may be easier to target, but there is also a need to target the right sub-groups of people in associated professions.

Stakeholders from CAMHS and DAMHS talked about the cascading systems within Trusts. One had not seen information specifically about the PHA funded training. Others thought that their training managers do their best to cascade training opportunities down but acknowledged that the volume of emails arriving with individuals can make it difficult to see all the training opportunities.

Difficulties in attending

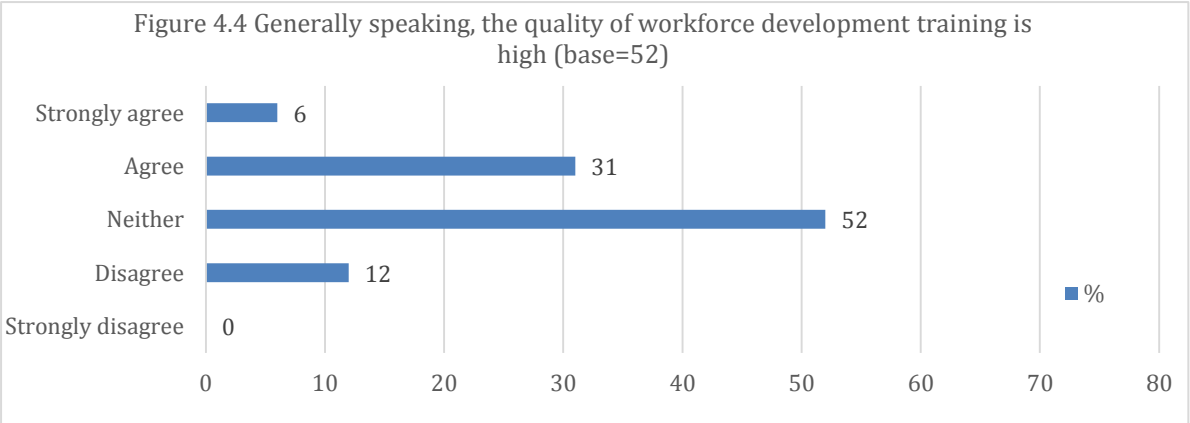
Even where information does get through to the right people, there can be barriers to attendance. Barriers specifically mentioned were:

- Difficulties in releasing staff to attend;
- No cover for staff when they go on training;
- Courses are in the wrong locations;
- The cost of people travelling from rural areas is high;
- What is represented in Belfast does not always represent the problems in the West; and;
- Other professional bodies e.g. teachers and youth workers are not able to go to training whilst working.

4.5 Quality of Workforce Development Training

Amongst those who expressed an opinion, 31% agreed that the quality of workforce development training is high, with most (52%) neither agreeing nor disagreeing and 12% disagreeing (Figure 4.4). The number expressing no opinion (i.e. neither agreeing nor disagreeing) largely arises from focus group participants who had not, themselves, attended any of the training.

Figure 4.4 Generally speaking, the quality of workforce development training is high (base=52)



There was little discussion in the focus groups on this topic. Amongst those who did express some negativity, the following points were made:

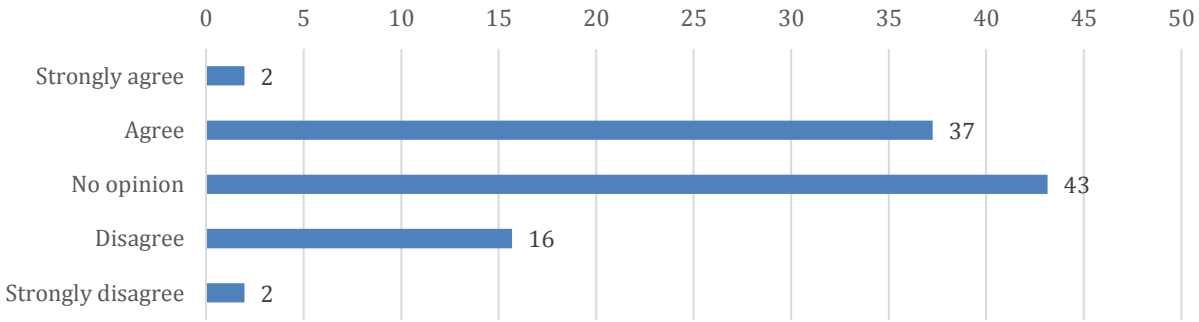
- The quality can depend on the individual trainer;
- Training always seems to have good evaluations at the end of training sessions, but perhaps this is not the best way to measure satisfaction;
- There were mixed, though largely positive views on the training on motivational interviewing; and,
- WDACT expressed the opinion that the gold standard of training that they had in the past on drugs and alcohol was said by PHA to be only level 2. In their opinion, it was better than the newer one that is said to be level 3.

Stakeholders from CAMHS and DAMHS did not feel able to comment on the quality of training as, with the exception of 1 course attended by one of the stakeholders, they had not participated in any of it or heard any specific feedback.

4.6 Application of Workforce Development Training

Figure 4.5 shows that, of those that expressed an opinion, the majority thought that the workforce development training is being applied in the workplace *(note that those expressing no opinion had no experience of workplace development training)*.

Figure 4.5 Generally speaking, workforce development training is being used and applied in the workplace (base=51)



Focus group participants discussed the need to have better monitoring and feedback on the extent to which training was useful or applicable in the workplace. At the moment, such feedback is sporadic.

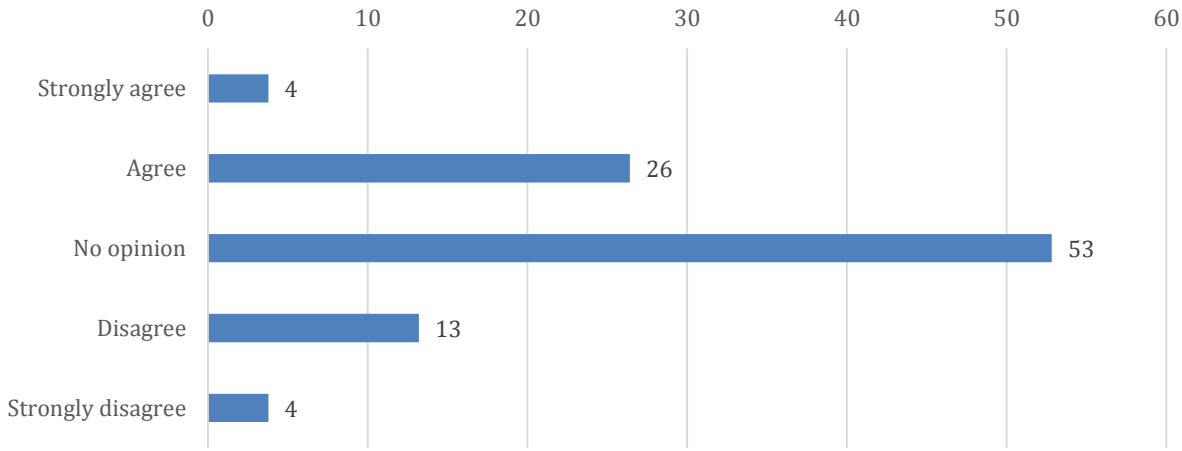
A better process of monitoring and feedback would distinguish between the application of skills and the application of awareness. The former, it was argued, is easier to see in practice.

Stakeholders from CAMHS and DAMHS did not feel able to comment on the application of training as, with the exception of 1 course, attended by one stakeholder, they had not participated in any of it or heard any specific feedback.

4.7 Value of the Workforce Development Training

Figure 4.6 shows that 30% of focus group participants thought the value of workforce development training is high, whilst 17% disagreed.

Figure 4.6 Given the costs and the investment in time, the value of current workforce development training is high (% N=53)



Some commented that the longer courses could be compressed into a shorter timeframe. Others argued that shortening courses might work for more experienced staff, but those who come to the training with a lower level of skill or knowledge may still need the longer courses. Different levels of training for staff with different levels of skill or competence might help in this regard.

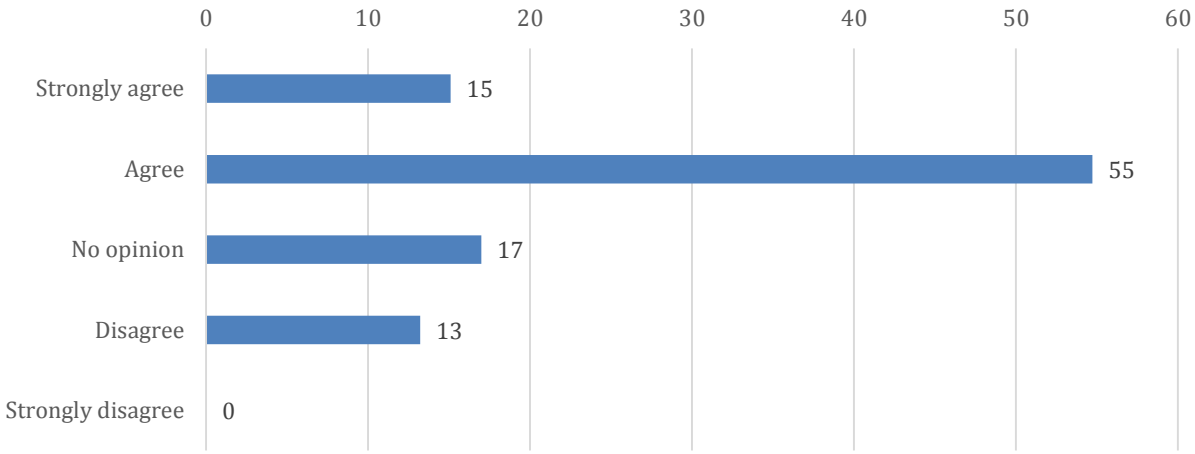
WDACT participants made the point that time investment for a given course is higher for those who have greater distances to travel. A half day course that runs in Belfast, can turn out to be a long, full day, commitment to someone from WDACT due to travel time. The cost/benefit analysis for WDACT is, therefore, skewed by travel times and travel costs.

To achieve the best value for money, stakeholders from CAMHS and DAMHS would prefer training to be given locally, responding to the needs of the moment and specifically targeted at their frontline staff.

4.8 Constraints in Releasing Staff to Attend Training

Figure 4.7 shows that a majority (70%) agreed that constraints in releasing staff present barriers to the uptake of training.

Figure 4.7 Uptake of workforce development training is lower than it should be because of constraints in releasing staff (base=53)



General feedback on the difficulties in releasing staff

The general consensus amongst focus group attendees is that it is becoming increasingly difficult to get time away from the job for training. Training is still seen as valuable and necessary, but getting time to do it is increasingly difficult, particularly within the statutory sector.

Stakeholder interviewees emphasised that the training profiles for their service always take priority when approving training. They also commented on the general levels of workforce pressure that makes it difficult to find time for training.

One focus group participant who works with and trains teachers, commented that they just can't be released from their jobs. Training has to be carried out in 1hour or 1.5-hour blocks after school or 45 mins over lunch time.

Training location

The issue of location came up with WDACT, NDACT and SDACT. The time commitment and travel costs for staff are greater the further they need to travel, creating greater barriers to training than for those who live closer to training locations.

One stakeholder interviewee commented on the time and costs associated with travel and the extra pressures created on work schedules by Time Off In Lieu (TOIL).

Easier to get released for mandatory or accredited training

Where training is mandatory or high priority, there is rarely any difficulty in getting released, but non-mandatory training poses greater difficulties. Where the training carries an accreditation, there is more investment and more return for the organisation and release for staff is easier to justify. One stakeholder commented, however, that pressures on staff time are so great that even getting time off for mandatory training can be difficult.

Difficulties in releasing blocks of staff

Releasing more than one member of staff at a time poses difficulties. Training needs to be offered at different times throughout the year to allow different staff from the same team to attend. If there were more rolling programmes on a more frequent basis then staff would not have to be released all at once. PSNI, for example, will just release one member of staff at a time for training as they prioritise the need to have officers on the ground.

Stakeholders were unanimous in the view that it is difficult to release significant numbers of staff when there are pressing problems at the coal face.

Planning for time away from the job

Pressures on clinical capacity may result in staff not being able to take time out for training. The Integrated Elective Access Protocol (IEAP) *[implemented by DoH across all Trusts]* places restrictions on planned leave/absence, in particular, a minimum of 6 weeks' notice if a clinic is to be cancelled or reduced. If information about courses does not reach potential participants quickly enough, the IEAP rules could place a bar on their participation. This is also an issue if places on courses only become available at short notice if, for example, someone who registered to attend has cancelled.

Even where IEAP does not apply, staff find it difficult to combine work commitments and training commitments, especially if there is no cover when they are absent for training purposes. For example, stakeholders commented that, as days away from patients mean that patients have to wait longer to be seen, then the managers have to balance training demands against patient demands. That means that managers often have to say "no" to training.

Travel costs

Some Trusts will stop mileage being paid after a set number of miles have been travelled or when budgets run out during a financial year. Many volunteers may not get expenses or have travel costs covered at all. The absence of travel costs may provide an additional disincentive to releasing staff.

Use distance learning more

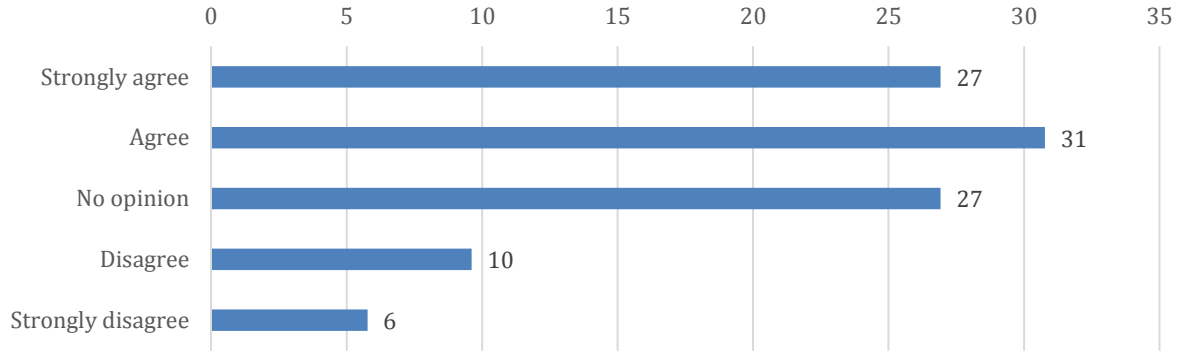
Some focus group participants suggested that the E Learning platform could be used for awareness training or lower level training. Whilst skills-based training generally needs to be done face to face, using distance learning for other courses could reduce the overall pressures within a unit in releasing staff.

4.9 Training Location

Figure 4.8 shows that the location of workforce development training does present barriers to uptake (58% agreed that location presents barriers).

There were differing opinions across the focus groups, with those who live and work outside Belfast, in WDACT, SDACT and NDACT, all raising training location as a difficulty. The BDACT/SEDACT focus group did not see this as an issue for themselves, though they did acknowledge that is a problem for those who live far away from Belfast. Those in BDACT/SEDACT made the point that, although the majority of training is located near Belfast, that is fair because that is where the majority of training participants live.

Figure 4.8 Workforce development training locations present barriers to uptake for staff, particularly those staff working outside Belfast (base=52)



The WDACT focus group was strongest in the opinion that location affects uptake. Half day training needs a full day commitment because of travel times. Travelling to Belfast in time for courses that start first thing in the morning involve a very early start and often necessitate people having to make alternative arrangements for child care and school runs.

The extra time commitment required, WDACT argued, also has a knock on effect on the extent of staff cover needed to release staff and the extra lost time that staff have to catch up. Distant locations also put extra pressures on travel budgets.

NDACT argued that busy practitioners are put off if they have to add extra time to their day to travel to far away training locations. SDACT asked for a more equitable spread of training across Northern Ireland and a training calendar that offers repeat courses at different venues.

Stakeholders from outside Belfast cited travel time, and the associated extra costs in terms of mileage allowance and TOIL, as barriers to staff being able to take up training. One suggested that more training should be delivered using a central location within each Trust area.

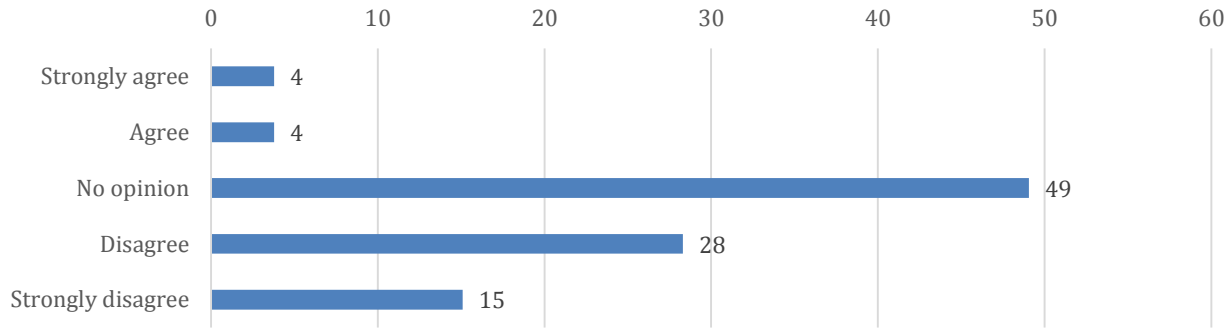
Representatives of training providers listed some of the measures that they had tried to take in order to make location more equitable, including running courses outside Belfast. Courses had also been arranged at employer locations, but turnout on these had been low.

Distance learning and E Learning were proposed as solutions, particularly for non-skills based training.

4.10 Accreditation

Of those who expressed an opinion, a majority thought that current workforce development training does not meet the career development needs of staff (Figure 4.9).

Figure 4.9 Current workforce development training offers sufficient accreditation to meet the career development needs of staff (base=53)



A number of issues were raised about accreditation.

Non-accredited training is not attractive to staff who want to move or seek promotion

All the focus groups commented that training that is not accredited is often not considered by any future employer. For promotion purposes, too, non-accredited training does not usually score at shortlisting or interview.

Professional staff, seeking to build a career portfolio, do not see non-accredited courses as being of high value. Voluntary sector workers also value accredited courses, particularly if they are using the voluntary sector as a stepping stone to a career in the statutory sector.

A counter view was presented by one CAMHS manager who commented that, whilst pursuing career development through accreditation and certificates is of interest to staff, it is insufficient motivation in itself to attend a given course as most of his staff are already educated to degree level with additional qualifications.

Non-accredited courses are still attractive if they help with skills development

Whilst accreditation is attractive in terms of career development, most focus group participants could still see value in training that increases skill level or performance on the job. Courses that update practice or offer practical help are still valued, but a non-accredited course will still not be as popular as an accredited one.

Accreditation and competencies

A number of focus group participants said that training needs to be mapped to Drugs and Alcohol, National Occupational Standards (DANOS). Others thought that OCN accreditation was important.

Whatever the accreditation body, most focus group attendees thought that it is important for training to be accredited in such a way that it scores points on personal improvement plans and links into skills frameworks.

Again, the stakeholder managers from CAMHS and DAMHS had a different emphasis, valuing training where it is relevant to the job, regardless of whether it is accredited or not. Accreditation for personal gain is judged to be of little value to the Trust compared with training, accredited or not, that builds skills and capacity.

A need for progressions pathways with linked competencies

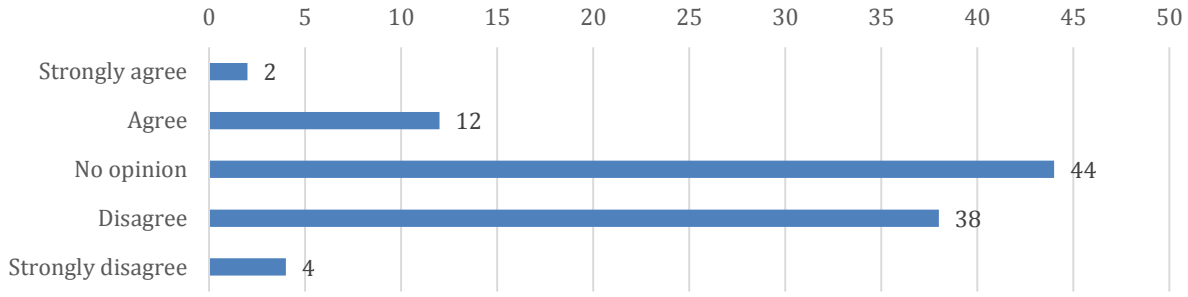
There was some discussion, particularly in the BDACT and SEDACT focus group, about the need for progression and progression pathways to be mapped out. This, it was argued, needs to be done in a way that allows all experience and training to count towards career development.

Linking training and competence development in this way would also help to address the issue of an ageing workforce and promote a more strategic way of looking at how skills and experience are retained in the sector.

4.11 Capacity (Supply and Demand)

A majority of those who expressed an opinion, thought that there is not enough capacity for staff to get all the training they need (Figure 4.10).

Figure 4.10 There is sufficient workforce development training capacity for staff to get the training that they need. (base=50)



Some focus group members had been unable to take up courses because they were already full. They noted that this happens more often with accredited courses.

Some linked training capacity to the need for rolling programmes, arguing that courses should be offered at different times throughout the training calendar in order to allow different members of teams to attend.

The issue of training progression was also discussed with a number arguing that there is not enough advanced or update training available.

4.12 Moving Forward

Each focus group ended with a short discussion on the way forward. These discussions were generally used by participants to emphasise the most important points that they had made earlier. Some issues are, therefore, repeated below, but this is important as they represent the priorities as seen by the DACTs.

What workforce is PHA targeting?

