






Methamphetamine and emerging drugs of concern: A training needs analysis of Australian alcohol and other drug helplines

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Abstract

Introduction: Fielding greater than 100,000 calls annually, telephone helplines are an important point of entry to alcohol and other drug (AOD) support and services in Australia. Methamphetamine and emerging drugs can present a particular challenge for this workforce. We sought to identify training needs for these services, so that appropriate targeted resources can be developed.

Methods: We distributed an anonymous, online, cross-sectional survey to helpline staff from New South Wales, Queensland, South Australia, Victoria and Western Australia. Based on the WHO Hennessy-Hicks training needs analysis tool, participants were asked: to rate on a 7-point likert scale the importance of a topic to their practice and how well they perform in relation to the topic; open-ended questions specifying their own self-perceived training needs; and demographic data.

Results: Of 50 participants, 29 completed the full survey (median age 49 [IQR 30–57.5]; median time working in AOD sector 6 years [IQR 1–20]). The results identified a need for: practical community-informed population relevant information for culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander peoples for calls relating to methamphetamine and emerging drugs of concern; training and resources with a particular focus on families and friends of people who use methamphetamine and emerging drugs; and readily accessible up-to-date information on new and emerging drugs and treatment of related disorders.

Discussion and Conclusions: This training needs analysis provides a structured approach to supporting the first-line AOD counsellors to provide up-to-date and accurate information to assist Australians seeking information, support and advice.

KEYWORDS

methamphetamine, novel psychoactive substances, remote care, survey, telehealth

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1 | INTRODUCTION

Methamphetamine dependence and regular use in Australia has increased in the past decade [1, 2], yet the evidence base for treatments and interventions for methamphetamine use disorder is still emerging [3, 4]. Other emerging drugs of concern include new psychoactive substances appearing on the market, novel drug classes that are potentially harmful and new formulations of older drug classes for which problems related to their use are emerging, for example, synthetic cannabinoids, novel benzodiazepines and fentanyl [5].

Alcohol and other drugs (AOD) services provide people with a range of interventions that influence and support reduction or cessation of harmful substance use, safer consumption and promote health and wellbeing. In Australia, often a first point of entry to these services is telephone-based AOD helplines such as the state and territory Alcohol and Drug Information and Support Services. Fielding greater than 100,000 calls annually, these helplines can provide education, information, referral, crisis counselling and support around both illicit substances and other substances of concern to people worried about their substance use, their families and friends. While evidence is limited, Australian and international studies have demonstrated effectiveness from AOD helplines in supporting reduction of substance use and increasing uptake into treatment [6]. Furthermore, these services have the potential to redress inequitable access to health care services through improving access to isolated communities (representing a significant component of rural health care) [7, 8] and marginalised people, many of whom may live in metropolitan regions but do not engage with health services due to concerns over stigmatisation and discrimination [9].

Australian AOD telephone services are run through state health departments and, as such, the level of service provision varies. In a 2012 evaluation of the national AOD telephone services, Roche et al. [10] defined the variability of services offered through these helplines as spanning across 3 levels, ranging from: the provision of AOD specific information and advice targeted to general members of the public and referral to specialist services where appropriate; provision of screening, assessment, triage and appropriate referral to specialist advice; and provision of brief interventions, ongoing specialised counselling services, ongoing case management, and provision of information and advice to other professional case workers. They recognised that some helplines may provide all three service levels concurrently. Such variability means that staff training needs are diverse, while telephone counsellors have to keep up with rapidly changing drug use trends and new treatment evidence.

There are limited published guidelines available to telephone and internet counselling services which provide specific evidence-based support for clients with concerns related to methamphetamine [11], while the constantly evolving landscape of substance use means that training requirements and resource needs should be regularly evaluated.

