# ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remunerations and Well-being

ATODA
Alcohol Tobacco & Other Drug Association ACT

2019

ATODA Monograph Series

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ISBN 978-0-6484763-0-6

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Published by the Alcohol Tobacco and Other Drug Association ACT (ATODA)

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Suggested citation: Alcohol Tobacco and Other Drug Association ACT (ATODA). ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being. ATODA Monograph Series, No.8. Canberra: ATODA. 2019.

Available at: www.atoda.org.au

Supported by

**ATODA Monograph Series, No. 8**

# ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being

# ATODA

This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). Its purpose is to lead and influence positive outcomes in policy, practice and research by providing collaborative leadership for intersectoral action on the social determinants of harmful drug use, and on societal responses to drug use and to people who use drugs. ATODA works to provide alcohol, tobacco and other drug related expertise in the areas of policy; sector workforce development and capacity building; research, data and evaluation; health services planning; coordination and partnerships; training and education; communication; information and resources.

ATODA's vision is a healthy, well and safe ACT community with the lowest possible levels of alcohol, tobacco and other drug related harms.

Underpinning ATODA's work is a commitment to health equity, the social and cultural determinants of health, and the values of collaboration, participation, diversity, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, services, policy workers, practitioners, consumers and their friends and families in the ACT and region.

Monographs in the series are:

No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children

No 2. ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014

No 3. Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017. An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment.

No 4. Service User Satisfaction and Outcomes Survey 2015: A census of people accessing specialist alcohol and other drug services in the ACT.

No 5. The specialist alcohol, tobacco and other drug sector: a description and examination of treatment and support approaches.

No 6. ACT Alcohol and Other Drug Safer Families Program 2017 – 2021: Design, Model, Implementation Plan and Evaluation Framework.

No 7. Secondary analysis of 2015 – 16 ACT Data reported to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS).

We hope this monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, well and safe ACT community.

Carrie Fowlie
Chief Executive Officer, ATODA

# Acknowledgments

We acknowledge the Traditional Custodians of the lands of the ACT and we pay our respects to the Elders, families and ancestors.

The *ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being* (the Workforce Profile) was developed and implemented in a collaborative manner. The Profile would not have been possible without the cooperation of the Executive Officers of ACT specialist AOD services and the support of the ACT ATOD Workers' Group.

We would like to thank all of the staff from the participating organisations:

- Alcohol and Drug Services, ACT Health[a]
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra and Goulburn
- Directions Health Services
- Karralika Programs Inc
- The Salvation Army
- Ted Noffs Foundation ACT
- Toora Women Inc

In particular, we thank the representatives who coordinated the distribution and collection of the surveys within their organisations. Each was instrumental in facilitating the survey, resulting in an excellent participation rate by the ACT AOD workforce in the survey—it was completed by 171 staff.

For the 2017 survey, data analysis and report write up was undertaken by Anke van der Sterren, with the design and implementation of the survey coordinated by Melinda Petrie. Additional support was provided by Xiaolan Li (data analysis), Mathieu Leclerc (data entry and cleaning), and Kelsey Petrie (data entry). The final draft was reviewed by David McDonald, Social Research & Evaluation.

Other ATODA staff contributed to the practical implementation of the survey, data interpretation, and report review: Carrie Fowlie, Amanda Bode, Lisa Alleva and Julie Robert. This report builds on the work undertaken for the 2006, 2009, 2011, and 2014 Workforce Profiles. ATODA acknowledges the contributions of David McDonald, Dr Ray Lovett and Mieke Snijder to previous profiles and reports.

ATODA also thanks the ACT Health Directorate for providing funding for the project.[b]


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[a] At the time of the 2017 Workforce Profile, Alcohol and Drug Services was located within ACT Health. Following a restructure in 2018, Alcohol and Drug Services is part of Canberra Health Services.
[b] Since the implementation of the workforce profile in 2017, ACT Health has undergone a restructure; since 2018, the ACT AOD Workforce Profile is funded by the ACT Health Directorate.

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## List of Acronyms

| | |
|---|---|
| ACT | Australian Capital Territory |
| AHPRA | Australian Health Practitioner Regulation Agency |
| ADS | Alcohol and Drug Services |
| AOD | alcohol and other drug |
| ATOD | alcohol tobacco and other drug |
| ATODA | Alcohol Tobacco and Other Drug Association ACT |
| CAHMA | Canberra Alliance for Harm Minimisation and Advocacy |
| CALD | Culturally and linguistically diverse |
| CEO | Chief Executive Officer |
| EO | Executive Officer |
| FTE | Full time equivalent |
| LGBTIQ | Lesbian, gay, bisexual, transgender, intersex and queer |
| NSW | New South Wales |
| QS | Qualifications Strategy |
| SMBM | Shirom-Melamed Burnout Measure |
| SPSS | Statistical Package for the Social Sciences |
| TCU-ORC | Texas Christian University Organizational Readiness for Change |
| TOP | Treatment Outcomes Profile |
| TOS | Therapeutic Optimism Scale |
| WHO | World Health Organization |

# Executive Summary

This report presents the results from the fifth three-yearly Australian Capital Territory (ACT) Alcohol and Other Drug (AOD) Workforce Profile conducted in 2017. The AOD Workforce Profile is funded by the ACT Health Directorate and is administered by the Alcohol Tobacco and Other Drug Association ACT (ATODA) in partnership with specialist AOD services.

There are eleven specialist alcohol and other drug services in the ACT that, at the time of the survey, delivered 34 programs. The 2017 Workforce Profile involved administering two surveys at nine of these specialist AOD services in the ACT (delivering 32 programs). These surveys were:

- a Workers' Survey administered to workers in participating specialist AOD services
- an Organisation Survey completed by an Executive Officer or manager at each participating service.

The Workforce Profile aims to develop a better understanding of the specialist AOD workforce in the ACT by monitoring and demonstrating outcomes relating to workforce capacity and identifying areas in need of further development and investment. Specifically, the ACT AOD Workforce Profile provides information to:

- improve workforce planning for both the alcohol, tobacco and other drug (ATOD) sector as a whole, and for individual organisations
- inform capacity building and development of the ATOD sector
- improve the targeting of workforce development initiatives, in particular training and qualifications opportunities
- identify and improve the delivery of initiatives that support the AOD workforce, including in particular those that improve worker well-being
- identify and implement strategies for improved recruitment and retention
- ensure a workforce capable of delivering quality services, and of supporting service users to achieve AOD treatment outcomes
- monitor the impact of the application of workforce strategies, awards and legislation on remuneration and other conditions of employment in the ATOD sector—e.g. the ACT AOD Qualifications Strategy (QS), the Equal Remuneration Order.

## Estimation of the size of the total ACT AOD workforce

The total AOD workforce in the participating organisations is estimated to be 300 staff, including positions vacant at the time of the survey.[c] Between 2014 and 2017, there was an increase in actual employed staff numbers (i.e. excluding vacant positions) of 17% (239 staff in 2014 compared to 279 staff in 2017).

[c] There are estimated to be a further seven ATOD positions in Aboriginal and Torres Strait Islander specific services bringing the total estimated workforce to 307 staff.

## Survey response rates

All nine participating specialist AOD services completed Organisation Surveys, and 171 Workers' Surveys were returned. This equates to a response rate of 61.3% for the Workers' Survey.

## Demographics of the workforce

Of the survey respondents, 69.5% were female and 30.5% male. The average age of the workforce was 44 years old, with the highest number of workers concentrated in the 40 – 49 year old age group. The distribution of workers over age groups is similar for male and females. Fewer than 5 people identified as being of Aboriginal origin (with none identifying as Torres Strait Islander, or both Aboriginal and Torres Strait Islander). Most of these were not employed in an Aboriginal and Torres Strait Islander identified position. The majority of the survey respondents (71.8%) were born in Australia, and 10.8% spoke a language other than English at home.

## Job roles and employment status

Almost half (47.6%) of the Workers' Survey respondents were AOD Workers, with 16.7% Managers, 10.1% Administrators, and 7.7% Counsellors. 'Other roles' (3.6%) included Researchers, Policy Officers, and Project Officers. For people whose main roles were Administrator, Executive, Manager or Researcher/Policy Officer/Project Officer, 57.1% of them also took on a dual responsibility as an AOD Worker.

Of Workers' Survey respondents, 78.7% categorised themselves as workers with direct-client-contact for at least some of their role. Direct-client-contact workers reported spending about 36.0% of their time on non-client-contact activities (e.g. data entry, meeting attendance, professional development, etc).

In the Organisation Survey it was reported that: 41.6% of staff were employed in permanent full-time positions and 6.2% in fixed-term full-time positions; 31.0% were employed in permanent part-time positions and 5.8% in fixed-term part-time positions; and 15.5% in casual positions. In the Workers' Survey, part-time workers (31.8%) and casual workers (10.6%) were underrepresented indicating the need for strategies to improve their participation in future surveys.

Workers reported working an average of 34.5 hours per week, with Nurses and Executive working the longest hours (each averaging more than 40 hours per week).
The average years working in the ATOD sector was just over 7 years, however, about half of the workers had been working in the ATOD sector for approximately 5 years or fewer. About one-third of workers (31.6%) have been in the ATOD sector for fewer than 2 years, and 8.4% for 20 years or more. Over half (56.8%) of the survey respondents had their last paid employment position outside the ATOD sector. Among these, about one-third had worked in each of non-government settings (31.2%), government settings (32.3%), and private settings (34.4%).

The majority (71.2%) of respondents indicated that they planned to "remain in my current role" in the next 12 months. Twenty-one percent had plans to study in the next 12 months. Thirty-

two workers (18.8%) planned to seek promotion opportunities within their organisation and/or within the sector (15 workers indicated both options).

### Remuneration and non-remuneration entitlements

The average pre-tax base hourly rate for all job categories (excluding Executives) was $34.20. For AOD workers only, the average pre-tax base hourly rate was $30.90, equating to an average pre-tax annual income of $61,058.40. Hourly pay increases with education level—the differences in pay rate are significant when comparing workers with an education level up to and including a diploma, to workers with a bachelor degree or higher. As with previous profiles, non-remuneration based entitlements and incentives were common to all organisations.

### Qualifications

The ATOD sector has a well-qualified workforce, with just over half (50.3%) of the respondents having a bachelor or above qualification. Many respondents had qualifications in multiple areas of study: about half of all respondents (49.7%) had qualifications in an ATOD-specific area; 70.8% had qualifications in a non-ATOD health/social/behavioural sciences area; and 40.4% had a qualification in other areas of study (i.e. non-ATOD and also not in the health/social/behavioural sciences areas).

Respondents of the Organisation Survey reported that 79.4% of workers met the ACT ATOD Qualification Strategy (QS) requirements. This is a similar proportion as reported in the 2014 survey—75.4%. Workers survey data showed that 61.2% met the QS requirements, and for those 50 workers who did not yet meet the requirements, 12 needed only to complete or update their First Aid requirements, 11 were currently undertaking training, and 14 were planning to commence in the next 12 months.

More than half (54%) of the respondents thought a Certificate IV was an appropriate minimum level of qualification; 14% thought the minimum level of qualification should be above the Certificate IV; 5% thought the minimum level of qualification should be below the Certificate IV; and the remaining respondents were either not sure or didn't know.

### Professional development

The majority of workers (66.2%) indicated they had participated in some professional development opportunities offered by their organisation in the last 12 months. On a scale of 1 (strongly disagree) to 5 (strongly agreed), keeping skills up-to-date was rated as being very important to workers in all organisations (average score 4.3, with the lowest score 4.0); and workers were good at regularly updating and improving their skills (average score 3.7). Organisations were perceived to provide good to excellent encouragement and support for professional growth (average score 3.8, with an organisational score range of 3.5 to 4.4). Professional development needs vary widely by organisation and employment category.

### AOD practice supervision

Seven out of eight organisations with staff having direct-client-contact (i.e. excluding ATODA) provided access to AOD practice supervision for staff. Of these seven organisations, all provided access to practice supervision by someone external to the organisation, with six also providing practice supervision internally. Barriers cited in the Organisation Survey to making

AOD practice supervision available to staff were cost and time, but also the limited availability in the ACT of people to provide AOD-specific practice supervision.

Workers' Survey respondents were asked whether they received any supervision in their current role. About a quarter (24.7%) of the respondents stated that they had received AOD practice supervision only; about another quarter received management supervision only (26.5%); and 28.9% of the respondents received both AOD practice supervision and management supervision. For those people who did not receive any supervision, the most common reason was 'practice supervision not relevant to their current role'. The majority of direct-client-contact workers receiving AOD practice supervision 'strongly agreed' or 'agreed' that AOD practice supervision was important for their work with the clients; the AOD practice supervision they received provided adequate support for their own well-being in the workplace and for working with clients; and their organisations facilitated/provided for AOD practice supervision.

### Recruitment and retention

Of the eight organisation that answered the question, all indicated that they have some trouble with recruitment. The particular roles or areas of expertise that organisations found difficult to recruit to were mostly positions that required very specific and high-level AOD qualifications and/or expertise (e.g. counselling, nurses with dosing and inpatient withdrawal expertise, peer workers, AOD case managers).

Three organisations have an Indigenous Employment Strategy, with others indicating that they have a specific (unwritten) strategy for increasing the employment of Aboriginal and/or Torres Strait Islander people.

### Worker well-being measures

For the first time, the Workers' Survey included validated scales to assess a number of well-being measures: overall well-being (with subscales of psychological health, physical health, and quality of life); opportunities for professional growth; stress; burnout; job satisfaction; and therapeutic optimism. Consistent with the literature on workforce wellbeing, this survey found positive correlations between well-being, job satisfaction and professional growth; and between therapeutic optimism, and both job satisfaction and professional growth. Both stress and burnout were negatively correlated with overall well-being, job satisfaction and professional growth; that is, higher stress and burnout were correlated with lower levels of overall well-being, job satisfaction and professional growth.

On average, workers self-reported moderately high overall well-being, with 72% of workers scoring greater than the mid-point score of 30 on the scale. The subscales of psychological and physical well-being and quality of life scored moderately well. Greater well-being was associated with older age.

Workers reported moderately strong job satisfaction, with 90% of workers reporting scores greater than the neutral mid-point of 30, and 81.9% agreeing that they were satisfied with their job.

The survey found moderately strong professional growth among workers in ACT specialist AOD services—86.1% of workers reported scores greater than the neutral mid-point of 30. There was a correlation between longer time working in the ATOD sector and lower professional growth scores, and females were more likely to report higher scores on the professional growth scale.

On average, as a group, ATOD workers reported moderate stress levels and low levels of burnout. Stress scores were spread evenly above and below the neutral mid-point score of 30, and 1.8% reported a burnout out score that indicated they experienced symptoms of burnout, on average, more than 'quite frequently'. Greater stress and burnout were associated with lower age, being a permanent worker, and having a Bachelor degree.

Workers reported a high average score for therapeutic optimism, with 84.3% agreeing that they are generally optimistic about client outcomes.

### Informing AOD service planning, quality frameworks and resourcing

Information contained within this profile of the workforce, and mapped across previous profiles, will provide a valuable data source for whole-of-Territory AOD health service planning including appropriate costing.

The information presented in this profile provides a better understanding of the specialist AOD workforce in the ACT by monitoring and demonstrating outcomes relating to workforce capacity and identifying areas in need of further development and investment.

# 1 Introduction

This report presents the results from the fifth three-yearly Australian Capital Territory (ACT) Alcohol and Other Drug (AOD) Workforce Profile[d] conducted in 2017. The AOD Workforce Profile is funded by the ACT Health Directorate[b] and is administered by the Alcohol Tobacco and Other Drug Association ACT (ATODA) in partnership with specialist AOD services.

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- inform the development of capacity of the ATOD sector
- improve the targeting of workforce development initiatives, in particular training and qualifications opportunities
- identify and improve the delivery of initiatives that support the AOD workforce, including in particular those that improve worker well-being
- identify and implement strategies for improved recruitment and retention
- ensure a workforce capable of delivering quality services, and of supporting service users to achieve AOD treatment outcomes
- monitor the impact of the application of workforce strategies, awards and legislation on remuneration and other conditions of employment in the ATOD sector—e.g. the ACT AOD Qualifications Strategy (QS), the Equal Remuneration Order.

## 1.1 Background of the Workforce Profile

In 2009, the ACT alcohol, tobacco and other drugs (ATOD) Executive Directors' Group agreed that a regular mapping of pay and conditions of the ACT ATOD sector should be conducted. This was to be undertaken through a regular survey of workers in the ATOD sector, and published in a publicly accessible document. Although initially just a survey of workers, in 2014

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[d] The survey was previously referred to as the ACT ATOD Workforce Qualification and Remuneration Profile, but due to the expansion of the survey to include significant new components (e.g. supervision and well-being), the Profile has been renamed. Previously, the profile included 'tobacco' in the title, but this has been removed to reflect that this profile has not sought to provide coverage of tobacco specialists and specialisations (although nicotine dependence treatment is provided by AOD workers alongside AOD treatment).

the Workforce Profile was expanded to include a survey of organisations—this has been repeated in 2017.

The Workforce Profile has become part of the agreed quality activities reflected in service agreements between the ACT Health Directorate and non-government AOD services. Results of the previous Workforce Profiles conducted in 2006, 2009, 2011 and 2014 are available on the ATODA website: www.atoda.org.au.

The next ACT AOD Workforce Profile is planned as part of the three-year contract period from 2019 – 2022.

## 1.2 Why conduct Workforce Profiles?

The *National Alcohol and Other Drug Workforce Development Strategy 2015 – 2018* identifies, as one of its outcome areas, the need to understand the specialist AOD prevention and treatment workforce. This outcome is specifically for the purposes of strengthening the knowledge base to conduct effective workforce development and planning. The challenges identified for workforce development and planning include:

- addressing recruitment and retention issues
- identifying commonly understood AOD workforce capabilities, matching capabilities to roles, and creating pathways to achieving these
- enhancing the capacity of the AOD workforce to respond to the complexity of service user needs, including as these change over time
- improving the capacity of the workforce to respond to the needs of specific priority groups—e.g. children and families, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) groups, people who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ)
- improving consumer participation and involvement in service provision, policy and planning
- enhancing the capacity of other sectors to respond to, prevent, and reduce AOD-related harm—e.g. community, welfare, criminal justice and education sectors.

As noted in the national Workforce Development Strategy, meeting these challenges requires a comprehensive understanding of the current and future capacities and needs of the AOD workforce. This is one of the key reasons for undertaking workforce profiles, including this ACT AOD Workforce Profile.

Other jurisdictions in Australia have also undertaken AOD workforce profiles, with many having conducted multiple profiles over several years. The most recently published surveys include:

- Characteristics & well-being of the NSW non-government AOD workforce (2018)[1]
- Comprehensive Alcohol and other Drug Workforce Development in Western Australia (2017—demographic information describing the profile of the workforce included in Appendix C of the report)[2]
- NT AOD Specialist Workforce Profiling Survey (2016)[3]
- Alcohol, Tobacco and other Drugs Council Tasmania Workforce Survey 2016[4]

- 2013 Victorian Alcohol and Other Drug Workforce Survey[5,e]

Several of these workforce profiles have been used to inform the 2017 ACT AOD Workforce Profile, in particular to inform the wording of particular questions and/or answer options, and in the incorporation of well-being-related questions (see Section 2.1.1 and Appendix C).

### *1.2.1 Why measure workforce well-being?*

This Workforce Profile is the first in the ACT AOD sector to include and report on workforce well-being (in addition to the information reported previously on qualifications and remuneration). There is a considerable body of literature documenting the benefits of maintaining a healthy workforce not only for its own sake (i.e. wanting people to remain well), but also for the economic benefits that it brings to an organisation (e.g. the impact of physically and emotionally well workers on improved productivity). Organisations also hold legislative responsibilities to maintain and protect the health of their employees (e.g. through the *ACT Work Health and Safety Act 2011*). The well-being of healthcare workers has also been found to influence patient outcomes—for example the impact of worker burnout on reduced quality of safety-related health care.[6] The well-being of the AOD workforce, and putting in place strategies to address this, is, therefore, recognised as important to the provision of quality services.[7] Well-being in this context refers to a broader definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[8]

The well-being of any workforce has been found to be associated with job satisfaction, organisational commitment, and absence of stress and burnout. The theoretical interactions of these components for the AOD workforce have been, for instance, presented and discussed in the resource *Stress and Burnout: A Prevention Handbook for the Alcohol and Other Drugs Workforce*, as summarized in Figure 1. The causes of stress and burnout come from the interactions between multiple job demands and a lack of, or inefficiently or ineffectively placed, resources in the workplace. These conditions can lead to increased anxiety and frustration, and higher stress and burn out. Stress and burnout will affect client outcomes, worker health and well-being, and organisational functioning, including by reducing job satisfaction, lowering organisational commitment and increasing turnover and absenteeism.

Acknowledging the interactions between these factors and the importance of considering worker well-being, it was timely to include questions about worker well-being within the 2017 ACT AOD Workforce Profile. For further discussion of the questions and scales used, see Section 2.1.2 and Appendix D.

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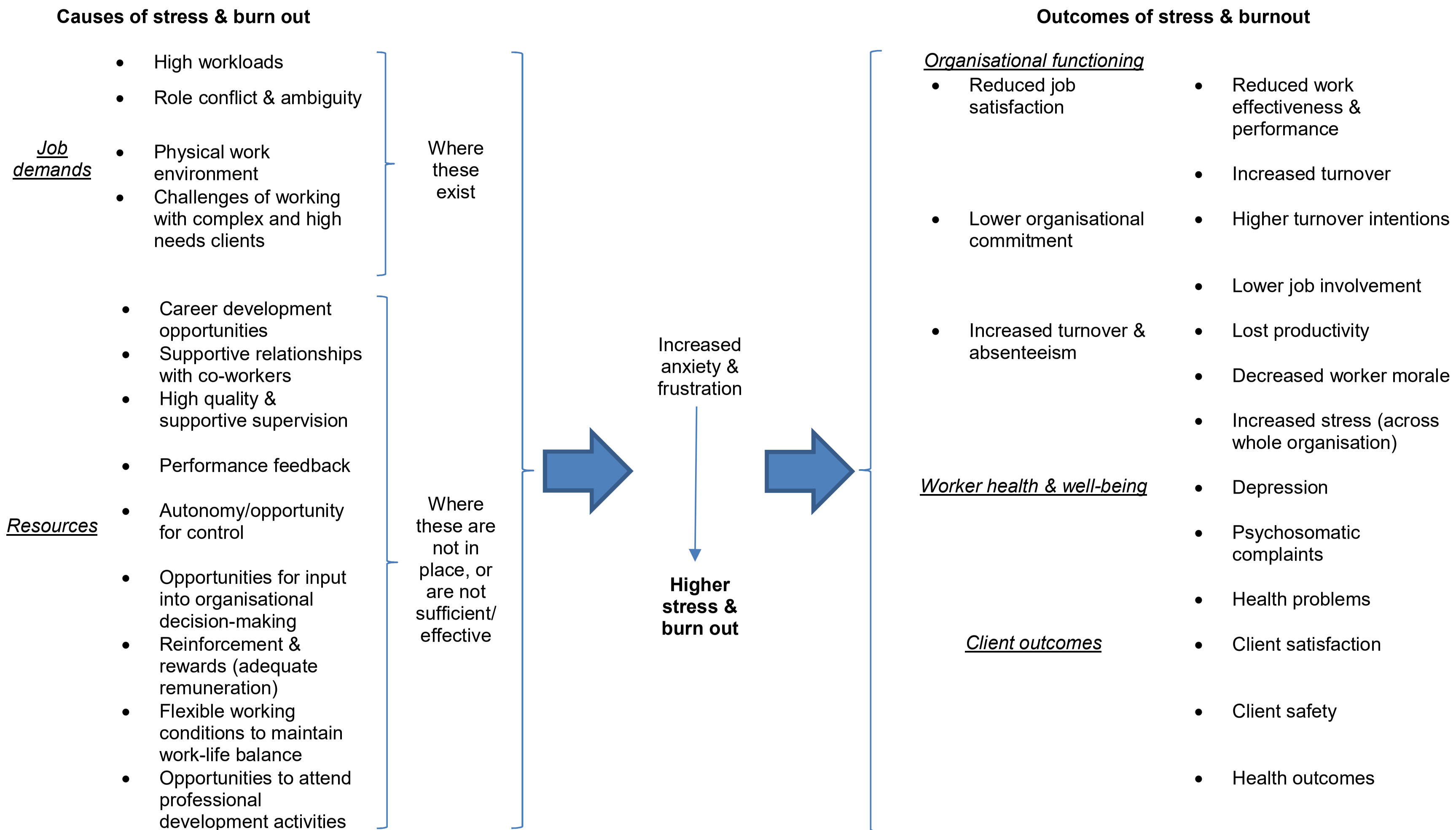
[e] Agency and Worker Surveys from the 2016 Victorian Alcohol and Other Drug Services workforce study are available at https://www2.health.vic.gov.au/alcohol-and-drugs/alcohol-and-other-drug-workforce/aod-data-workforce-planning; findings from the 2016 survey were not yet published at the release of this ATODA report.