A consistent question in the focus groups was about which workforce or part of the workforce PHA is targeting with its training.

There were calls for a mapping exercise that would identify the core professions and services, setting them in context with those that work peripherally to the sector or who come into contact with patients and clients early in their journey. Mapping the sector(s) in this way would assist in developing a more strategic training framework that focused on the training needs of different professions, linked to the type of contact or interventions that they typically have with patients and clients. This would clearly distinguish between, for example, those who need specific skills training and those who need awareness training.

Awareness training and skills training

Linked to the discussion on "*which workforce*" was a debate about who needs skills training and who needs awareness training. It was argued that awareness training, and training for those whose sole focus is not drugs and alcohol, needs a lighter touch than skills training for frontline staff. Awareness training. It was suggested, can be delivered in different ways, for example, by distance or online learning, whilst skills-based training is better done face to face.

Further, the outcomes of awareness training will be different from the outcomes of skills training and need to be measured in different ways. Skills outcomes should be evident on the job, but awareness outcomes and the application of awareness training is more difficult to measure.

Be more responsive to local training need

WDACT argued that training needs differ in the West, partly because of different demographics, the incidence of poverty and the suicide rate amongst young men. SDACT commented that their rural communities exhibit greater levels of alcohol misuse than elsewhere. Both DACTs asked for training that was tailored, at least in part, to the specific needs of their areas.

WDACT suggested that the training provider could work through the DACTs so that training more closely reflected local need.

Progression

The issue of skills development and progression arose again in these final discussions. Courses that are offered at only one level will not be taken up repeatedly by staff, so there is a need to develop next-level and advanced offerings. A training calendar that showed follow-on options was suggested as was the need for the building blocks of skills development to be identified and linked to courses.

4.13 Stakeholder Views on Critical Areas and Necessary Supports

Stakeholders were asked about the most pressing areas of training that PHA needs to address as a priority. The critical areas echoed much of the focus group discussions, the main points being:

- Ongoing updates on drugs and psychoactive substances as picture changes rapidly;
- Training on the management of more complex cases *(note that participants did not always use the correct terms when explaining particular training);*
- Dealing with child protection issues alongside drugs and alcohol; and,
- Training on the contextual reasons for substance abuse, for example, peer pressure, family and lifestyle issues and the intervention strategies that might be appropriate in each case.

In terms of supports, stakeholders suggested:

- Practical, short training interventions delivered, where possible, locally. These would be focused on the specific issues that local staff meet in their work and, being delivered locally, would reduce time spent away from the workplace;
- More funding directed at training generally; and,

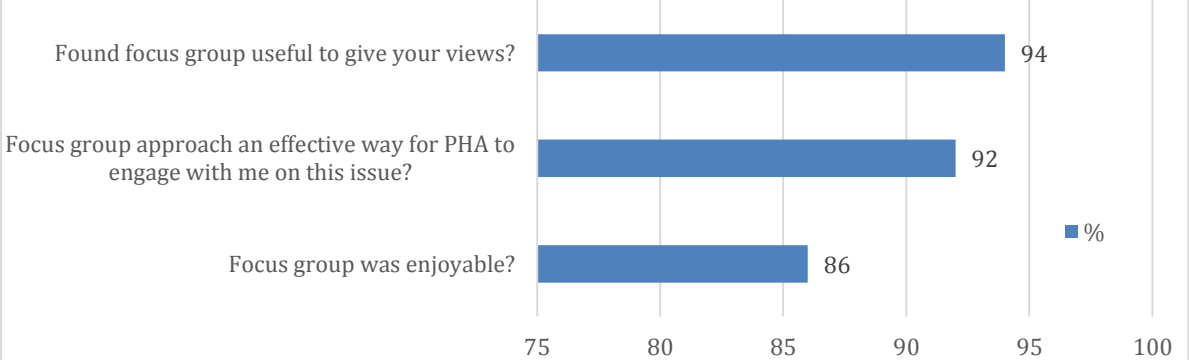
- Skills based training that can be applied to the job, rather than a focus on building individual training portfolios.

4.14 Focus Group Evaluation

At the conclusion of each focus group, participants were invited to answer a number of evaluation questions.

Figure 4.11 shows that 94% of participants found the groups useful in giving their views, 86% found them enjoyable and 92% thought that they were an effective way for PHA to engage with them on these issues.

Figure 4.11: Focus group evaluation (base=50)



5. Survey of Selective Staff Groups Working with or Coming into Contact with Substance Users

An online survey was conducted with various staff groups as outlined in Section 3.3 (Methodology). The survey was conducted in May and June 2018, with 267 respondents taking part.

5.1 Sample Profile

Table 5.1 presents the profile of the staff taking part in the survey and shows that most (64%) are frontline workers, with 90% having direct contact with people presenting with drugs and alcohol issues.

Almost three out of four (74%) said they work with adults with 53% working with children and young people. Approximately one quarter (27%) spend more than 80% of their time working directly with those presenting with alcohol and drugs related issues.

The greatest proportion (31%) of respondents are based in the Southern Trust, with relatively fewer respondents based in the Northern (10%) and South Eastern (12%) Trusts. Sixteen percent of respondents are members of a DACT.

Table 5.1: Profile of survey respondents (n=267)

		%	n
Status	Front line worker	72	191
	Manager	19	52
	Trainer or training provider	4	10
	Other	5	14
Direct contact with people presenting with drugs and alcohol issues	Yes, drugs	4	11
	Yes, alcohol	5	12
	Yes, both drugs and alcohol	82	218
	No	10	26
Working with target groups	Mainly with adults	47	126
	Mainly with children / young people (under 25)	26	69
	Equally with adults and children / young people	27	72
% of your work involving direct contact with people presenting with drugs and alcohol related issues	None	7	18
	1-20%	31	83
	21%-40%	12	33
	41%-60%	11	28
	61%-80%	12	33
	81%-100%	27	72
Member of DACT	Yes	16	42
	No	84	225
Trust	Belfast	23	62
	Northern	10	27
	Southern	31	83
	South Eastern	12	32
	Western	15	41
	Regional – cover all areas	8	22

Table 5.2 presents a breakdown of respondents by sector.

Table 5.2: Profile of survey respondents by sector (n=267)

	%	n
Other Health and Social Care Trust (not CAT or children's services)	15.0	40
Non-statutory provider of substance misuse services	13.9	37
Social services / Family and Children's Services	12.7	34
Community Addiction Team (CAT)	9.7	26
Homeless Charity	9.7	26
Community Organisation	8.2	22
General housing provider (e.g. housing association, NIHE)	6.4	17
Children's/Youth Charity	5.2	14
CAMHS/DAMHS	3.7	10
PBNI / PSNI / YJA / PCSP / Probation	2.6	7
Mental Health Charity	1.9	5
Pharmacy	1.9	5
Family Support Hub	1.5	4
16+ education: university, regional college, training provider	1.1	3
Education (school or alternative setting)	1.1	3
Other training provider (substance misuse)	0.7	2
Local Council	0.4	1
Women's Organisation	0.4	1
Other[4]	3.7	10

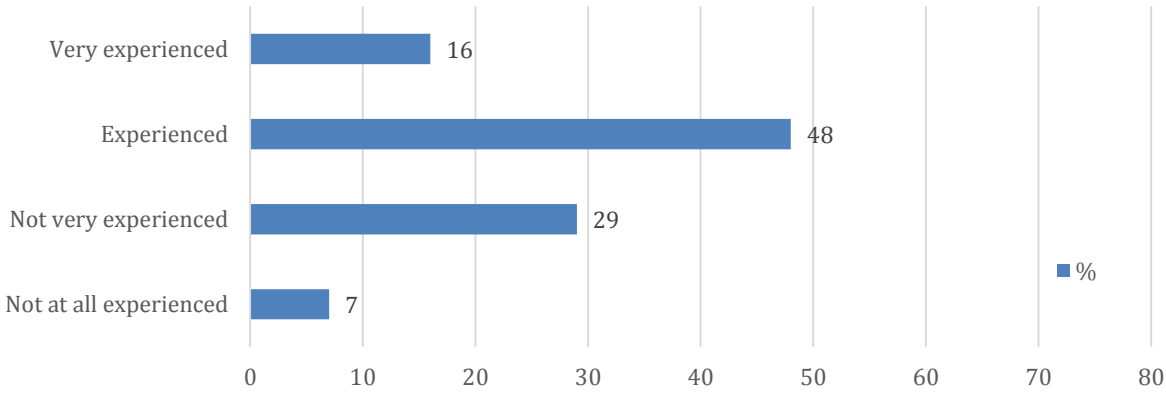
[4] Includes: substance misuse liaison (n=1); children and young person's health (n=1); floating support worker (n=1); midwife (n=2); support group (n=1); charity (n=1); care in prisons and community (n=1); voluntary organisation (n=1); and, regional charity (n=1).

5.2 Experience of Working in the Alcohol and Drugs Sector

All respondents were asked to self-rate their level of experience in the alcohol and drugs sector.

Figure 5.1 shows that 64% of respondents said they were either *'very experienced'* (16%) or *'experienced'* (48%) in the sector, whereas 36% said they were either *'not very experienced'* (29%) or *'not at all experienced'* (7%).

Figure 5.1: How would you rate your level of experience of working in the alcohol and drugs sector? (base=267)



There were a number of statistically significant differences in response between different groups of respondents.

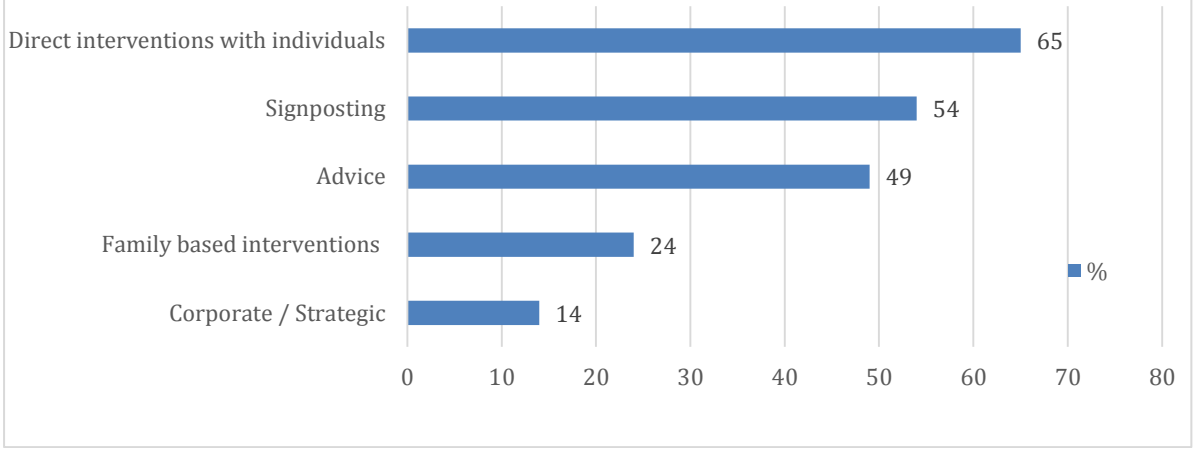
- Those with direct contact with those presenting with alcohol and drug issues were more likely to self-rate themselves as experienced in the sector (66% vs. 42%);
- Those who spend a greater percentage of their time working with those presenting with alcohol and drug issues were more likely to self-rate themselves as experienced in the sector (<=20%: 39%; 21%-60%: 57%; and, 61%+: 86%);
- Members of the local DACTs were more likely to say they are experienced in the sector (86% vs. 60%);
- Those based in the Southern Trust were less likely to say they are experienced in the sector (Belfast: 69%; Northern: 93%; Southern: 36%; South-Eastern: 75%; Western: 71%; and, Regional: 91%);

5.3 Nature of Work with Those Presenting with Alcohol and Drug Issues

All respondents were asked about the nature of their work with people presenting with alcohol and drugs issues.

Figure 5.2 shows that 65% of respondents were involved in direct interventions with individuals, with 54% involved in sign-posting and 49% offering advice. Approximately one in four (24%) said they were involved in family based interventions, with 14% involved at a corporate / strategic level.

Figure 5.2: What is the nature of your work with people presenting with drugs and alcohol related issues? (base=267)



There were a number of statistically significant differences in response between different groups of respondents.

Advice

- More likely to be offered by frontline workers (50%) compared with others (37%)[5];
- More likely to be offered by those with direct contact (49%), with those presenting with alcohol and drug related issues compared with others (19%);
- More likely to be offered by those who spend a greater percentage of their time working with those presenting with alcohol and drug issues (<=20%: 35%; 21%-60%: 48%; and, 61%+: 56%);

Signposting

- More likely to be undertaken by those working in the South Eastern Trust (Belfast, 57%; Northern, 48%; Southern, 42%; South-Eastern, 75%; Western, 56%; and, Regional, 64%);

Family based Interventions

- More likely among those working equally with adults and children / young people (43%) compared with those working only with adults (14%) or only with children / young people (25%);
- More likely among those who are members of a DACT (41% vs. 22%);
- More likely among those who said they are experienced (29%) in working in the alcohol and drugs sector compared with those who rated themselves as inexperienced (18%)[6];

[5] Note that is variable in based on A1 in the questionnaire (front line workers as a separate category compared with all other respondents)

Direct Interventions with Individuals

- More likely to be offered by frontline workers (65%) compared with others (49%);
- More likely to be offered by those with direct contact (65%) with those presenting with alcohol and drug related issues compared with others (15%);
- More likely among those who spend a greater percentage of their time working with those presenting with alcohol and drugs problems (<=20%: 37%; 21%-60%: 57%; and, 61%+: 85%);
- More likely among those experienced (73%) in working in the alcohol and drugs sectors compared with those who rated themselves as inexperienced (39%);

Corporate / Strategic

- More likely among those in management or training provider roles (25%) compared with frontline workers (9%);
- Less likely among those in contact with those presenting with alcohol and drug issues (11% vs. 39%);
- More likely among those experienced (19%) in working in the alcohol and drugs sector compared with those who rated themselves as inexperienced (5%)
- More likely among those who are members of a DACT (38% vs. 9%);
- Most likely among those working regionally (Belfast: 13%; Northern: 15%; Southern: 4%; South-Eastern: 25%; Western: 10%; and, Regional: 46%);

[6] Note that this variable is based on responses to A6 (very experienced and experienced were combined to form a separate category and not very and not at all experienced formed a second category. Don't know formed a third category)

5.4 Adequacy of Substance Misuse Related Training to Date

Respondents were invited to say if they felt the amount of substance misuse related training they have received to date is sufficient to allow them to do their job effectively.

Table 5.2 shows that respondents most commonly said that their training to date is adequate (34%), with 20% saying they have not received any training, or it has been a while since they received training. Other common responses included: keeping knowledge updated (17%); more role specific training required (13%); and, more training on new substances (12%).

Table 5.2: Do you feel the amount of substance misuse related training you have received to date is sufficient, or adequate, to allow you to do your job effectively? (n=253)

	%	n
Adequate/sufficient level of training	34	40
I have not received any training/or have not received training in years	20	24
Keep knowledge updated - possibly on a 6 or 12 month basis	17	20
More role specific training required	13	16
More training on new substances such as legal highs and new drugs coming on to the scene	12	14
Should be a tiered approach to training - basic, intermediate and advanced to meet all practitioner needs	6	7
More focus and training required on harm reduction and the use of therapeutic tools	5	6
Training in NI is patchy with no specific post graduate courses or access to subject specific training i.e. dealing with withdrawal	4	5
More focused training on drug and alcohol misuse	4	5
Remove barriers to accessing training - such as minimal education levels if you need that training for a specific role, time away from work resulting in build-up of workload	3	3
Focused training has enabled me to do my job better	3	3
Current level of training outdated and insufficient	3	3
Lack of advanced / higher level training courses	2	2
I have attended various courses	2	2
Within Statutory Services - mandatory training takes priority over job specific training	2	2
Not seen as priority	2	2
Longer induction period required	1	1
I feel confident I can do my job without training	1	1
Too many courses cancelled due to staff shortages or funding issues	1	1
Basic training is very good - provides a good foundation of knowledge and skills	1	1
Gained most of my knowledge through experience	1	1
Difficult to access Naloxone, DBT and Dual Diagnosis training	1	1
Need to use more external training experts	1	1
Other[7]	3	3
DK	1	1

[7] Included: should be a tiered approach to training and NICE guidelines provide direction (n=1); big changes in this area due to changing drug trends (n=1); and, not sufficient around safeguarding (n=1).

5.5 Attended or Delivered Workplace Development Training on Alcohol and Drugs

Respondents were asked if they had attended or delivered workplace development training (*i.e. training commissioned by PHA and delivered by a training provider)*.

Figure 5.3 shows that more than half (57%) of all respondents said they had attended workplace training, with 2% saying they had delivered and attended PHA commissioned training. Approximately one in ten (12%) respondents said they had attended and delivered workplace development training.

Figure 5.3: Have you attended or delivered any workplace development training on alcohol and drugs?

There were a number of statistically significant differences in response between different groups of respondents.

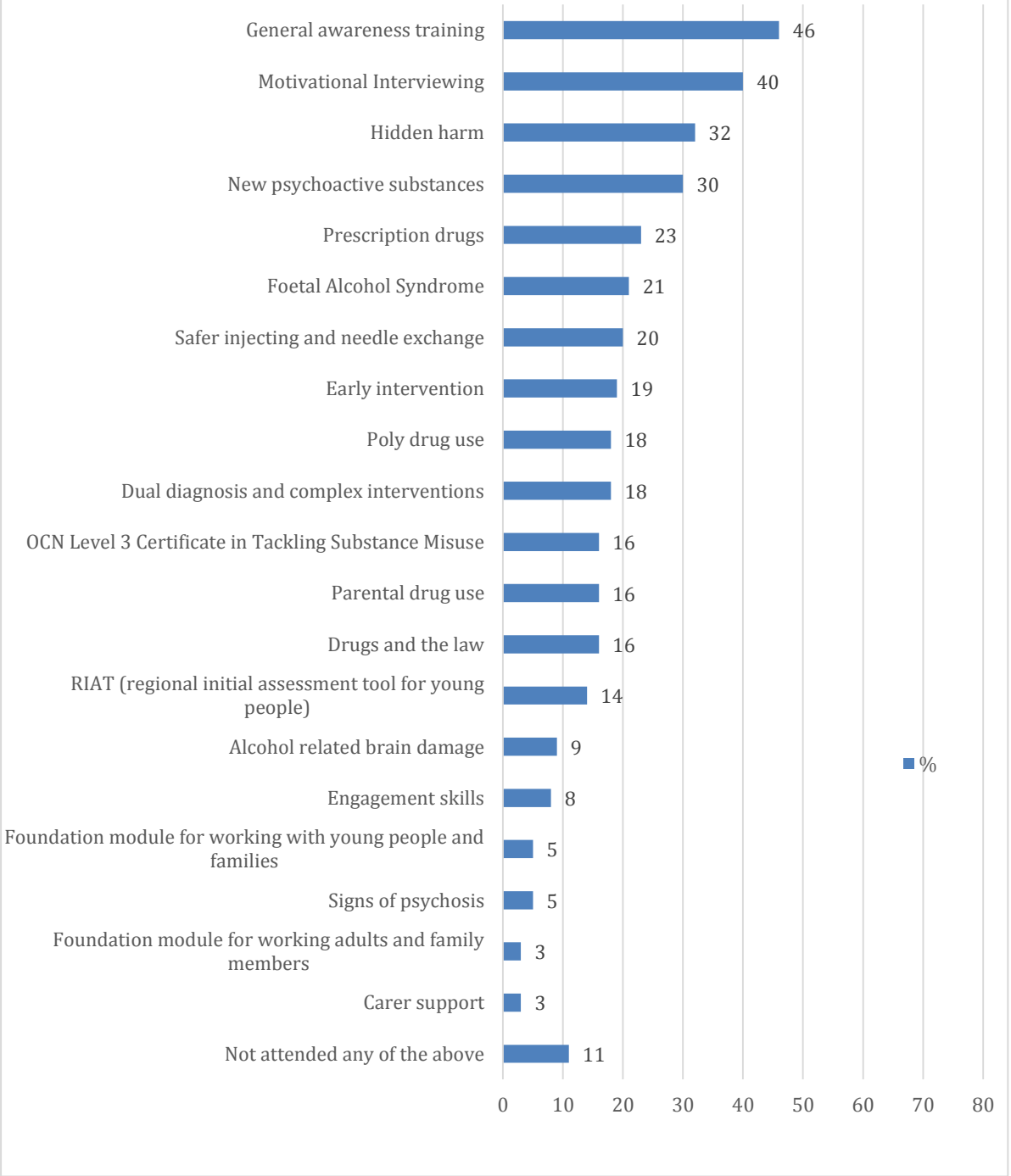
- Those working mainly with adults (78%) were more likely to have attended PHA commissioned workplace training, compared with those working mainly with children (52%) and those working equally with adults and children (69%);
- Those who spend a greater percentage of their time working directly with those presenting with alcohol and drugs issues were more likely to have attended (<=20%: 57%; 21%-60%: 71%; and, 61%+: 79%);
- Members of the local DACTs were more likely to have attended (83% vs. 66%);
- Those based in the Southern Trust were less likely to have attended PHA commissioned workplace development training (Belfast: 73%; Northern, 82%: Southern: 43%; South-Eastern: 84%; Western: 81%; and, Regional: 96%);
- Those saying they are experienced in the alcohol and drugs sector were more likely to say they had attended PHA commissioned workplace development training (77% vs. 55%);

5.5.1 Attendance at Workplace Development Training

The 69% (n=184) of all respondents who attended workplace development training were asked which types of training they had attended.