Training Needs Analyses (TNA) are performed across health care and other sectors to support effective continued professional development and patient outcomes [12]. Continued professional development opportunities are highly valued and can contribute to staff retention and improved service delivery [13, 14]. Conducting an analysis of training needs fosters a partnership between trainees and trainers, and ensures demand-driven evidence dissemination and training which aligns with staff needs [15]. While there is no standard approach to TNA in any setting, the Hennessy-Hicks (HH) TNA [16] has been more widely used in primary health care settings [15], and is a psychometrically valid tool developed to ensure that health care workers acquired the skills they need to successfully perform their jobs [17].

In Australia, the installation of the single national number (hotline) which triages to states and territories provides an opportunity to strengthen information sharing across the country, with this in mind the aim of this training needs analysis was to identify knowledge and resource gaps for AOD helpline service professionals dealing with calls related to methamphetamine and emerging drugs (MED) to better focus the development of educational materials and resources.

2 | METHODS

2.1 | Study design

Between October 2021 and April 2022, health and welfare professionals from the AOD telephone helplines in New South Wales, Queensland, Victoria (servicing Victoria, Tasmania, the Northern Territory and Australian Capital Territory), South Australia and Western Australia were invited to participate in the study via e-mail, distributed by the respective service managers. There was no sample size calculation, all staff were invited to participate. No study incentives/reimbursements were provided to participants. After providing informed consent, participants completed an anonymous, online cross-sectional survey. The survey was hosted on the Research Electronic Data Capture system, a secure web application for building and managing online surveys and databases [18, 19]. Ethics approval was obtained from the St Vincent's Hospital Human Research Ethics Committee (2021\ETH00140) on 11 February 2021 under National Mutual Acceptance.

2.2 | Instruments

The survey was made up of three parts: (i) collection of basic respondent demographics and qualifications; (ii) a questionnaire based on the World Health Organization HH TNA tool [16]; and (iii) free text space for respondents to specify their own self-perceived training needs and barriers.

The HH TNA tool is designed to be flexible, allowing adaption for use by health care workers within any setting without compromising its psychometric properties. The main part of the questionnaire consists of a core set of 30 items covering five sub-ordinate categories that can be considered central to the role of effective care delivery: research/evaluation of evidence; communication/teamwork; clinical tasks; administration; and management/supervision. Participants rate on a 7-point likert scale the importance of a topic or item to their practice along with a rating of how well they perceive their performance in relation to the topic, where 1 = not at all important or performed well and 7 = very important or performed very well. Items that are rated to have a higher level of importance but are performed poorly are deemed high intervention priorities and should be a target for training. To meet the requirements of this study, the questions were minimally modified. To do this, the primary author (FB) reviewed each item for relevance to the setting and purpose of the study and substituted those that did not meet the needs of the sample population. Substitutions were made in keeping with MED priorities identified by Australian researchers, clinicians, consumers, their families and other caregivers [5].

The qualitative element of the survey consisted of open-ended questions, with free text space for respondents to specify their own self-perceived training needs in relation to specific psychoactive substances; caller groups; and barriers to training or accessing resources specific to MED. The entire survey draft was distributed to all participating telephone helpline service managers for review and feedback.

2.3 | Analysis

Descriptive analyses were used to explore the participants demographic characteristics and qualifications. We used IBM® SPSS® Statistics for Windows (Version 27.0) to analyse the quantitative data, comparing self-assessed importance and performance ratings for each task to identify training needs. Mean scores for each importance and performance item were calculated, and training needs identified by the mean difference between these scores, with the larger difference

indicating a greater training need [16, 20]. Individual paired-sample *t* tests were used to confirm that the difference between importance and performance scores were significant, as advocated by the survey tool authors [16, 21]. To demonstrate the absolute degree of importance or performance of each item, mean results were also plotted on a quadrant graph, where a score of 4 or more indicates a higher level of importance or performance [20]. Items in the upper left quadrant, receiving a score of 4 or above for importance but less than 4 for performance indicate an urgent training need. Those in the lower left quadrant, scoring less than 4 for both importance and performance suggest a training need, but not an urgent one. Performance scores of 4 or above indicate performance on these items were satisfactory and no intervention is required [16].