**Figure 1 Interactions between causes and outcomes of stress and burnout**
Source: Adapted from Skinner & Roche 2005[7]



## 1.3 Participants in the Workforce Profile

The specialist ACT alcohol, tobacco and other drug (ATOD) sector includes eleven government and non-government services that provide a diverse range of programs to prevent and reduce harms associated with ATOD use in the ACT community. The frontline specialist AOD services offer a range of programs including: assessment; information and education; harm reduction services; counselling; case management; withdrawal support; pharmacotherapy support; outreach support; rehabilitation; and relapse prevention[f]. These specialist AOD services are supported by the peak organisation, ATODA—the Alcohol Tobacco and Other Drug Association ACT.[g]

The following nine ACT specialist AOD organisations participated in the 2017 Workforce Profile:

- Alcohol and Drug Services, ACT Health (ADS)[h]
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra and Goulburn
- Directions Health Services[i]
- Karralika Programs Inc
- The Salvation Army
- Ted Noffs Foundation ACT
- Toora Women Inc

Although a number of these organisations also provide services within New South Wales (NSW) and other jurisdictions, this Workforce Profile is only completed by workers providing services within the ACT.

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[f] See the ACT ATOD Services Directory (version 17 updated April 2019) at: directory.atoda.org.au
[g] See page i for further information about ATODA.
[h] Since the 2017 survey was completed, ACT Health has undergone a restructure—in 2018 Alcohol and Drug Services became part of Canberra Health Services.
[i] Directions Health Services was known as Directions ACT in the previous Workforce Profiles

# 2 Methods

The method used to conduct the 2017 Workforce Profile was consistent with previous years and is outlined below.

## 2.1 Survey development

The 2017 Workforce Profile included two survey instruments:

- Organisation Survey (Appendix A):
    - 30 questions relating to:
        - staff profiles (including demographics, employment status; roles and qualifications)
        - training and professional development
        - staff entitlements
        - staff recruitment and retention
        - supervision
        - well-being.
    - Completed by Chief Executive Officers (CEO)/Executive Directors/Program Managers or other agreed representatives of the organisation.

- Workers' Survey (Appendix B):
    - 47 questions relating to:
        - demographics
        - employment status
        - roles
        - training and qualifications
        - remuneration
        - work history
        - supervision
        - professional development needs and processes.
    - 5 new questions on well-being examining physical and psychological health, overall quality of life, job satisfaction, professional growth, stress, burnout, and clinical optimism. The questions were based on validated scales (see Section 2.1.2 and Appendix D).
    - Completed by permanent, contract and casual staff.

The 2017 Workforce Profile surveys (both Organisation and Workers') included an one-off supplementary section to monitor the range of tobacco management and smoking cessation activities within the ATOD sector, as well as tobacco use and cessation behaviours and attitudes among AOD workers. Findings from this supplementary section are not included in this document and will be reported separately.

### *2.1.1 Changes to the 2017 survey*

The 2017 survey has incorporated a number of changes based on:

- an internal ATODA review of previous ACT AOD Workforce Profile surveys
- consultations with the ACT ATOD sector via the Executive Officers and Workers' Group meetings—this included the identification of worker well-being as a key topic for inclusion in the 2017 Workforce Profile
- a review of workforce profile surveys conducted by other AOD peak organisations in Australia, and internationally-conducted surveys.

In both survey instruments, there were revisions made to the layout, wording and order of questions and response categories to enhance clarity and flow. In addition, the following changes were made:

- revisions to questions to ensure consistency in wording and response categories across both surveys
- expansion of the range of questions to capture the staffing profile, recruitment and retention issues and strategies, and the provision of AOD practice supervision
- inclusion of new questions on worker well-being and how to better support worker well-being (described in Section 2.1.2)
- removal of questions that were no longer relevant or informative (e.g. removal of the non-remuneration based employee benefits from the Workers' Survey)
- inclusion of an one-off supplementary tobacco management and smoking cessation section.

A table detailing all changes between the 2014 and 2017 surveys is included in Appendix C.

The Organisation Survey was piloted with Executive Officers at two services, and the Workers' Survey was piloted with the ACT ATOD Workers' Group. Feedback was used to improve the clarity and ordering of questions.

Ethics approval for the conduct of the project was received from the ACT Health Human Research Ethics Committee (ETHLR.14.113), with amendments approved by the Low Risk Sub-Committee on 13 June 2017.

### *2.1.2 Worker well-being scales*

On suggestion from the Executive Officers and Workers' Group, the 2017 Workforce Profile incorporated questions to ascertain the level of well-being in the ACT AOD workforce and to examine how this is related to various other employment factors.

As shown in Table 1, the 2017 Workforce Profile used a number of validated scales to measure well-being, professional growth, job satisfaction, stress, burnout and therapeutic optimism. Further details about these scales, including the question items, how these have been validated, and how the scales are scored is available in Appendix D.

**Table 1 Summary of well-being items measured in the 2017 AOD Workforce Profile and the corresponding scales used**

| Question | Item | Scale |
|---|---|---|
| 48 | *Overall well-being* | Health and Social Functioning section of the Treatment Outcomes Profile (Public Health England)[9] |
| | Subscales:<br>- *Psychological health*<br>- *Physical health*<br>- *Overall quality of life* | |
| 39 | *Professional Growth* | Texas Christian University Organizational Readiness for Change (TCU-ORC) measure[10]<br>• adapted from the 'Growth', 'Satisfaction', and 'Stress' scales<br>• two items taken from the 'Staffing' scale—to be considered as individual questions |
| 49 | *Satisfaction* | |
| | *Stress* | |
| | *Staffing* | |
| 50 | *Stress and burnout* | Shirom-Melamed Burnout Measure (SMBM).[11,12] |
| | Subscales:<br>- *Physical fatigue*<br>- *Emotional exhaustion*<br>- *Cognitive weariness* | |
| 51 | *Therapeutic Optimism* | Elsom Therapeutic Optimism Scale (TOS)[13] (as adapted by Best *et al*[12,14] |
| | Subscales:<br>- *General Treatment Outcome Expectancy*<br>- *Personal Treatment Outcome Expectancy*<br>- *Pessimism* | |

## 2.2 Survey administration

The Organisation Surveys were distributed to the Chief/Executive Officer (EO) of each organisation. The EOs were responsible for how they completed the survey; some completed it themselves, while others allocated this responsibility to other personnel within the organisation (e.g. Managers of each program; Human Resources Officer).

A contact person was appointed by their EO to take responsibility for the administration of the Workers' Survey within each organisation. ATODA staff liaised with these contact persons to ascertain how many surveys each organisation would need (i.e. how many workers were employed at the organisation). Each organisation coordinated with ATODA to devise an individualised strategy for survey implementation that would work best for their programs.

For about half of the organisations, ATODA workers attended a staff meeting at the organisation to explain the purpose of the survey and, in some cases, to administer it 'on the spot' during the meeting. This was a successful strategy for promoting participation in those

organisations. In other organisations, the contact person took responsibility to distribute, follow up and collect the surveys.

Workers' Surveys were completed between June and September 2017, with each organisation given approximately 4-weeks (or longer by negotiation) to distribute, complete and collect the surveys.

## 2.3 Survey analysis and data reporting

Data were entered into Microsoft Excel workbooks and extracted for analysis in IBM SPSS (Statistical Package for the Social Sciences), using two separate databases, one for the Organisation Survey and one for the Workers' Survey. Statistics used include: the Pearson product-moment correlation coefficient ($r$); two-sample t-tests ($t$); and the $F$ statistic used in one-way analyses of variance (ANOVA), in which cases the mean ($M$) and the standard deviation ($SD$) have also been reported. Where appropriate, the related '$p$' values have been reported. These indicate the probability of the observed relationships between variables having occurred by chance—$p$ values of less than .05 are considered to be statistically significant. Cohen's guidelines (1988) have been used to interpret the strength of correlations, with:[15]

- small correlation $r = .10$ to $.29$
- medium correlation $r = .30$ to $.49$
- large correlation $r = .50$ to $1.0$

Proportions have been calculated using the number of valid responses to each question. Some participants in the Workers' Survey chose not to answer particular questions, so for some questions the responses are fewer than the total number of returned surveys. Results from the 2017 survey are also compared to data from previous surveys where relevant.

Some data should be interpreted with caution, owing to small numbers of participants at some services and outliers within the data. It should be noted that to preserve anonymity of workers participating in the survey, this report does not show response frequencies for fewer than 5 people where this could affect anonymity. In some cases response categories have been collapsed together in order to enable reporting.[j]

[j] For example, job roles 'nurse practitioner', 'clinical psychologist only', 'other psychologist only' and 'social worker only' are grouped as 'other clinical roles', and 'researcher/policy officer/project officer' are grouped with 'other roles'.

# 3 Results

The following results include data from both the Workers' and Organisation surveys. Where it is not specified, it should be assumed that the data comes from the Workers' Survey.

## 3.1 Estimation of the size of the total ACT AOD workforce

The size of the total ACT AOD workforce was estimated using information from the Organisation Survey. The survey asked:

- "How many staff does your organisation currently employ?" (Q6)
- "What is the current number of staff vacancies in your organisation?" (Q16).

Together these questions have been used to generate an estimate of the size of the workforce.

As seen in Table 2, the total workforce in the participating organisations is estimated to be 300 staff,[k] which includes positions vacant at the time of the survey's implementation (21)—note that this figure refers to actual staff numbers, not full time equivalent (FTE) positions.

This is an increase compared to the previous 2014 profile when the workforce was estimated to be 239 staff (although the 2014 figure does not include vacant positions). Between 2014 and 2017, there was an increase in *actual* employed staff numbers (i.e. excluding vacant positions) from 239 to 279 staff—a 17% increase. Assuming similar numbers of vacant positions between the 2014 and 2017 surveys, there has, therefore, been a 17% increase in the AOD workforce over the past three years.

**Table 2 Estimated size of the total Alcohol and Other Drug (AOD) workforce, 2017**
Source: 2017 ACT AOD Workforce Profile—Organisation Survey

| Organisation | Staff currently employed at organisation (Q6) | Number of current staff vacancies (Q16)[l] | Estimated size of total workforce |
|---|---|---|---|
| Alcohol and Drug Services (ADS) | 75 | 7 | 82 |
| Alcohol Tobacco and Other Drug Association ACT (ATODA) | 7 | 1 | 8 |
| Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) | 6 | 0 | 6 |
| CatholicCare Canberra & Goulburn | 14 | 1 | 15 |
| Directions Health Services | 74 | 2 | 76 |
| Karralika Programs | 46 | 3 | 49 |
| The Salvation Army | 21 | 0 | 21 |

[k] This does not include a further 7 AOD positions in Aboriginal and Torres Strait Islander community-controlled services (note that this figure is FTE positions, not staff); including these brings the total estimated workforce to at least 307 staff.
[l] It is not clear whether respondents answered this question in terms of FTE positions or absolute number of positions. The conservative lower number of absolute number of positions has been used in this estimate.

| Ted Noffs Foundation | 24 | 7 | 31 |
|---|---|---|---|
| Toora Women | 12 | 0 | 12 |
| **Total** | **279** | **21** | **300** |

## 3.2 Survey response rates and comparability

As shown in Table 3, a total of 9 Organisation and 171 Workers' Surveys were returned—equating to a 100% response rate for the Organisation Survey (for participating specialist AOD services)[m] and an overall response rate of 61.3% for the Workers' Survey.[n] The response rate for the Workers' Survey is higher than the response rate in 2014, when it was estimated that 52% of the workforce completed the survey. The response rates of the three largest organisations—Alcohol and Drug Services, Directions Health Services and Karralika Programs—varied from 44.6% to 71.7%.

**Table 3 Workers' Survey response rates by organisation, 2017**
Sources: 2017 ACT AOD Workforce Profile—Organisation Survey and Workers' Survey

| | **Organisation Survey** | **Workers' Survey** | |
|---|---|---|---|
| **Organisation** | **Staff currently employed at organisation (Q6)** | **No. surveys returned** | **Response rate %** |
| ADS | 75 | 35 | 46.7% |
| ATODA | 7 | 7 | 100% |
| CAHMA | 6 | 5 | 83.3% |
| CatholicCare | 14 | 6 | 42.9% |
| Directions Health Services | 74 | 33 | 44.6% |
| Karralika Programs | 46 | 33 | 71.7% |
| The Salvation Army | 21 | 22 | 100%[o] |
| Ted Noffs Foundation | 24 | 18 | 75% |
| Toora Women | 12 | 12 | 100% |
| **Total** | **279** | **171** | **61.3%** |

[m] Note that the Organisation Survey response rate refers to those organisations participating in the Workforce Profile—it excludes two organisations that decided not to participate.
[n] The Workers' Survey response rate has been calculated using the "number of staff currently employed at the organisation" as the denominator; this reflects the number of staff available to respond to the survey at the time of its implementation, and is able to be compared to response rates from previous years.
[o] Note that the surveys returned exceeds the number of staff employed at The Salvation Army. Due to circumstances at the organisation, data collection was undertaken at two different time points, resulting in additional staff completing the survey (i.e. new employees had replaced staff who had already completed the survey but who had since left the organisation). To enable a more accurate reflection of the response rate, The Salvation Army response rate has been recorded as 100% (rather than 105%).

### *3.2.1 Comparability of the survey*

The managers completing the Organisation Surveys were also asked to complete a form for each individual staff member to provide general demographic details and some basic information about their employment and qualifications. This enabled, to some extent, a comparison between the group of workers answering the Workers' Survey and the overall ACT AOD workforce. Managers only completed profile forms for 230 current employees (out of 279 staff currently employed at the organisations), so this does not represent the profile of the entire workforce; however, it does provide a point of comparison.

Table 4 shows a comparison between some key characteristics of the workforce as reported in the Organisation Survey compared to the responses from the Workers' Survey. This shows that the responses through the Workers' Survey could be seen to be broadly representative of the entire ACT AOD workforce for gender and time worked at the organisation. Similar to surveys in previous years, proportionately more full-time workers completed the survey than part-time or casual workers, representing a potential response bias.

Proportions of respondents by job roles were similar for most categories across both the Organisation and Worker's Surveys, with the exception of 'Manager', 'Other clinical roles' and 'Other roles'. It is possible that there were some discrepancies in how workers described their roles if they were 'team leaders'—some may have categorised this as 'Manager' while others may have seen themselves as an 'AOD Worker only'.

'Other clinical roles' includes Nurse Practitioners, General Practitioners, Addiction Medicine Specialists, other Medical Practitioners, Clinical Psychologists, other Psychologists, Psychiatrists and Social Workers. The Workers' Survey did not include any responses from General Practitioners, Addiction Medicine Specialists, Other Medical Specialists and Psychiatrists, and low response rates from Clinical and Other Psychologists, and Social Workers.

**Table 4 Comparison between key characteristics of the workforce as reported in the Organisation Survey (n=230) and the Workers' Survey (n=171), 2017**

Sources: 2017 ACT AOD Workforce Profile—Organisation Survey and Workers' Survey

| | 2017 Organisation Survey (staff profiles, n=230) | 2017 Workers' Survey (n=171) |
|---|---|---|
| **Gender*** | | |
| Male | 32.9% | 30.5% |
| Female | 67.1% | 69.5% |
| **Employment status** | | |
| Permanent full-time | 41.6% | 49.4% |
| Fixed term full-time | 6.2% | 8.2% |
| Permanent part-time | 31.0% | 27.1% |
| Fixed term part-time | 5.8% | 4.7% |
| Casual | 15.5% | 10.6% |

| Time worked at organisation | | |
|---|---|---|
| Fewer than 12 months | 30.4% | 29.0% |
| More than 12 months | 69.6% | 71.0% |
| **Main job roles** | | |
| AOD Worker only | 50.4% | 47.6% |
| Nurse only | 5.3% | 6.0% |
| Counsellor only | 6.1% | 7.7% |
| Administrator | 11.4% | 10.1% |
| Executive | 3.9% | 5.4% |
| Manager | 9.6% | 16.7% |
| Other clinical roles only | 6.1% | 3.0% |
| Other roles | 7.0% | 13.7% |

*no respondents identified, or were identified, as ‘other’

## 3.3 Demographics of the workforce

Respondents were asked about their age, gender and cultural background.

### *3.3.1 Age group and gender*

Of the survey respondents, 116 (69.5%) were female and 51 (30.5%) male. This is consistent across time with results from earlier Workforce Profiles. According to the Organisation Survey, there were a total of 10 women-specific identified positions in ACT specialist AOD services in 2017.

The average age of the workforce was 44 years old, with the highest number of workers concentrated in the 40 – 49 year old age group. Figure 2 shows the distribution of workers over age groups—this distribution is similar for male and females. As shown in Figure 3, the average ages of workers vary among organisations, with Ted Noffs Foundation having the lowest average age (33 years) and The Salvation Army the highest (50 years) among all the organisations.

**Figure 2 Age distribution of ACT AOD workforce (2017)**
Source: 2017 ACT AOD Workforce Profile—Workers’ Survey

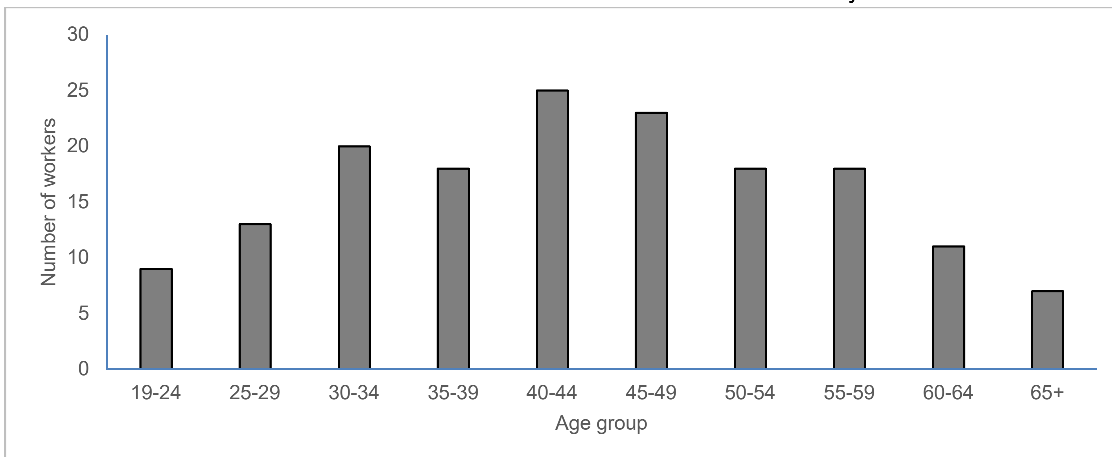
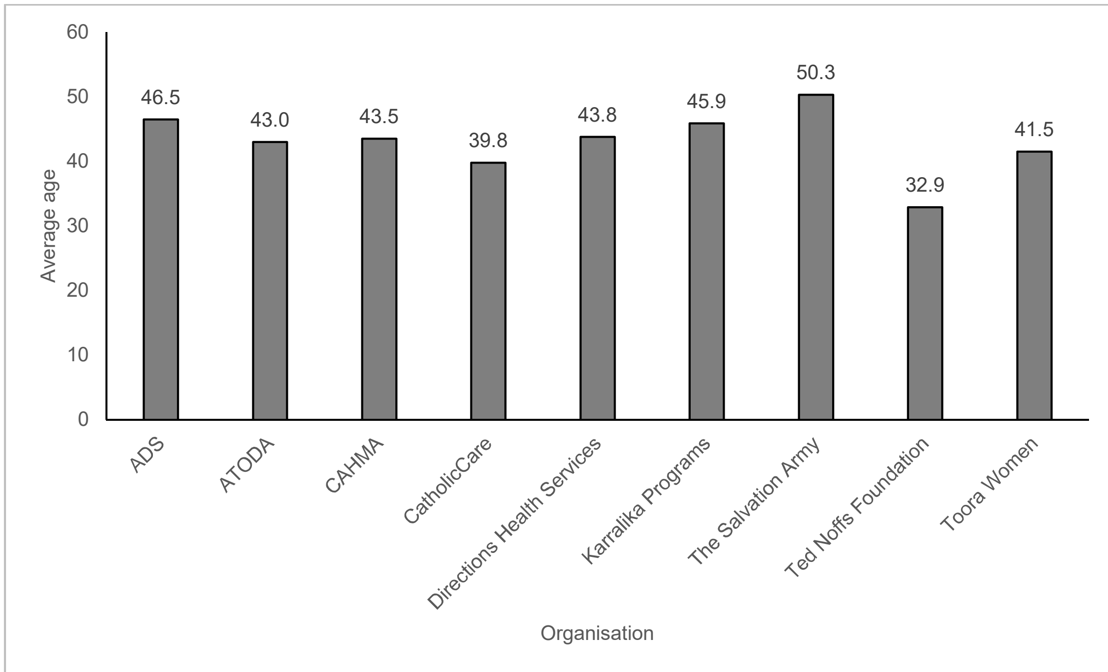


**Figure 3 Average age of the ACT AOD workforce by organisation (2017)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




### *3.3.2 Cultural and linguistic diversity*

According to the Organisation Survey there were a total of 4 Aboriginal and Torres Strait Islander and 1 culturally and linguistically diverse (CALD) identified positions in the participating specialist AOD services.[p] The Organisation Survey did not ask CEOs/Managers to estimate the number of workers identifying as Aboriginal and/or Torres Strait Islander.

Of respondents to the Worker Survey:

- Fewer than 5 people identified as being of Aboriginal origin (with none identifying as Torres Strait Islander, or both Aboriginal and Torres Strait Islander). Most of these were not employed in an Aboriginal and Torres Strait Islander identified position
- The majority of the survey respondents, 117 (71.8%) were born in Australia, with 14 (8.6%) born in the United Kingdom
- 18 (10.8%) spoke a language other than English at home (see Box 1).

[p] Note that these identified positions exclude those located in the Aboriginal and Torres Strait Islander Community Controlled services.

**Box 1 List of languages other than English spoken at home by survey respondents**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | |
|---|---|
| Arabic | Hebrew |
| Catalan | Indonesian |
| Chinese | Maori |
| Fante | Serbian |
| French | Spanish |
| German | |

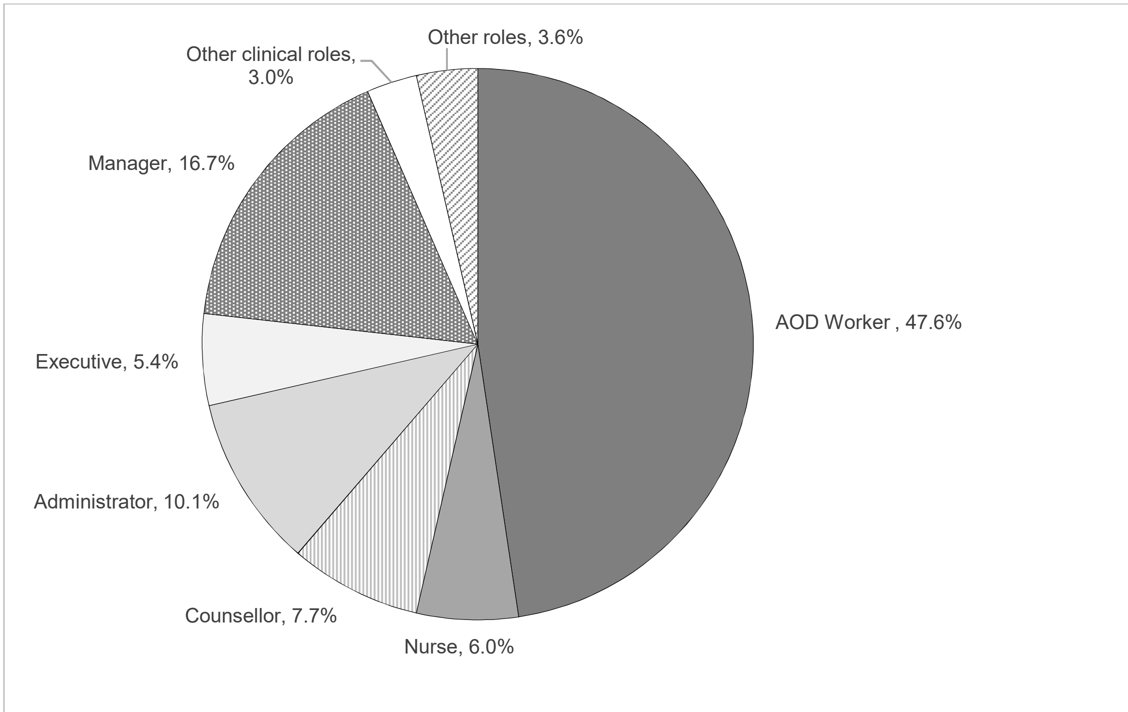
## 3.4 Job roles

As seen in Table 4 (section 3.2.1), EOs identified half of the AOD workforce as being AOD Workers (50.4%), with 11.4% Administrators, and 9.6% Managers. Of the Administrators, Executives, Managers and workers in 'Other Roles' who also had secondary responsibilities (23 of 75 workers), most (74%) had a secondary role as an Alcohol and Other Drug Worker. As shown in Figure 4, almost half (47.6%) of the Workers' Survey respondents were AOD Workers, with 16.7% Managers, 10.1% Administrators, and 7.7% Counsellors. 'Other roles' (3.6%) included Researchers, Policy Officers, and Project Officers. For people whose main roles were Administrator, Executive, Manager or Researcher/Policy Officer/Project Officer, 57.1% of them also took on a dual responsibility as an AOD Worker (see Figure 5). Some categories (i.e. General Practitioners, Addiction Medicine Specialists, Other Medical Specialists and Psychiatrists) did not include any respondents.