Figure 5.4 shows that just under half (46%) of those attending PHA commissioned training had attended general awareness training, with 40% having attended motivational interviewing training, 32% hidden harm training and 30% training on new psychoactive substances. Note that 11% of those indicating that they had attended PHA commissioned training, said they had not attended any of the training listed in Figure 5.4.

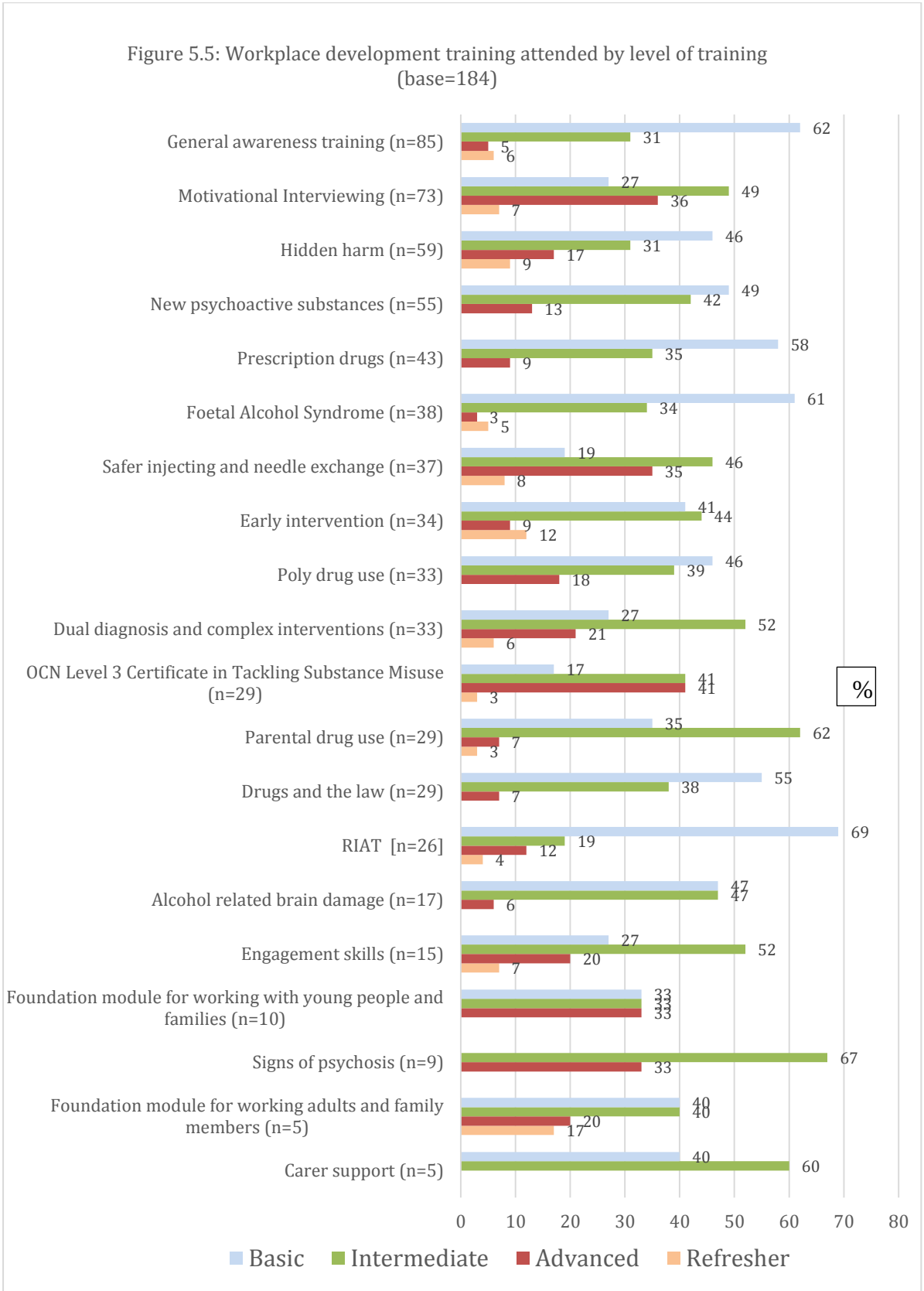
Figure 5.4: Which of the following PHA workplace development training have you attended? (base=184)



5.5.2 Level of Workplace Development Training Attended

Figure 5.5 shows the levels at which respondents achieved training for each type of training, with basic or intermediate training most common for each training area *(e.g. 62% of those undertaking general awareness training indicated that this training was at a basic level, with 31% saying it was at an intermediate level)*.

Figure 5.5: Workplace development training attended by level of training (base=184)



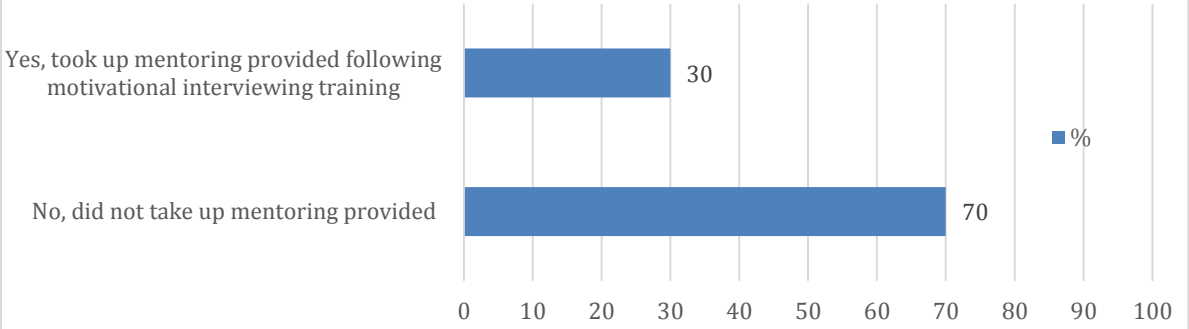
5.5.3 Motivational Interviewing Training and Take Up of Mentoring Option

Respondents who had undertaken training on motivational interviewing (27%, n=73) were asked if following this training, they had taken up the mentoring provided.

Figure 5.6 shows that 30% had taken up the mentoring provided following their motivational interviewing training, with most not doing so.

Among those who had taken up the mentoring provided, all had found it helpful in their work.

Figure 5.6: Following your training on Motivational Interviewing did you take up the provided mentoring? (base=73)



Respondents who had not taken up the mentoring provided were asked why not. Table 5.3 shows that the most common reason for not taking up mentoring was that it was not offered or provided (53%), with 9% saying they didn't feel they needed it and 6% saying they couldn't access higher level training in order to proceed to mentoring stage.

Table 5.3: Reasons for non-take up of mentoring training following MI training (base=47)

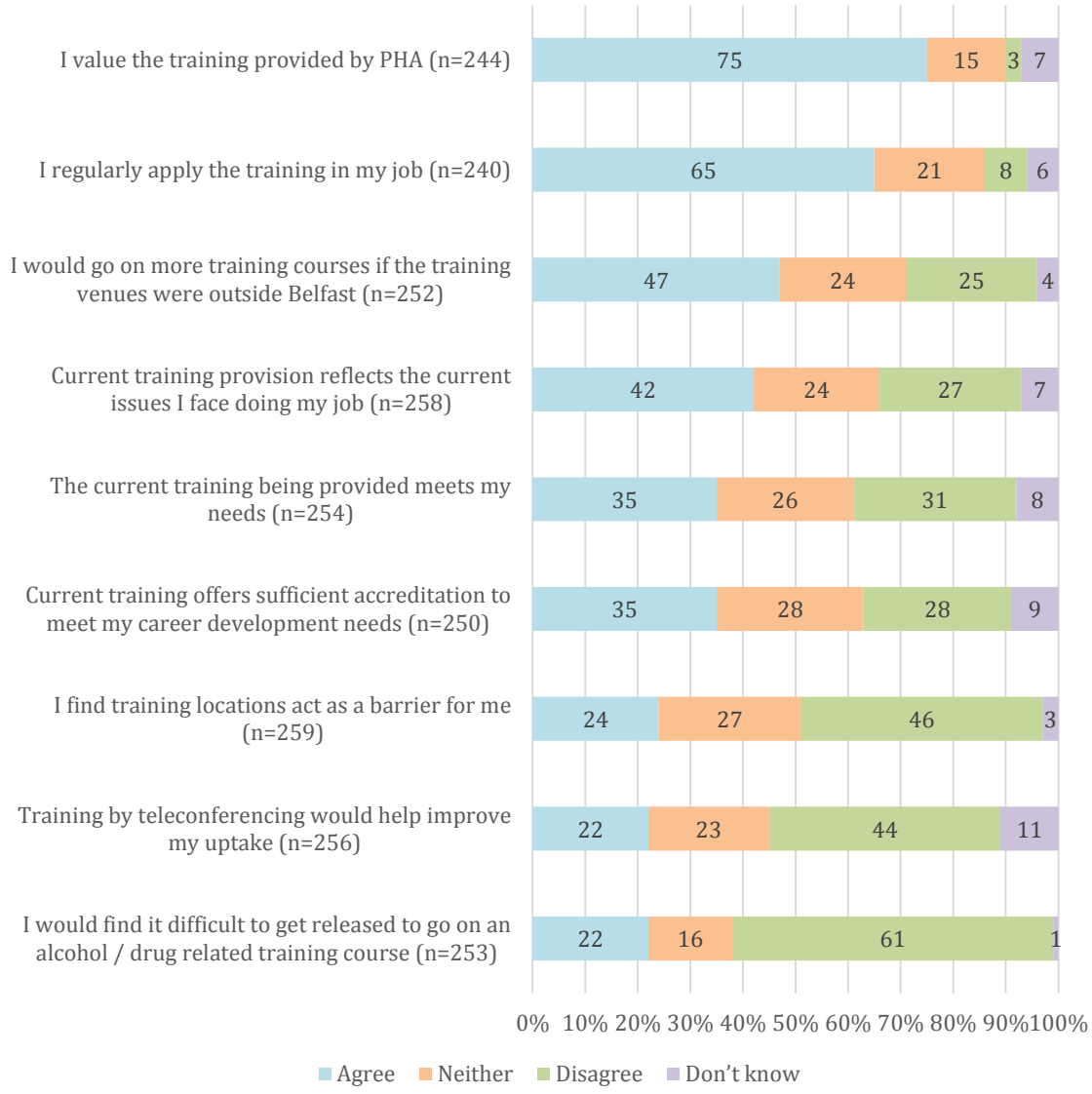
	%	n
Was not offered/made aware of mentoring provision	53	25
I didn't feel I needed it	9	4
Could not access higher level of training in order to proceed to mentoring stage	6	3
Mentoring offered through a different organisation to my own - more difficult to arrange	4	2
Change in my role	4	2
Barriers to training - lack of funding if sessional worker/workload to heavy	4	2
Did not find out about the course until after the event	2	2
Facilitator was intimidated by my level of knowledge so did not feel they could mentor me	2	1
Course was not run by PHA	2	1
Funding issues	2	1
Only offered one type of training	2	1
I did not feel confident in my skill set to proceed to mentoring	2	1
Completed MI training but had to rely on other team members for support	2	1
DK/Not sure	4	2

5.6 Opinion on Workplace Development Training Commissioned by PHA

Respondents were asked to say if they agreed or disagreed with a range of statements about current workplace development training provided by PHA.

The highest level of agreement was recorded for the statement *'I value the training provided by PHA'(75%)*, whereas the lowest level of agreement was recorded for the statements '*training by teleconferencing would help improve my uptake'* (22%), and '*I would find it difficult to get released to go on an alcohol / drug related training course'* (22%).

Figure 5.7: Please say if you agree or disagree with each of the following statements about current workplace development training on substance misuse provided by PHA? (base=267)



There were a number of statistically significant differences in response by key respondent groups.

Statement: I value the training provided by PHA

- There were no differences in response

Statement: I regularly apply the training in my job

- Those who spend a greater percentage of their time working directly with those presenting with alcohol and drugs problems were more likely to agree (<=20%: 46%; 21%-60%: 71%; and, 61%+: 82%);
- A higher level of agreement among those based in the Western Trust (Belfast: 66%; Northern: 69%; Southern, 54%:; South-Eastern, 69%:; Western, 82%: and, Regional: 68%);
- A higher level of agreement among those who said they are experienced in working in the sector (78% vs. 43%);

Statement: I would find it difficult to get released to go on an alcohol / drug related training course

- A higher level of agreement among those working mainly with adults (27% vs. 6%);

Statement: I find training locations act as a barrier for me

- A higher level of agreement among those based in the Western Trust (Belfast: 10%; Northern: 37%; Southern: 24%; South-Eastern: 19%; Western: 45%; and, Regional: 15%);

Statement: Current training offers sufficient accreditation to meet my career development needs

- A higher level of disagreement amongst those who spend a greater percentage of their time working directly with those presenting with alcohol and drugs problems (<=20%: 20%; 21%-60%: 25%; and, 61%+: 39%);

Statement: The current training being provided meets my needs

- A higher level of agreement among those who said they are experienced in working in the sector (40% vs. 25%);

Statement: Current training provision reflects the current issues I face doing my job

- A higher level of agreement among those who said they are experienced in working in the sector (47% vs. 33%);

Statement: I would go on more training courses if the training venues were outside Belfast

- A higher level of agreement among those working with children (55% vs. 39%);

Statement: Training by teleconferencing would help improve my uptake

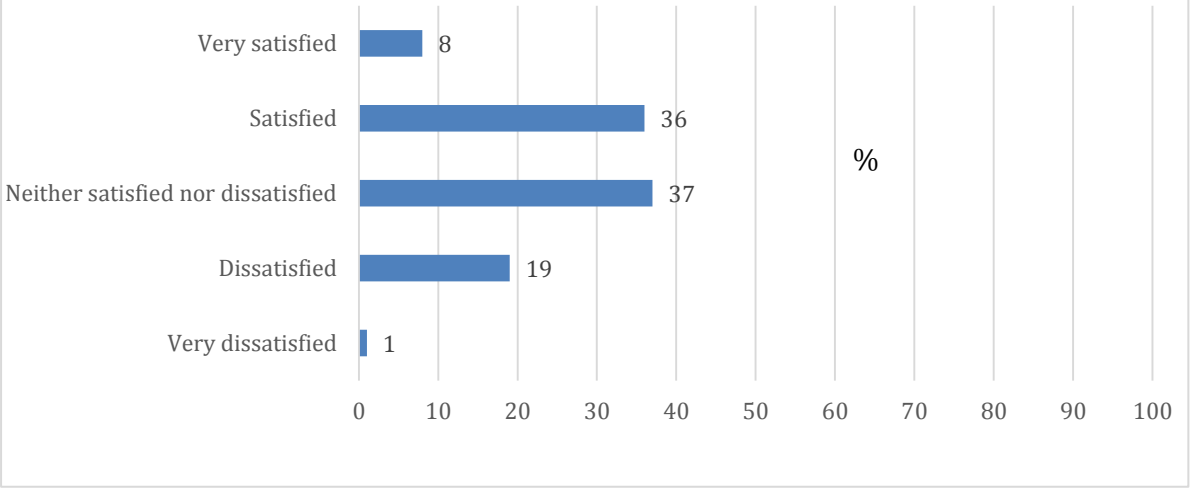
- A higher level of agreement among those based in the Western Trust (Belfast: 9%; Northern: 63%; Southern: 63%; South-Eastern: 38%; Western: 80%; and, Regional: 24%);

5.7 Satisfaction with Current Workplace Development Training on Alcohol and Drugs

Respondents were asked to reflect on the current workplace development training on alcohol and drugs and to say how satisfied there are with it.

Figure 5.8 shows that 44% of all respondents said they are either *'very satisfied'* or *'satisfied'* with the quality of current workforce development training on alcohol and drugs, with 20% either *'dissatisfied'* (19%) or *'very dissatisfied'* (1%).

Figure 5.8: Overall, how satisfied or dissatisfied are you with the quality of current workforce development training on alcohol and drugs? (base=267)



There were a couple of statistically significant differences in response by key respondent groups.

- A higher level of satisfaction among those who said they are experienced in working in the sector (53% vs. 26%);
- A higher level of satisfaction among those who work regionally (Belfast: 48%; Northern: 44%; Southern: 24%; South-Eastern: 50%; Western: 54%; and, Regional: 73%);

Those who were dissatisfied with current workplace development training provision were asked why, with 28% saying that no training has been made available or offered. Similar numbers cited lack of advanced training (15%), a need for more role specific training (15%), and that training is not currently seen as a priority (15%).

Table 5.4: Why are you dissatisfied with current workforce development training on alcohol and drugs? (base=47)

	%	n
No training made available / offered	28	13
Lack of advanced / higher level training	15	7
More role specific training required	15	7
Not seen as a priority - not enough emphasis on alcohol and drug misuse training	15	7
More training on new substances such as legal highs, prescription drug misuse and new drugs coming on to the scene	11	5
Remove barriers to access training - time away from work resulting in build-up of workloads	9	4
More focus and training required on harm reduction and the use of therapeutic tools	9	4
Lack of funding prevents access to certain courses	4	2
There should be more up to date research based substance misuse training	4	2
Limited or no training for statutory services staff	4	2
More evidence based training required - current level of training outdated and insufficient	4	2
More refresher courses required	4	2
Training in NI is patchy with no specific courses to access advocacy and empowerment training to address structural barriers faced by those using substances	2	1
Need to use more external training experts	2	1

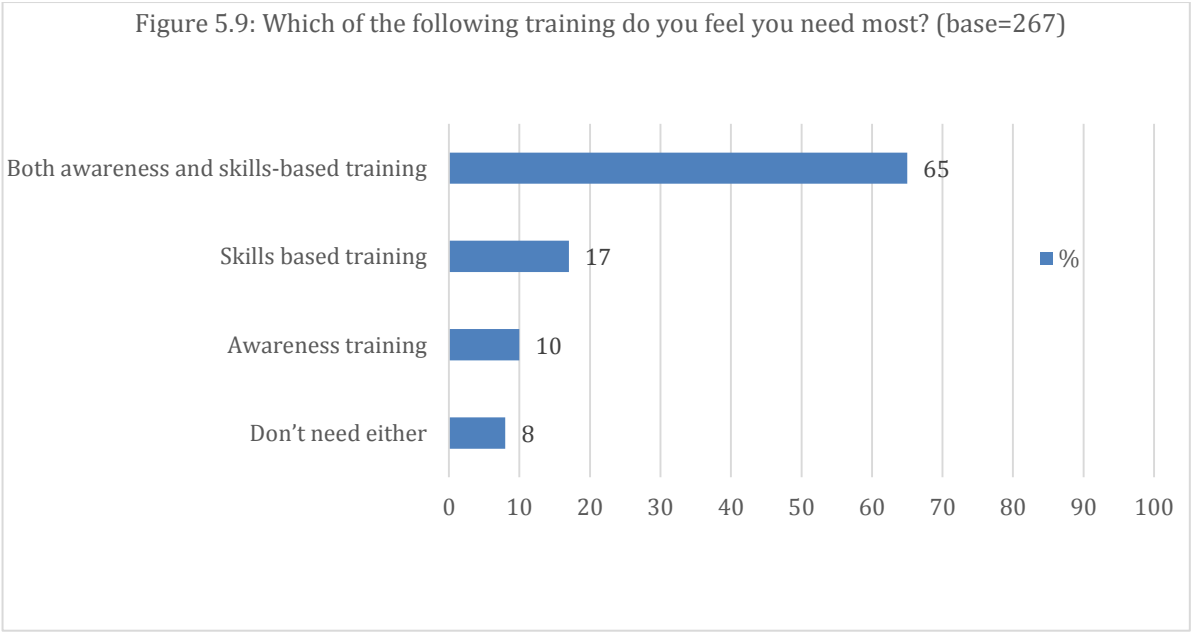
5.8 Current Training Needs

5.8.1 Priority Training Needs

Respondents were invited to say which type of training they need most.

Figure 5.9 shows that approximately two out of three (65%) respondents said they need both awareness and skills-based training, with 17% saying they need skills based training only, 10% awareness training only, and 8% saying they don't need either type of training.

Figure 5.9: Which of the following training do you feel you need most? (base=267)



There were a number of statistically significant differences in response by key respondent groups.