'The Drugs Wheel' taxonomy [22] was used to group psychoactive substances on which participants stated they would like more training on, as this particular method of classifying established and novel psychoactive drugs was developed as an educational tool with utility for those working in the AOD harm reduction sector [23].

To ensure training needs were comprehensively summarised, a descriptive content analysis approach was used to analyse the qualitative data. Qualitative description is an appropriate method when seeking a precise account of respondents' experiences, such as when conducting a needs assessment [24–27]. A coding frame was generated by two authors (FB and NE) in a data-driven way. The open-ended questions served as a general framework and a successively summarising approach to the text generated coding units [28, 29]. A descriptive summary of the findings is presented, organised by coding units and illustrated with quotes. Analysis was completed using Microsoft® Word for Microsoft 365® (Version 2205) without the use of qualitative analysis software.

3 | RESULTS

A total of 50 people, from an estimated workforce of 110 consented to participate. Amongst them, 29 (58%) completed the full questionnaire and 18 (36%) returned partially completed questionnaires (total, $n = 47$). Data obtained from partially completed questionnaires were only included if they contained responses to all items in the HH TNA tool. Ten participants were excluded due to incomplete data sets. This left a final sample of 37 respondents for the HH TNA, with qualitative and demographic data available for 29 of those 37 participants.

3.1 | Participant characteristics

Table 1 presents the demographic characteristics and qualifications of the participants who responded to this section ($n = 29$). The median age was 49 years (interquartile range 30–57.5), and 62% ($n = 18$) of participants identified as female. The majority of participants were counsellors (68%, $n = 23$), the length of time they had been working in the AOD sector ranged from 4 months to 42 years (median 6 years [interquartile range 1–20]).

TABLE 1 Demographics and qualifications of survey participants ($n = 29$).

| Variable | Percentage (n) | Median (IQR) |
|--|----------------|--------------|
| Gender | | |
| Female | 62 (18) | |
| Male | 35 (10) | |
| Other/prefer not to say | 3 (1) | |
| Age, years | | 49 (30–57.5) |
| 21–30 | 28 (8) | |
| 31–40 | 17 (5) | |
| 41–50 | 14 (4) | |
| 51–60 | 31 (9) | |
| 61–70 | 10 (3) | |
| Highest qualification | | |
| Secondary School Certificate/ High School Certificate | 4 (1) | |
| Diploma/Advanced Diploma/ Associates Degree | 4 (1) | |
| Bachelor Degree | 52 (15) | |
| Graduate Certificate | 4 (1) | |
| Graduate Degree | 14 (4) | |
| Master Degree | 24 (7) | |
| Professional identity ($n = 34$) | | |
| Nurse | 15 (5) | |
| Psychologist | 5 (2) | |
| Counsellor | 68 (23) | |
| Social worker | 12 (4) | |
| Time spent working in the AOD sector, years | | 6 (1–20) |
| 0–10 | 66 (19) | |
| 11–20 | 14 (4) | |
| 21–30 | 10 (3) | |
| 31+ | 10 (3) | |

Abbreviation: AOD, alcohol and other drugs.

3.2 | Quantitative analysis

3.2.1 | Training needs by importance and performance

When asked to rate on a 7-point likert scale the importance of each activity to the successful performance of their job, participants deemed all items important to success (mean score 5.59 [SD 1.25]). Respondents scored their performance as satisfactory (>4) on important topics such as building rapport, assessing clients' clinical needs, discussing treatment options and self-appraisal, see Table 2. High training needs were identified across seven activities, which included accessing and providing up-to-date information on cathinones, fentanyl and other novel psychoactive substances, accessing and participating in training related to MED, communicating with culturally and linguistically diverse (CALD) clients (in calls relating to MED) and (of borderline importance) promoting fentanyl testing as a health promotion activity. Of the five TNA categories (research/evaluation of evidence; communication/teamwork; clinical tasks; administration; and management/supervision), the highest ranked scores for training requirements were clustered around the domains of research/evaluation of evidence and clinical tasks related to specific populations.