All role categories had more female than male workers, for example: 62.3% of AOD workers were female; 81.3% of Executives were female; and 88.9% of Managers were female. This is consistent with the proportions observed in the previous Workforce Profiles.

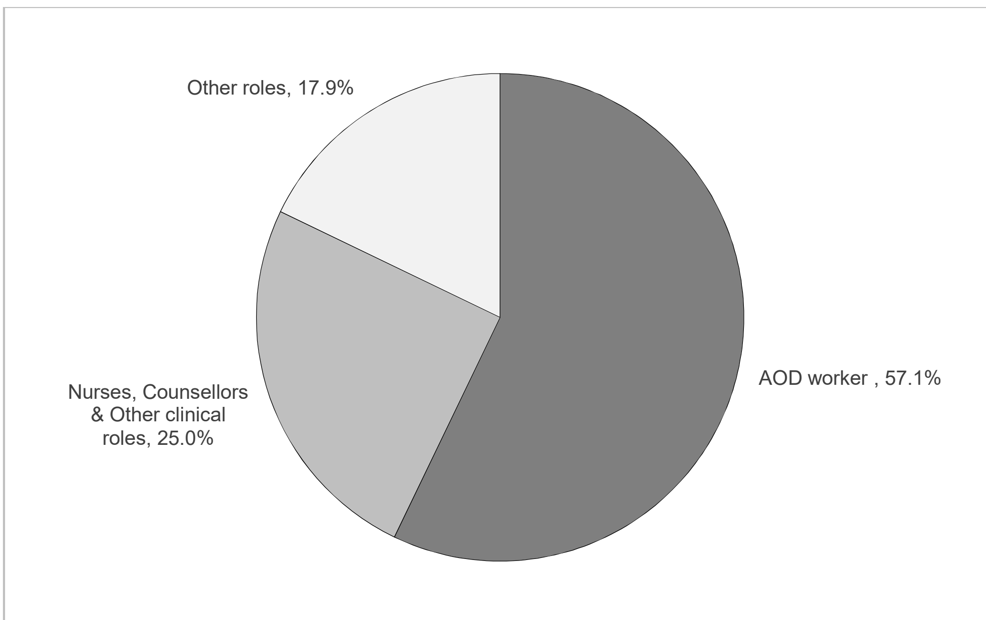
Twenty-five (14.8%) workers were in roles that required them to be registered with the Australian Health Practitioner Regulation Agency (AHPRA).

**Figure 4 Main roles of the Workers' Survey respondents**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: To preserve anonymity where response numbers are low, 'other clinical roles' includes 'nurse practitioner', 'clinical psychologist only', 'other psychologist only' and 'social worker only'; and 'other role' includes the response categories of 'researcher/policy officer/project officer' and 'other'.

**Figure 5 Dual responsibilities for survey respondents who are Administrators, Executives, Managers or Researchers/Policy Officers/Project Officers**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



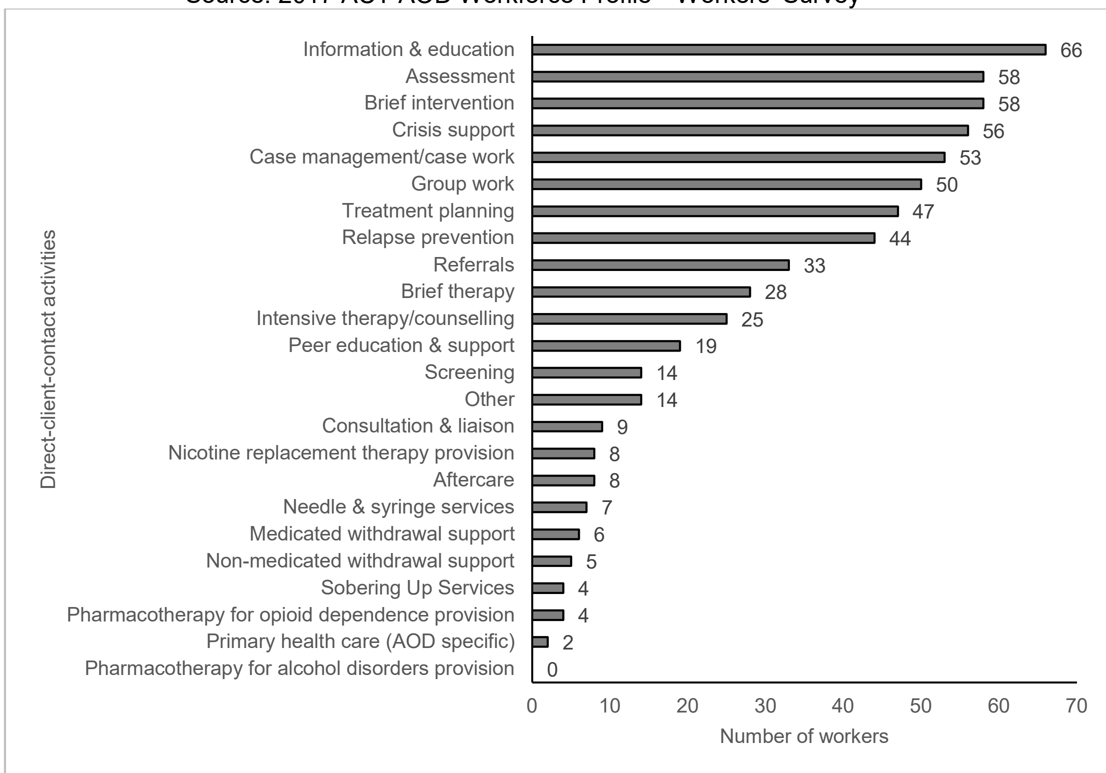
### 3.4.1 *Direct-client-contact vs non-client-contact activities*

Workers' Survey respondents were categorised into direct-client-contact workers and non-client-contact workers based on their self-reported engagement in any kind of direct-client-contact activities and their roles (see Appendix E). Of the valid survey responses, 133 (78.7%) were categorised as direct-client-contact workers and 36 (21.3%) were non-client-contact workers. This is comparable to the figures reported in the Organisation Survey of 84.7% direct client contact workers and 15.3% non-client-contact workers.[q]

Most people employed in the ATOD sector undertake a mix of direct-client-contact and non-client-contact activities. Workers who were categorised as direct-client-contact workers (n=133) reported spending, on average, 64.0% of their time on direct-client-contact activities with the highest numbers reporting the following activities (Figure 6):

- Information and education (66)
- Assessment (58)
- Brief interventions (58)
- Crisis support (56)
- Case management/case work (53)

**Figure 6 Numbers of direct-client-contact workers undertaking each type of direct-client-contact**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




[q] Note that the definition of 'direct-client-contact' and 'non-client-contact' may differ between the Organisation and Workers' Surveys—CEOs/managers completing the Organisation Survey self-defined the difference between the two.

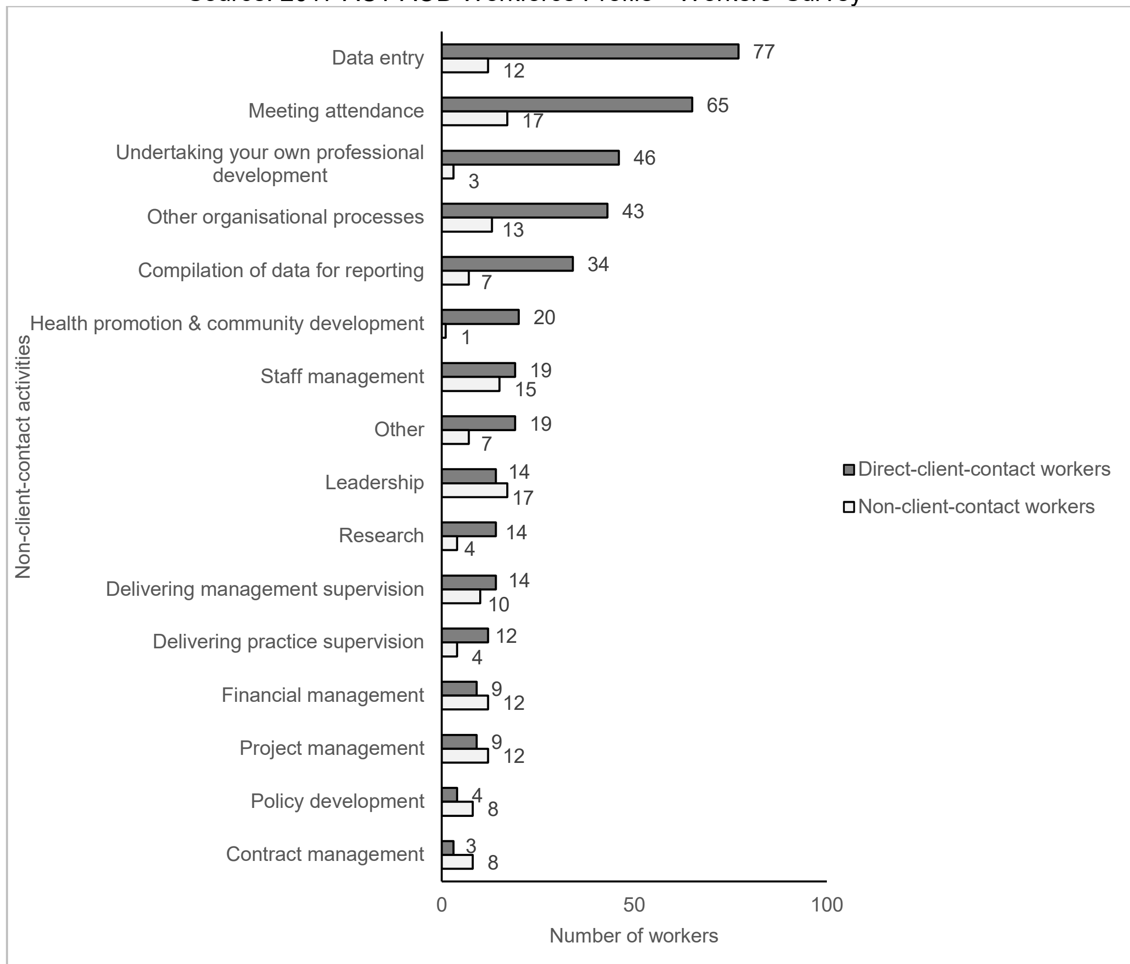
Direct-client-contact workers reported spending, on average, 36.0% of their time on non-client-contact activities with the highest numbers reporting the following activities (Figure 7):

- Data entry (77)
- Meeting attendance (65)
- Undertaking your own professional development (46)
- Other organisational processes (43)
- Compilation of data for reporting purposes (34)

Among those workers who were categorised as non-client-contact workers (n=36), the highest numbers reported the following non-client-contact activities (Figure 7):

- Leadership (17)
- Meeting attendance (17)
- Staff management (15)
- Other organisational processes (13)
- Financial management (12)
- Project management (12)
- Data entry (12)

**Figure 7 Numbers of direct-client-contact workers and non-client-contact workers undertaking each type of non-client-contact activity**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



After excluding ATODA (where no workers have direct-client-contact), the variations among organisations of average time spent on direct-client-contact versus non-client-contact activities is not significant (p=.098).

## 3.5 Employment status

In the Organisation Survey it was reported that: 41.6% of staff were employed in permanent full-time positions and 6.2% in fixed-term full-time positions; 31.0% were employed in permanent part-time positions and 5.8% in fixed-term part-time positions; and 15.5% in casual positions. Overall, similar proportions of males and females were employed in full-time, part-time and casual positions.

Data from the Organisation Survey shows that proportions of full-time, part-time and casual staff differed from service to service. At the Alcohol and Drug Service, ACT Health (75.6%), Ted Noffs Foundation (70.8%), and Karralika Programs (59.1%) the majorities of staff were employed full-time. The majority of staff at CAHMA (66.7%) and Toora Women (90%) were employed part-time (Figure 8).

In the Workers' Survey, more than half (57.6%) of the respondents indicated that they were full-time employees—49.4% permanent full-time and 8.2% fixed term full-time; 31.8% worked part-time—27.1% permanent part-time and 4.7% fixed term part-time; and 10.6% were casual workers[r] (Figure 9). For fixed term contract employees, the average total duration of their contract was 13.5 months.

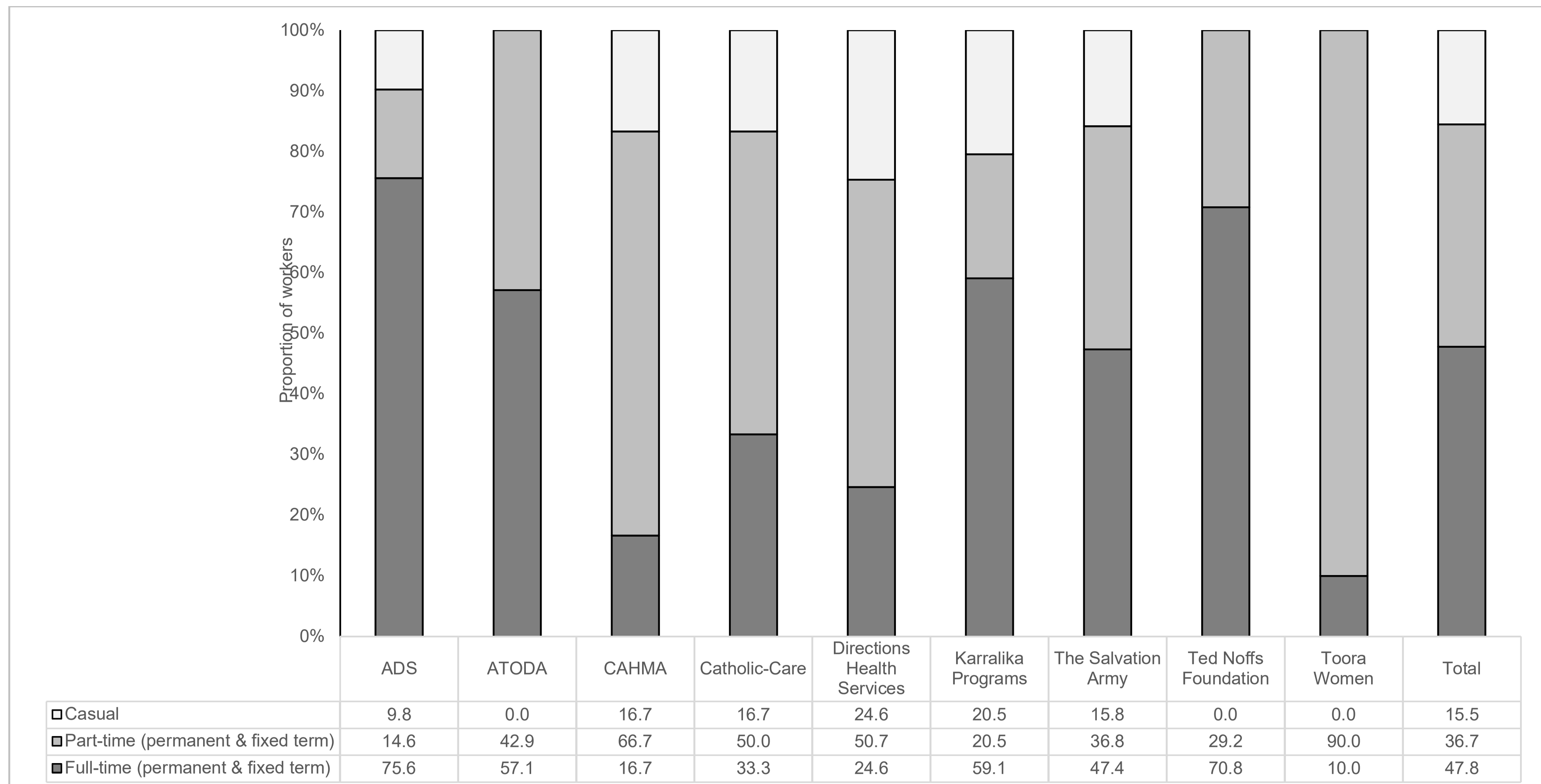
Of workers responding to the survey, higher proportions of female workers indicated they were employed part-time than for male workers (34.8% vs 21.6%, respectively)—this is in contrast to the 2014 profile where the proportions were similar (36.6% and 38%).

For AOD workers, the role with the highest proportion of respondents (see Section 3.4), similar proportions of workers were employed full-time (44.3%) and part-time (40.5%), with 15.2% employed casually. Most (86.5%) of Executives and Managers were employed full-time.

[r] Note that casual workers were not asked to specify if they were full-time or part-time.

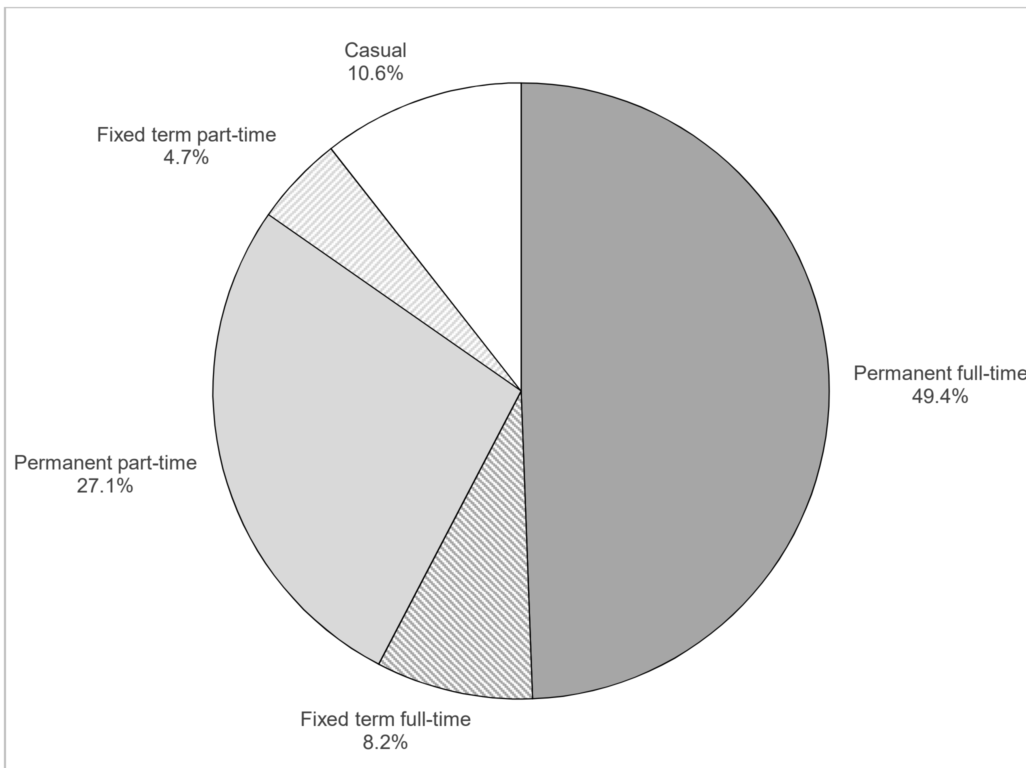
**Figure 8 Proportions of workers employed in full-time, part-time and casual positions by organisation (as reported in the Organisation Survey)**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | ADS | ATODA | CAHMA | Catholic-Care | Directions Health Services | Karralika Programs | The Salvation Army | Ted Noffs Foundation | Toora Women | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Casual | 9.8 | 0.0 | 16.7 | 16.7 | 24.6 | 20.5 | 15.8 | 0.0 | 0.0 | 15.5 |
| Part-time (permanent & fixed term) | 14.6 | 42.9 | 66.7 | 50.0 | 50.7 | 20.5 | 36.8 | 29.2 | 90.0 | 36.7 |
| Full-time (permanent & fixed term) | 75.6 | 57.1 | 16.7 | 33.3 | 24.6 | 59.1 | 47.4 | 70.8 | 10.0 | 47.8 |

**Figure 9** **Proportions of workers employed in full-time, part-time and casual positions (as reported in Workers' Survey)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




## 3.6 Hours worked

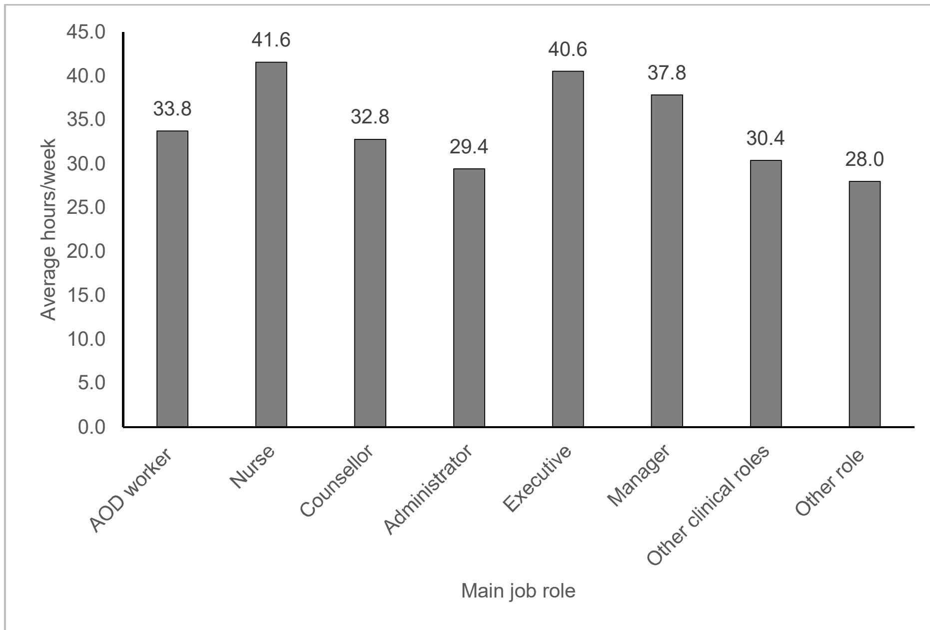
In the Organisation Survey, the EOs reported between 35 to 38 hours per week as their organisations' full-time hours. Respondents of the Workers' Survey indicated that they worked an average of:

- 38.1 hours for full-time workers (permanent and fixed-term)
- 31.6 hours for part-time workers (permanent and fixed-term)
- 23.6 hours for casual workers

The average for all workers was 34.5 hours per week, which is slightly higher than reported in the previous 2014 Workforce Profile (33.6 hours per week), but the same as reported in 2011 (34.5 hours per week).

As demonstrated in Figure 10, Nurses and Executives work the longest hours in the workforce, each averaging more than 40 hours per week.

**Figure 10** **Average weekly working hours by main job role**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: To preserve anonymity where response numbers are low, 'other clinical roles' includes 'nurse practitioner', 'clinical psychologist only', 'other psychologist only' and 'social worker only'; and 'other role' includes the response categories of 'researcher/policy officer/project officer' and 'other'.

## 3.7 Remuneration and non-remuneration entitlements

As indicated in the Organisation Survey, services operate under a range of different employment awards with several having their own award. These are listed in Box 2.