Both Awareness and Skills Training

- Those with direct contact with those presenting with alcohol and drugs issues were more likely to say they need both awareness and skills training (67% vs. 46%);
- Those who spend a moderate amount of their time working directly with those presenting with alcohol and drugs problems were more likely to say they need awareness and skills training (<=20%: 61%; 21%-60%: 74%; and, 61%+: 63%);
- Respondents inexperienced in the sector were more likely to say they need awareness and skills training (73% vs. 60%);

Awareness Training

- Those working with adults were less likely to say they need awareness training (71% vs. 86%);
- Those who spend less time working directly with those presenting with alcohol and drugs problems were more likely to say they need awareness training (<=20%: 81%; 21%-60%: 77%; and, 61%+: 67%);
- Respondents experienced in the sector were less likely to say they need awareness training (66% vs. 90%);
- Those not members of the DACT teams were more likely to say they need awareness training (77% vs. 60%);
- Those based in the South Eastern Trust were less likely to say they need awareness training (Belfast: 66%; Northern: 74%; Southern: 84%; South-Eastern: 53%; Western: 83%; and, Regional: 77%);

Skills Training

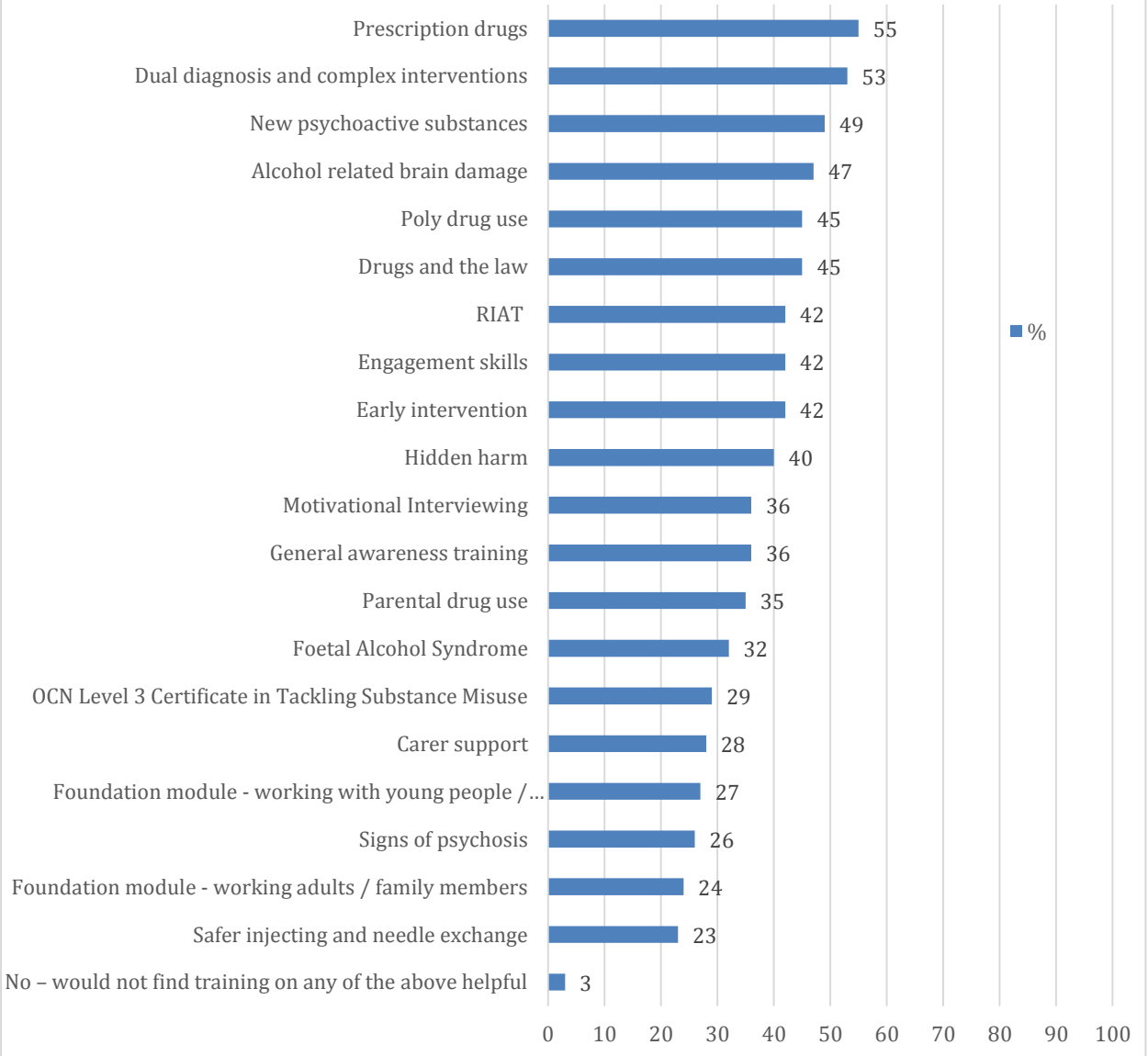
- Those with direct contact with those presenting with alcohol and drugs issues were more likely to say they need skills training (85% vs. 58%);
- Those who spend less time working directly with those presenting with alcohol and drugs problems were less likely to say they need skills training (<=20%: 74%; 21%-60%: 89%; and, 61%+: 87%);

5.8.2 Specific Training Needs

As part of the training needs assessment, the survey was an opportunity for PHA to find out about the specific training needs of those working with or coming into contact with people who misuse substances and what level these needs should be at. Respondents were asked to think about their own training needs and say what would be helpful for them.

Figure 5.10 shows that respondents most commonly said they need training on prescription drugs (55%), dual diagnosis and complex interventions (53%), and in new psychoactive substances (49%).

Figure 5.10: Thinking about your own training needs, please say if you feel you would find training on any of the following helpful. (base=267)



Alcohol related brain damage

- More likely to be cited by those working mainly with adults (mainly with adults: 56%; mainly with children and young people: 38%; equally with adults and children / young people: 42%);
- More likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 36%; 21%-60%: 48%; and, 61%+: 58%);

Carer support

- No significant differences;

Drugs and the law

- Less likely to be cited by those working with adults (41% vs. 57%);

Dual diagnosis and complex interventions

- More likely to be needed by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 36%; 21%-60%: 61%; and, 61%+: 66%);
- More likely to be cited by those saying they are experienced in the sector (64% vs. 33%);
- More likely to be cited by those in a regional role (Belfast:, 61%; Northern: 63%; Southern: 45%; South-Eastern: 44%; Western: 44%; and, Regional: 82%);

Early intervention

- Less likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 47%; 21%-60%: 49%; and, 61%+: 32%);

Engagement skills

- Most likely to be cited by those who spend a moderate amount of time working directly with those presenting with alcohol and drugs problems (<=20%: 40%; 21%-60%: 57%; and, 61%+: 34%);

Foetal Alcohol Syndrome

- More likely to be cited by those working mainly with children and young people (mainly with adults: 25%; mainly with children and young people: 45%; equally with adults and children / young people: 32%);
- More likely to be cited by those saying they are inexperienced in the sector (41% vs. 27%);
- More likely to be cited by those in the Southern Trust (Belfast: 21%; Northern: 22%; Southern: 47%; South-Eastern: 28%; Western:, 24%; and, Regional: 36%);

General awareness training

- More likely to be cited by those who spend less time working directly with those presenting with alcohol and drugs problems (<=20%: 50%; 21%-60%: 38%; and, 61%+: 22%);
- More likely to be cited by those saying they are inexperienced in the sector (54% vs. 26%);
- More likely to be cited by those who are not members of DACTs (40% vs. 14%);
- More likely to be cited by those in the Southern Trust (Belfast: 29%; Northern: 44%; Southern: 52%; South-Eastern: 22%; Western: 24%; and, Regional: 27%);

Hidden harm

- More likely to be cited by those working mainly with children and young people (mainly with adults: 39%; mainly with children and young people: 57%; equally with adults and children / young people: 26%);
- More likely to be cited by those saying they are inexperienced in the sector (51% vs. 34%);
- More likely to be cited by those in the Southern Trust (Belfast: 34%; Northern: 33%; Southern: 55%; South-Eastern: 31%; Western:, 29%; and, Regional: 41%);

Motivational Interviewing

- More likely to be cited by those with direct contact with those presenting with alcohol and drugs related issues (39% vs. 12%);

New psychoactive substances

- Less likely to be cited by those who spend less time working directly with those presenting with alcohol and drugs problems (<=20%: 38%; 21%-60%: 54%; and, 61%+: 57%);
- More likely to be cited by those saying they are experienced in the sector (54% vs. 41%);

Parental drug use

- More likely to be cited by those working with children and young people (41% vs. 27%);
- More likely to be cited by those who spend less time working directly with those presenting with alcohol and drugs problems (<=20%: 46%; 21%-60%: 33%; and, 61%+: 25%);
- More likely to be cited by those saying they are inexperienced in the sector (43% vs. 30%);
- More likely to be cited by those in the Southern Trust (Belfast:, 31%; Northern: 22%; Southern: 51%; South-Eastern: 28%; Western: 17%; and, Regional: 41%);

Poly drug use

- More likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%, 32%; 21%-60%, 46%; and, 61%+, 56%);
- More likely to be cited by those experienced in the sector (50% vs. 35%);

Prescription drugs

- No significant differences;

RIAT (regional initial assessment tool for young people)

- Least likely to be cited by those working mainly with adults (12%) compared with those working mainly with children / young people (36%) and those working equally with adults and children / young people (29%);

Safer injecting and needle exchange

- More likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 16%; 21%-60%: 23%; and, 61%+: 36%);
- More likely to be cited by those saying they are experienced in the sector (33% vs. 13%);
- More likely to be cited by members of DACTs (41% vs. 23%);
- More likely to be cited by those working in a regional role (Belfast: 31%; Northern: 48%; Southern: 13%; South-Eastern: 19%; Western: 15%; and, Regional: 59%);

Signs of psychosis

- More likely to be cited by those with direct contact with those presenting with alcohol and drugs related issues (44% vs. 19%);
- More likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 27%; 21%-60%: 46%; and, 61%+: 53%);
- More likely to be cited by those experienced in the sector (49% vs. 28%);
- More likely to be cited by those working in a regional role (Belfast: 39%; Northern: 41%; Southern: 33%; South-Eastern: 31%; Western:, 56%; and, Regional: 73%);

Foundation module for working with young people and families

- More likely to be cited by those working with children / young people (35% vs. 18%);

Foundation module for working adults and family members

- More likely to be cited by those working with adults (29% vs. 12%);
- More likely to be cited by those who spend more time working directly with those presenting with alcohol and drugs problems (<=20%: 16%; 21%-60%: 25%; and, 61%+: 32%);
- More likely to be cited by those experienced in the sector (29% vs. 16%);

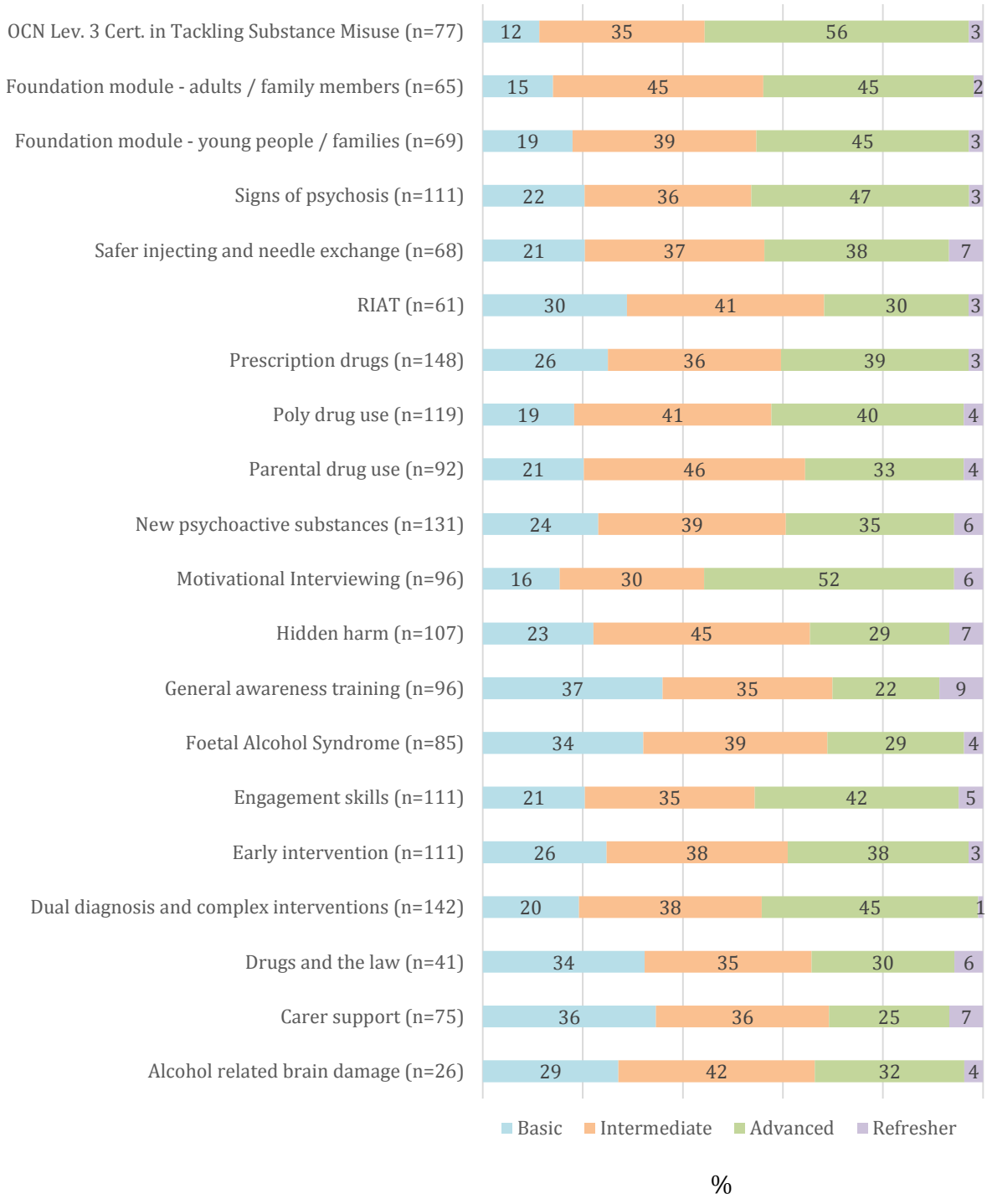
OCN Level 3 Certificate in Tackling Substance Misuse

- More likely to be cited by those with direct contact with those presenting with alcohol and drugs related issues (31% vs. 8%);
- Less likely among those who spend less time working directly with those presenting with alcohol and drugs problems (<=20%: 15%; 21%-60%: 38%; and, 61%+: 37%);
- More likely to be cited by those experienced in the sector (35% vs. 18%);

5.8.3 Specific Training Needs and Level Required

Having identified their specific training needs, respondents were then asked to say what level their training needs should be at. Figure 5.11 shows that for the most common training need (prescription drugs, n=148), 26% said they required basic level training, 36% intermediate level, 39% advanced and 3% at refresher level. A key point however, is that across all training needs, respondents believed that the training should be at either an intermediate or advanced level.

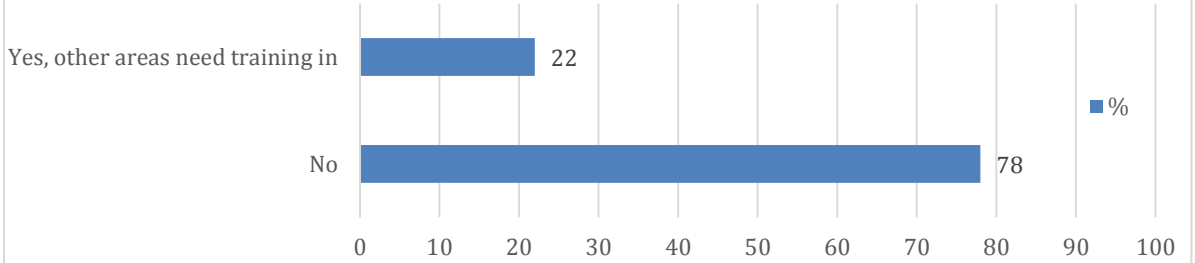
Figure 5.11: Of the different types of training you identified, please say at what level you would need this training to be at? (%)



5.9 Other Training Requirements

Approximately one in five (22%) respondents said they need *'other'* alcohol and drug related training (Figure 5.12).

Figure 5.12: Are there any other alcohol and drugs related areas that you feel you need training in? (base=267)



There with some significant differences between respondent groups:

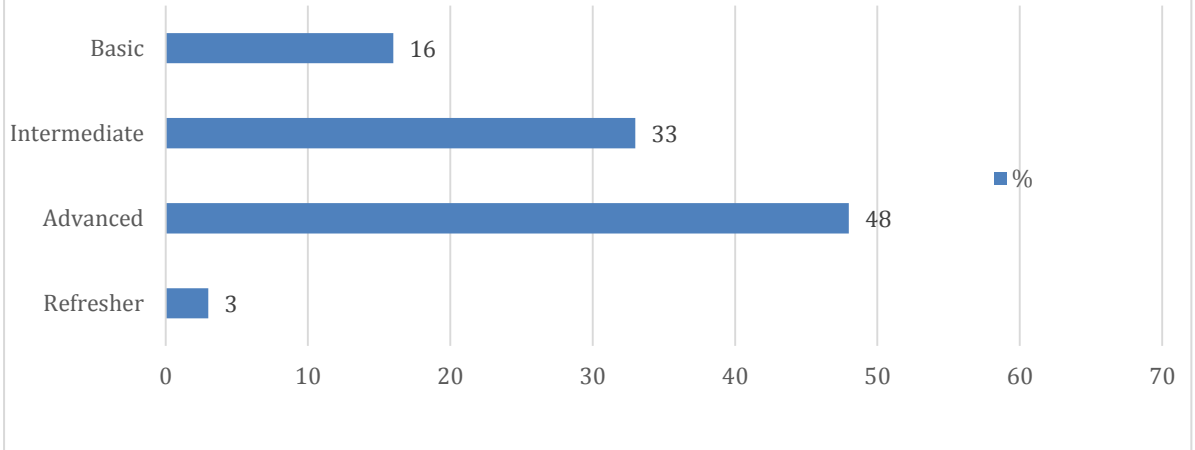
- Those who spend more time working directly with those presenting with alcohol and drugs problems were more likely to say they need additional training (<=20%: 14%; 21%-60%: 16%; and, 61%+: 33%);
- Those who are more experienced in the sector were more likely to say they need additional training (29% vs. 9%);
- Those who work regionally were more likely to say they need additional training (Belfast: 21%; Northern: 37%; Southern: 13%; South-Eastern: 28%; Western:, 12%; and, Regional: 50%);

5.9.1 Specific Additional Training Needs

Respondents were invited to list up to three additional training needs and to say at what level these needs should be at.

Of the 22% (n=58) of respondents identifying additional training needs, a total of 128 suggestions were made of which almost half (48%) were identified as *'advanced'* training needs, 33% as *'intermediate'*, 16% as *'basic'* and 3% as *'refresher'*.

Figure 5.13: Profile of additional training needs (base=58) [note some respondents identified more than one additioanl training need]



Set out below are the key training themes emerging under intermediate and advanced training needs, with the themes consistent. For example, there were calls for training on the impacts of alcohol and drug use on those using drugs as well as their families and broader society. There was also a call for more training on engaging with different stakeholders on the issue including developing communication skills as well as working collaboratively with other parties. Training around the management of drug and alcohol service was also suggested, as well as training and accreditation on dual diagnosis and the interaction of complex mental health issues and drug use.

Listed in Tables 5.5 to 5.8 are verbatim lists of suggested additional training needs by the level required *(please note that some respondents listed the level that they needed additional training at but did not specify the actual training need)*.

Additional Basic Training Needs

Table 5.5: Additional ***basic*** training needs cited
Brief advice and brief intervention across the workforce
Early stages of Korskoffs
Effective conversations
Hidden harm awareness across the workforce
Prescription drugs
Steroid use

Additional Intermediate Training Needs

In relation to intermediate training needs the key themes to emerge included training on (Table 5.6):

- the impacts of alcohol and drug use on individuals, families society etc, including access to services;
- engaging with service users in terms of recovery, safe withdrawal, education, etc.;
- issues around clinical management (e.g. assessment, education, harm reduction, engaging with service users, therapeutic approaches, etc.); and,
- complex needs (e.g. homelessness, learning disability and trauma).

Table 5.6: Additional ***intermediate*** training needs cited
Assessment models
Better understanding of how to access specific addiction services
CBT
Detox management
Effects
Engaging service users
Foetal development
Functioning drug misuse
Harm reduction (X 2)
Harm reduction assessment and implementation - Alcohol
Hidden harm
Homelessness/housing and connection with D&A use
Impact of alcohol on society and drugs
Impact of long term use of drugs/alcohol on parents
Learning Disability and Drugs / Alcohol misuse
Long term effects of alcohol misuse
Recovery models
Safe withdrawal from illicit drugs and alcohol
Solution focussed therapy
Suicide and self-harm
Supporting family members where there is substance misuse
Systemic family therapy
The knowledge to education for client and family
Trauma and its links with drug misuse
What testing is accurate to detect different drugs/alcohol

Additional Advanced Training Needs

In relation to intermediate training needs the key themes to emerge included training on (Table 5.7):

- Dual diagnosis, assessment and screening including accreditation, including advanced courses, complex mental health needs and drug use, motivational interviewing;
- Engagement, advocacy and liaison, developing communication skills and collaborative working;
- Harm reduction and recovery from addiction and prevention;
- Audit and research;
- Management of drug and alcohol services, opiate treatment services, training for trainers; and,
- Working with children and young people.