3.3 | Qualitative analysis

3.3.1 | Emerging drugs of concern

When asked to comment on particular emerging drugs on which participants would like further training, respondents listed a range of both established drugs and novel psychoactive substances, as listed in Table 3. The most commonly cited were: depressants (particularly gamma hydroxybutyrate, coded 5 times); stimulants (particularly cathinones, coded 5 times); opioids (particularly fentanyl and its analogues, coded 4 times); and methamphetamine, coded twice.

3.3.2 | Caller groups

When asked if there were any sub-groups of callers that respondents felt required clinical skills strengthening to answer, families, friends and concerned others were the prominent response, coded 10 times. Participants felt that they were expected to 'fix' a problem for the caller and highlighted a level of expectation to have 'exact knowledge' about MED in order to offer the absolute correct information to them.

TABLE 2 Hennessy-Hicks Training Needs Scores ranked highest to lowest ($n = 37$).

| Training needs (highest to lowest) | Topic (in relation to methamphetamine and emerging drugs) | Importance (mean score) | Performance (mean score) | Training needs score ($I-P$ mean difference) |
|------------------------------------|--|-------------------------|--------------------------|---|
| 1 | Providing information to clients and/or families on cathinones | 4.43 | 2.51 | 1.92 |
| 2 | Promoting fentanyl testing as a health promotion activity | 4.05 | 2.32 | 1.73 |
| 3 | Accessing and participating in training | 5.65 | 4.05 | 1.59 |
| 4 | Communicating with culturally and linguistically diverse clients | 6.22 | 4.65 | 1.57 |
| 5 | Providing information to clients and/or families on novel psychoactive substances | 5.38 | 3.97 | 1.41 |
| 6 | Accessing relevant literature on novel psychoactive substances | 5.00 | 3.73 | 1.27 |
| 7 | Providing information to clients and/or families on fentanyl/carfentanil | 5.32 | 4.14 | 1.19 |
| 8 | Appraising your own performance | 6.32 | 5.14 | 1.19 |
| 9 | Personally coping with change in the health service and keeping up to date with information | 5.84 | 4.68 | 1.16 |
| 10 | Communicating with Aboriginal clients | 6.00 | 4.92 | 1.08 |
| 11 | Organising your own time effectively, in relation to the management and learning of emerging drugs of concern. | 5.32 | 4.32 | 1.00 |
| 12 | Discussing and sharing recent research findings amongst colleagues | 4.86 | 3.86 | 1.00 |
| 13 | Identifying emerging drugs through your practice that warrant/require further information and resources | 5.38 | 4.41 | 0.97 |
| 14 | Discussing treatment options | 6.59 | 5.68 | 0.92 |
| 15 | Locating and accessing relevant resources related to MED for your clinical work | 5.49 | 4.59 | 0.89 |
| 16 | Highlighting new areas of concern, such as emerging drugs, to your workplace | 5.19 | 4.30 | 0.89 |
| 17 | Applying recent evidence on MED into your own practice | 5.38 | 4.51 | 0.86 |
| 18 | Communicating with colleagues about MED | 5.65 | 4.89 | 0.76 |
| 19 | Assessing clients clinical needs | 6.46 | 5.73 | 0.73 |
| 20 | Providing information to clients and/or families on GHB | 5.57 | 4.86 | 0.70 |
| 21 | Communicating with lesbian, gay, bisexual, transgender or queer clients | 6.32 | 5.65 | 0.68 |
| 22 | Pursuing your own research | 4.59 | 3.95 | 0.65 |
| 23 | Critically evaluating research and information | 4.62 | 3.97 | 0.65 |
| 24 | Recording and inputting routine data | 6.14 | 5.49 | 0.65 |
| 25 | Establishing a rapport with clients | 6.70 | 6.11 | 0.59 |
| 26 | Communicating with families | 6.49 | 5.92 | 0.57 |
| 27 | Treating clients in crisis | 6.16 | 5.62 | 0.54 |