**Box 2** **Employment awards used in ACT specialist AOD services**
Source: 2017 ACT AOD Workforce Profile—Organisation Survey

- ACT Public Sector Health Professionals Enterprise Agreement.
- Nursing and Midwifery Enterprise Agreement 2013-2017.
- ACT Public Sector Medical Practitioners Enterprise Agreement 2013-2017.
- ACT Public Service Administrative and Related Classifications Enterprise Agreement 2013-2017.
- ACT Community Sector Multiple Enterprise Agreement 2014-2018
- Social, Community, Home care and Disability Services Award
- CatholicCare Canberra and Goulburn Enterprise Agreement 2015 - 2017.
- Directions ACT Enterprise Agreement 2014.
- Karralika Programs Single Enterprise Agreement

All respondents to the Workers' Survey were asked to provide information on their base hourly rate of remuneration. The average pre-tax base hourly rate was:

- $35.07 for all respondents (median $32.39; range $14.00[s] to $80.00)
- $30.90 for AOD workers only (median $31.00; range $23.00 to $47.64)

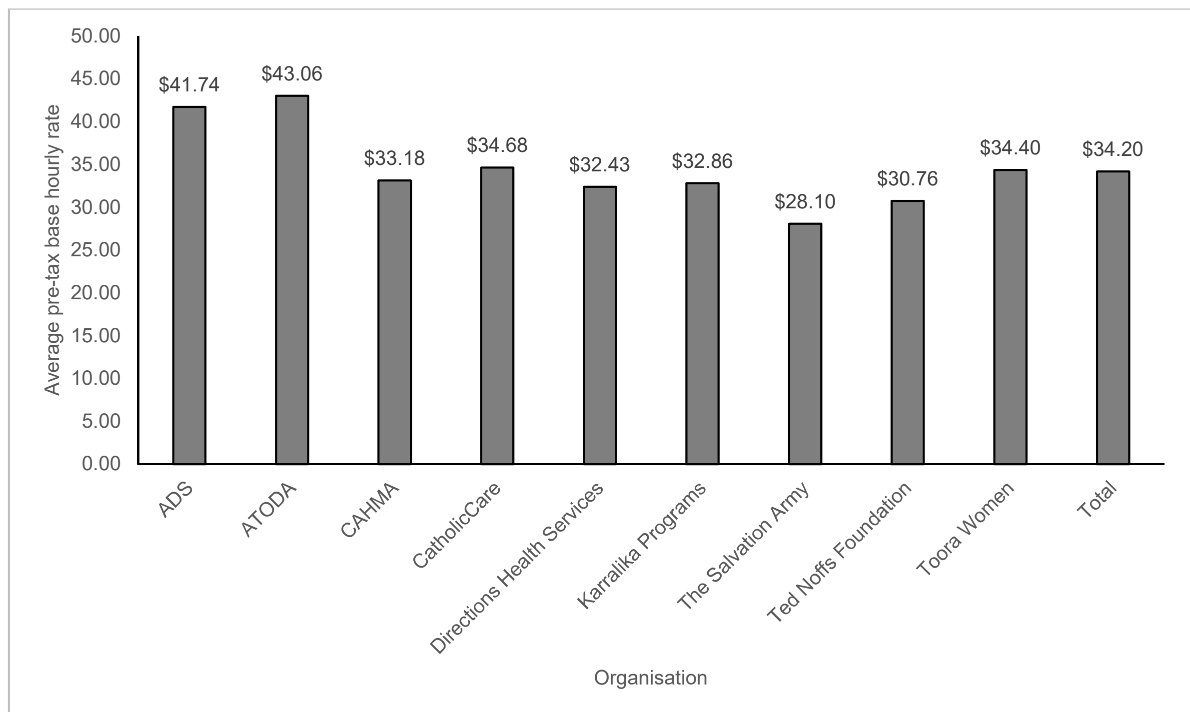
It is clear from these figures that the distribution of the data is skewed. This skewness comes largely from the data of Executives, who had a much higher average pre-tax base hourly rate than other job role categories ($60.73), and were also least likely to have provided their average pre-tax base hourly rate (only 56% completed this question, compared to more than 75% for each of the other job role categories).

Consequently, when Executives were excluded from the analysis, the average pre-tax base hourly rate for all remaining job categories was $34.20 (median $32.00; range $14.00[s] to $61.99).

Figure 11 shows the average pre-tax base hourly rate by organisation for all workers except Executives.

**Figure 11 Average pre-tax base hourly rate of pay by organisation for all workers excluding Executives**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey

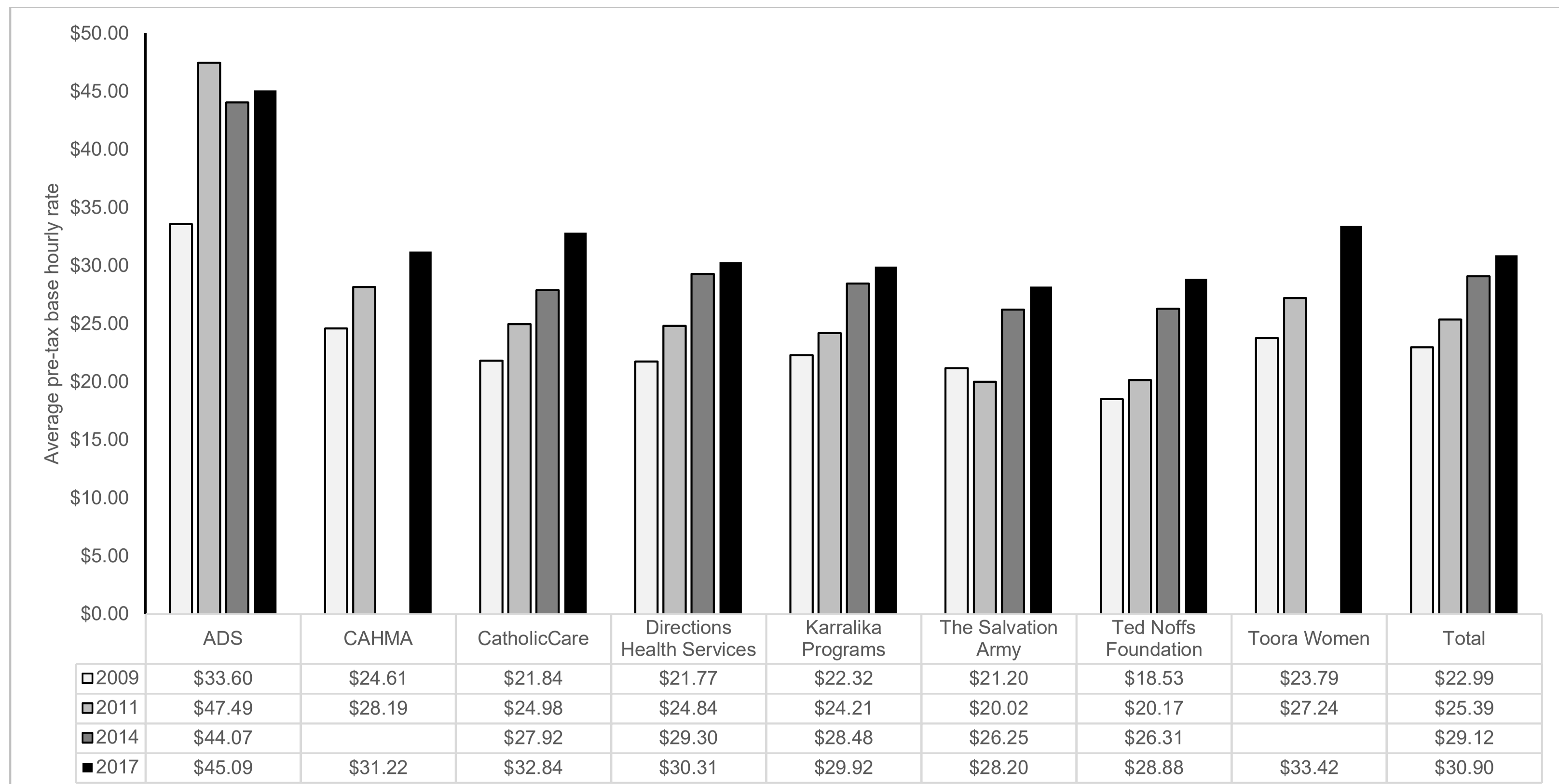



[s] As this figure is below the pre-tax hourly rates required in the awards listed above (Box 2), it is likely to be a reporting error (e.g. the respondent reported their post-tax earnings).

Figure 12 shows how the average pre-tax base hourly pay rate has changed over time for *AOD Workers only* across the different organisations (ATODA is excluded, as there are no AOD Workers). Previous Workforce Profiles included the classifications of Clinical AOD Workers and Non-Clinical AOD Workers, which broadly (but not exactly) maps onto the 2017 categorisation of AOD Workers. Despite this, the pay rates could be broadly compared over time, showing a trend towards an increase in pay rates over the years of the surveys (Figure 12).

**Figure 12** **Comparison over time of average pre-tax base hourly rate of pay of AOD Workers only, by organisation (2009, 2011, 2014 and 2017), and for all AOD Workers**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | ADS | CAHMA | CatholicCare | Directions Health Services | Karralika Programs | The Salvation Army | Ted Noffs Foundation | Toora Women | Total |
|---|---|---|---|---|---|---|---|---|---|
| 2009 | $33.60 | $24.61 | $21.84 | $21.77 | $22.32 | $21.20 | $18.53 | $23.79 | $22.99 |
| 2011 | $47.49 | $28.19 | $24.98 | $24.84 | $24.21 | $20.02 | $20.17 | $27.24 | $25.39 |
| 2014 | $44.07 | | $27.92 | $29.30 | $28.48 | $26.25 | $26.31 | | $29.12 |
| 2017 | $45.09 | $31.22 | $32.84 | $30.31 | $29.92 | $28.20 | $28.88 | $33.42 | $30.90 |

Notes:

- 'AOD Workers' was the category used in the 2017 Workforce Profile; earlier Profiles used the categories 'Clinical ATOD Worker' and 'Non-Clinical ATOD Worker', which have been combined for the purposes of this graph
- In the 2014 Workforce Profile, there were no workers who identified as 'ATOD Workers' at CAHMA, and the data from Toora Women could not be used (see 2014 Workforce Profile report for an explanation)[16]

As demonstrated in Figure 13, on average people aged between 40 and 59 years are earning more than people who are younger than 40 years or older than 60 years.

**Figure 13 Average pre-tax base hourly rate of pay by age group**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

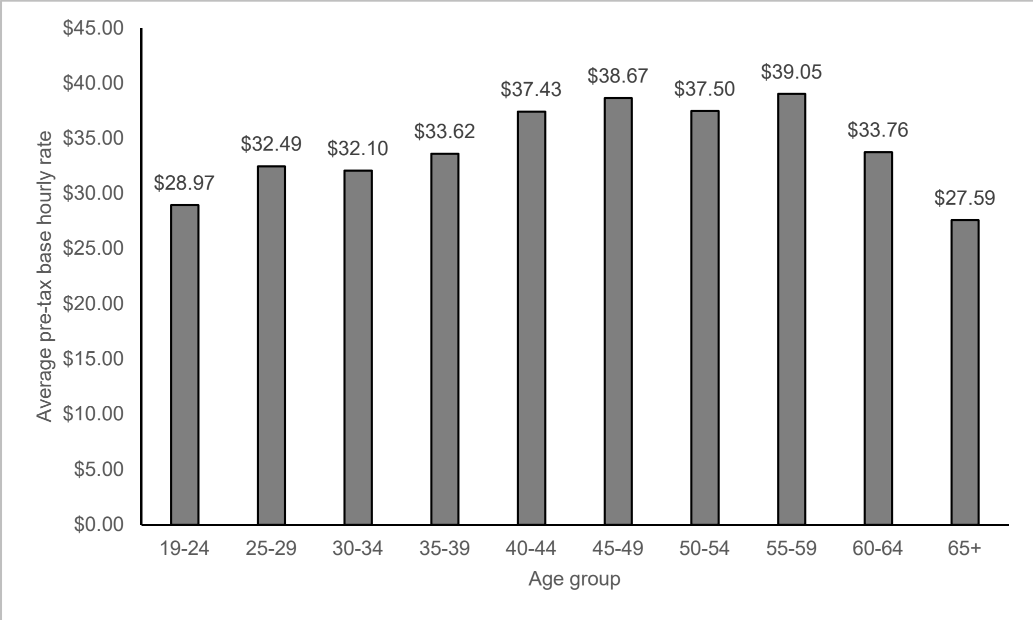
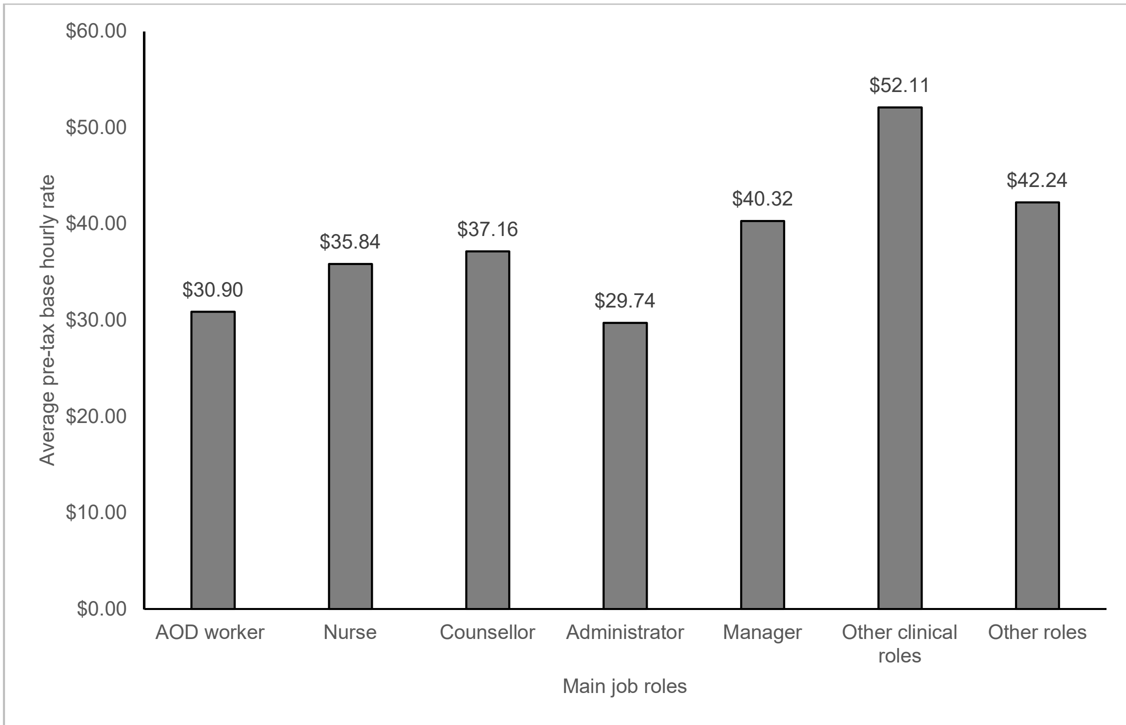



Figure 14 shows that Administrators and AOD Workers earn lower pre-tax base hourly rates compared to others; this difference is significant (p=0.000). There is no significant difference in pre-tax hourly pay rates between males and females, nor in relation to length of time that workers have been in the ATOD sector, in their current organisation, or in their current position.

There was also a significant difference in the average pre-tax base hourly rate between direct-client-contact workers and non-client contact workers (p<0.05)—$33.71 and $40.83 respectively. This difference is likely due to the higher pay received by Executives (who are non-client contact workers); when Executives are removed from the analysis, the difference is no longer significant.

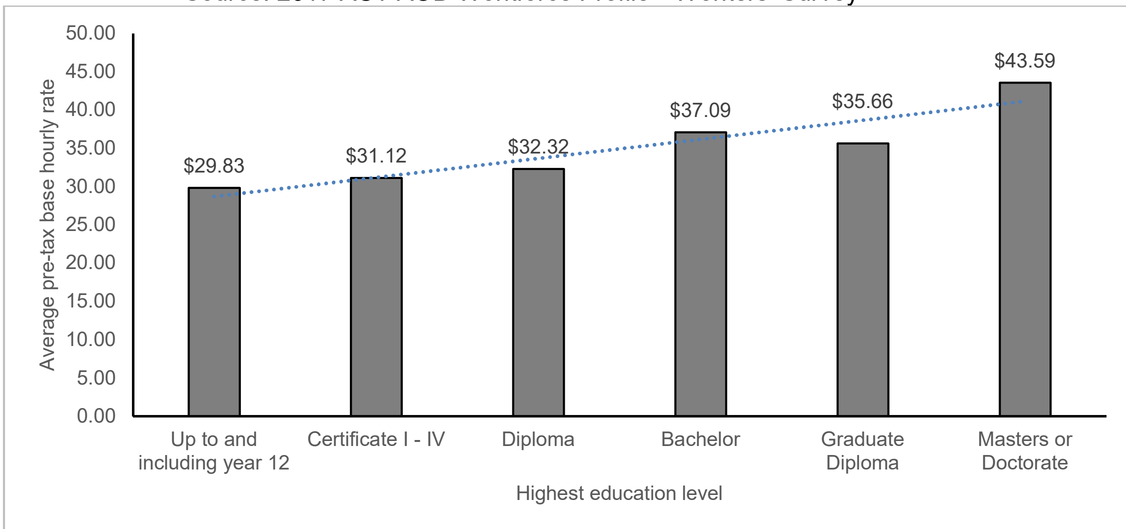
**Figure 14** **Average pre-tax base hourly rate of pay by main job role**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: To preserve anonymity where response numbers are low, 'other clinical roles' includes 'nurse practitioner', 'clinical psychologist only', 'other psychologist only' and 'social worker only'; and 'other role' includes the response categories of 'researcher/policy officer/project officer' and 'other'.

Figure 15 shows the pre-tax base hourly rate of the survey respondents by highest education level, with the trend-line showing that hourly pay increases with education level—the differences in pay rate are significant between workers with an education level up to and including a diploma, and workers with a bachelor degree or higher (p=.000).

**Figure 15** **Average pre-tax base hourly rate of pay by respondents' highest education level**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



### 3.7.1 *Entitlements*

People completing the Organisation Survey were asked to identify the additional entitlements offered by their organisation. Box 3 show examples of the types of benefits that are offered to employees (not all are available in each organisation).

**Box 3 Additional entitlements offered to employees of specialist AOD services**
Source: 2017 ACT AOD Workforce Profile—Organisation Survey

- Above award payments
- Access to professional development (during work hours)
- Additional paid leave (e.g. between Christmas and New Year)
- Annual salary increments (other than as required by award)
- Bereavement leave
- Birthday leave
- Carers leave
- Childcare
- Christmas bonus
- Conference leave
- Cultural leave
- Domestic and family violence leave
- Emerging Leaders Program
- Employee Assistance Program
- Family leave
- First Aid allowance
- Flexible work practices
- Free parking
- Fringe benefits tax exemption / salary packaging
- Indexation
- Leave loading
- Maternity leave (paid)
- Maternity leave (unpaid)
- Paternity leave (paid)
- Paternity leave (unpaid)
- Private use of work phone
- Private use of work vehicle
- Purchase annual leave provisions
- Reimbursement of kilometres travelled
- Salary sacrifice to superannuation
- Special leave in lieu of working on public holidays
- Study assistance
- Study leave (paid)
- Study leave (unpaid)
- Time in lieu or paid overtime
- Travel allowance
- Unpaid leave provisions
- Work Health and Safety allowance

## 3.8 Work history

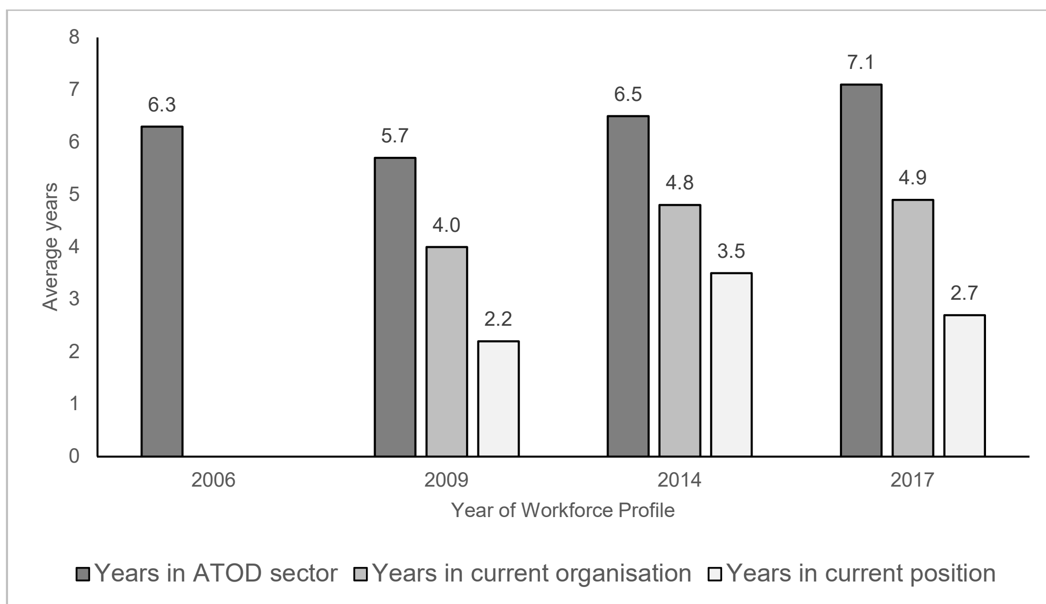
Table 5 shows the average and median number of years that workers indicated they have worked in the ATOD sector, in their current organisation, and in their current position. While the average years working in the ATOD sector was just over 7 years, about half of the workers had been working in the ATOD sector for approximately 5 years or fewer. About one-third of workers (31.6%) have been in the ATOD sector for fewer than 2 years, and 8.4% for 20 years or more.

**Table 5** **Workers' average years in the ATOD sector, in their current organisation, and in their current position**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | Average (mean) (years) | Median (years) | Range |
|---|---|---|---|
| **Years in ATOD sector** | 7.1 | 4.9 | 2 months – 40 years |
| **Years in current organisation** | 4.9 | 3.0 | 1 month – 30 years |
| **Years in current position** | 2.7 | 1.3 | 1 day – 30 years |

Figure 16 shows that there has been a trend towards a slight increase over time in the average years that workers are in the ATOD sector and in their current organisations, while the average years in their current positions rose between 2009 and 2014 and then fell again in 2017.

**Figure 16** **Workers' average years in the ATOD sector, in their current organisation, and in their current position—change over time**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

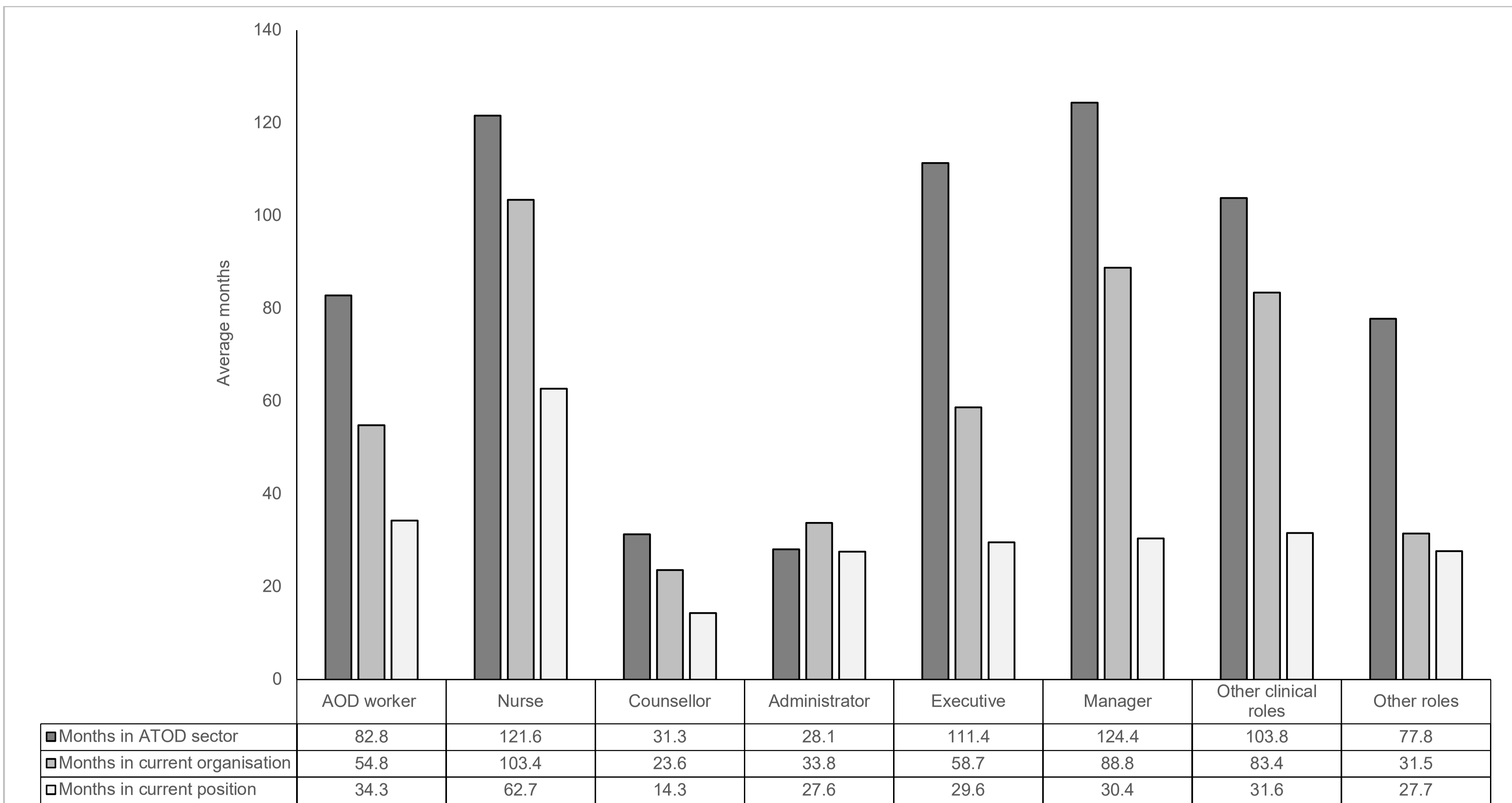



Note: This data is not available for the survey conducted in 2011. The 2006 Workforce Profile did not report specifically on years in current organisation and years in current position.