Table 5.7: Additional ***advanced*** training needs cited
Accreditation / certification for interventions workers (not counselling)
Accredited post graduate training including theory, interventions and evidence based practice
Addiction and trauma
Advanced courses on addiction, as previously supplied by Leeds
Advanced dual diagnosis.
Advocacy & liaison with input from substance user interest groups (e.g. INPUD)
After care
Alcohol
Alcohol and drugs and working with ADS young people
Alcohol and drugs and working with young people with ADHD
All types of Drug Overdose
Assessment and screening of substance misuse
Audit and research
Collaborative working within the sector
Communication skills and how best to encourage engagement
Complex Mental health issues and how substances effect those using.
Drug administration route transitions
Drugs and alcohol
Dual diagnosis (X 3)
Dual diagnosis response
Dual diagnosis with accreditation
First Aid training for service users under the influence of substances
Harm reduction & recovery from addiction
Harm reduction techniques
Heroin (X2)
Identifying signs that a parent is under the influence of a substance
Intervention
Managing Drug and Alcohol Services
Mental health and substance use
Mental health young people
Motivational interviewing (X 3)
Non-medical prescribing
Opiate Treatment services
Pregabalin
Pregabalin misuse and changing drug trends
Prescription medication and how it interacts with the person.
Prevention
Psychosis in drug misuse
Responding to the trauma - underlying issues
Social behaviour network therapy
Substance use and the Mental Capacity Act
Tackling substance misuse
Training for Trainers who Train Others to Train in Naloxone use/ Over-dose
Trauma informed interventions
Trauma skills training
Understanding addiction
Working creatively with children & YP
Working with challenging behavioural characteristics (personality disorder) and addiction
Working with children Hidden Harm
Working with substance users with depression / anxiety

Additional Refresher Training Needs

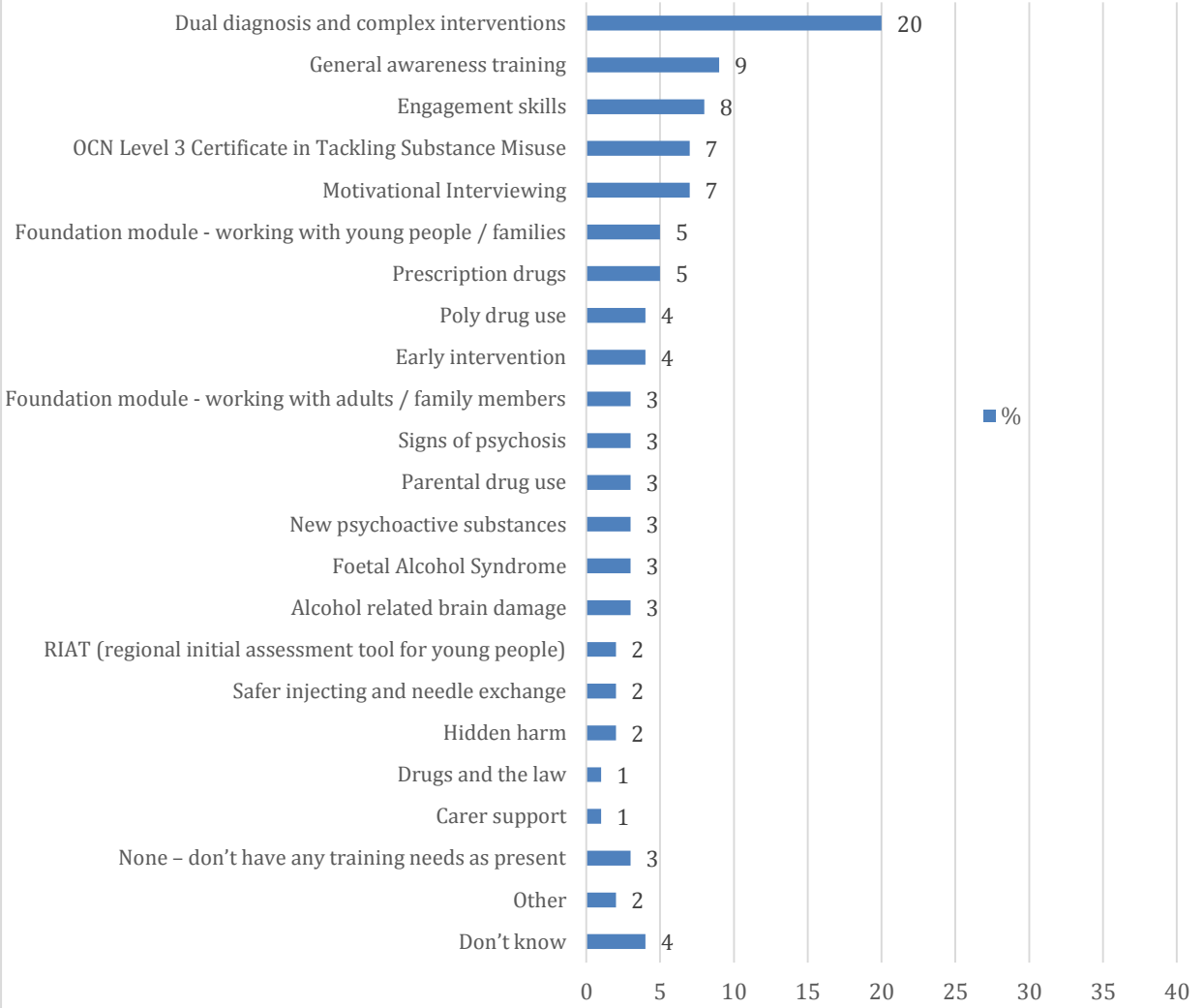
Table 5.8: Additional ***refresher*** training needs cited
Cross addiction
Recovery principles
Drugs and the law

5.9.2 Main Priority for Additional Training Need

Respondents were asked to think about their own training needs and to say which training need is a priority for them personally.

Figure 5.18 shows that one in five (20%) identified dual diagnosis and complex interventions as their priority training need, with general awareness training cited by 9% of respondents.

Figure 5.18: Again, thinking about your own needs, which area is the ***main priority for you personally?*** (base=267)



There were some statistically significant differences between respondent groups.

- Respondents with direct contact with those presenting with alcohol and drugs related issues more likely to identify dual diagnosis and complex interventions as a training need (21% vs. 8%);
- Those working with children and young people were more likely to identify the foundation module for working with young people and children (9% vs. 0%) as well as general awareness training (11% vs. 6%);

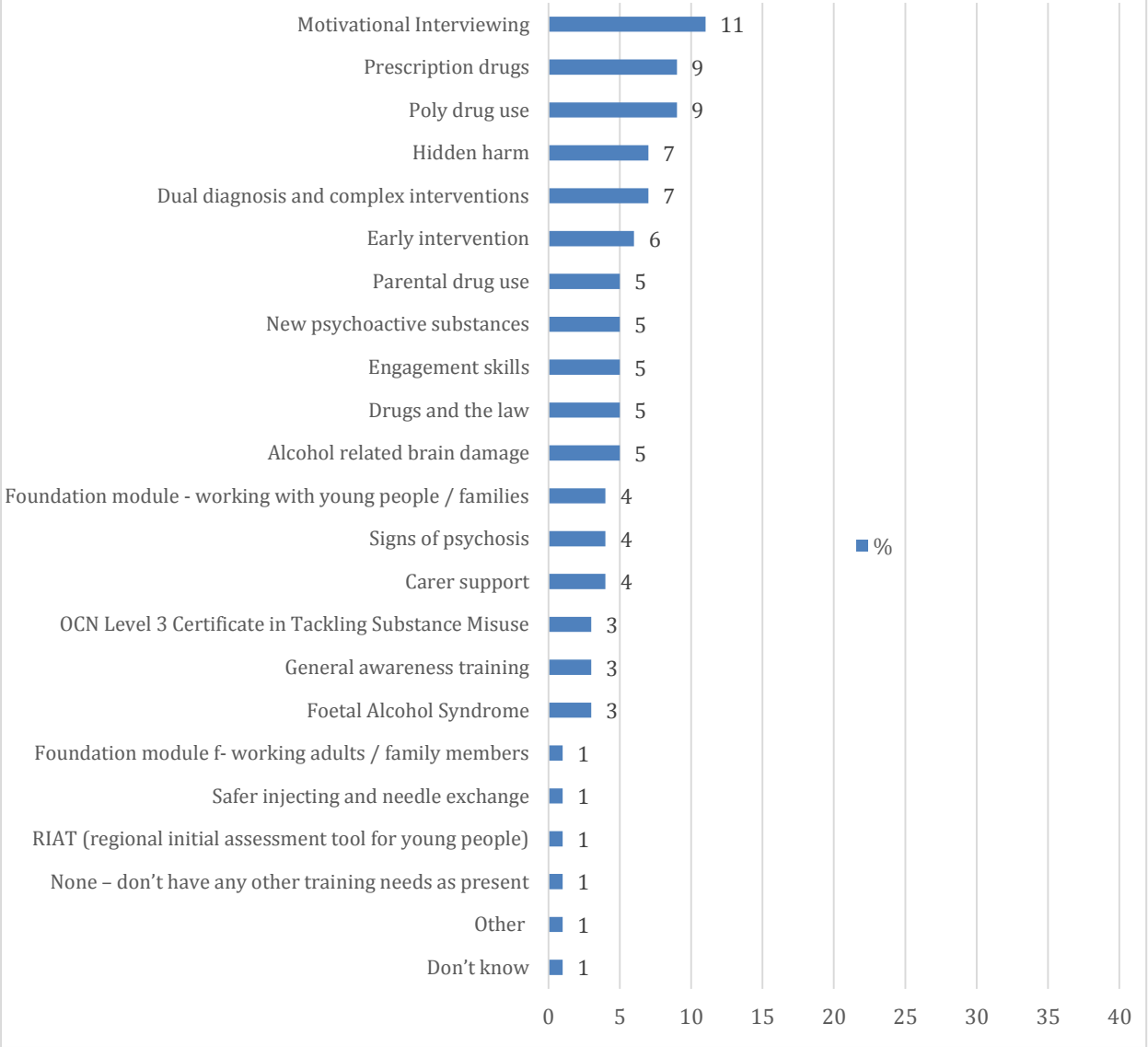
- Those spending more of their time working directly with those presenting with alcohol and drugs related issues were more likely to list dual diagnosis and complex interventions as a training need (<=20%: 6%; 21%-60%: 20%; and, 61%+: 32%), with this group also more likely to list poly drug use (<=20%: 1%; 21%-60%: 0%; and, 61%+: 9%);

- Those more experienced in the sector were more likely to identify dual diagnosis and complex interventions as a training need (28% vs. 5%), with those who said they are inexperienced in the sector more likely to cite general awareness training (20% vs. 2%).

5.9.3 Second Priority for Additional Training Need

Figure 5.19 shows that 11% identified motivational interviewing as their second biggest priority in terms of training need, with prescription and poly drug use listed by 9% of respondents respectively.

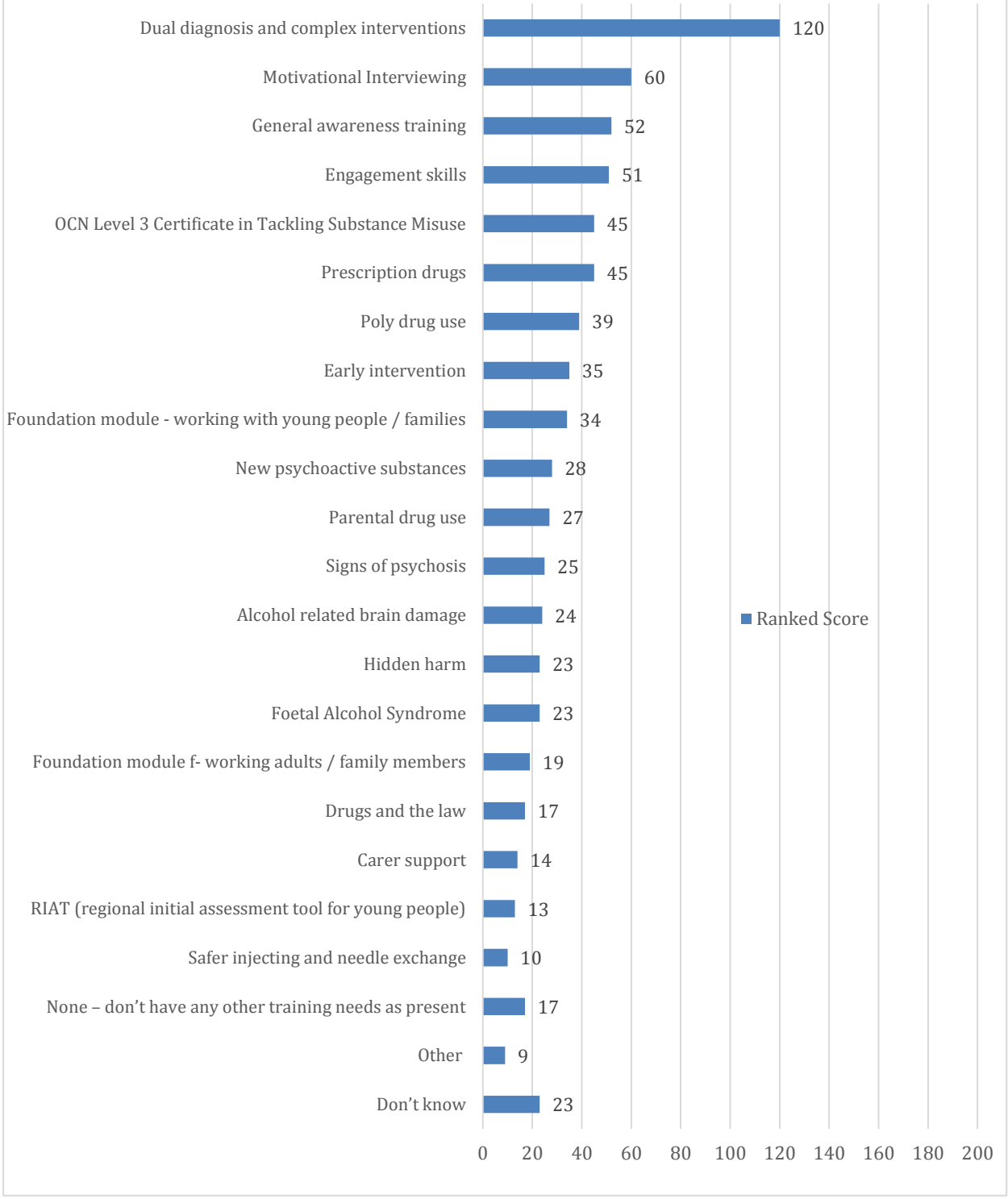
Figure 5.19: Again, thinking about your own needs, which area is the ***second biggest priority for you personally?*** (base=267)



5.9.4 Ranked Priority Training Need

Figure 5.20 presents an overview of the weighted ranked priorities in terms of training needs. Each item ranked first was given a weight of 2 with items ranked second given a weight of 1. Combing both weighted scores shows that dual diagnosis is the training need ranked highest using this method, with motivational interviewing ranked second highest, general awareness training ranked third highest and so on.

Figure 5.20: Ranked priority training needs (base=267)

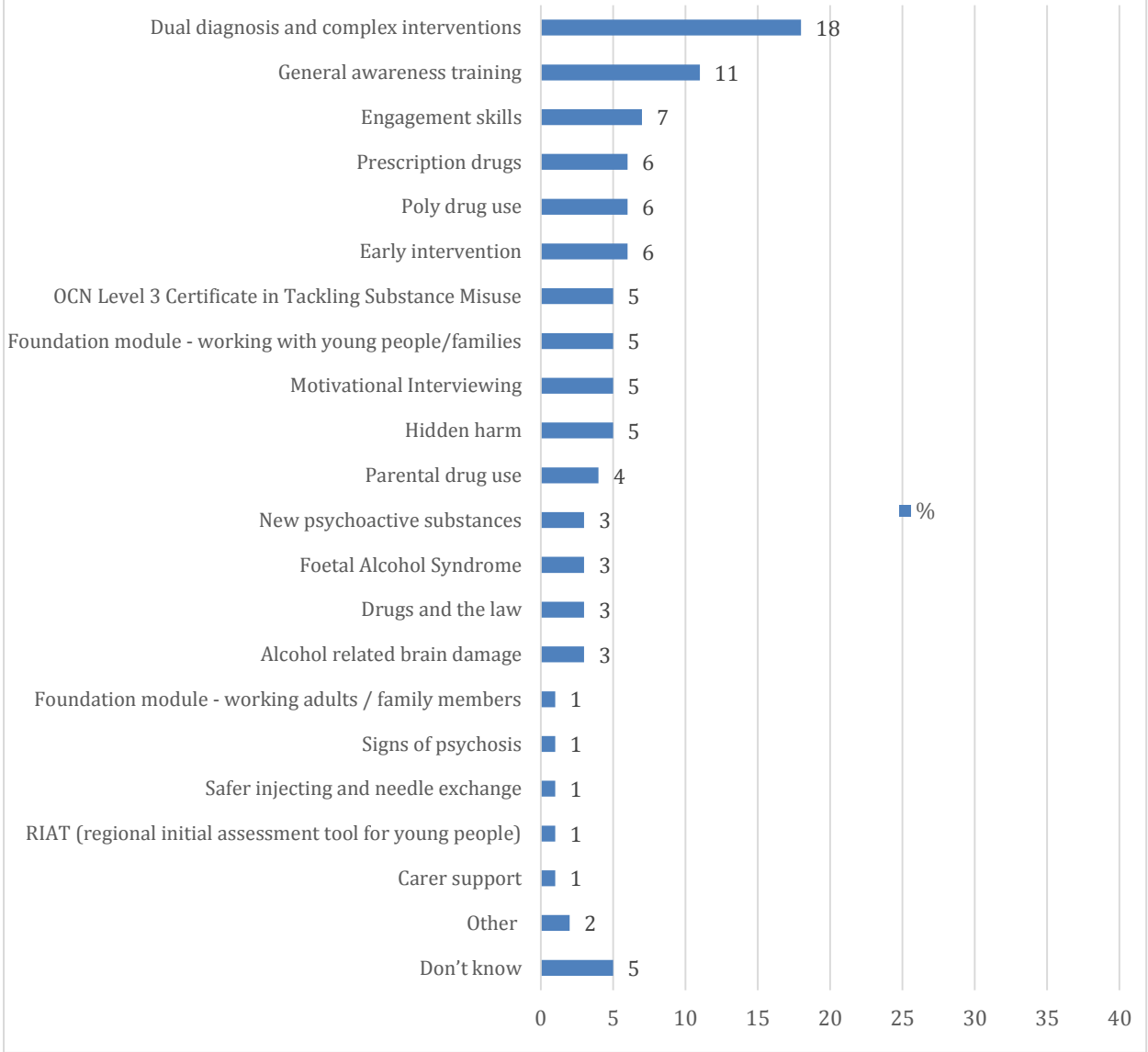


5.9.5 Priority Training Need within Sector

Respondents were asked to think about the sector they work in and say what they feel is the main training need at present.

Figure 5.21 shows that respondents most commonly said that dual diagnosis (18%), and general awareness training (11%), were the main training needs at present.

Figure 5.21: Thinking about ***the sector you work in***, what do you feel is the ***main training need*** at present? (base=267)



There were some statistically significant differences between respondent groups.

- Those working with children and young people were more likely to identify general awareness training (15% vs. 7%), and the foundation module for working with young people and children (9% vs. 0%), as the main training needs in their sector;
- Those spending more of their time working directly with those presenting with alcohol and drugs related issues were more likely to list dual diagnosis and complex interventions (<=20%: 10%; 21%-60%: 18%; and, 61%+: 27%), and poly drug use (<=20%: 2%; 21%-60%: 2%; and, 61%+:, 11%), as the main training needs in their sector;

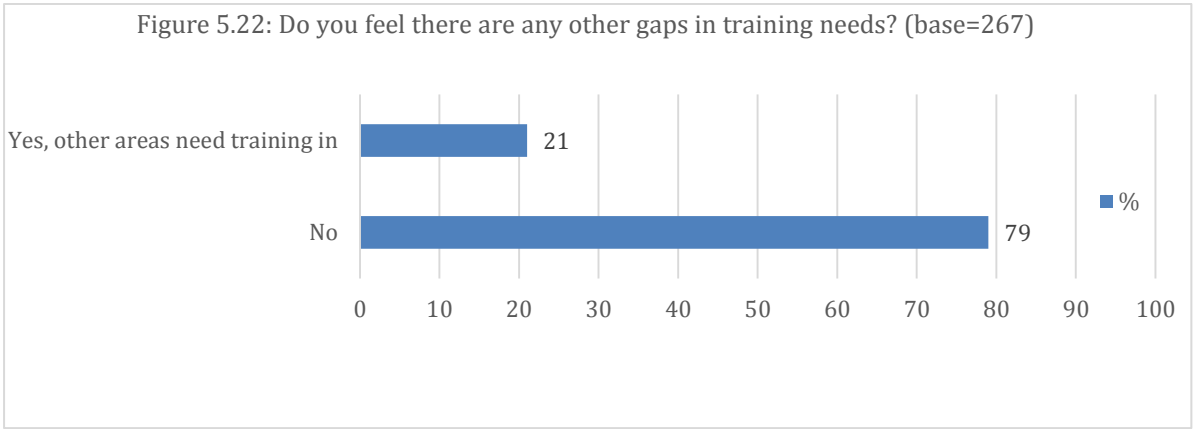
- Those more experienced in the sector were more likely to identify dual diagnosis and complex interventions (23% vs. 9%) as the main training need in their sector, with those who said they are inexperienced more likely to cite general awareness training (19% vs. 7%) as the main training need;

- Those working in regional roles were more likely to say that dual diagnosis and complex interventions is the main training need in their sector (Belfast: 21%; Northern: 33%; Southern: 6%; South-Eastern: 25%; Western:, 10%; and, Regional:, 45%), with the same true for poly drug use (Belfast: 5%; Northern: 4%; Southern:, 1%; South-Eastern: 0%; Western: 15%; and, Regional: 18%);

5.9.6 Other Gaps In Training Needs

Approximately one in five (21%) respondents said there are other alcohol and drug related training needs (Figure 5.22) *[note that there were no statistically significant differences in response to this question by any of the key respondent background characteristics]*.

Figure 5.22: Do you feel there are any other gaps in training needs? (base=267)



Respondents who felt there were gaps in training needs were asked to say briefly where they believed the gaps to be. These responses (n=49) are listed on a verbatim basis below:

The key themes highlighted by respondents included ***a call for a more progressive training programme*** with a greater focus on skills and accreditation (particularly integrating accreditation with existing educational courses) including refresher courses.