TABLE 2 (Continued)

| Training needs (highest to lowest) | Topic (in relation to methamphetamine and emerging drugs) | Importance (mean score) | Performance (mean score) | Training needs score (I–P mean difference) |
|------------------------------------|---|-------------------------|--------------------------|--|
| 28 | Using data management systems | 5.81 | 5.32 | 0.49 |
| 29 | Planning and organising an individual clients care | 5.62 | 5.14 | 0.49 |
| 30 | Making do when resources are limited/not available | 5.14 | 4.78 | 0.35 |

Abbreviations: GHB, gamma hydroxybutyrate; MED, methamphetamine and emerging drugs.

‘Family members, particularly parents are very challenging at times, as they expect us to “fix” the problem and often become disgruntled when we are unable to do so.’—Participant 4

‘Parents, family members and significant others of those who use methamphetamine are a caller group which I personally difficult to manoeuvre around. There are a lot of expectations for us to have the exact knowledge around MEDs and to offer the absolute correct information to them.’—Participant 30

Some of the complexity in responding to this caller group was attributed to misinformation in the media influencing public perception of substance use disorders and some prevailing prejudicial views.

‘Families often have AOD ideas that are 20 or 30 years out of date, making them more susceptible to stories on “A Current Affair” about new substances. So really good information about what MED are and are not, prevalence of use, effects on their loved ones etc. would be great.’—Participant 31

‘I can struggle with some loved ones presentations, especially if there is a biased or stigmatising view of substance users.’—Participant 48

Other caller groups that participants identified as more challenging to answer included people seeking treatment for substance use disorders and those in withdrawal (coded 4 times), intoxicated callers (coded 3 times), people who use drugs (coded 3 times), callers in rural areas (coded twice), people directed to call by the Court (coded once), people with negative past treatment experiences (coded once) and those with substance use disorders related to medication prescribed to manage pain (coded once).

TABLE 3 Drugs of concern ranked according to frequency of report by respondents.

| Drugs of concern by ‘Drugs Wheel’ classification (Adley, 2022 ^a) | Times coded |
|--|-------------|
| Depressants | |
| GHB | 5 |
| Novel benzodiazepines | 3 |
| Amyl nitrate | 1 |
| Stimulants | |
| Cathinones | 5 |
| Methamphetamine | 2 |
| Opioids | |
| Fentanyl and its analogues | 4 |
| AH-7921 | 1 |
| Empathogens | |
| PMA | 1 |
| PMMA | 1 |
| Psychedelics | |
| DMT | 1 |
| Cannabinoids | |
| Synthetic cannabinoids | 2 |
| Dissociatives | |
| Ketamine | 1 |
| Nitrous oxide | 1 |
| Methoxetamine | 1 |

Abbreviations: DMT, dimethyltryptamine; GHB, gamma hydroxybutyrate; PMA, paramethoxyamphetamine; PMMA, paramethoxymethamphetamine.

^aAdley, M. The Drugs Wheel—NPS/Established version 1.0.4, 2022.

[Internet] [Cited 17 May 2022]. Available from http://www.thedrugswheel.com/downloads/TheDrugsWheel_IntlEng_1_0_4.pdf.

3.3.3 | Barriers to training or accessing resources in relation to MED

When asked if participants felt there were barriers to training or accessing resources in relation to MED, respondents largely stated that there were none or that

they were not aware of either barriers or accessibility issues to training or resources (coded 11 times). For the other participants, time constraints were a key theme, coded 9 times. Participants felt that it was challenging to find time to participate in training or conduct their own study or research amongst a busy working week and constant caseloads.