Figure 17 shows that on average workers who are currently Managers, Nurses and Executives have been in the ATOD sector for the longest duration. Workers who are currently Nurses, Managers and in 'Other clinical roles' stayed in their current organisations for the longest duration. Workers who are currently in Counsellor and Administrator roles have had the least amount of time in their current position, in their current organisations, and in the ATOD sector. Note that this analysis relates to the *current* role of workers—they may have held other positions at other times in their careers.

**Figure 17 Average length of time (months) in the ATOD sector, current organisation, and current position, by current primary job role**

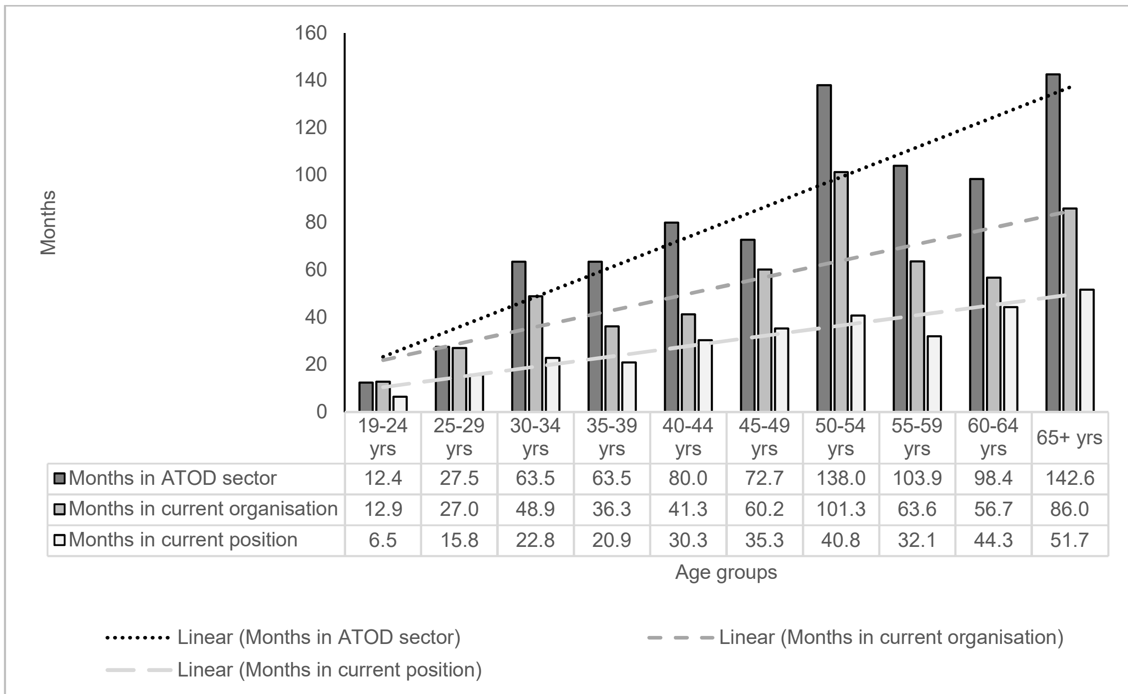
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | AOD worker | Nurse | Counsellor | Administrator | Executive | Manager | Other clinical roles | Other roles |
|---|---|---|---|---|---|---|---|---|
| Months in ATOD sector | 82.8 | 121.6 | 31.3 | 28.1 | 111.4 | 124.4 | 103.8 | 77.8 |
| Months in current organisation | 54.8 | 103.4 | 23.6 | 33.8 | 58.7 | 88.8 | 83.4 | 31.5 |
| Months in current position | 34.3 | 62.7 | 14.3 | 27.6 | 29.6 | 30.4 | 31.6 | 27.7 |

As seen in Figure 18, and not surprisingly, time in the ATOD sector, organisation and current position corresponds to age, with older workers having worked longer in each situation.

**Figure 18 Average length of time (months) in ATOD sector, current organisation, and current position, by age group**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

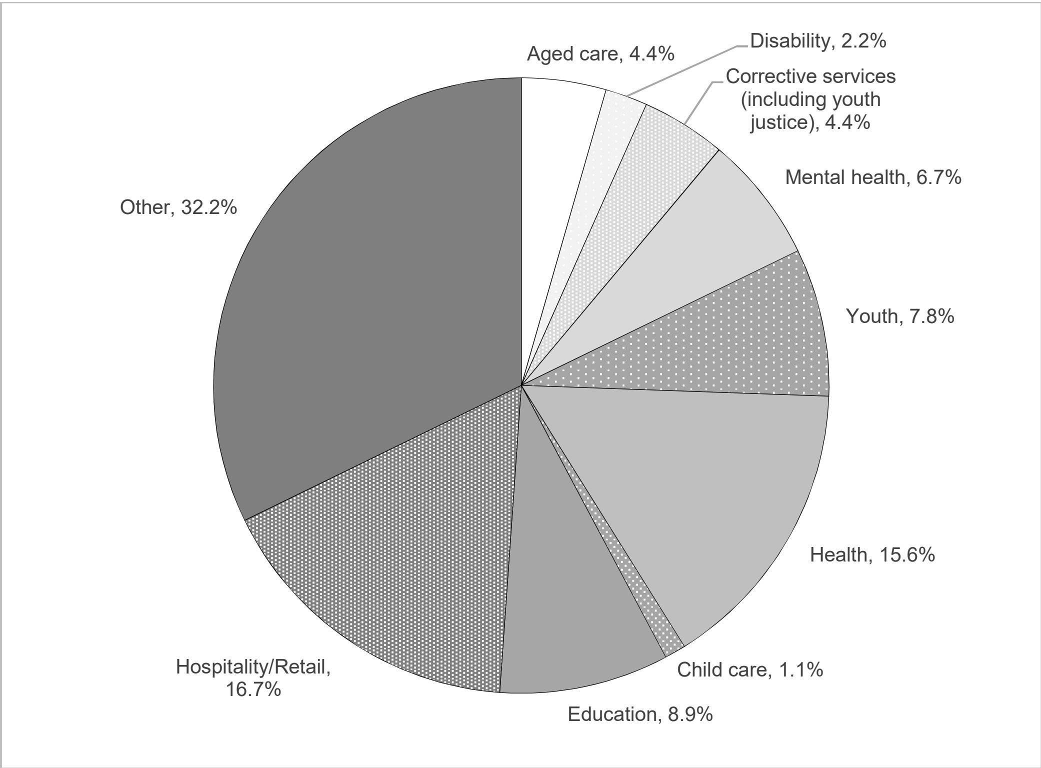



| | 19-24 yrs | 25-29 yrs | 30-34 yrs | 35-39 yrs | 40-44 yrs | 45-49 yrs | 50-54 yrs | 55-59 yrs | 60-64 yrs | 65+ yrs |
|---|---|---|---|---|---|---|---|---|---|---|
| Months in ATOD sector | 12.4 | 27.5 | 63.5 | 63.5 | 80.0 | 72.7 | 138.0 | 103.9 | 98.4 | 142.6 |
| Months in current organisation | 12.9 | 27.0 | 48.9 | 36.3 | 41.3 | 60.2 | 101.3 | 63.6 | 56.7 | 86.0 |
| Months in current position | 6.5 | 15.8 | 22.8 | 20.9 | 30.3 | 35.3 | 40.8 | 32.1 | 44.3 | 51.7 |

Over half (56.8%) of the survey respondents had their last paid employment position outside the ATOD sector. Among these, about one-third had worked in each of non-government settings (31.2%), government settings (32.3%), and private settings (34.4%).

When examined by sector, respondents whose last position was outside the ATOD sector reported having been employed in the hospitality/retail (16.7%), health (15.6%), education (8.9%), youth (7.8%) and mental health (6.7%) sectors. Nearly one-third had worked in an 'other' sector, which included for example: research, environment, finance, construction (Figure 19).

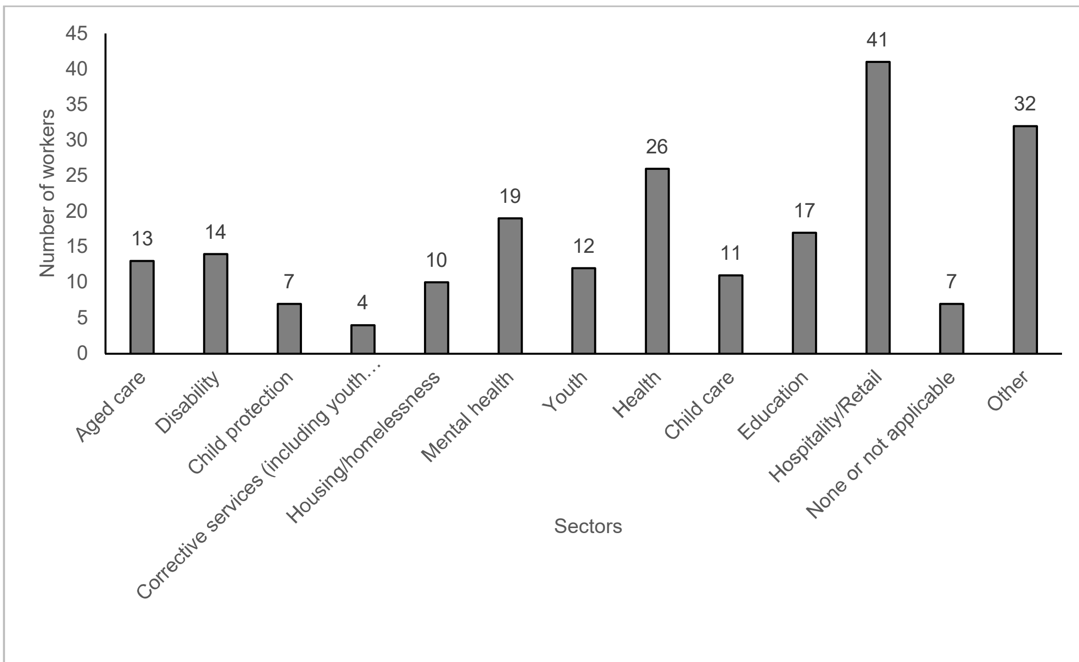
**Figure 19 Workers' reported last paid employment position if outside the ATOD sector**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: There were no responses for 'Child protection' and 'Housing/homelessness'

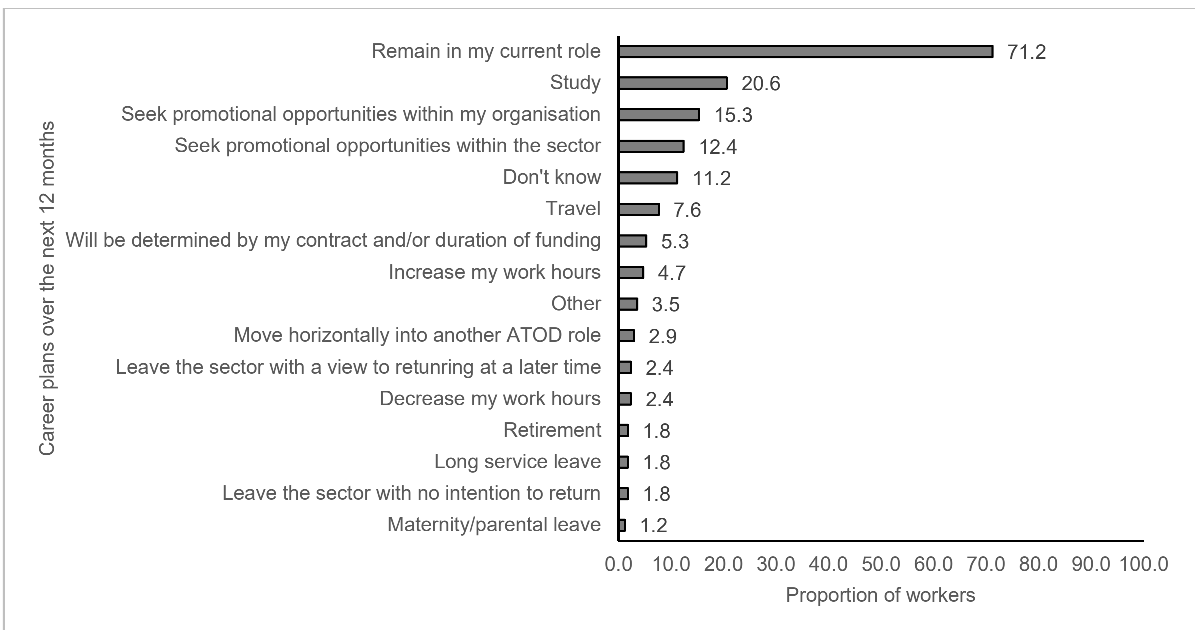
Workers were also asked which other sectors they had *ever* had experience working in before joining the ATOD sector—workers could indicate multiple responses. Forty-one workers had previous experience in the hospitality/retail sector, 26 in the health sector, and 19 in the mental health sector. Other sectors (32 workers) included, for example: building and construction; Aboriginal Health; Family and Domestic Violence Services; information technology (Figure 20).

**Figure 20 Other sector(s) that survey respondents have worked in**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Survey respondents were asked "What are your career plans over the next 12 months?", with the majority (71.2%) responding that they planned to "remain in my current role" in the next 12 months (see Figure 21). Twenty-one percent had plans to study in the next 12 months. Thirty-two workers (18.8%) planned to seek promotion opportunities within their organisation and/or within the sector (15 workers indicated both options).

**Figure 21 Survey respondents' career plans over the next 12 months**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: Workers could indicate multiple responses.

## 3.9 Qualifications

### *3.9.1 Qualifications attained*

Workers were asked to describe the qualifications that they had completed—many workers had multiple qualifications in different areas of study. Respondents described the levels and types of qualifications they had as follows:

- about half (49.7%) had qualifications in an ATOD-specific area
- 70.8% had qualifications in a non-ATOD health/social/behavioural sciences area
- 40.4% had a qualification in other areas of study (i.e. non-ATOD and also not in the health/social/behavioural sciences areas).

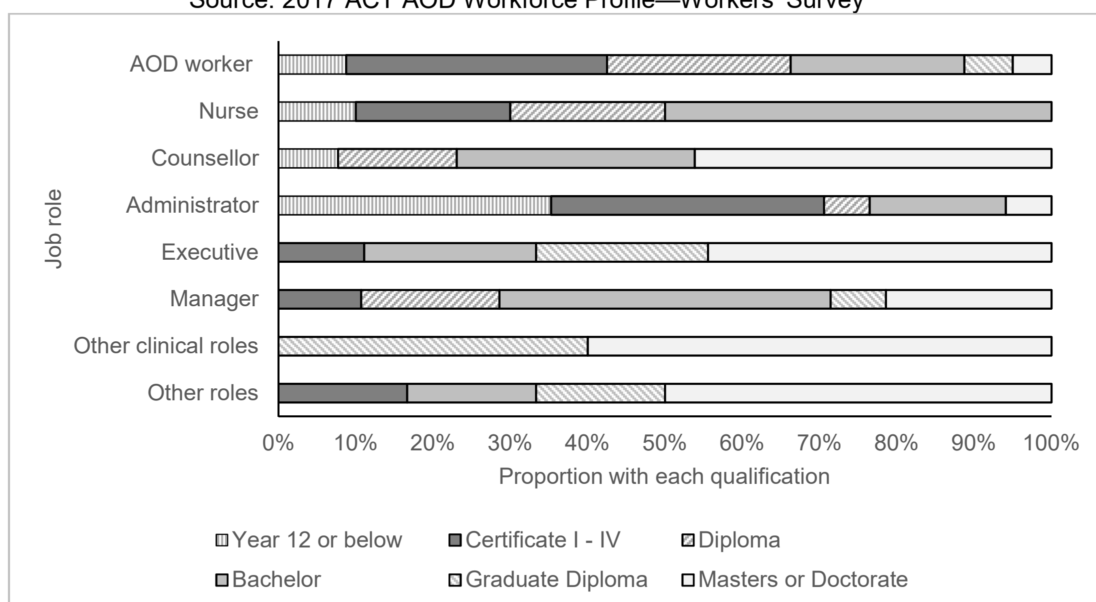
Just over half (50.3%) of the respondents had a bachelor or above qualification (see Table 6).

**Table 6 Survey respondents' overall highest education qualifications**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Highest education level | Frequency | Proportion (%) |
|---|---|---|
| Up to and including Year 12 | 15 | 8.8 |
| Certificate I-IV | 40 | 23.4 |
| Diploma | 30 | 17.5 |
| Bachelor Degree | 46 | 26.9 |
| Graduate Diploma | 12 | 7.0 |
| Masters or Doctoral Degree | 28 | 16.4 |
| Total | 171 | 100.0 |

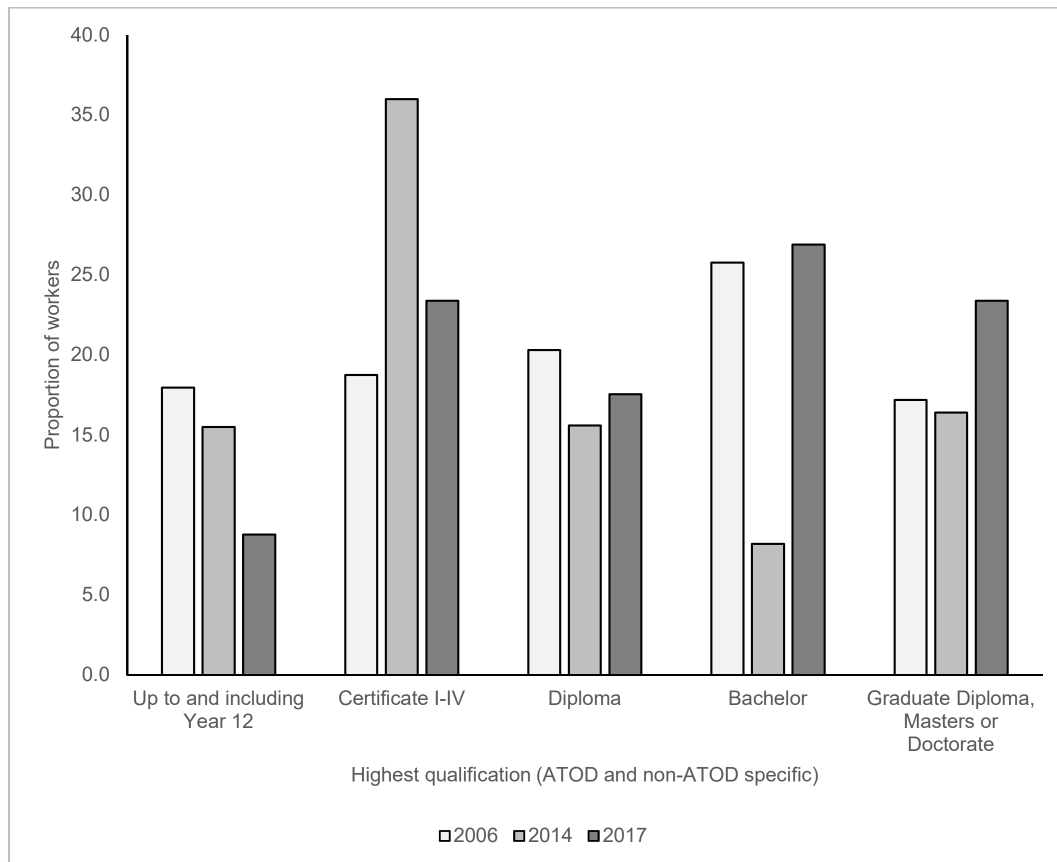
The highest qualifications among AOD workers were: 27 (33.8%) had attained a Certificate I-IV; 19 (23.8%) had a Diploma; and 27 (33.8%) had a Bachelor degree or higher (Figure 22).

**Figure 22 Highest education qualifications of workers by their main roles**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



As seen in Figure 23, the trend over time has been towards an increasingly qualified workforce.

**Figure 23 Highest education qualifications of the survey respondents over time (comparing 2006, 2014 and 2017 surveys)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note that the data from the 2009 and 2011 Workforce Profiles are not reported as they are only available for AOD Qualifications, and are therefore not comparable to this data which relates to *all* qualifications.

### *3.9.2 Current study*

The majority (65.9%) of the respondents were not undertaking any study or training at the time of the survey. Of those doing study or training (n=56)

- most (30) were undertaking ATOD-related studies, including
  - 12 undertaking the AOD Skill Set subjects
  - 7 studying towards a Certificate IV in AOD
- 11 were studying towards a Bachelor degree in a health-related field (non-ATOD)

## 3.10 Qualifications Strategy

The ACT Alcohol and Other Drug Qualifications Strategy (previously the Minimum Qualification Strategy) requires relevant workers in specialist AOD services to have:

1. either completed an:
    a. ATOD qualification at Certificate IV or higher, or
    b. have completed a tertiary qualification in a health-, social- or behavioural-related field plus completed the 'AOD Skill Set'
2. a current First Aid qualification

ACT Health provides funding to support the development and implementation of the Qualifications Strategy through ATODA including the provision of full training subsidies to eligible workers.

Appendix E includes a full description of the ACT AOD Qualification Strategy (QS).

Respondents of the Organisation Survey identified a total of 194 workers as having direct-client-contact (i.e. those workers to whom the QS applies), of whom 154 met the requirements of the QS (79.4%). This is a similar proportion as reported in the 2014 survey—75.4%.[t]

Figure 24 shows Workers' Survey respondents' progress against the QS, both completed and in progress.

Of the valid survey responses (n=169), 36 were non-client-contact workers and 133 were direct-client contact workers. As the QS only applies to workers with direct-client-contact, only these 133 workers were considered in the subsequent analysis. Of the 133 workers, 4 were excluded from the analysis as their progress against the QS could not be determined from the responses provided.

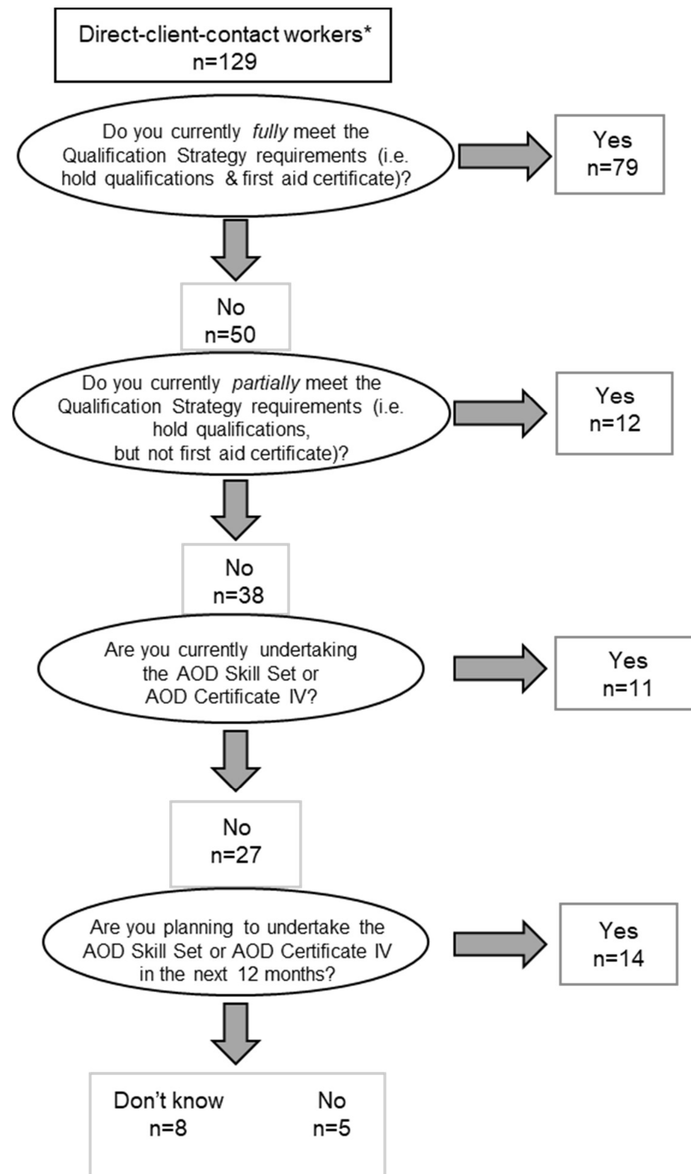
Figure 24 shows that.