There was also a call for more training on working with substance use and co-occurring mental health and problems associated with trauma ***(dual diagnosis),*** with a call for this type of training to be specific to young people, those with ASD and other behaviour and learning difficulties.

The importance of further training on ***engaging and interacting with families*** and providing appropriate family support was also highlighted. A specific need is training around parental drug use and child protection was also mentioned.

Training on ***specific interventions*** was also cited with areas identified including: conflict management; telephone Interventions; relapse prevention; personality disorder traits; the use of technology to engage specific groups; Naxalone; motivational interviewing; and, giving brief advice and support.

Training to ***develop knowledge*** such as how drugs and alcohol can impact on mental health including understanding of what drug use looks like in working environments as well as providing information on drugs and alcohol (e.g. impacts on the unborn, emotional wellbeing of young people, etc.).

A further theme to emerge is that ***training should be specific to staff groups*** and settings (e.g. nursing staff, community sector, voluntary sector and other key staffing groups). These staffing groups provide opportunities for significant intervention within their working environments.

- **structured teaching on developing systems for Service user involvement - developing partnerships with SU's *Accredited courses for Service users - developing 'employment opportunity' awards for people who want to progress into paid employment in this field *Accredited courses - learning opportunities with awards that add to academic 'points' based systems i.e. Towards degrees, foundations etc - important for volunteers, new entry workers, 'addiction specialism unqualified' workers*
- *Accredited formal training that can lead to enhanced practice and personal development*
- *Adolescent mental health needs*
- *Again, as previously stated this area changes all the time. There is a need for regular refresher training in this area. Particularly in a worker being skilled and confident to identify when a parent is misusing substances but denying the same.*
- *Assessment and screening for substance misuse and dual diagnosis*
- *Availability of sessions*
- *Children affected by domestic violence and substance misuse in the home are then having to have contact with the perpetrator without prior intervention around understanding what happened. Some sort of counselling or preparation for the children.*
- *Community training is very missed and needed*
- *Conflict management. Telephone Interventions. Relapse Prevention. Prevention training. Alcohol and Drugs: Exploitation / Homelessness / Suicide*
- *DBT as majority of service users present with personality disorder traits*
- *Direct skills to teach and apply with patients*
- *Harm reduction, understanding 12 step recovery, understanding addiction and recovery from addiction. Dual diagnosis all. Every client I am seeing at present is using both alcohol, illegal and legal drugs.*
- *How drug and alcohol affect your mental health*
- *I always feel there is room for improvement Offering accreditation for courses helps Dual Diagnosis training advanced level*
- *I believe training on drugs and alcohol abuse in young people with ASD and other behaviour and learning difficulties.*
- *I feel some of the training is good but again some is very basic and I think there needs to be a differentiation level in terms of basic, intermediate and advanced in each area. Also, for voluntary sector it should be accessible for all workers as often there are cost implications which can determine whether or not you get on the training course.*
- *I feel that the training at times can be generic and almost a brief overview. As we are dealing with complex cases we need to be aware and have a greater in depth of knowledge in order to support our clients properly.*
- *I feel there is a gap in training for family support and how families are affected by drugs/alcohol misuse.*
- *I have noticed a lot of the young people we deal with its not the parents who are dealing with them but they are living with Grandparents who find it very difficult to understand substance misuse and everything that goes with it.*

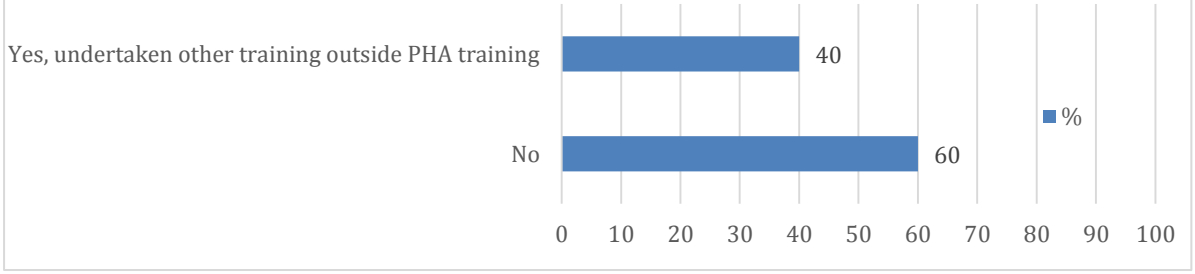
- *Innovative services – e.g. equine therapy How best to use technology to engage different populations Importance of family engagement How best to work with other services to deliver broad-based treatment as research indicates this is the most successful Icelandic model Using the great outdoors Holistic approach - working with the WHOLE person Importance of Adverse Childhood Experiences*
- *Intensive skills based workshops*
- *It's great when working with substance abuse to be aware of the substances available and know signs and symptoms, effects and outcomes, but I feel it's more important to actively engage and distract users, counselling services with realistic timeframes and continuity of care, accessible locations and joint communication between all professionals, to show the person they are supported and there are more positive ways to utilise their lives, give them a positive outlook therefore they can be empowered to take control of their own issues and build their confidence and self-esteem.*
- *Limited support for Stat Staff. GP engagement Develop other clinicians/professional's roles in Addictions*
- *Lots drug mental health interventions support for workers and rights. Investing in evidence based practices*
- *LSD and hallucinations*
- *Mental health and personality disorders*
- *Mental health/ trauma and alcohol/ substance misuse*
- *More experience needed with alcohol issues*
- *More knowledge on substance misuse and what this looks like in day to day work*
- *More skills based training*
- *More up to date training on all areas of drug use and overdose*
- *Motivational interviewing Chronic Drug use*
- *Naloxone training and delivery, although we provide it ,some staff still haven't got it*
- *Not enough*
- *Prevention More Family intervention based training*
- *Progression pathway from knowledge based to skills based courses, basic to intermediate and advanced levels. Some basic training could be provided online. Training could be more responsive to changing needs. Tools or training to support organisations to identify workforce training needs*
- *Referral Pathways between community and statutory sectors*
- *Risk assessment and interventions re parental drug misuse and child protection, i.e. Hidden harm at an advanced level*
- *Social reintegration*
- *The Trust I work in does not encourage /facilitate staff development*
- *Training for nursing staff caring for young people presenting with alcohol misuse to children's and young people's unit*
- *Training offered needs to accommodate a whole range of levels of knowledge, skills and expertise and would be more beneficial to be offered as tiered programmes i.e. Foundation, intermediate and advanced so that it can be more relevant and beneficial to those attending. More funding is needed for training and development needs to ensure that all practitioners willing and eager to progress their knowledge and skills have the opportunities to do so.*

- *Training to be more accessible i.e. Closer to the Derry area.*
- *Trauma , brief advice giving (across the wider work force) Hidden Harm across the work force*
- *Trauma informed interventions and issues related to childhood attachment and mental health.*
- *What works to break the addiction cycle? We can maybe understand impact, reason for addiction, what it looks like, impact on families but what can we do about it. Strategies of for engaging families to bring about change*
- *With prescription abuse*
- *Would like more information on drugs. Effects on mother and her unborn baby. I would like educated on the types of drugs that are out there.*
- *Young people comorbidity/substance misuse. Impact of substances misuse on brain development/ emotional development in young people.*

5.10 Undertaken Other Training outside of PHA's Workplace Development Training

Figure 5.23 shows that 40% of respondents had undertaken other training on substance misuse outside of the PHA's current workplace development programme.

Figure 5.23: Have you undertaken any other training on substance misuse outside of the PHA's current workplace training programme? (base=267)



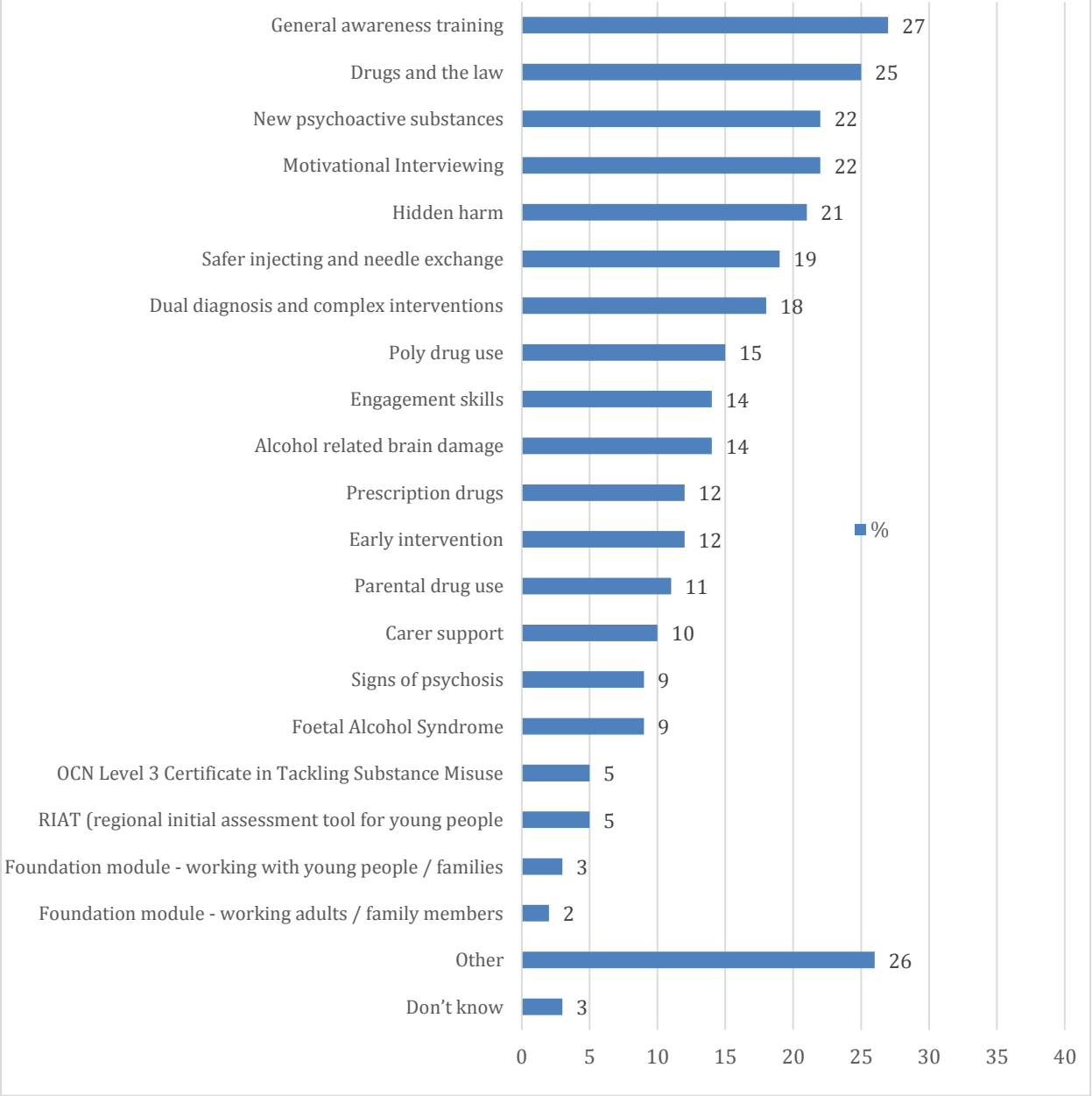
There were some statistically significant differences between respondent groups.

- Those spending more of their time working directly with those presenting with alcohol and drugs related issues were more likely to have undertaken other training on substance misuse outside of PHA provided training (<=20%:, 32%; 21%-60%:, 38%; and, 61%+: 49%);
- Those more experienced in the sector were more likely to have undertaken other training on substance misuse outside of PHA provided training (49% vs. 23%);
- Those who work in the Southern Trust were less likely to have undertaken other training on substance misuse outside of PHA provided training (Belfast: 44%; Northern: 52%; Southern: 21%; South-Eastern: 59%; Western: 44%; and, Regional:, 50%);

5.10.1 Other Types of Workplace Development Training Undertaken

Amongst those who had undertaken other *(non PHA)* training (n=106), general awareness training was most common (27%), followed by drugs and the law (25%), training on new psychoactive substances (22%), and training on motivational interviewing (22%). Twenty-six percent cited other training[8].

Figure 5.24: Other training undertaken outside of PHA workplace development training (base=106)



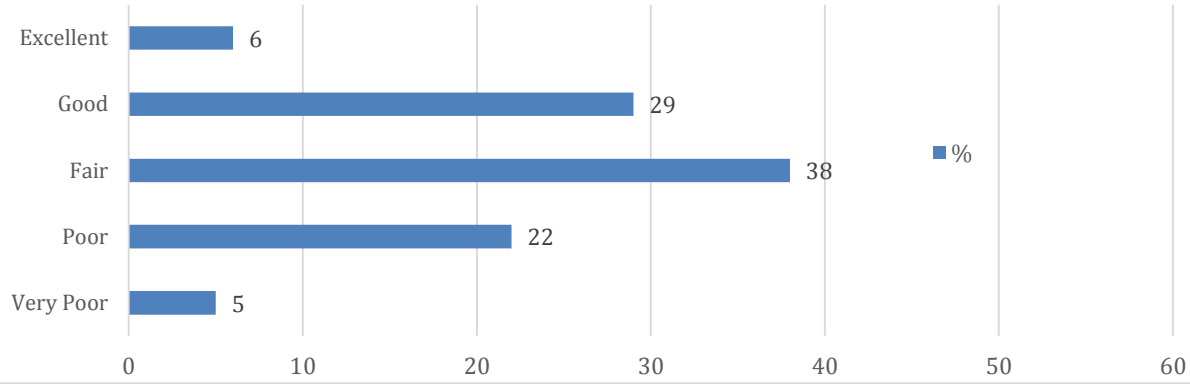
[8] Included: 5 step method (n=1); child protection / risk management (n=1); Derry Healthy Living (n=1); distance learning on substance misuse (n=1); Icelandic Model of prevention (n=1); effective prevention (n=1); harm reduction (n=2); family therapy systemic practice (n=1); L2 modules on alcohol and counselling (n=1); L2 understanding substance misuse (n=1); MBRP (n=1); Trauma and Addiction (n=3); Assessment Skills (n=1); Mental health first aid (n=2); working with interpreters (n=1); Naloxone administration (n=2); Opioids (n=1); relapse prevention (n=1); substitute prescribing (n=1); addiction from a psychodynamic perspective (n=1).

5.11 Awareness, and Accessibility and Communication of Workplace Training Opportunities

5.11.1 Awareness of Current Workplace Training Opportunities on Alcohol and Drugs

Approximately one in three (35%) rated their awareness of current workplace training availability as either *'excellent'* (6%) or *'good'* (29%), with 38% rating their awareness as *'fair'* and 27% as either *'poor'* (22%) or *'very poor'* (5%).

Figure 5.25: How would you rate your awareness of what current workplace training opportunities are currently available on alcohol and drugs? (base=279)



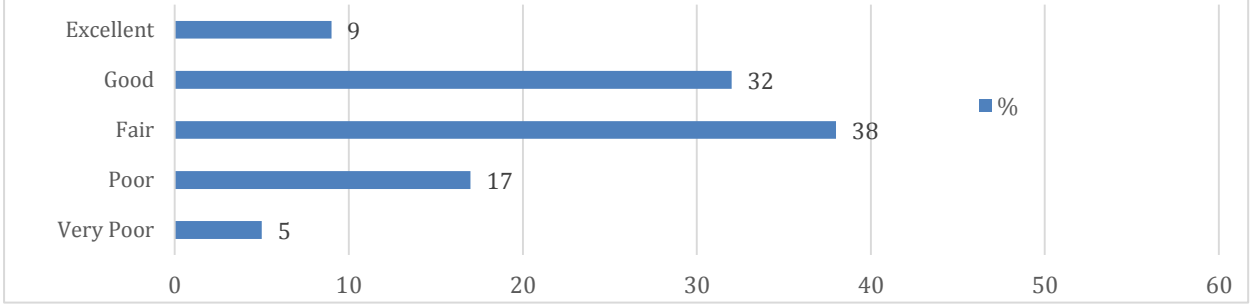
There were some statistically significant differences between respondent groups.

- Those working with children and young people were more likely to rate their awareness of current workplace development training opportunities as either poor or very poor (34% vs. 20%);
- Those spending less of their time working directly with those presenting with alcohol and drugs related issues were more likely to rate their awareness as either poor or very poor (<=20%: 34%; 21%-60%: 28%; and, 61%+: 21%);
- Those more experienced in the sector were more likely to rate their awareness as either excellent or good (44% vs. 19%);
- Members of DACTs were more likely to rate their awareness as either excellent or good (52% vs. 32%);
- Those working in regional roles were more likely rate their awareness as either excellent or good (Belfast: 32%; Northern: 37%; Southern: 29%; South-Eastern: 28%; Western: 46%; and, Regional: 55%);

5.11.2 Quality of Information or Communications on Alcohol and Drug Related Training Courses

Approximately four out of ten (41%) respondents rated the quality of the information or communications they get on alcohol and drug-related training courses as either *'excellent'* (9%) or *'good'* (32%), with 38% rating the quality as *'fair'* and 22% as either *'poor'* (17%) or *'very poor'* (5%).

Figure 5.26: How would you rate the quality of the information or communications you get on alcohol and drug-related training courses (i.e. are the objectives of the training clear)? (base=279)



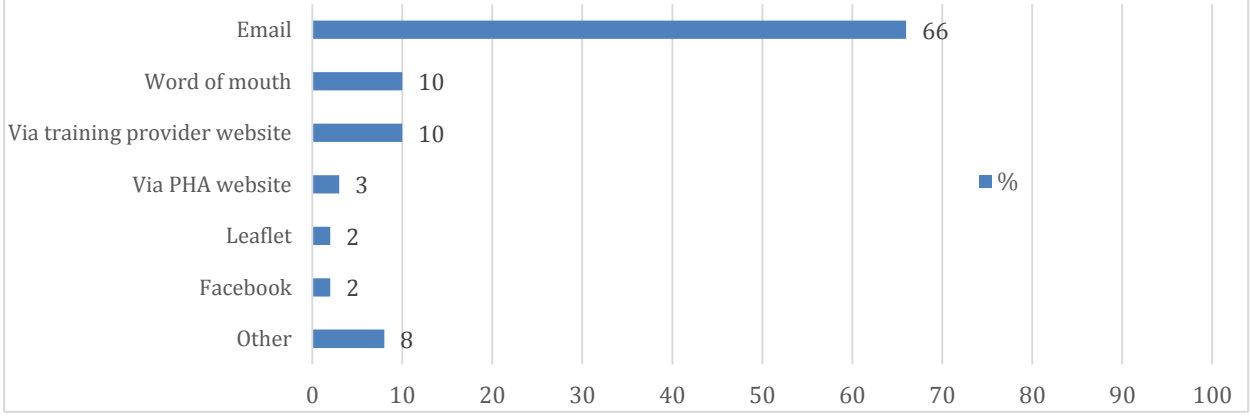
There were some statistically significant differences between respondent groups.

- Those more experienced in the sector were more likely to rate the quality of information and communications they get on alcohol and drugs related training courses as either excellent or good (50% vs. 27%);
- Those working in in the Southern Trust area were more likely to rate the quality of information and communications they get on alcohol and drugs related training courses as either 'poor' or 'very poor' (Belfast: 21%; Northern: 7%; Southern: 37%; South-Eastern: 9%; Western: 12%; and, Regional: 9%);

5.11.3 Sources of Awareness of Training on Alcohol and Drugs

Respondents were asked how they normally find out about training on alcohol and drugs, with most (66%) respondents doing so by email. Of the sources listed, word of mouth (10%) and via a training provider website (10%), were the next most common.

Figure 5.27: How do you normally find out about training on alcohol and drugs? (base=279)

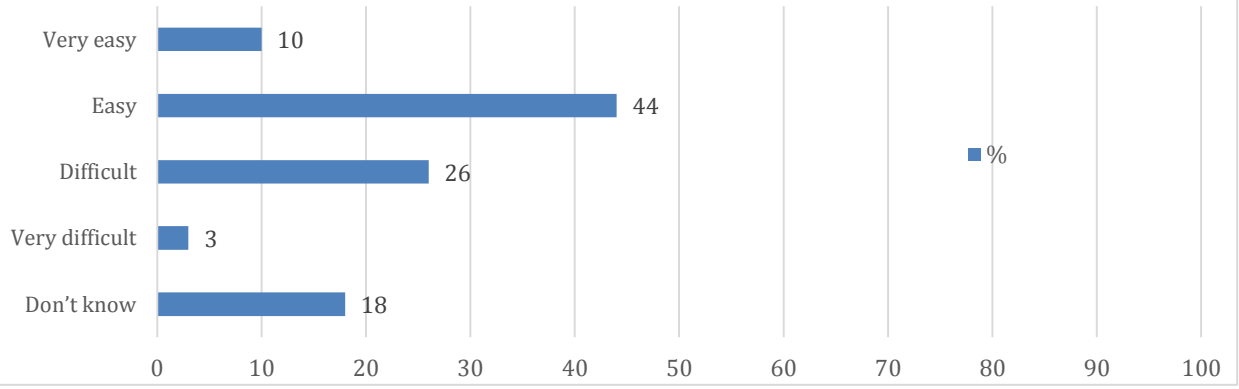


There was one statistically significant difference, with members of DACTs more likely to find out about courses via email (88% vs. 62%).