‘Having rostered shift time to allow me to spend time researching and updating my skills can be challenging.’—Participant 20

Others articulated a lack of awareness of practical substance-specific information relating to emerging drugs of concern, treatment modalities and caller population groups that could be translated into AOD Counselling calls (coded 8 times).

‘Finding thorough, evidence-based information and resources with practical applications for counsellors, and for people querying/concerned regarding MED. Definitely less (if at all) medicalised, and more practical information and training, as well as training for communicating with specific client groups, namely Aboriginal and Torres Strait Islanders, CALD, ageing, and LGBTIQ+ populations.’—Participant 26

A number of participants suggested a dedicated ADIS database of emerging drugs resources could be a solution to this problem (coded 4 times).

‘It may be nice to have a database for us to look at, especially with emerging drugs as it can be quite challenging to be always up to date with these drugs.’—Participant 30

‘A dedicated document to ADIS workers (integrated with database?) citing all known emerging drugs and treatment modalities if any.’—Participant 50

4 | DISCUSSION

In this paper, we have described the findings of an exercise conducted to identify knowledge gaps and upskilling opportunities across the national network of AOD helplines, relating to MED. In doing so, resources and training can be developed specific to the needs of this workforce. Training needs that emerged out of the data include: practical, population specific (CALD, lesbian,

gay, bisexual, transgender, intersex, queer + [LGBTIQ +], Aboriginal and Torres Strait Islander, people affected by someone else’s MED use) information for MED; a particular focus on families, friends and concerned others of people who use MED; and readily accessible up-to-date information on new and emerging drugs and treatment of related disorders. The most prominent barriers to accessing training or resources were time, awareness and cost. Another published AOD Training Needs Analysis conducted in Northern Ireland identified similar emerging themes [30], such as the need for ongoing updates on drugs and psychoactive substances in a rapidly changing landscape and for practical, short, focussed and easily accessible training interventions or resources. Our results are also consistent with an Australian research priority setting study for issues related to MED [5] which identified a need to improve communication on evidence-based treatment and interventions for consumers as a priority. Key training needs identified were similar across the quantitative and qualitative analyses, except for communicating with families around MED, which respondents reported that they performed well on the HH TNA (mean score 5.92/7), yet qualitatively highlighted as the population group in which they would most benefit from further targeted training.

This study has limitations. As a cross-sectional survey, the data may be subject to non-responder bias [31]. Participants who completed the survey are likely to be those who are most interested in the topic. The size of the sample has some impact on generalisability, approximately 45% of the national AOD helpline workforce responded (the number is approximated as some staff work across multiple helplines) and 26% completed the full questionnaire. Nevertheless, participant demographics reflect those of the government AOD workforce in general in Australia (in relation to age, qualifications, experience) [32], indicating our sample may be representative of the AOD helpline workforce. As frontline service providers in the AOD sector, it may be that the results here provide insight into emerging themes that may be shared across other areas in the sector. Further work should be conducted to evaluate shared and divergent areas of workforce training requirements across the AOD sector more broadly. The HH TNA was modified to fit the specific subject matter and workforce, the impact of which is unknown. It was deemed important by the service providers to exclusively focus on MED within the questionnaire; therefore, we chose to accept this risk to decrease redundant questions. No a priori decisions were made to weight any particular item within the scale; therefore, the relative importance of each of the 30 items was equivalent. Future work could examine the

necessary core competencies of this cohort, but this was outside the scope of the present study.

By implementing a structured mixed-methods approach, we successfully identified key training needs for AOD helplines that inform workforce development policy nationally. The results indicate helpline staff require evidence-based information, including brief interventions and other health promotion advice, on novel psychoactive substances and other substances for families, friends and treatment seekers. There is limited evidence on the impact of methamphetamine use on families, friends and concerned others [33, 34], however qualitative studies on general AOD use highlight the feeling of helplessness and isolation experienced by caregivers and concerned others [35–37]. This may explain the pressure reported by some AOD helpline counsellors to find solutions for the caller, further compounded by the relative paucity of evidence-based interventions for the management of MED. Counsellors may benefit on training on how to support concerned others, such as: counselling methods to reduce stress and anxiety; help to develop interactions that encourage self-responsibility; conflict management techniques; and helping the family member to develop coping strategies to minimise the negative impact of AOD use on themselves [38].