- Of the remaining 129 workers, 79 (61.2%) fully met the Qualifications Strategy requirements (requirements 1 and 2 listed above)
- Of the 50 workers who did not meet the QS requirements,
    - 12 had completed the AOD training / qualifications requirements of the QS, but did not have a current First Aid Certificate.
    - 11 workers were currently undertaking the AOD Skill Set units
- Of the 27 who had not yet attained or were not yet undertaking any AOD Skill Set units, 14 were planning to commence this training in the next 12 months
- 13 workers were neither currently meeting, undertaking nor planning to undertake the AOD Skill Set (10.1% of the 129 workers)—they either indicated that they were not planning to commence training in the next 12 months, or 'did not know' whether they would be or not.

[t] Although this is not directly comparable as the 2014 Workforce Profile reports on all workers, not just those with direct-client-contact only (as in the 2017 Workforce Profile).

Most (80.3%) of the survey respondents classified as having direct-client-contact indicated they had a current Provide First Aid Certificate or equivalent.

**Figure 24 Survey respondents' progress against the Qualifications Strategy**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

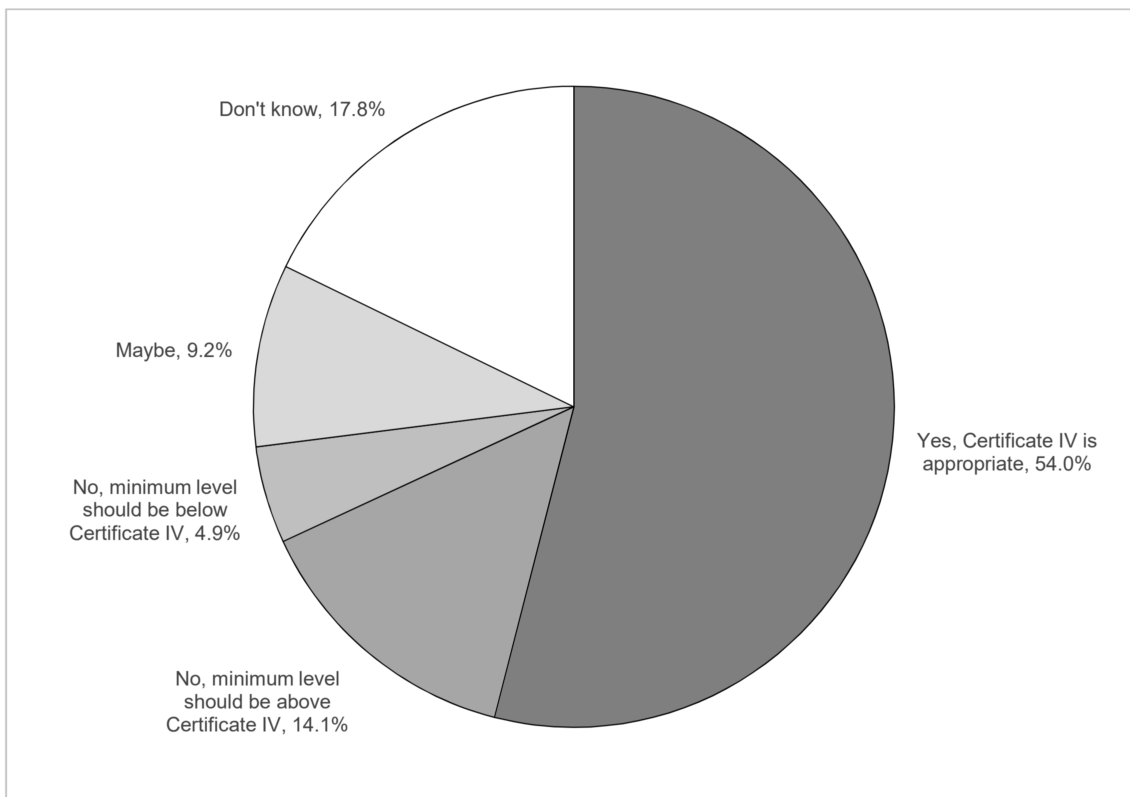



*. This figure includes direct-client-contact workers whose progress against the Qualification Strategy could be determined from their responses to the survey (i.e. 129 workers of the 133 direct-client-contact workers) For details of the analysis for this figure, please refer to Appendix E.

Survey respondents were asked to indicate if they thought a Certificate IV was an appropriate *minimum* level of qualification for the AOD workforce in the ACT. As demonstrated in Figure 25, more than half (54%) of the respondents thought a Certificate IV was an appropriate minimum level of qualification; 14% thought the minimum level of qualification should be above

the Certificate IV; 5% thought the minimum level of qualification should be below the Certificate IV; and the remaining respondents were either not sure or didn't know.

**Figure 25 Survey respondents' opinions regarding whether or not Certificate IV is an appropriate minimum qualification for the AOD workforce in the ACT**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Workers gave a number of reasons for their answers that have been themed in Box 4. Themes crossed over the response categories, but the most consistent responses included that: lived experience and/or long-term experience working in the sector should be taken into account when considering the level of qualifications required; having higher qualification expectations could put AOD work out of reach for many workers; and that the complexity of AOD issues is significant and requires higher levels of training than that provided by the AOD Certificate IV.

**Box 4 Common themes in survey respondents' reasons for responses regarding whether or not Certificate IV is an appropriate minimum qualification for the ATOD workforce in the ACT**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey

**Lived experience and/or years in the sector should be considered**

*"Having to have Cert IV as minimum excludes valuable and skilled people who have lived experience. This is an invaluable resource and support for the clients"*

**Training in other sectors is also useful or necessary**

*"Other qualifications such as youth work or mental health are at times more useful"*

**A higher [than Certificate IV] expectation of training would put AOD work out of reach for many**

*"Provides foundation skills but recognises not everyone can study at a higher level, but is still a good worker"*

**Complexity of issues in AOD requires higher level of training**

*"AOD is a specialist role, clients can be very complex meaning staff need the appropriate skills to support them"*

**More study than [a Certificate IV] is not compensated for by the low pay**

*"We get paid nowhere near enough to make it worth any more study"*

**Certificate IV is sufficient when supplemented with ongoing training**

*"Yes [Certificate IV is sufficient], provided that further training is continued on regular basis (ie. courses)"*

**More intensive work requires higher qualifications**

*"Higher qualifications should be required for more intensive psychosocial/ therapeutic activities"*

**Higher qualifications, including in a health-, social- or behavioural-related field, should be sufficient without the AOD Skill Set**

*"A BA Psychology should also be sufficient. I do not see it necessary to do a 4 core competencies course"*

**Not sure of the quality of the course**

*"Not convinced of the quality of the content in the Certificate IV. Notice deficits in training into practice"*

## 3.11 Professional development, training and support

EOs/Managers completing the Organisation Survey indicated that:

- Six organisations have individual professional development plans for all or most of their staff.
- Two organisations provide a professional development budget specifically for each staff member (as a proportion of their wages); however, 2 other organisations have professional development budgets allocated specifically within each program/project, and 2 further organisations indicated that they have funding for professional development within their organisational budgets.

- Across the ACT ATOD sector, organisations offer student placements to more than 54 students per year, with around half of these in the government service. Consistent with the types of treatment offered, all placements for Certificate IV AOD students (14) are in the non-government specialist AOD services, while the majority of nursing and medicine student placements (24 of 27) are in the government service.

In the Workers' Survey, the majority of workers (66.2%) indicated they had participated in some professional development opportunities offered by their organisation in the last 12 months.

A professional growth scale was included in the Workers' Survey and is reported in Section 3.15.2. However, it is worth reporting separately on a number of the individual questions asked as part of this scale:

- Your organisation encourages and supports professional growth
- Keeping your skills up-to-date is a priority for you
- You do a good job of regularly updating and improving your skills

These were answered on a scale of 1 (strongly disagree) to 5 (strongly agree), with the average responses (out of 5.0) to these questions reported in Table 7. Keeping skills up-to-date is very important to workers in all organisations (average score 4.3, with the lowest score 4.0). Organisations are perceived to provide good to excellent encouragement and support for professional growth (average score 3.8, with an organisational score range of 3.5 to 4.4). Workers are good at regularly updating and improving their skills (average score 3.7).

**Table 7 Responses to questions about professional growth by organisation**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | Your organisation encourages and supports professional growth | Keeping your skills up-to-date is a priority for you | You do a good job of regularly updating and improving your skills |
|---|---|---|---|
| Alcohol and Drug Services | 3.8 | 4.4 | 3.8 |
| ATODA | 4.3 | 4.3 | 3.6 |
| CAHMA | 4.4 | 4.4 | 3.2 |
| CatholicCare | 3.7 | 4.7 | 3.8 |
| Directions Health Services | 4.3 | 4.5 | 3.9 |
| Karralika Programs | 3.5 | 4.0 | 3.4 |
| The Salvation Army | 3.7 | 4.2 | 3.8 |
| Ted Noffs Foundation | 3.5 | 4.4 | 3.4 |
| Toora Women | 3.8 | 4.7 | 4.3 |
| **Total** | **3.8** | **4.3** | **3.7** |

### *3.11.1 Professional development priorities*

Not surprisingly, organisations and workers indicated a variety of professional development priorities, as listed in Box 5. Among the CEOs/Managers who completed the Organisation Survey, cultural/diversity awareness or competency training was cited by three organisations. A large number of workers indicated the desire to complete or undertake specific formal study/training opportunities, with high numbers also indicating the wish to undertake a variety of different types of other available general training opportunities (e.g. improve knowledge of AOD). Twenty-seven workers specifically cited their desire to keep up-to-date with AOD information about changes in AOD trends, treatments, services and policies. There were a high number of mentions (42) of training in management, leadership, governance and associated skills. Five workers also mentioned that there were limitations to their professional development opportunities, including having the time and resources to undertake them, and having support from their employers.

**Box 5 Training and professional development priorities for workers and organisations over the next 3 years**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey and Organisation Survey

| Professional development priorities | Number of times mentioned | |
|---|---|---|
| | **Workers** | **Organisations** |
| **General** | | |
| • Completing or undertaking study/training (AOD-specific, including AOD Skill Set, or other) | 40 | |
| • Keeping up-to-date on AOD information (e.g. trends, new treatments, services, policy) | 27 | |
| • Want to take-up available training opportunities (e.g. external, internal, on-the-job; seminars, workshops, conferences) | 20 | 1 |
| **Direct-client-contact professional development** | | |
| • Training related to particular therapies/treatments | | |
| • General skills and interventions in AOD | 10 | |
| • Specialist counselling skills/training | 13 | 2 |
| • Various behavioural therapies (e.g. Brief Intervention, Motivational interviewing, Dialectical behaviour therapy, Acceptance and commitment therapy, SMART Recovery) | 12 | 1 |
| • Various psychotherapies (e.g. Eye movement desensitisation and reprocessing therapy, Accelerated experiential dynamic psychotherapy) | 5 | |
| • Group work | 4 | |
| • Other | 10 | |
| • Training related to particular issues | | |
| • Mental Health training, including suicide prevention | 15 | 1 |

| | | |
|---|---|---|
| • Safety/Domestic and Family Violence/managing aggressive behaviour/Therapeutic Crisis Intervention | 11 | |
| • Responding to trauma/grief | 10 | 1 |
| • Particular drugs of concern and treatment approaches (e.g. cannabis/ methamphetamines) | 4 | 1 |
| • Working with particular groups | | |
| • Diversity training (Aboriginal and Torres Strait Islander/CALD/LGBTIQ) | 5 | 3 |
| • Working with children and young people | 5 | |
| • Working with families | 3 | |
| • First Aid training | 9 | |
| • Training related to particular roles (e.g. Needle and Syringe Program worker, Intake worker, Case Manager) | 7 | |
| **Non-client-contact professional development** | | |
| • Management, leadership, governance and associated skills (e.g. media, advocacy) | 42 | 1 |
| • Other administration/project management skills | 15 | |
| • Practice supervision (accessing or receiving training) | 14 | 1 |
| • Information Technology skills | 11 | |
| • Policy/research/evaluation | 8 | 2 |
| • Data reporting and/or analysis | 6 | |
| • Quality improvement (e.g. organisational development, Qualifications Strategy) | | 2 |
| **Other** | 11 | |

### *3.11.2 Membership of professional bodies*

Most of the survey respondents (66.3%) were not members of any professional bodies, and 16.6% were a member of an 'other' association or group not listed in the answer options. The rest of the respondents (17.1%) indicated they were members of the following professional bodies: Australian Association of Social Workers; Australian Nursing Federation; Australian Psychological Society; Australian Counselling Association; Drug and Alcohol Nurses Association; Nursing and midwifery Board of Australia; and Psychotherapy and Counselling Federation of Australia.

## 3.12 AOD practice supervision

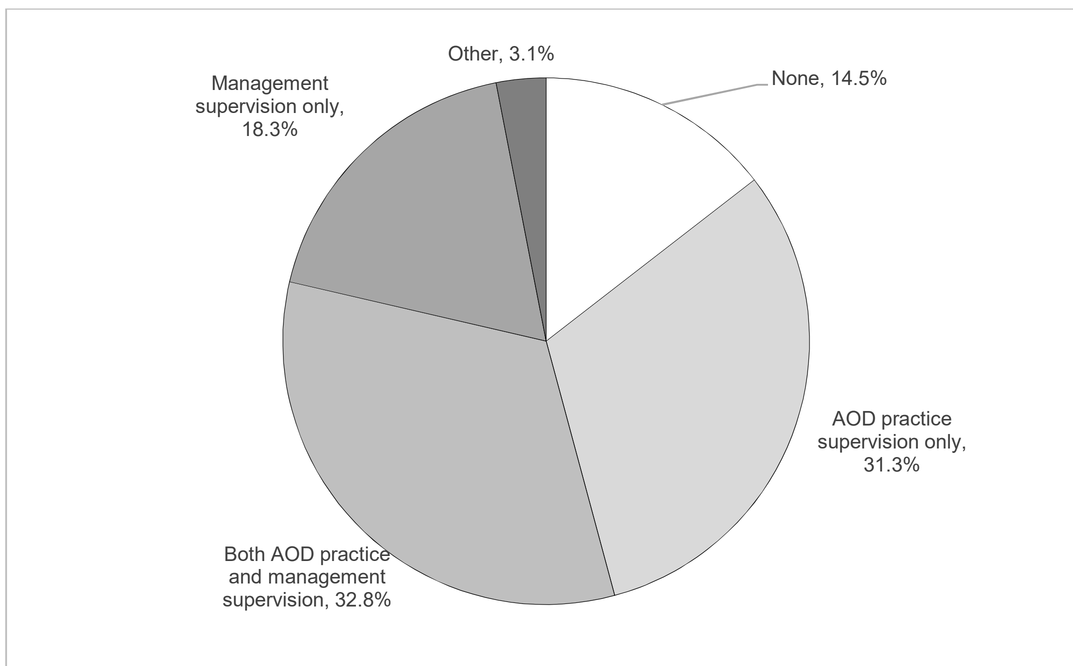
Seven out of eight organisations with staff having direct-client-contact (i.e. excluding ATODA) provided access to AOD practice supervision for staff. Of these seven organisations, all provided access to practice supervision by someone external to the organisation, with six also providing practice supervision internally.

Barriers cited in the Organisation Survey to making AOD practice supervision available to staff were cost and time, but also the limited availability in the ACT of people to provide AOD-specific practice supervision. Strategies that organisations used to engage AOD practice supervision included: sourcing private clinicians; engaging external experts under service agreements; and accessing supervision through the broader organisation (for services that operated in multiple jurisdictions). Some services utilised both one-on-one and group options for supervision, through in-person, phone or Skype (4 services) modes of access.

Workers' Survey respondents were asked whether they received any supervision in their current role. About a quarter (24.7%) of the respondents stated that they had received AOD practice supervision only; about another quarter received management supervision only (26.5%); and 28.9% of the respondents received both AOD practice supervision and management supervision. For those people who did not receive any supervision, the most common reason was 'practice supervision not relevant to their current role'.

When considering just workers with direct-client-contact (as the intended recipients of AOD practice supervision), the majority (64.1%) received AOD practice supervision (either only, or as well as management supervision) (Figure 26).

**Figure 26 Type of supervision received by direct-client-contact workers**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Of those workers who are in direct-client-contact roles and receive practice supervision:

- 55.0% only receive this externally to their organisation
- 21.3% only receive this internally to their organisation
- 23.8% receive their practice supervision both internally and externally

For those workers receiving any practice supervision internally (either exclusively, or in combination with receiving it externally):

- 60.0% receive this supervision from someone who is not also providing their management supervision
- 34.3% receive this supervision from the same person who is also providing their management supervision

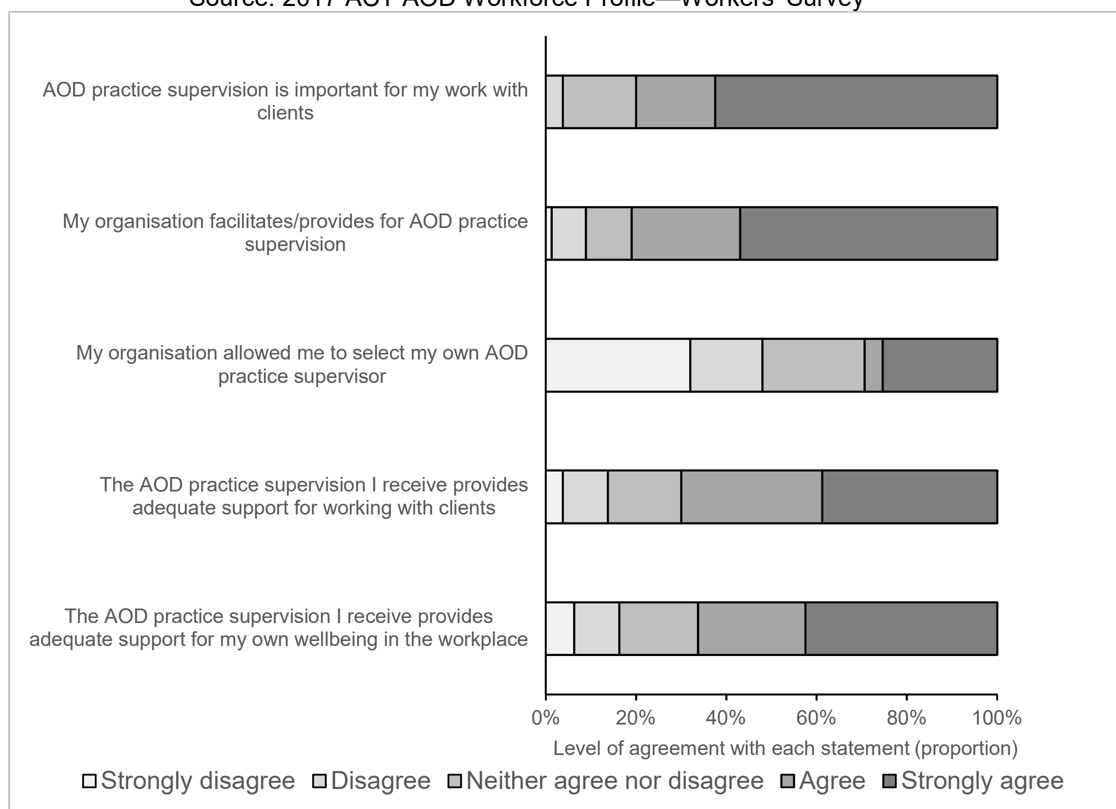
Among workers who are in direct-client-contact roles and receive practice supervision:

- 83.3% are receiving this practice supervision fortnightly (14.1%) or monthly (69.2%); others received practice supervision every 3 months (11.5%) or every 6 months (5.1%)
- Most (72.5%) are satisfied with the practice supervision they receive.

The majority of Administrators (68.8%), Managers (85.7%), and all Researchers/Policy Officers/Project Officers reported receiving management supervision.

Figure 27 shows that the majority of direct-client-contact workers receiving AOD practice supervision ‘strongly agreed’ or ‘agreed’ that AOD practice supervision was important for their work with the clients; the AOD practice supervision they received provided adequate support for their own well-being in the workplace and for working with clients; and their organisations facilitated/provided for AOD practice supervision. However, about half of the respondents (48.0%) ‘strongly disagreed’ or ‘disagreed’ that their organisation allowed them to select their own AOD practice supervisors, with a further 22.7% ‘neither agreeing nor disagreeing’.

**Figure 27 Level of agreement on statements regarding AOD practice supervision among direct-client-contact workers receiving practice supervision**
Source: 2017 ACT AOD Workforce Profile—Workers’ Survey



## 3.13 Recruitment and retention

Those completing the Organisation Survey answered a series of questions about recruitment issues in their services.

Current vacancies in organisations were from a range of role types, including case managers, support workers, counsellors, administration staff, and registered nurses. The average time taken to fill staff vacancies over the last 12 months was 2.9 months (answered by 6 organisations).

Of the eight organisations that answered the question, all indicated that they have some trouble with recruitment. The Organisation Survey asked respondents to rank the factors that prevent them from achieving their desired recruitment outcomes. The following factors rated most often in the top three reasons:

- Low numbers of applicants (in the top three reasons for 7 organisations)
- Applicants do not have enough relevant AOD experience (5 organisations)
- Applicants have inadequate training and education (4 organisations)
- Insufficient remuneration (4 organisations)

Two factors—'applicants are not strongly aligned with the organisation's values' and 'stigma associated with the AOD sector'—were not seen as being as influential on recruitment as the factors listed above.

Consistent with the factors cited above, the particular roles or areas of expertise that organisations found difficult to recruit to were mostly positions that required very specific and high-level AOD qualifications and/or expertise (e.g. counselling, nurses with dosing and inpatient withdrawal expertise, peer workers, AOD case managers).

Organisations have used a variety of methods to recruit staff, with the most common methods being: online (9 services); student placements—Certificate IV AOD or tertiary (7 services); print (6); employment agencies (6); and social media (4).

Of these most-used methods, the most successful were perceived to be: online (average rating of 3.7/5.0) and employment agencies (3.7/5.0), followed by student placements (3.2/5.0). Of these most-used methods, print was not rated as being as effective (2.2/5.0), along with social media (2.4/5.0). Other recruitment methods that had been used by only one or two agencies included: graduate programs; secondments; and volunteers—these had been successful for the services using them.

Three organisations have an Indigenous Employment Strategy, with others indicating that they have a specific (unwritten) strategy for increasing the employment of Aboriginal and/or Torres Strait Islander people.

When respondents to the Organisation Survey were asked about their impressions of the main reasons for staff leaving their organisation their responses were:

- Changing to jobs with more opportunity (6 organisations), including:
    - From part-time to full-time employment
    - To take up another position

    - Following a career path
    - Going to a government job that pays more money
- Retirement (mentioned by 1 organisation)
- Moving interstate (2 organisations)
- End of the contract period (1 organisation)

## 3.14 Upcoming challenges for the AOD workforce

Organisations were asked to list their top three challenges for the AOD workforce over the next 3 years (Box 6).

**Box 6 Upcoming challenges for the ACT AOD workforce**
Source: 2017 ACT AOD Workforce Profile—Organisation Survey

*Recruitment and retention issues*

- attracting and retaining highly specialist qualified staff in the context of less competitive remuneration (particularly for non-government organisations)
- attracting Aboriginal and Torres Strait Islander workers to the ATOD sector
- meeting demands for a more professionalised workforce

*Funding/policy issues*

- working within an unstable policy and funding environment (both Territory and Commonwealth)
- working with new funding sources and approaches
- inadequate funding to the ATOD sector

*Responding to the needs of specific populations (in particular, young people and families), and responding to changing needs of the sector and clients*

*Continuing to implement and maintain quality assurance processes (e.g. accreditation)*

## 3.15 Worker well-being measures

The Workers' Survey included validated scales to assess a number of well-being measures: overall well-being (with subscales of psychological health, physical health, and quality of life); opportunities for professional growth; stress; burnout; job satisfaction; and therapeutic optimism. These scales are described in greater detail in Appendix D. This section reports on each individual well-being measure using two approaches.

Firstly, the scores for each scale and sub-scale are reported in relation to the mid-point score of that scale (or sub-scale). Scores greater than the mid-point reflect agreement with the scale's attribute, with higher scores reflecting stronger agreement. Conversely, scores below the mid-point reflect disagreement with the scale's attribute, with lower scores reflecting stronger disagreement.

Scores for each scale (except for health and well-being, and burnout) are also reported by grouping scores according to whether workers 'agreed' (scores between 35.0 – 50.0), 'neither agreed nor disagreed' (scores between 25.0 – 34.9), or 'disagreed' (scores between 10.0 –

24.9). This enables comparison of the scores with other workforce profiles in the ATOD sector in Australia and New Zealand (see Discussion, Section 4). Burnout scores have been categorised as 'burned out' (score above 5.5) and 'not burned out' (score below 5.5) (see Section 3.15.3).