5.11.4 Difficulty in Finding Out about Current Workplace Training on Alcohol and Drugs

Respondents were asked how easy or difficult it is to find out about current workplace training on alcohol and drugs, with just over half (54%) finding it either *'very easy'* (10%) or *'easy'* (44%) and 29% finding it either *'difficult'* (26%) or *'very difficult'* (3%).

Figure 5.28: How easy or difficult is it to find out about current workplace training on alcohol and drugs? (base=279)



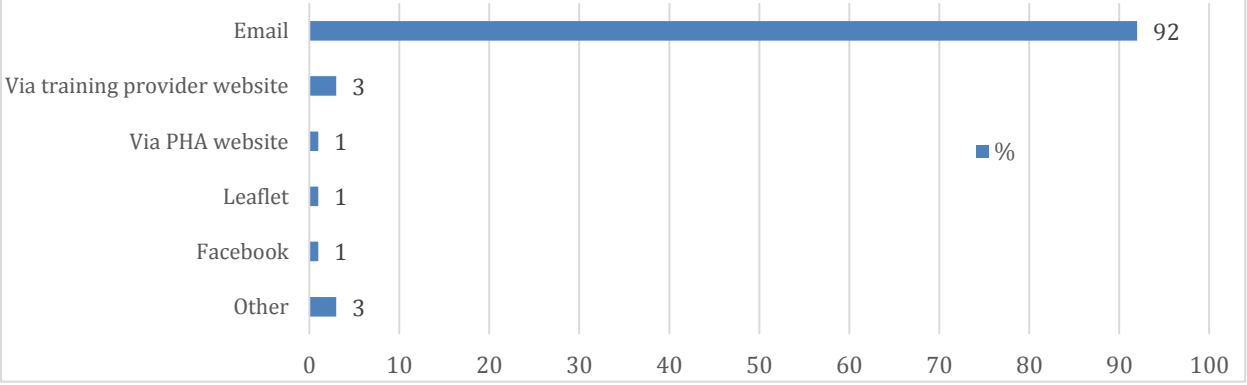
There were some statistically significant differences between respondent groups.

- Those more experienced in the sector were more likely to say they find it very easy or easy to find about current workplace development training on alcohol and drugs (61% vs. 41%);
- Members of DACTs were more likely to say they find it very easy or easy to find about current workplace development training on alcohol and drugs (86% vs. 48%);

5.11.5 Preferred Way to Find Out about Workplace Training Opportunities

More than nine out of ten (92%) respondents said that email is the best way for them to find out about workplace training opportunities on alcohol and drugs in their sector[9].

Figure 5.29: What is the best way of letting you know about workplace training opportunities on alcohol and drugs in your sector? (base=279)



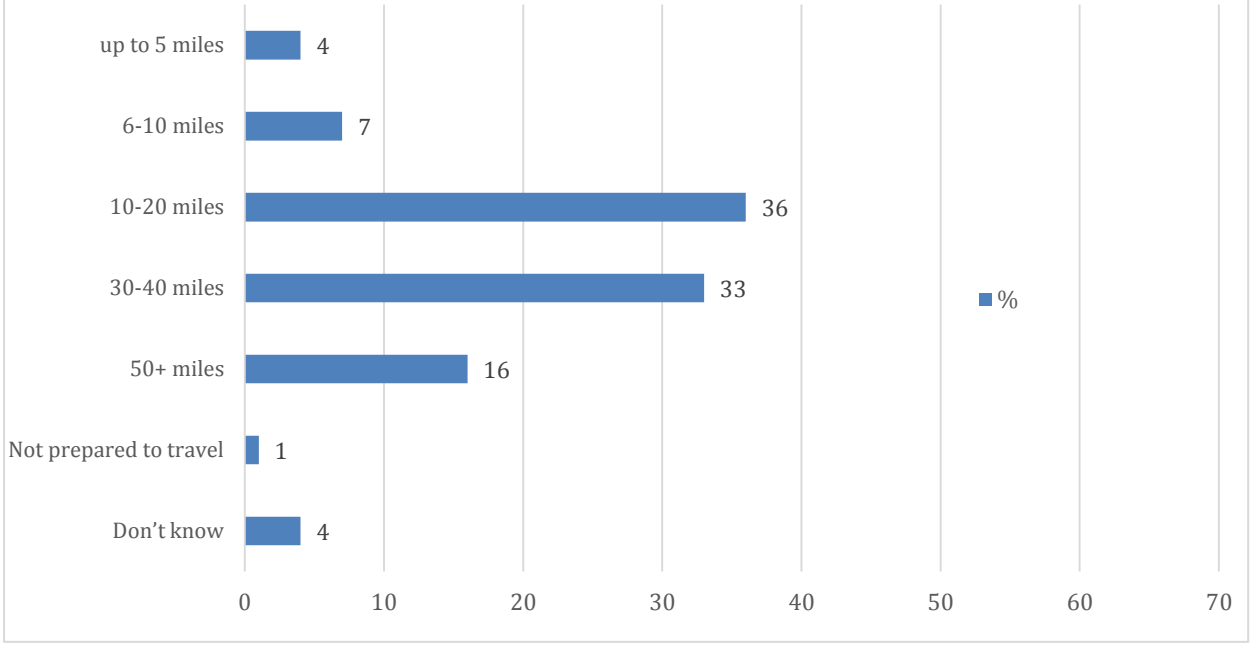
[9] Other sources included: a moderated forum promoting training updates, analysing needs and developing responses (n=1); communityni website (n=1); intranet (n=1); marketing via email but would be useful to have one website containing details of all training (n=1); via BHSCT – Beeches (n=1) and, Trust training system (n=1).

5.11.6 Distance Prepared to Travel to Training Courses

Respondents were asked how far they would be prepared to travel to training courses on alcohol and drugs.

Figure 5.30 shows that 36% said they would be prepared to travel between 10-20 miles to training courses on alcohol and drugs, with one in three (33%) prepared to travel between 30-40 miles. Almost half (49%) of respondents said they would be prepared to travel at least 30 miles.

Figure 5.30: How far are you prepared to travel to training courses on alcohol and drugs? (base=279)



There were some statistically significant differences between respondent groups.

- Those more experienced in the sector were more likely to say they would be prepared to travel 30 miles+ to avail of training (57% vs. 35%);
- Members of DACTs were more likely to say they would be prepared to travel 30 miles+ to avail of training (76% vs. 44%);
- Those working in regional roles were more likely to say they would be prepared to travel 30 miles+ to avail of training (Belfast: 29%; Northern: 56%; Southern: 51%; South-Eastern: 39%; Western: 61%; and, Regional: 82%);

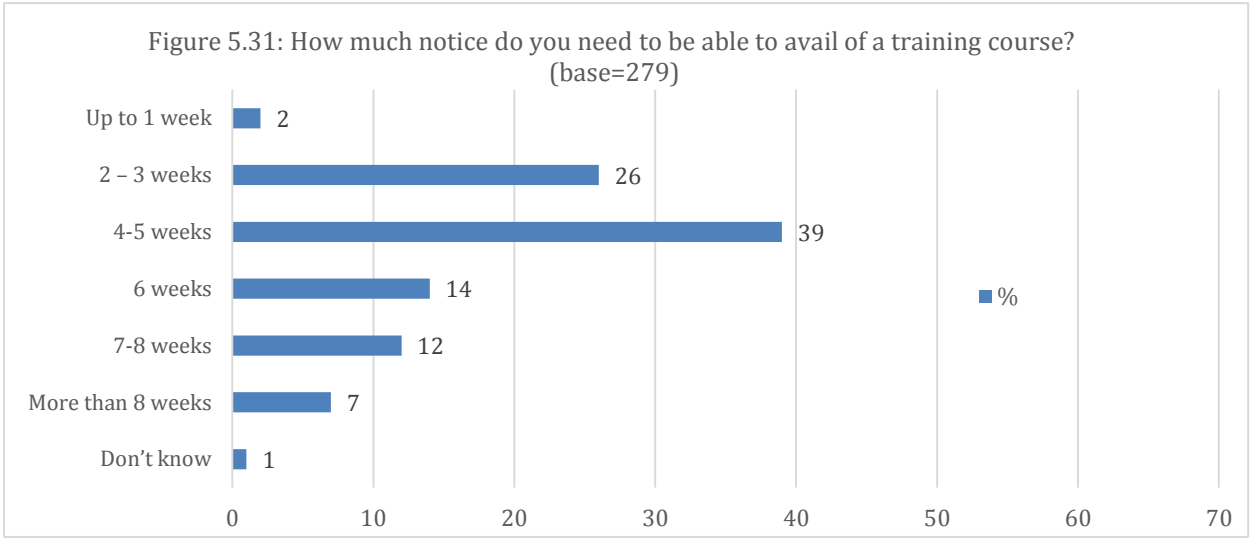
5.11.7 Amount of Notice Required to Avail of Training Courses on Alcohol and Drugs

Respondents were asked to say how much notice they would need to avail of training courses on alcohol and drugs.

Figure 5.31 shows that respondents most commonly said they would need 4 - 5 weeks' notice (39%), with 26% saying they would need 2-3 weeks' notice. One in three (33%) said they would need at least 6 weeks' notice.

For the purposes of subgroup analysis this respondents were categorised into three groups *(needing up to 3 weeks' notice: needing 4-5 weeks' notice: needing notice of 6 weeks or more)*. Using this approach found no statistically significant differences in response between any of the key respondent groups.

Figure 5.31: How much notice do you need to be able to avail of a training course? (base=279)



5.12 Further Suggestions on How Training Needs can be Further Addressed

At the end of the questionnaire, respondents were invited to make further suggestions on how the training needs of those working in the alcohol and drugs sector can be further addressed. Suggestions were made under a number of key themes:

A need to ***promote knowledge and awareness*** of what training is available. This could be done centrally and reflect all levels of training need, including the needs of individual teams. It was suggested that a menu of training provision at all levels should be made available and communicated to all staff. It was also suggested that there should be opportunities for senior managers to get a more informed understanding of topic / training provision given the significant impact of substance use.

Allied to the above point is a call for ***a mechanism for communicating training needs*** as they arise. This would require regular contact with front line workers regarding changing trends and needs.

It was suggested that training provision needs to be ***mapped to DANOS and more formal structures*** to provide a greater level of accountability and governance. It was also suggested that accredited training will offer more professional benefits and in many cases the training being offered should be pitched at a higher level as well as being broader and more skills based.

Other suggestions included: more training on the links between mental health and drug use; a greater focus on the training needs of those working in children's services; how to identify drug use among older people; greater service user involvement; the need for more training and for training to better funded (and ringfenced where appropriate); the need for a greater range of training providers; a need for more support from management particularly

around staff release and for training to be mandatory; greater collaborative working; and, training staff in local areas to deliver training.

Listed below are the verbatim suggestions offered by respondents.

- *A deeper knowledge of the services available and what actual practical support they provide*
- *A menu of training at different levels and mapped to skills frameworks would enable managers to plan development for staff and services. A mechanism for communicating training needs as they arise so providers can be responsive. Tailoring of training to suit particular services or settings.*
- *All training in Northern Ireland should be mapped to DANOS in relation to Workforce development. You should not be working within Drugs and Alcohol unless you have been fully trained. To act within social care, you need to be registered with NISCC however we have no body to hold workers to account. Unless registered with FDAP (Federation of Drug & Alcohol Practitioners).*
- *An opportunity for senior managers to get a more informed understanding of the topic given it is a major feature of many families / young people involved with social services and the effect on behaviour, accommodation, lifestyle , education / training and employment.*
- *Better link to the specific impact of alcohol and drugs on people with severe and enduring mental ill health - particularly how it interacts with medications for Schizophrenia or depression.*
- *Children's services. Looked after children need up to date information on what drugs are currently on streets i.e. Xanax. Staff need up to date information on effects etc... Advice on different classes - types.*
- *Funding needs to be made available for attendance at training. Also posts need to be filled to allow staff to be free to attend same.*
- *Have central place to list training modules that allows potential trainees to register their interest, so that once enough interest in a course is reached that course can be run.*
- *How to help identify an elderly person with drug and alcohol issues as they have spent years hiding the problem and are unwilling to accept they have a problem and find out what support there is for support workers and families in the local area.*
- *I feel if training courses were accredited this would be more of an incentive to attend and complete.*
- *I feel it needs to be pitched at a higher level and especially for staff who have many years' experience working in alcohol and drugs. University level with a university qualification at the end of this would be more challenging for staff.*
- *I would encourage the PHA to consider developing a community of practice for motivational interviewing skilfulness building and sustainability. There are examples of this in Scotland and other regions that support a model of developing MI coaches who then support practice groups and help keep practitioners developing their MI skilfulness to competency levels.*
- *I would be keen for the ONC course to be offered more frequently and perhaps offered to individual organisations to ensure uptake.*
- *I would suggest training is more geared to suit individual/teams' level of experience. Some training I have attended has been very basic and in one case to the point of being patronising - and the outcome can essentially be a waste of my/my organisations time. In some areas, I feel training would be better provided by frontline workers who have specialist knowledge, 'live' experience and expertise e.g. people who are not 'trainers' per se.*
- *Include Service User Involvement in the delivery of training.*
- *Increased training.*
- *It may be beneficial for participants to know how the training can develop them professionally. Despite working for an organisation specifically focused on supporting people affected by alcohol and drugs, I am struggling to develop my career pathway despite having good experience and training. I value the training that I have, however it is not enough to secure higher paid positions.*

- *It would be helpful if a range of providers could be available to deliver future training programmes.*
- *It would be useful if emails were sent to advise staff of training opportunities.*
- *Maybe an online group where professionals / support staff can access information in real time.*
- *Mixed training with other agencies would give an awareness as to what each agency can offer and promote each other's strengths.*
- *More funding to make training accessible to all.*
- *More information on drugs. Happy re alcohol information.*
- *More information on services that will promote the persons strengths instead of focusing on their addictions.*
- *More reactive training.*
- *More skills based training. More availability of 'in-house' training.*
- *More support from managers to invest in staff to best work with service group users.*
- *More training available in the Western Trust Area.*
- *Motivational interviewing with mentoring.*
- *No employer can allow people to attend training because of time and budget restrictions, so people have to do CPD in holiday time. Could this be factored in funding for posts? I was aware of 8 practitioners wanting to do OCN level 3 this year who could not be released even as annual leave.*
- *I feel there should be more advanced courses offered to front line workers as at present substance misuse is getting bigger with more complex issues such as CPTSD/PTSD and other mental health disorders. Furthermore, mental health suffers are self-medicating because of a lack of services and front line support. Free private supervision for frontline workers is needed also. Thanks for doing the questionnaire but focus groups would have been better as there is so much more to cover.*
- *Part of mandatory training.*
- *Postgraduate accredited training qualifications.*
- *Promotion of partnership working voluntary and statutory services for comprehensive support and better outcomes for clients.*
- *Referral Pathways training across sectors.*
- *Regular contact with front line practitioners to explore what they need to fulfil their roles.*
- *Regular updates for new information / refreshers - 2 hour sessions.*
- *Ringfence resources specifically for statutory staff that needs to be sent on addiction training.*
- *There needs to be a variety of training that meet everyone's needs.*
- *This is more general feedback but relevant to the design and delivery of training as well.*
- *Substance misuse is not a term generally accepted in progressive harm reduction and the term substance use is applied due to its less judgmental and less top-down nature.*
- *Time is a factor trying to obtain time of work. ASCERT communicate effectively but obtaining time off is a problem.*
- *Train staff in local areas to deliver the topics in their area.*
- *Training in counselling to help people talk and deal with traumas and feelings. Also arrest referral work where patients can be supported for drug related offences.*

- *Training that is made available to me through work email is delivered through Ascert and from what I can see this is basic/intermediate. I would like to be able to avail of other training delivered in other areas as I am funded by PHA however would not have any correspondence.*

- *Up to date knowledge on what drugs are available on the street, internet etc. Impact of specific drugs. What people do with the drugs to get a 'hit' e.g. mix with other substances etc.*

- *We need to target those who currently work with children in other sectors so that they can become more aware of parental drug misuse, hidden harm impacts and can intervene directly with those children e.g. better role out of steps to cope. There should be a better evaluation system built in following each course so the PHA gets proper user feedback e.g. re MI. This needs to be evaluated better as there is little difference between intermediate and advanced levels, other than the mentoring sessions.*

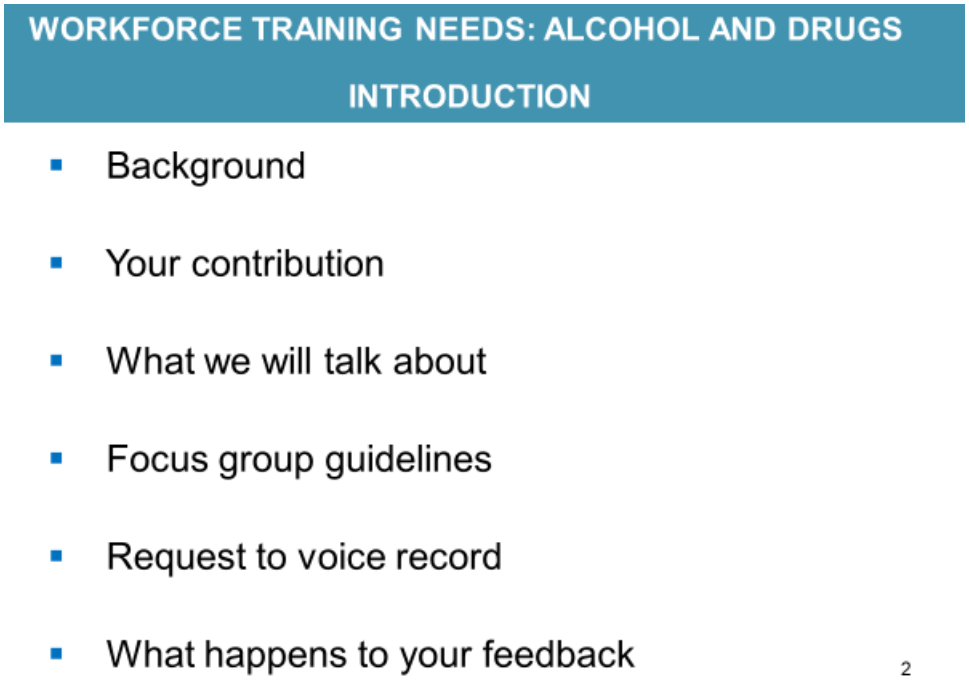
- *Whilst the training needs for those working in the alcohol and drugs sector are being met, little or no support is giving to supporting those working in this field.*

- *Wider brief advice/hidden harm across the workforce. The MI work has been very good. Training seems aimed at voluntary and community sectors.*

Appendices

Appendix A (Focus Group Discussion Guide)


WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS
Part 1
Introduction
HSC
Public Health
Agency
social market research
SMR


WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS
INTRODUCTION
Background
Your contribution
What we will talk about
Focus group guidelines
Request to voice record
What happens to your feedback
2

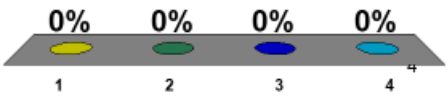
WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Part 2

About you

Which sector are you in?
(Choose ONE)

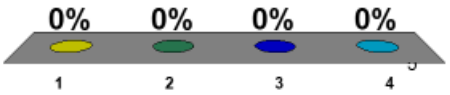
- HSCT
- Crime and safety (PSNI, YJA, PCSP, Probation)
- EA
- PHA
- PSNI
- Local authority
- Training provider
- Substance Misuse services
- Other



And have you? (Choose any that apply)

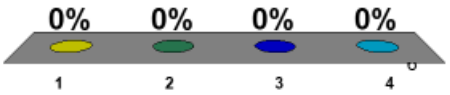
1. Attended any of the workforce development training?

2. Delivered any of the workforce development training?



General question 1.
What is your general satisfaction level with current workforce development training? (Choose ONE)

1. Very satisfied
2. Satisfied
3. Neutral
4. Unsatisfied
5. Very unsatisfied



WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Part 3

Areas of Training Need

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS
Flip Chart Session.

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS
Flip Chart Session.

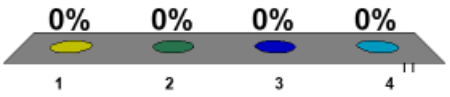
9

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Part 4
Opportunity, quality, investment, application.

Statement: Information about workforce development training opportunities reaches everyone who needs to know about it

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



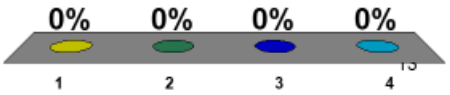
Statement: Information about workforce development training opportunities reaches everyone who needs to know about it

WHY DO YOU SAY THAT?

12

Statement: Generally speaking, the quality of workforce development training is high

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



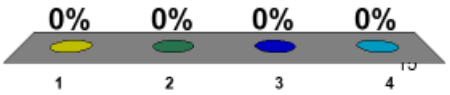
Statement: Generally speaking, the quality of workforce development training is high

WHY DO YOU SAY THAT?

14

Statement: Generally speaking, workforce development training is being used and applied in the workplace

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



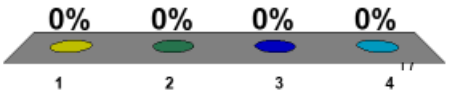
Statement: Generally speaking, workforce development training is being used and applied in the workplace

WHY DO YOU SAY THAT?

16

Statement: Given the costs and the investment in time, the value of current workforce development training is high

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



Statement: Given the costs and the investment in time, the value of current workforce development training is high

WHY DO YOU SAY THAT?