Additional population-specific resources for helpline staff should be developed in partnership with experienced stakeholders. Population-specific interventions have been shown to reduce methamphetamine use amongst LGBTI people [39], while an evaluation of an online intervention aimed at Aboriginal and Torres Strait Islander people who use methamphetamine is underway [40]. There is very limited evidence on the effectiveness of AOD interventions and resources developed for culturally diverse communities, but an acknowledgement that differing cultural perspectives greatly influence AOD treatment engagement and that culturally appropriate resources are needed [41, 42]. Genuine community engagement and co-design [43] is central to the production of any population-specific resources.

To mitigate training barriers, such as limited time for research and education identified by participants here, any resources developed should be brief and easily accessible. Helpline staff indicated that access to information in lay language would assist in communicating with callers in an accessible way. A centralised source of up-to-date resources and training for AOD helpline staff may reduce the burden on services; however, the value of locally produced training and resources which take into account place-based variation in drug use and treatment contexts should not be overlooked. Furthermore, work could be done to engage AOD helpline staff in training on how to translate research evidence into

practice. Building confidence to interact with the evidence and incorporate findings into practice will support staff beyond specific knowledge gain, to improve future evidence uptake and self-directed evaluation of evidence.

This study has implications for frontline leaders, educators and policymakers. The training needs identified here traverse direct knowledge gain through to skills development. Leaders can be aware of this in planning education series, and promote other work done within the sector across a variety of modalities such as webinars, short video abstracts and online training modules. Work such as the study reported here can leverage the collaborations established in the process of study implementation, to build clinical-academic alliances that deliver knowledge translation reflective of the priorities of the end-user. Larger studies to map the AOD sector more broadly would also allow for more nuanced analysis of training needs by various professions or roles within the sector.

Telephone helplines are an important point of entry to AOD support and services in Australia. MED present particular challenges for this workforce, given the treatment options for methamphetamine use disorders are still evolving and the continued emergence of both new psychoactive substances and reformulations of older drug classes. Understanding the training needs of AOD helpline professionals is key to ensuring ongoing optimal care for clients of these services. Our analysis found a number of areas to guide future helpline workforce training and development, including population specific information, support for families, friends and concerned others, and accessible information on new evidence related to MED and treatment options.

AUTHOR CONTRIBUTIONS

Florence Bascombe, Krista J. Siefried and Nadine Ezard conceptualised the study. Florence Bascombe designed and directed the project, conducted the formal analysis, and prepared the original draft. Stacey Child, Rick Loos, Hazel Sgouras, Lynn Stevens and Hollie Wilson contributed to the design and implementation of the research. Brendan Clifford, Krista J. Siefried and Nadine Ezard reviewed and edited the manuscript.

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CONFLICT OF INTEREST STATEMENT

FB is an employee of Médecins Sans Frontières Australia & New Zealand and holds an Adjunct position at UNSW and has no other interests to declare. KJS is an employee of UNSW, NCCRED and holds an Adjunct at St Vincent's Hospital Sydney and has no other interests to declare. NE is an employee of St Vincent's Hospital Sydney and seconded to UNSW, NCCRED and has no other interests to declare. BC is an employee at UNSW, NCCRED and St Vincent's Hospital Sydney and has no other interests to declare. HS has no interests to declare. SC is an employee of the Government of Western Australia Mental Health Commission and has no other interests to declare. RL is an employee of Eastern Health and has no other interests to declare. LS is an employee of Drug and Alcohol Services of South Australia and has no other interests to declare. HW is an employee of Queensland Health and has no other interests to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, FB, upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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