This section will also report on how these well-being measures interrelate with each other, and then how each relates to a selection of items: organisation; job role; age; gender; current working arrangement; pre-tax base hourly rate; highest education qualification; months in the ATOD sector; and average weekly working hours.

### *3.15.1 Overall well-being—physical and psychological health and quality of life*

Workers were asked to rate their well-being in the past 4 weeks on sub-scales for psychological health, physical health, and quality of life. These were rated on scales where 0 = 'the worst you have ever felt', 10 = 'average', and 20 = 'the best you have ever felt'. Table 8 shows the means (averages), medians and ranges for overall well-being and for each of the subscales: the mean score for overall well-being was 38.3 (the mean of the sums of the three sub-scales); and half of the workers scored their overall well-being at 40.0 or more (out of 60.0).

The mid-point (or neutral) score for the overall well-being scale is 30 (i.e. half way between the minimum score of 0 and maximum score of 60). The average (mean) score (38.3) is above this mid-point, as is the median score of 40.0 (Table 8).

**Table 8 Attributes of scores for overall well-being, and subscales of psychological health, physical health, and quality of life**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale / Attribute | Psychological health (Scale 0–20) (n=169) | Physical health (Scale 0–20) (n=168) | Quality of Life (Scale 0–20) (n=170) | Overall well-being (Scale 0–60) (n=167) |
|---|---|---|---|---|
| Mean (average) | 12.6 | 12.0 | 13.6 | 38.3 |
| Std deviation | 4.3 | 4.6 | 4.3 | 11.7 |
| Median | 13.0 | 12.0 | 15.0 | 40.0 |
| Range | 2 – 20 | 2 – 20 | 2 - 20 | 9 - 60 |

Well-being scores were grouped according to their relationship to the mid-point score of 30, with scores greater than the mid-point (i.e. > 30) indicating better overall well-being and scores less than the mid-point (i.e. <30) indicating worse well-being. As seen in Table 9, the majority of workers (72%) indicated 'better overall well-being' (a score greater than the mid-point score of 30). This is also shown graphically in Figure 28, where a higher proportion of overall well-being scores are spread above the mid-point of 30, and half of scores are above the median of 40.0.

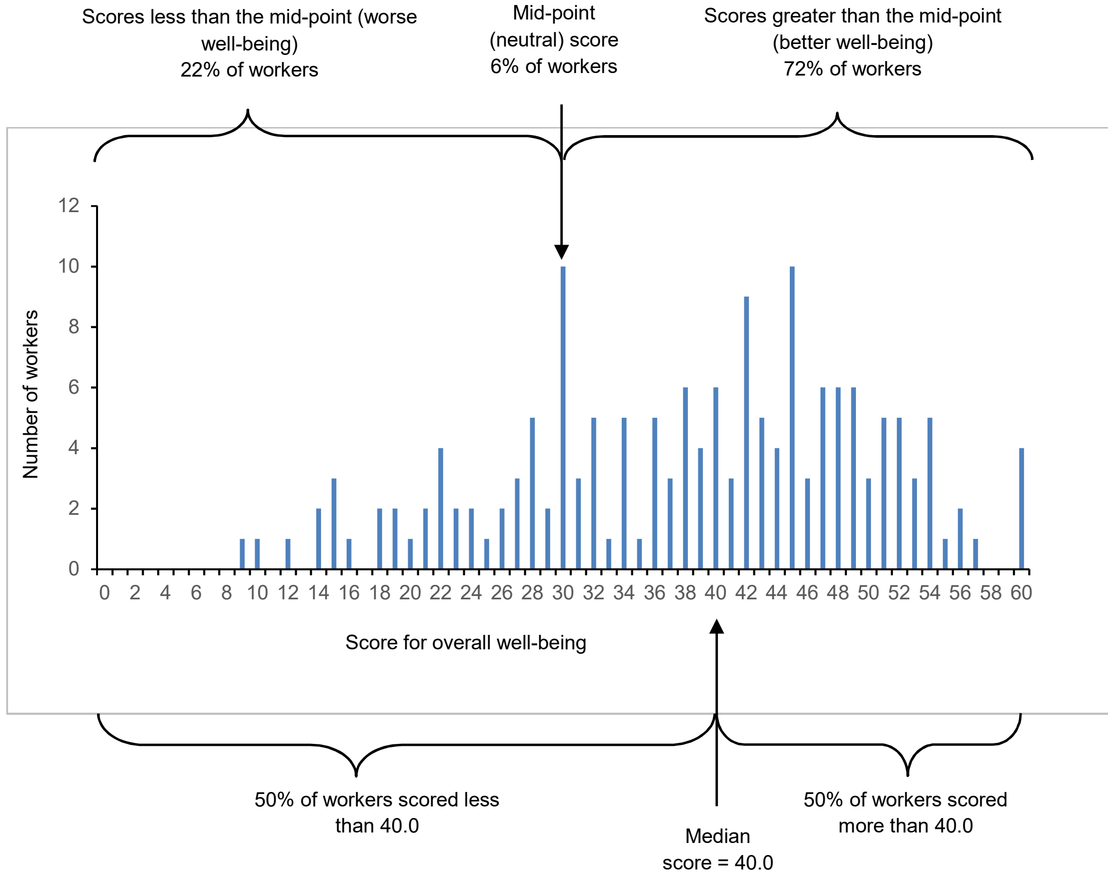
Average scores for the subscales of psychological health, physical health and quality of life were also above the sub-scales' mid-point (neutral) scores of 10. For each well-being sub-scale, over half of workers indicated 'better well-being' (i.e. scoring above the mid-point)—63%, 58% and 71% for the psychological health, physical health and quality of life scales

respectively (Table 9). Physical health was lower than the other subscales for all measures of mean and median, and in comparison to the neutral mid-point.

**Table 9 'Better' vs 'worse' health and well-being—distribution of scores above and below the neutral mid-points for well-being scales (psychological health, physical health, quality of life, and overall well-being)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Score descriptor | Score range | No. of workers | % |
|---|---|---|---|---|
| **Overall well-being (n=167)** | *Better overall well-being* | Scores greater than the mid-point (i.e. > 30) | 120 | 71.9 |
| | *Neutral overall well-being* | Scores at the mid-point (i.e. = 30) | 10 | 6.0 |
| | *Worse overall well-being* | Scores less than the mid-point (i.e. < 30) | 37 | 22.2 |
| **Psychological health (n=169)** | *Better psychological health* | Scores greater than the mid-point (i.e. > 10) | 107 | 63.3 |
| | *Neutral psychological health* | Scores at the mid-point (i.e. = 10) | 33 | 19.5 |
| | *Worse psychological health* | Scores less than the mid-point (i.e. < 10) | 29 | 17.2 |
| **Physical health (n=168)** | *Better physical health* | Scores greater than the mid-point (i.e. > 10) | 98 | 58.3 |
| | *Neutral physical health* | Scores at the mid-point (i.e. = 10) | 28 | 16.7 |
| | *Worse physical health* | Scores less than the mid-point (i.e. < 10) | 42 | 25.0 |
| **Quality of Life (n=170)** | *Better Quality of life* | Scores greater than the mid-point (i.e. > 10) | 120 | 70.6 |
| | *Neutral Quality of life* | Scores at the mid-point (i.e. = 10) | 27 | 15.9 |
| | *Worse Quality of life* | Scores less than the mid-point (i.e. < 10) | 23 | 13.5 |

**Figure 28** **Frequencies of scores for the overall well-being scale showing the spread of scores in relation to the mid-point score (30) and median score (40.0), n=167**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




### *3.15.2 Job satisfaction, professional growth and staffing*

This section reports on the scales for job satisfaction—the degree to which workers are satisfied with their job—and professional growth—the extent to which workers value and use opportunities for their own professional growth. For a description of the scales used, and how these are calculated and interpreted, please see Appendix D. This section also reports on two questions related to staffing. These questions come from a validated staffing scale (see Appendix D), but as they are two isolated questions, they must be considered independently.

Table 10 shows that respondents to the 2017 ACT AOD Workforce Profile reported moderately strong job satisfaction and opportunities for professional growth. The mean and median scores for each of these scales is above the neutral mid-point of 30.

**Table 10 Attributes of scores for job satisfaction and professional growth**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Mean (average) | Std deviation | Median |
|---|---|---|---|
| Job satisfaction (Scale 10–50; n=171) | 40.2 | 6.7 | 40.0 |
| Professional growth (Scale 10–50; n=165) | 38.7 | 7.7 | 40.0 |

Figures 29 and 30 show the spread of scores in relation to the neutral mid-point score of 30, and the spread according to whether they can be categorized as 'less than neutral' (i.e. < 30) or 'greater than neutral' (i.e. > 30).

- Figure 29 shows a clear distribution of scores to the right of the graph—that is, greater than the mid-point, indicating more scores reported above 30 than below for job satisfaction. Higher scores reflect greater job satisfaction. Most workers (90%) reported scores greater than 30, consistent also with the high mean (40.2) and median (40) (Table 10).
- Likewise, Figure 30 also shows a clear distribution of scores to the right of the graph—that is, greater than the mid-point, indicating more scores reported above 30 than below. Higher scores reflect greater opportunities for professional growth. Most workers (86%) reported scores greater than 30, consistent also with the high mean (38.7) and median (40.0) (Table 10).

**Figure 29 Number of workers reporting each score on the job satisfaction scale (from the TCU-ORC) and the spread relative to the mid-point (neutral) score of 30 (n=171)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

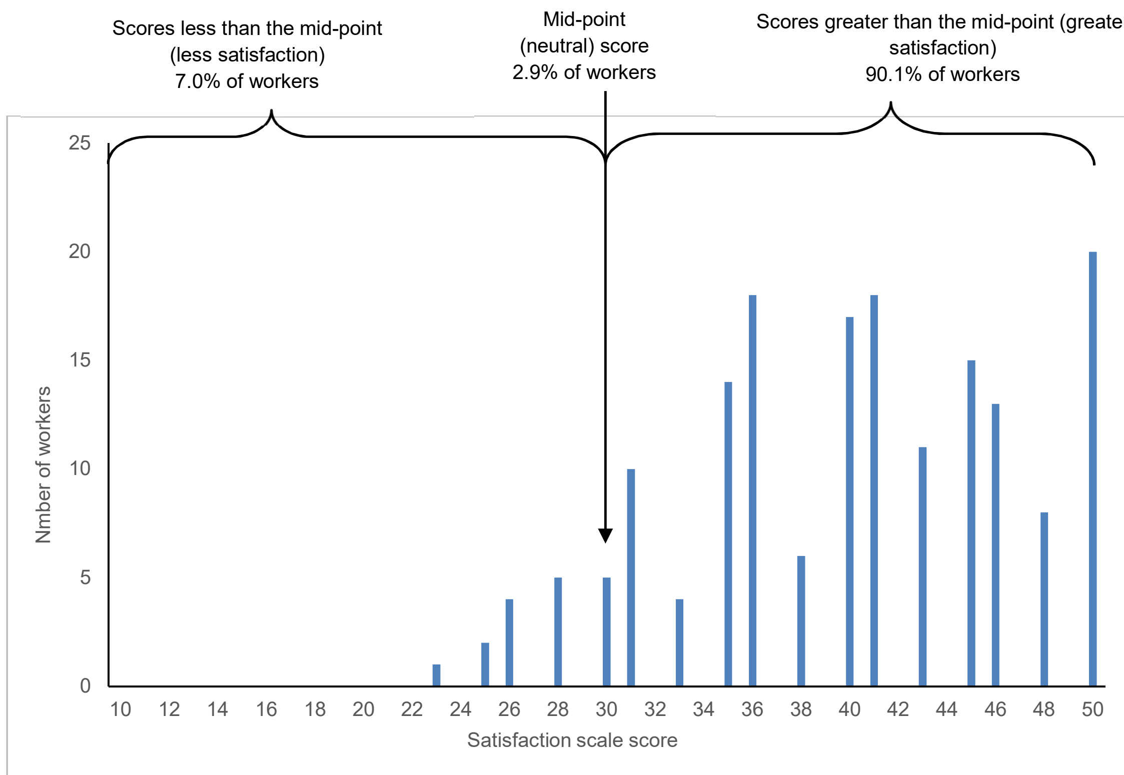
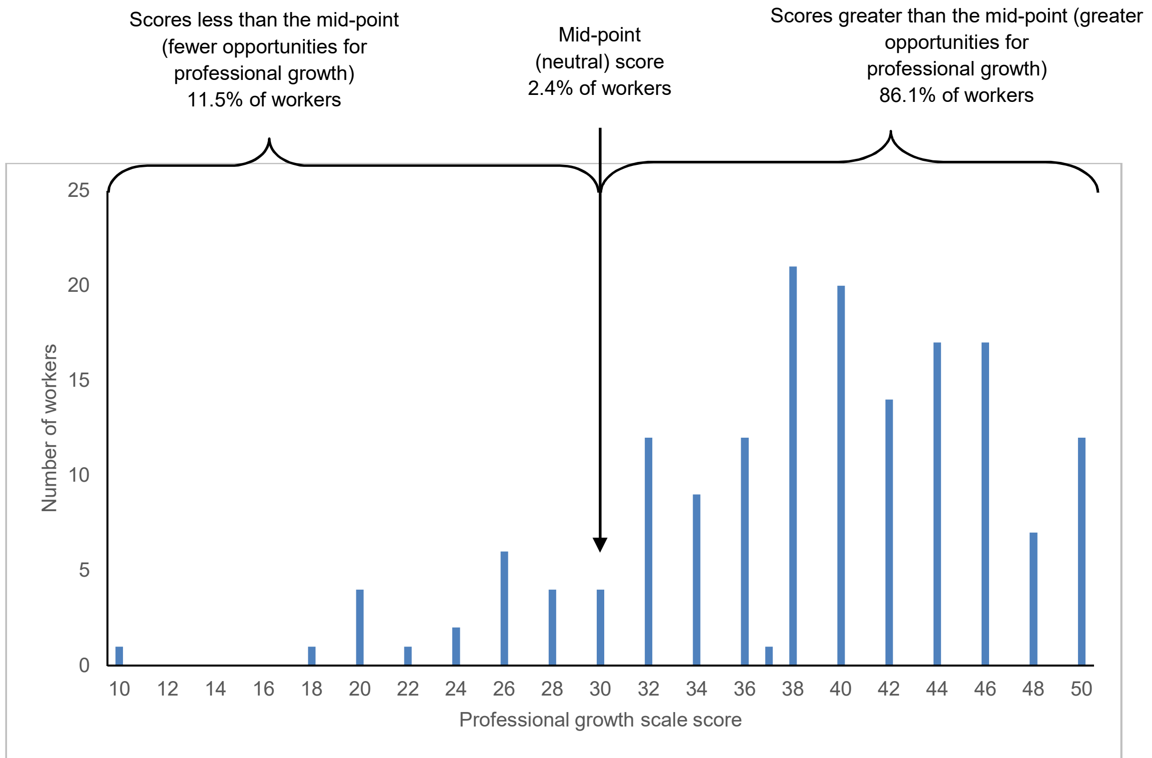
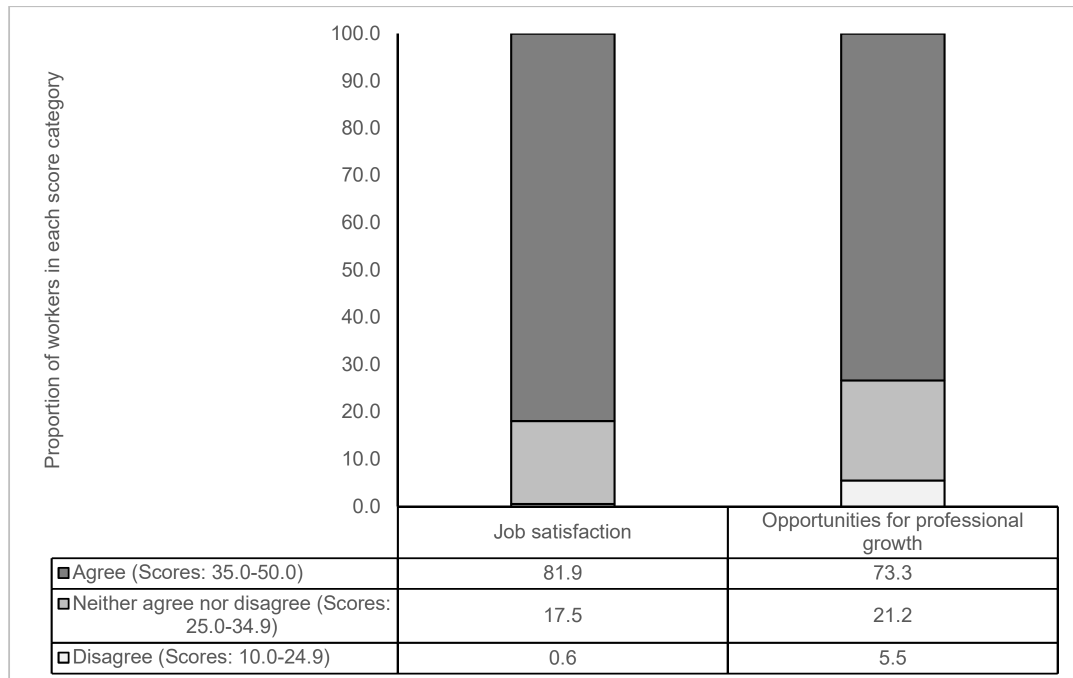


**Figure 30** **Number of workers reporting each score on the professional growth scale (from the TCU-ORC) and the spread relative to the mid-point (neutral) score of 30 (n=165)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



These two scales show consistent results when grouped according to whether workers 'agreed' (scores between 35.0 – 50.0), 'neither agreed nor disagreed' (scores between 25.0 – 34.9), or disagreed (scores between 10.0 – 24.9). Workers showed agreement that they were both satisfied with their job and had sufficient opportunities for professional growth, with greater proportions indicating scores between 35.0 and 50.0 (82% and 73% respectively) (Figure 31).

**Figure 31 Levels of agreement by workers on job satisfaction (n=171) and opportunities for professional growth (n=165)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

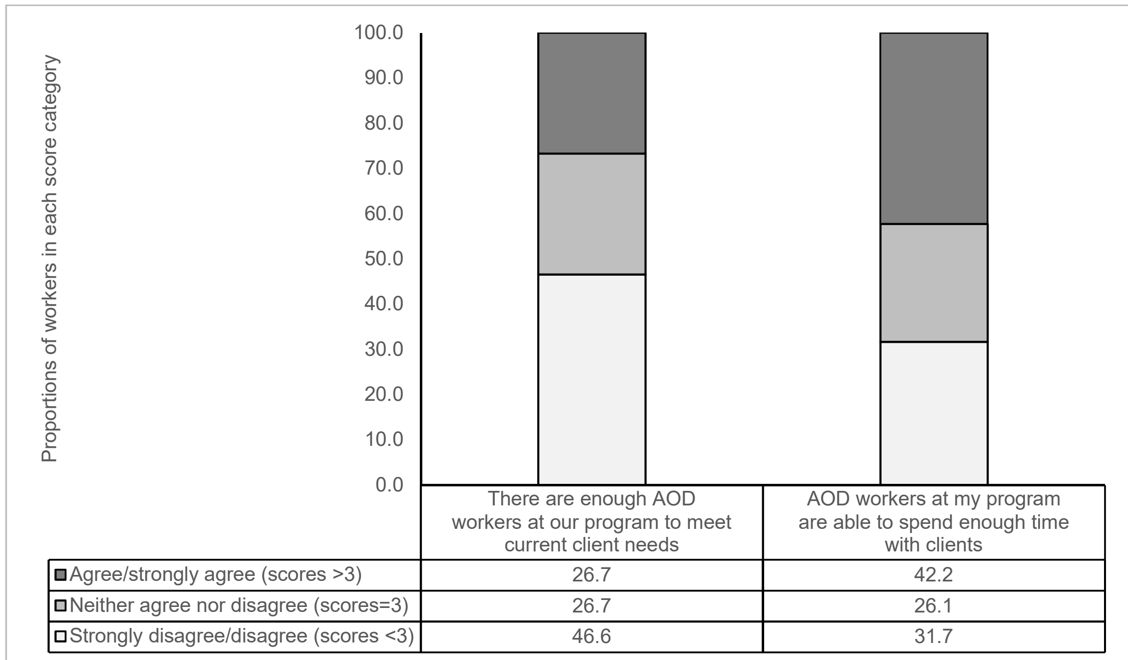



| | Job satisfaction | Opportunities for professional growth |
|---|---|---|
| Agree (Scores: 35.0-50.0) | 81.9 | 73.3 |
| Neither agree nor disagree (Scores: 25.0-34.9) | 17.5 | 21.2 |
| Disagree (Scores: 10.0-24.9) | 0.6 | 5.5 |

Workers were asked to rate two statements about staffing on a scale of 1 ('strongly disagree') to 5 ('strongly agree'). Despite feeling that staffing levels are not sufficient to meet current client needs, most respondents feel that workers at their program are able to spend enough time with clients:

- Workers scored the statement, "There are enough AOD workers at our program to meet current client needs", an average of 2.7 (out of 5.0). Figure 32 shows that almost half of workers (46.6%) 'strongly disagreed' or 'disagreed' with the statement.
- Workers scored the statement, "AOD workers at my program are able to spend enough time with clients", an average of 3.2 (out of 5.0). Figure 32 shows that 42.2% 'agreed' or 'strongly agreed' with this statement.

**Figure 32 Levels of agreement by workers on two questions about staffing**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | There are enough AOD workers at our program to meet current client needs | AOD workers at my program are able to spend enough time with clients |
|---|---|---|
| Agree/strongly agree (scores >3) | 26.7 | 42.2 |
| Neither agree nor disagree (scores=3) | 26.7 | 26.1 |
| Strongly disagree/disagree (scores <3) | 46.6 | 31.7 |

### *3.15.3 Stress and burnout*

This section reports on the scores for stress and burnout. For a description of the scales used, and how these are calculated and interpreted, please see Appendix D.

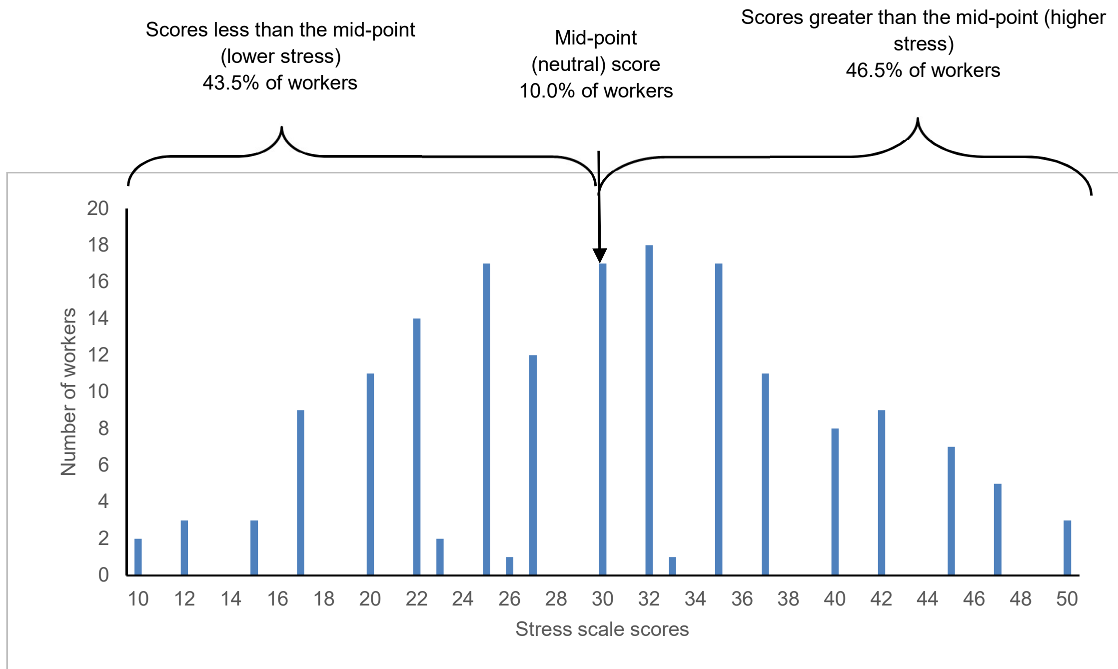
The stress scores were measured on a scale of 10 to 50, with a 'neutral' mid-point of 30. Table 11 shows that respondents of the ACT AOD Workforce Profile reported moderate levels of stress. The mean score is just above the neutral mid-point of 30.