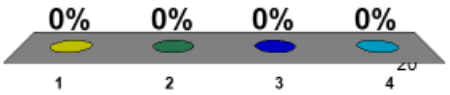
18

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Part 5
Catalysts and constraints.

Statement: Uptake of workforce development training is lower than it should be because of constraints in releasing staff

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



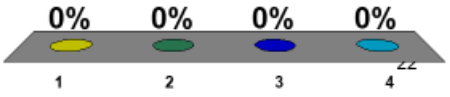
Statement: Uptake of workforce development training is lower than it should be because of constraints in releasing staff

WHAT SOLUTIONS ARE NEEDED, IF ANY?

21

Statement: workforce development training locations present barriers to uptake for staff, particularly those staff working outside Belfast

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



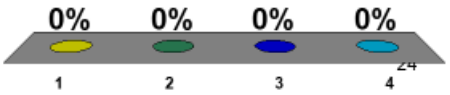
Statement: workforce development training locations present barriers to uptake for staff, particularly those staff working outside Belfast

WHAT SOLUTIONS ARE NEEDED, IF ANY?

23

Statement: Current workforce development training offers sufficient accreditation to meet the career development needs of staff

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



24

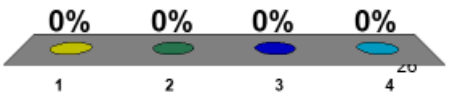
Statement: Current workforce development training offers sufficient accreditation to meet the career development needs of staff

WHAT SOLUTIONS ARE NEEDED, IF ANY?

25

Statement: There is sufficient workforce development training capacity for staff to get the training that they need

1. Strongly agree
2. Agree
3. No opinion
4. Disagree
5. Strongly disagree



Statement: There is sufficient workforce development training capacity for staff to get the training that they need

WHAT SOLUTIONS ARE NEEDED, IF ANY?

27

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Part 6
Moving forward:

Open Discussion

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

- What are the critical areas that need to be addressed by PHA?
- What other supports are necessary to enable and encourage the uptake of training?

29

WORKFORCE TRAINING NEEDS: ALCOHOL AND DRUGS

Thank You

HSC Public Health Agency

social market research SMR

30

Appendix B (Depth Interviews Topic Guide)

Name:		**Organisation:**	
Date:		**Time:**	

INTRODUCTION
To support the needs of the wide range of professionals who come into contact with substance misuse, PHA intends to develop a framework of alcohol and drug training against which it will commission future training programmes and services.

As part of this development, the PHA is carrying out a review of the current programme of training and we are consulting with those workforce groups targeted in the PHA and HSCB 'Joint Commissioning

Framework' on their further training needs.

1 Can I just check firstly what your role is in CAMHS (DAMHS)?

		Tick one
1	Nurse	
2	Social Worker	
3	Clinical Psychologist	
4	Psychiatrist	
5	Occupational therapist	
6	Other, (specify)	

2 And does your role involve you dealing directly with young people who have alcohol or drug issues?

		Yes	No
1	Role involves dealing directly with young people who have alcohol or drug issues		

3 Have you :

		Yes	No
1	Attended any of the workforce development training?		
2	Delivered any of the workforce development training?		

4 And, in overall terms, what is your general satisfaction level with current workforce development training? (Choose ONE)

Very Satisfied	Satisfied	Neutral	Not very satisfied	Not at all satisfied
1	2	3	4	5

IF NOT SATISFIED (CODE 4 OR 5) Can you sum up why you are not satisfied

4 (a) REASONS FOR DISSATISFACTION

5 **I'd like to get your views now on present and future training needs. First of all, what would you say are the main gaps, if any, in current training provision relating to alcohol and drugs?**

5 MAIN GAPS

6 **And does the sector that you work in have specific training needs in relation to alcohol and drugs that need to be addressed in the near future?**

6 SPECIFIC TRAINING NEEDS

7 **I am going to read some statements now and could you tell me if you Strongly agree, Agree, Disagree or Strongly disagree with them, or you may have no opinion. The first statement is**

"Information about workforce development training opportunities reaches everyone who needs to know about it"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you have any comment to make on information reaching everyone who needs to know about it?

7 (a) COMMENT

8 The next statement is: "Generally speaking, the quality of workforce development training is high"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you have any comment to make on the quality of workforce development training?

8 (a) COMMENT

9 The third statement is: "Generally speaking, workforce development training is being used and applied in the workplace"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you have any comment to make on how workforce development training is being used and applied in the workplace?

9 (a) COMMENT

10 The next statement is: "Given the costs and the investment in time, the value of current workforce development training is high"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you have any comment to make on the value of current workforce development training?

10 (a) COMMENT

11 There are some statements now about catalysts and constraints. I'd like to take your views on these and on any possible solutions that you might want to put forward.

The first statement is: "Uptake of workforce development training is lower than it should be because of constraints in releasing staff"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you like to comment on constraints in releasing staff and any possible solutions?

11 (a) COMMENT

12 The next statement is: "Workforce development training locations present barriers to uptake for staff, particularly those staff working outside Belfast"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you like to comment on training locations and any possible solutions?

12 (a) COMMENT

13 The third statement is: "Current workforce development training offers sufficient accreditation to meet the career development needs of staff"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree
1	2	3	4	5

And would you like to comment on accreditation and career development needs?

13 (a) COMMENT

14 And the fourth statement is: "There is sufficient workforce development training capacity for staff to get the training that they need"

Strongly agree	Agree	No opinion	Disagree	Strongly disagree

1	2	3	4	5

And would you like to comment on training capacity to meet all the needs of staff?

14 (a) COMMENT

15 **And just a couple of final questions to finish. First of all: "What are the critical areas of training that need to be addressed by PHA?**

15 critical areas

16 **And finally, "What other supports are necessary to enable and encourage the uptake of training?"**

16 Supports

17 **Can I just check before we finish if you are content for your responses to be attributed to you and your organisation?**

Options for attribution		Your preferred option (s)
1	I agree to have my responses attributed to me personally.	
2	I agree to have my responses attributed to the organisation I represent.	
3	I do not agree to have my responses published or attributed to me personally or to the organisation I represent.	

THANK INTERVIEWEE AND CLOSE

Appendix C (Survey Questionnaire)

Public Health Agency

Survey

FINAL

Training Needs Assessment
Alcohol and Drugs

19 April 2018 ***(amended 8/5/18)***

Introduction

This survey is part of a wider assessment of the training needs of those who come into contact with individuals who misuse substances. The survey is being conducted by Social Market Research (SMR) on behalf of the Public Health Agency.

Moving forward, PHA wishes to ensure that the training needs of professionals and other staff who come into contact with those misusing substances, continue to be met. This survey will help to support this objective and provides those working in the sector with an opportunity to say what is working well, as well as an opportunity to identify gaps in training provision, particularly as needs are changing.

The survey is anonymous and confidential, and your views are highly valued. The survey should take less than 10-minutes to complete. If you have any queries about any aspect of the survey, please feel free to contact Donal McDade at SMR (dmcdade@socialmarketresearch.co.uk**) [02890923362] or Dr Diana Gossrau-Breen at PHA** Diana.Gossrau-Breen@hscni.net **(0300 555 0114).**

Many thanks for supporting this training needs assessment.

Section A: About You

A1. Which of the following best describes your role in relation to alcohol and drugs? **(Select one only)**

Front line worker	1
Manager	2
Trainer or training provider	3
Other (please specify)	4

A2. Do you have direct contact with people presenting with drugs and alcohol issues? **(Select one only)**

Yes, drugs	1
Yes, alcohol	2
Yes, both drugs and alcohol	3
No	4

A3. Is your work mainly with adults or children and young people (i.e. aged under 25)?

Mainly with adults	1
Mainly with children / young people (aged under 25)	2
Equally with adults and children / young people	3
Other (please specify)	4

A4. What is the nature of your work with people presenting with drugs and alcohol related issues? **(Select all that apply)**

Advice	1
Signposting	2
Family based interventions	3
Direct interventions with individuals	4
Corporate / Strategic	5
Other (please specify)	6

A5. What percentage of your work involves direct contact with people presenting with drugs and alcohol related issues? **(Select one only)**

1-20%	1
21%-40%	2
41%-60%	3
61%-80%	4
81%-100%	5
Don't have direct contact with people presenting with substance misuse issues	6

A6. How would you rate your level of experience of working in the alcohol and drugs sector? **(Select one only)**

Very experienced	1
Experienced	2
Not very experienced	3
Not at all experienced	4
Don't know	5

A7. Do you feel the amount of substance misuse related training you have received to date is sufficient, or adequate, to allow you to do your job effectively? (Please type your answer below)

LEAVE 1000 CHARACTERS FOR ALL OPEN-ENDED QUESTIONS

A8. Have you attended or delivered any workplace development training on alcohol and drugs? **(Select one only)**

[Please note that this is training commissioned by the PHA and delivered mostly by ASCERT. There were also courses on motivational interviewing by Glenn Hinds].

Attended workplace development training	1	Go to A9
Delivered workplace development training	2	Go to A11
Attended and delivered workplace development training	3	Go to A9
No	4	Go to A11

A9. Which of the following PHA workplace development training have you attended? **(Select all that apply)**

Alcohol related brain damage	1.	Go to A10
Carer support	2.	
Drugs and the law	3.	
Dual diagnosis and complex interventions	4.	
Early intervention	5.	
Engagement skills	6.	
Foetal Alcohol Syndrome	7.	
General awareness training	8.	
Hidden harm	9.	
Motivational Interviewing	10.	
New psychoactive substances	11.	
Parental drug use	12.	
Poly drug use	13.	
Prescription drugs	14.	
RIAT (regional initial assessment tool for young people)	15.	
Safer injecting and needle exchange	16.	
Signs of psychosis	17.	
Foundation module for working with young people and families	18.	
Foundation module for working adults and family members	19.	
OCN Level 3 Certificate in Tackling Substance Misuse	20.	
Not attended any of the above	**21.**	**Go to A11**

A10. And what has been the level of this training you attended (i.e. basic, intermediate, advance, refresher etc)? **[only display items flagged at A9]**

	Basic	Intermediate	Advanced	Refresher
Alcohol related brain damage	1	2	3	4
Carer support	1	2	3	4
Drugs and the law	1	2	3	4
Dual diagnosis and complex interventions	1	2	3	4
Early intervention	1	2	3	4
Engagement skills	1	2	3	4
Foetal Alcohol Syndrome	1	2	3	4
General awareness training	1	2	3	4
Hidden harm	1	2	3	4
Motivational Interviewing	1	2	3	4
New psychoactive substances	1	2	3	4
Parental drug use	1	2	3	4
Poly drug use	1	2	3	4
Prescription drugs	1	2	3	4
RIAT (regional initial assessment tool for young people)	1	2	3	4
Safer injecting and needle exchange	1	2	3	4
Signs of psychosis	1	2	3	4
Foundation module for working with young people and families	1	2	3	4
Foundation module for working adults and family members	1	2	3	4
OCN Level 3 Certificate in Tackling Substance Misuse	1	2	3	4

ASK A10a if Motivational Interviewing selected at A9 else go to A11

A10a. Following your training on Motivational Interviewing did you take up the provided mentoring?

Yes	1	➔ Go to A10b
No	2	➔ Go to A10d

A10b. Did you find the provided mentoring helpful when applying Motivational Interviewing in your work?

Yes	1	➔ Go to A11
No	2	➔ Go to A10c

A10c. Why was the provided mentoring for Motivational Interviewing not helpful?

➔ Go to A11

A10d. Why did you not take up the provided mentoring after training on Motivational Interviewing?

Go to A11

A11. Please say if you agree or disagree with each of the following statements about current workplace development training on substance misuse provided by PHA?

Strongly agree	1
Agree	2
Neither agree nor disagree	3
Disagree	4
Strongly disagree	5
Don't know	6
Not applicable	7

1	I value the training provided by PHA
2	I regularly apply the training in my job
3	I would find it difficult to get released to go on an alcohol / drug related training course
4	I find training locations act as a barrier for me
5	Current training offers sufficient accreditation to meet my career development needs
6	The current training being provided meets my needs
7	Current training provision reflects the current issues I face doing my job
8	I would go on more training courses if the training venues were outside Belfast
9	Training by teleconferencing would help improve my uptake

A12. Overall, how satisfied or dissatisfied are you with the quality of current workforce development training on alcohol and drugs? **(Select one only)**

Very satisfied	1	Go to B1
Satisfied	2	Go to B1
Neither satisfied nor dissatisfied	3	Go to B1
Dissatisfied	4	Go to A13
Very dissatisfied	5	Go to A13

A13. Why are you dissatisfied with current workforce development training on alcohol and drugs?

Section B: Training Needs

B1. Which of the following training do you feel you need most? **(Select one only)**

Awareness training	1
Skills based training	2
Both awareness and skills-based training	3
Don't need either	4

B2. As part of a training needs assessment, PHA are interested in finding out about different training needs and what level these needs should be at. ***Thinking about your own training needs***, please say if you feel you would find training on any of the following helpful. **(Select all that apply)**

Alcohol related brain damage	1.	Go to B3
Carer support	2.	
Drugs and the law	3.	
Dual diagnosis and complex interventions	4.	
Early intervention	5.	
Engagement skills	6.	
Foetal Alcohol Syndrome	7.	
General awareness training	8.	
Hidden harm	9.	
Motivational Interviewing	10.	
New psychoactive substances	11.	
Parental drug use	12.	
Poly drug use	13.	
Prescription drugs	14.	
RIAT (regional initial assessment tool for young people	15.	
Safer injecting and needle exchange	16.	
Signs of psychosis	17.	
Foundation module for working with young people and families	18.	
Foundation module for working adults and family members	19.	
OCN Level 3 Certificate in Tackling Substance Misuse	20.	
No – would not find training on any of the above helpful	**21.**	**Go to B4**

B3. Of the different types of training you identified, please say at what level you would need this training to be at? **[only show items flagged at B2]**

	Basic	Intermediate	Advanced	Refresher
Alcohol related brain damage	1	2	3	4
Carer support	1	2	3	4
Drugs and the law	1	2	3	4
Dual diagnosis and complex interventions	1	2	3	4
Early intervention	1	2	3	4
Engagement skills	1	2	3	4
Foetal Alcohol Syndrome	1	2	3	4
General awareness training	1	2	3	4
Hidden harm	1	2	3	4
Motivational Interviewing	1	2	3	4
New psychoactive substances	1	2	3	4
Parental drug use	1	2	3	4
Poly drug use	1	2	3	4
Prescription drugs	1	2	3	4
RIAT (regional initial assessment tool for young people)	1	2	3	4
Safer injecting and needle exchange	1	2	3	4
Signs of psychosis	1	2	3	4
Foundation module for working with young people and families	1	2	3	4
Foundation module for working adults and family members	1	2	3	4
OCN Level 3 Certificate in Tackling Substance Misuse	1	2	3	4

B4. Are there any other alcohol and drugs related areas that you feel you need training in? **(Select one only)**

Yes	1	Go to B5
No	2	Go to B6

B5. Briefly, what other area (s) do you feel you need training in? Also, please say at what level you need this training to be offered at (i.e. basic, intermediate, advanced or refresher). **Please list up to 3 training needs.**

Training Need	**Basic**	**Intermediate**	**Advanced**	**Refresher**
1	1	2	3	4
2	1	2	3	4
3	1	2	3	4

B6. Again, thinking about your own needs, which area is the ***main priority for you personally?*** **(Select one only)**

Alcohol related brain damage	1	Go to B7
Carer support	2	
Drugs and the law	3	
Dual diagnosis and complex interventions	4	
Early intervention	5	
Engagement skills	6	
Foetal Alcohol Syndrome	7	
General awareness training	8	
Hidden harm	9	
Motivational Interviewing	10	
New psychoactive substances	11	
Parental drug use	12	
Poly drug use	13	
Prescription drugs	14	
Safer injecting and needle exchange	15	
RIAT (regional initial assessment tool for young people)	16	
Signs of psychosis	17	
Foundation module for working with young people and families	18	
Foundation module for working adults and family members	19	
OCN Level 3 Certificate in Tackling Substance Misuse	20	
Other (please specify)	21	
Don't know	22	
None – don't have any training needs as present	**23**	**Go to B8**

B7. And which area would be the ***second biggest priority for you personally?*** **(Select one only)**

Alcohol related brain damage	1
Carer support	2
Drugs and the law	3
Dual diagnosis and complex interventions	4
Early intervention	5
Engagement skills	6
Foetal Alcohol Syndrome	7
General awareness training	8
Hidden harm	9
Motivational Interviewing	10
New psychoactive substances	11
Parental drug use	12
Poly drug use	13
Prescription drugs	14
RIAT (regional initial assessment tool for young people)	15
Safer injecting and needle exchange	16
Signs of psychosis	17
Foundation module for working with young people and families	18
Foundation module for working adults and family members	19
OCN Level 3 Certificate in Tackling Substance Misuse	20
Other (please specify)	21
Don't know	22
None – don't have any other training needs as present	**23**

B8. Thinking about ***the sector you work in***, what do you feel is the ***main training need*** at present? **(Select one only)**

Alcohol related brain damage	1
Carer support	2
Drugs and the law	3
Dual diagnosis and complex interventions	4
Early intervention	5
Engagement skills	6
Foetal Alcohol Syndrome	7
General awareness training	8
Hidden harm	9
Motivational Interviewing	10
New psychoactive substances	11
Parental drug use	12
Poly drug use	13
Prescription drugs	14
RIAT (regional initial assessment tool for young people)	15
Safer injecting and needle exchange	16
Signs of psychosis	17
Foundation module for working with young people and families	18
Foundation module for working adults and family members	19
OCN Level 3 Certificate in Tackling Substance Misuse	20
Other (please specify)	21
Don't know	22

B9. Do you feel there are any other gaps in training needs? **(Select one only)**

Yes	1	Go to B10
No	2	Go to B11

B10. Briefly, what are these gaps?

B11. Have you undertaken any other training on substance misuse outside of the PHA's current workplace training programme? **(Select one only)**

Yes	1	Go to B12
No	2	Go to C1

B12. What area (s) did this training relate to? **(Select all that apply)**

Alcohol related brain damage	1
Carer support	2
Drugs and the law	3
Dual diagnosis and complex interventions	4
Early intervention	5
Engagement skills	6
Foetal Alcohol Syndrome	7
General awareness training	8
Hidden harm	9
Motivational Interviewing	10
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Safer injecting and needle exchange	16
Signs of psychosis	17
Foundation module for working with young people and families	18
Foundation module for working adults and family members	19
OCN Level 3 Certificate in Tackling Substance Misuse	20
Other (please specify)	21
Don't know	22

Section C: Awareness and Accessibility of Training Opportunities

C1. How would you rate your awareness of what current workplace training opportunities are currently available on alcohol and drugs? **(Select one only)**

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5

C2. How would you rate the quality of the information or communications you get on alcohol and drug-related training courses (i.e. are the objectives of the training clear)? **(Select one only)**

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5

C3. How do you normally find out about training on alcohol and drugs? **(Select one only)**

Email	1
Facebook	2
Instagram	3
LinkedIn	4
Leaflet	5
Via training provider website	6
Via PHA website	7
Word of mouth	8
Other (please specify)	9

C4. How easy or difficult is it to find out about current workplace training on alcohol and drugs? **(Select one only)**

Very easy	1
Easy	2
Difficult	3
Very difficult	4
Don't know	5

C5. What is the best way of letting you know about workplace training opportunities on alcohol and drugs in your sector? **(Select one only)**

Email	1
Facebook	2
Instagram	3
LinkedIn	4
Leaflet	5
Via training provider website	6
Via PHA website	7
Word of mouth	8
Other (please specify)	9

C6. How far are you prepared to travel to training courses on alcohol and drugs? **(Select one only)**

up to 5 miles	1
6-10 miles	2
10-20 miles	3
30-40 miles	4
50+ miles	5
Not prepared to travel	6
Don't know	7

C7. How much notice do you need to be able to avail of a training course? **(Select one only)**

Up to 1 week	1
2 – 3 weeks	2
4-5 weeks	3
6 weeks	4
7-8 weeks	5
More than 8 weeks	6
Don't know	7

Section D: About You Role and Organisation

D1. Which of the following best describes the organisation you work for? *[If your organisation covers more than one of these areas, please select the one that matches your job role best]*. **(Select one only)**

16+ education: university, regional college, training provider	1.
CAMHS/DAMHS	2.
Children's/Youth Charity	3.
Community Addiction Team (CAT)	4.
Community Organisation	5.
Education (school or alternative setting)	6.
Family Support Hub	7.
General housing provider (e.g. housing association, NIHE)	8.
Homeless Charity	9.
Local Council	10.
Mental Health Charity	11.
Non-statutory provider of substance misuse services	12.
Other Health and Social Care Trust (not CAT or children's services)	13.
Other training provider (substance misuse)	14.
PBNI / PSNI / YJA / PCSP / Probation	15.
Pharmacy	16.
Social services / Family and Children's Services	17.
Women's Organisation	18.
Other (please specify)	19.

D2. Are you a member of your local Drug and Alcohol Coordination Team (DACT)? **(Select one only)**

Yes	1
No	2

D3. Which Trust area are you based? **(Select one only)**

Eastern	1	Go to D5
Northern	2	
Southern	3	
South Eastern	4	
Western	5	
Regional – cover all areas	6	
Don't know	7	Go to D4

D4. Which is the nearest large town or City that your organisation is based in?

D5. Do you have any further suggestions on how the training needs of those working the alcohol and drugs sector can be further addressed?

Please feel free to forward the survey link to others you know who work in the substance misuse sector and who may have view on training needs.

Many thanks for taking part in this survey.