**Table 11 Attributes of scores for stress**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Mean (average) | Std deviation | Median |
|---|---|---|---|
| Stress (Scale 10–50; n=170) | 30.4 | 9.1 | 30.0 |

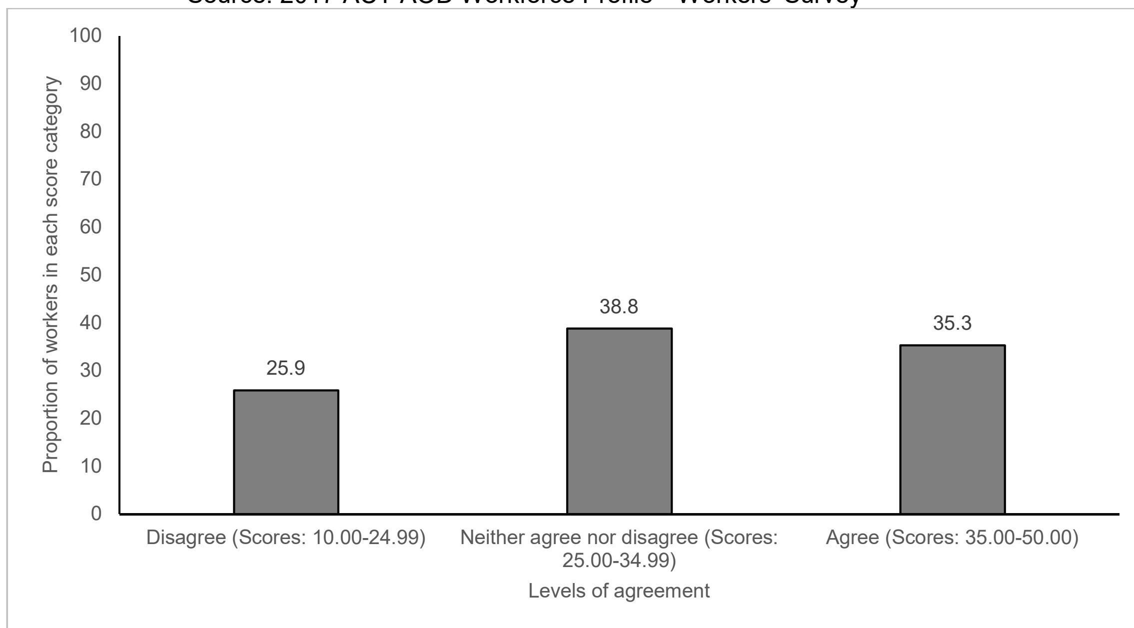
Figure 33 shows the spread of the stress scores in relation to the neutral mid-point (30). This shows an evenly spread distribution of scores around the neutral mid-point. Approximately equal proportions of workers reported higher stress (i.e. scores greater than 30) and lower stress (i.e. scores less than 30)—46.5% and 43.5% respectively. This is consistent with the mean (30.4) and median (30.0) above, both being on, or close to, the mid-point score (Table 11).

**Figure 33** **Number of workers reporting each score on the stress scale (from the TCU-ORC) and the spread relative to the mid-point (neutral) score of 30 (n=170)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




These results are consistent when grouped according to whether workers 'agreed' (scores between 35.0 – 50.0), 'neither agreed nor disagreed' (scores between 25.00 – 34.99), or 'disagreed' (scores between 10.0 – 24.9). Scores across the three categories were almost evenly distributed for the stress scale: 25.9% disagreed that they were stressed; 35.3% agreed that they were stressed; and 38.8% neither agreed nor disagreed (Figure 34).

**Figure 34** **Levels of agreement by workers on stress (n=170)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



Burnout was measured using a 14-item measure (Shirom-Melamed Burnout Measure—SMBM) on a scale from 1 (almost never experiencing particular feelings) to 7 (almost always experiencing particular feelings). Workers could be categorised as burned out if they scored at least 5.5 on the scale; this cut-off point corresponds to experiencing symptoms of burnout, on average, more than 'quite frequently', consistent with the idea that "burnout represents a crisis in a person's relationship with work"[17] (for more details, see Appendix D). The overall burnout measure consists of three sub-scales for emotional exhaustion, cognitive weariness and physical fatigue.

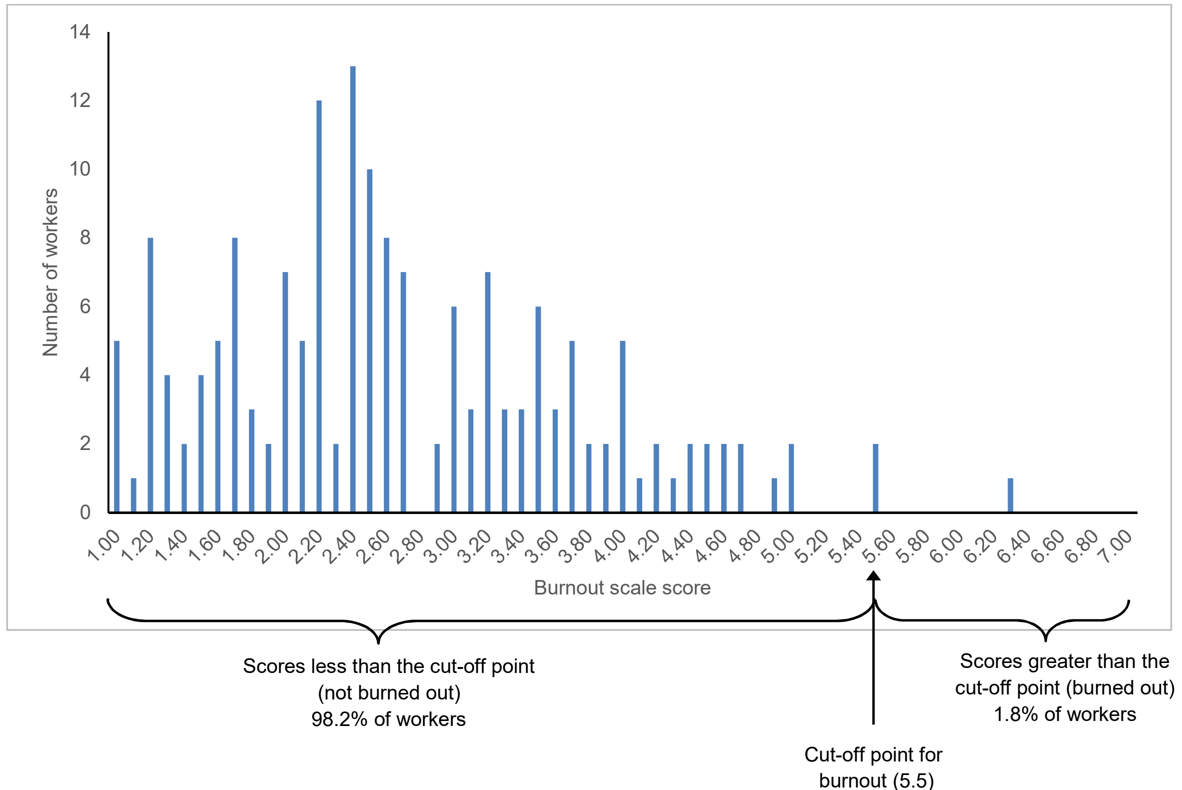
The means and medians of each of the burnout subscales and the overall burnout measure all show low levels of burnout among ACT AOD workers who participated in the Workforce Profile (Table 12).

**Table 12 Attributes of scores for overall burnout, and subscales of emotional exhaustion, cognitive weariness and physical fatigue**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Mean (average) | Std deviation | Median |
|---|---|---|---|
| Overall burnout (Scale 1–7;n=171) | 2.7 | 1.1 | 2.6 |
| Emotional exhaustion (n=171) | 2.1 | 1.2 | 2.0 |
| Cognitive weariness (n=171) | 2.6 | 1.2 | 2.2 |
| Physical fatigue (n=171) | 3.2 | 1.2 | 3.0 |

As seen in Figure 35, the spread of burnout scores are distributed to the left of the graph (i.e. towards low burnout). When the scores are categorized according to whether they are burned out (score at least 5.5) or not, only 2% can be classified as being burned out (i.e. experiencing symptoms of burnout more than 'quite frequently').

**Figure 35 Distribution of scores for the burnout scale (Shirom-Melamed Burnout Measure—SMBM) between 1.00 and 7.00, showing the cut-off point for burnout (5.50) (n=171)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




### *3.15.4 Therapeutic optimism*

Therapeutic optimism measures how optimistic workers are that their clients can achieve positive outcomes.

By definition, the therapeutic optimism scale (TOS) relates to workers who do therapeutic work with clients, and so the analyses below only include those workers with direct client contact (see Appendix E for information on how workers were classified as having direct client contact or non-client contact).

The TOS score is calculated by summing the scores from three sub-scales:[13]

- general treatment outcome expectancy – clinicians' perception of how well treatment will work out for their clients; includes 5 items, and generates a score between 5 and 25
- personal treatment outcome expectancy – clinicians' confidence that they can help the client to achieve positive outcomes; includes 3 items, and generates a score between 5 and 15
- pessimism – tendency to anticipate or emphasise undesirable outcomes; includes 2 items and generates a score between 5 and 10

The mid-point of the overall TOS is 30 (range of 10 to 50), and as can be seen in Table 13, both the mean (average) score and the median score in this workforce profile are above this mid-point, indicating a general agreement by workers with therapeutic optimism.

**Table 13 Attributes of scores for the therapeutic optimism scale and the subscales: general treatment outcome expectancy; personal treatment outcome expectancy; and pessimism**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Mean (average) | Std deviation | Median |
|---|---|---|---|
| Therapeutic optimism overall (Scale 10–50; n=127) | 39.4 | 4.8 | 40.0 |
| General treatment outcome expectancy subscale (Scale 5–25; n=127) | 20.4 | 2.5 | 20.0 |
| Personal treatment outcome expectancy subscale (Scale 5–15; n=129) | 11.0 | 2.1 | 11.0 |
| Pessimism subscale (Scale 5–10; n=129) | 8.0 | 2.1 | 8.0 |

Figure 36 shows the spread of TOS scores relative to the mid-point score of 30—the scores are strongly distributed to the right of the graph showing an inclination towards greater therapeutic optimism. The majority (96.1%) of workers with direct client contact indicated a therapeutic optimism greater than neutral (i.e. > 30). This shows that the majority of workers felt that they could impact on the outcomes of their clients.

The TOS shows consistent results when grouped according to whether workers 'agreed' (scores between 35.0 – 50.0), 'neither agreed nor disagreed' (scores between 25.0 – 34.9), or 'disagreed' (scores between 10.0 – 24.9). Workers showed high agreement with therapeutic optimism, with most indicating scores between 35.0 and 50.0 (84.3%) (Figure 37).

**Figure 36** **Number of workers reporting each score on the therapeutic optimism scale and the spread relative to the mid-point (neutral) score on 30 (n=127)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

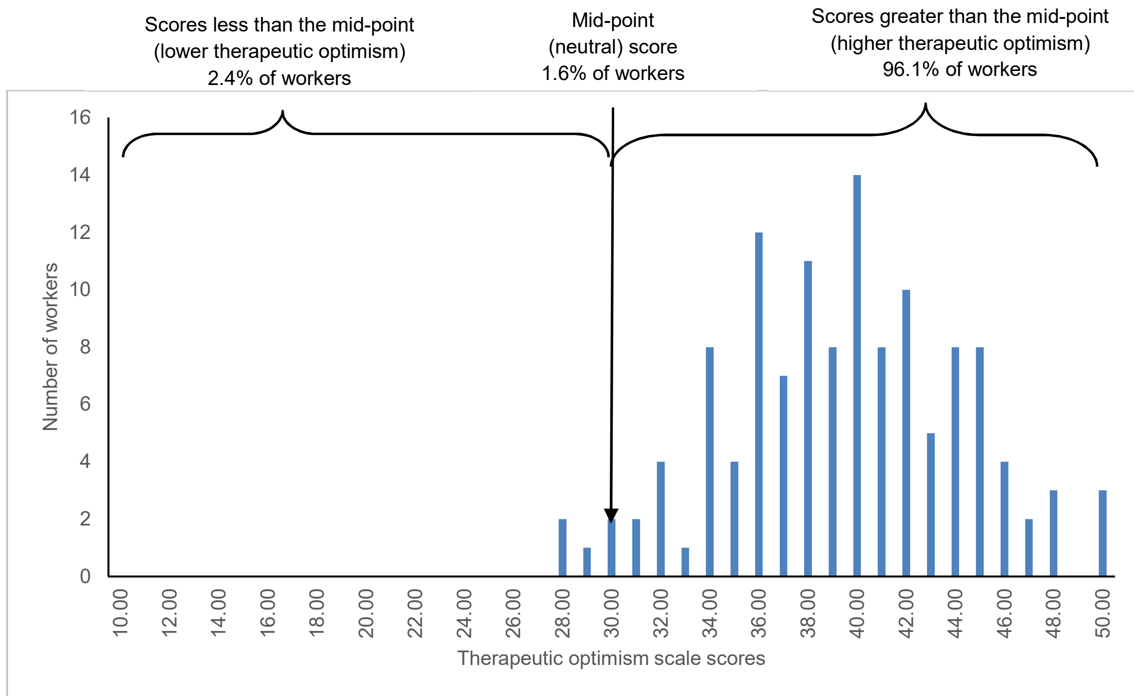
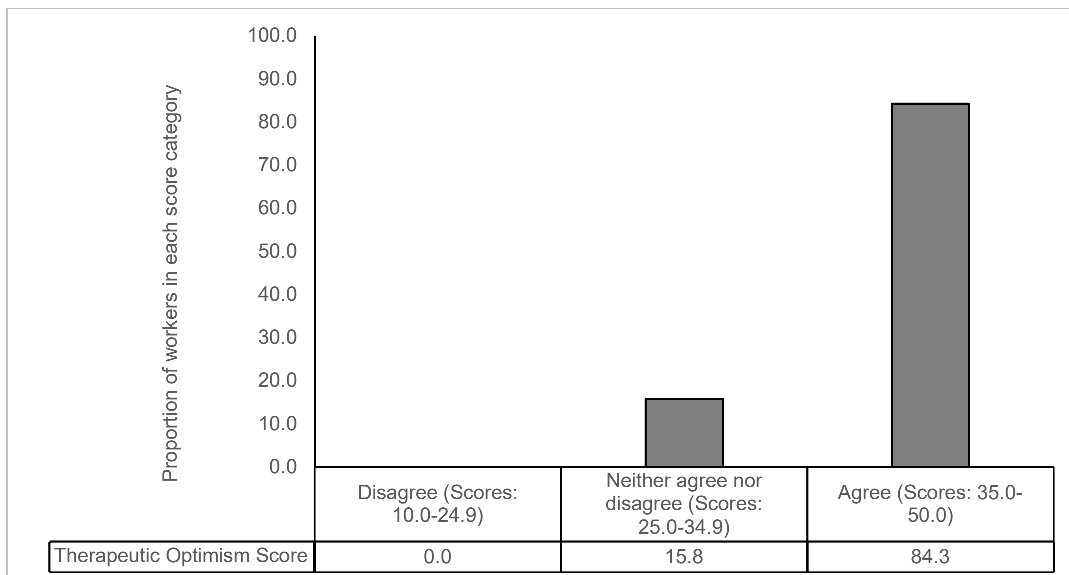



**Figure 37** **Levels of agreement by workers on therapeutic optimism (n=127)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | Disagree (Scores: 10.0-24.9) | Neither agree nor disagree (Scores: 25.0-34.9) | Agree (Scores: 35.0-50.0) |
|---|---|---|---|
| Therapeutic Optimism Score | 0.0 | 15.8 | 84.3 |

### *3.15.5 Association between well-being measures and job roles*

An analysis of relationships between job role and various well-being measures found that, while there were differences among some job role categories, these were not statistically significant.

Workers in 'other clinical roles' (Clinical Psychologist, other Psychologist, Social Worker, Nurse Practitioner) reported the highest average overall well-being score (48.2), followed by Executives (41.2) and Nurses (40.9) (Figure 38). All average well-being scores across all job roles are above the mid-point (neutral) score of 30 (indicating better overall well-being on average).

While there were some differences in scores for job satisfaction, professional growth, stress, and burnout among job roles, these differences were not statistically significant (Figures 39 and 40). Average job satisfaction was highest among executives and nurses, while average professional growth scored highest among 'other clinical roles' and executives. All job satisfaction and professional growth average scores were above the 'neutral' mid-point of 30 (Figure 39).

Average stress scores were highest among Executives and Managers. These two job role categories along with AOD Workers and Counsellors reported average stress scores above the mid-point of 30, while the remaining job categories reported average scores below 30 (Figure 39). Burnout was low for all job categories and well below the cut-off point for burnout of 5.5 (Figure 40).

**Figure 38 Average well-being scores (out of 60) for each job role**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

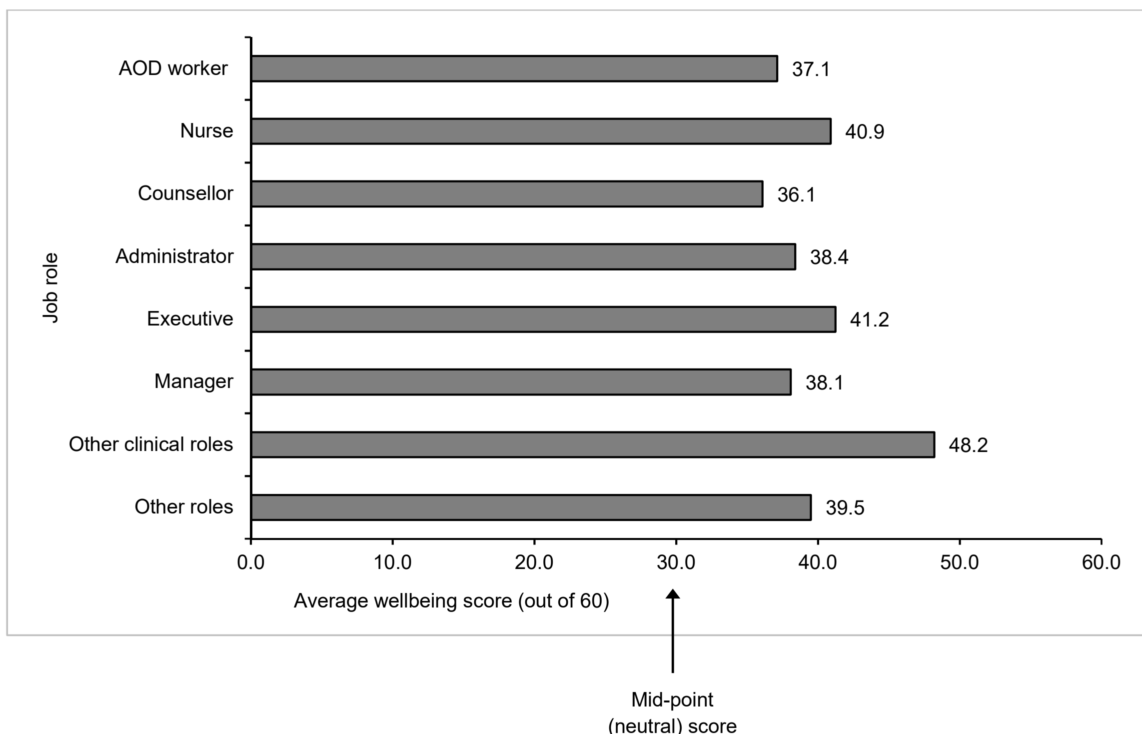
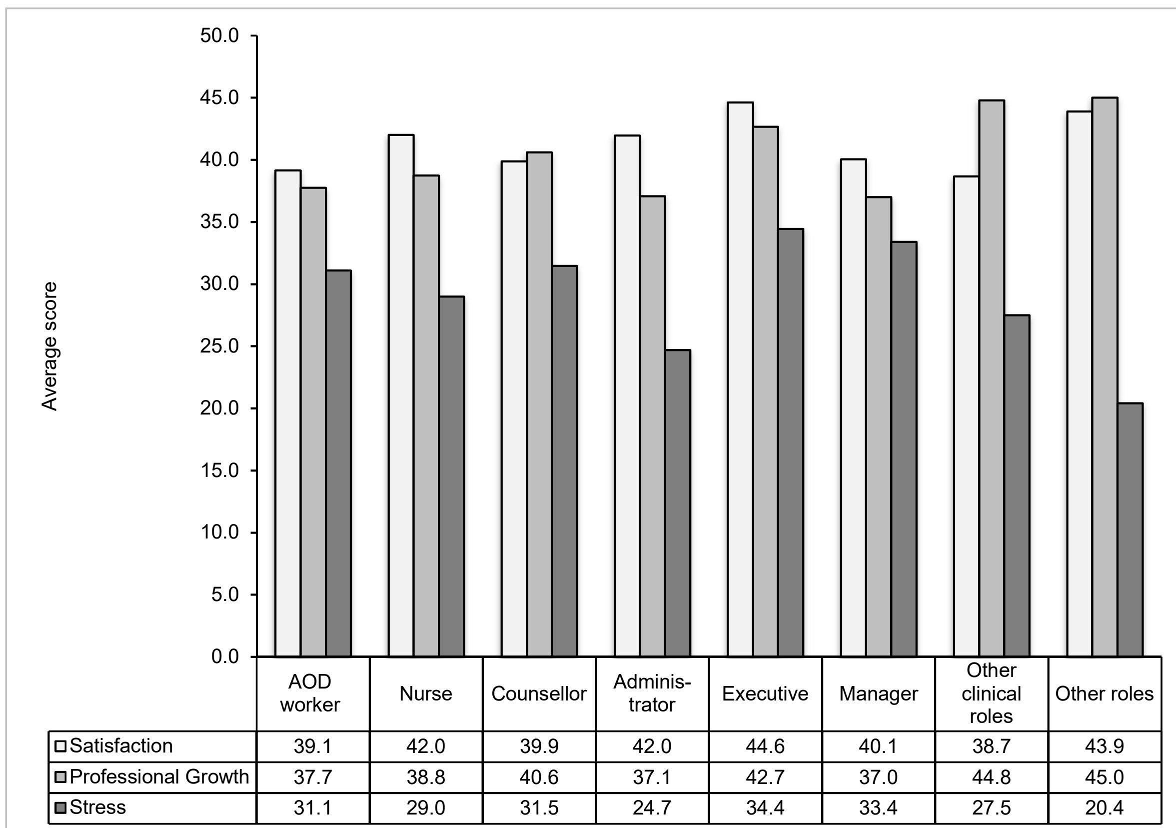
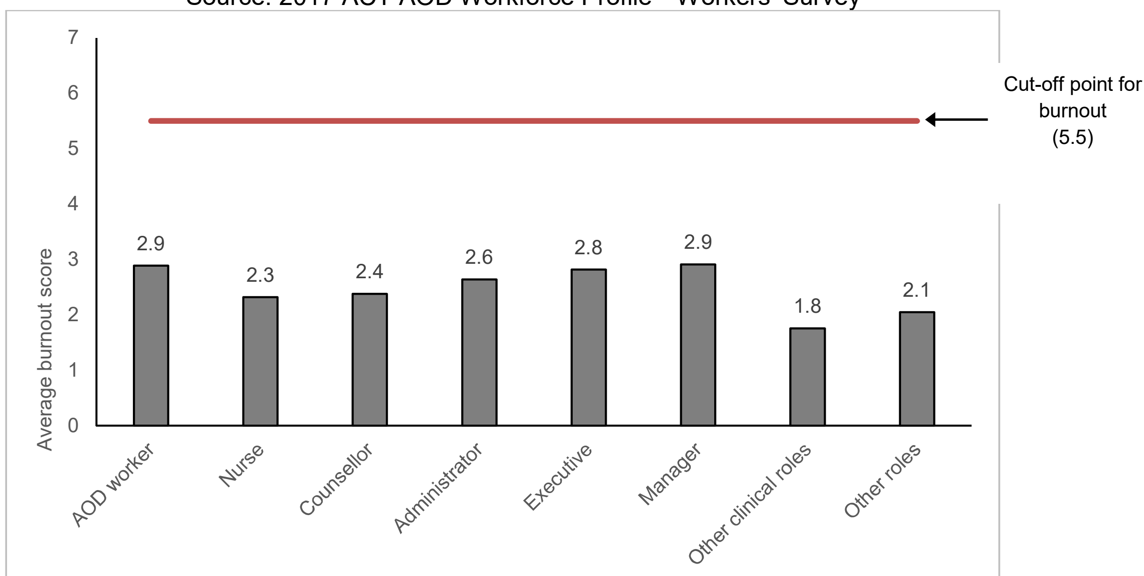


**Figure 39 Average scores for job satisfaction, professional growth and stress across job roles**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | AOD worker | Nurse | Counsellor | Adminis-trator | Executive | Manager | Other clinical roles | Other roles |
|---|---|---|---|---|---|---|---|---|
| Satisfaction | 39.1 | 42.0 | 39.9 | 42.0 | 44.6 | 40.1 | 38.7 | 43.9 |
| Professional Growth | 37.7 | 38.8 | 40.6 | 37.1 | 42.7 | 37.0 | 44.8 | 45.0 |
| Stress | 31.1 | 29.0 | 31.5 | 24.7 | 34.4 | 33.4 | 27.5 | 20.4 |

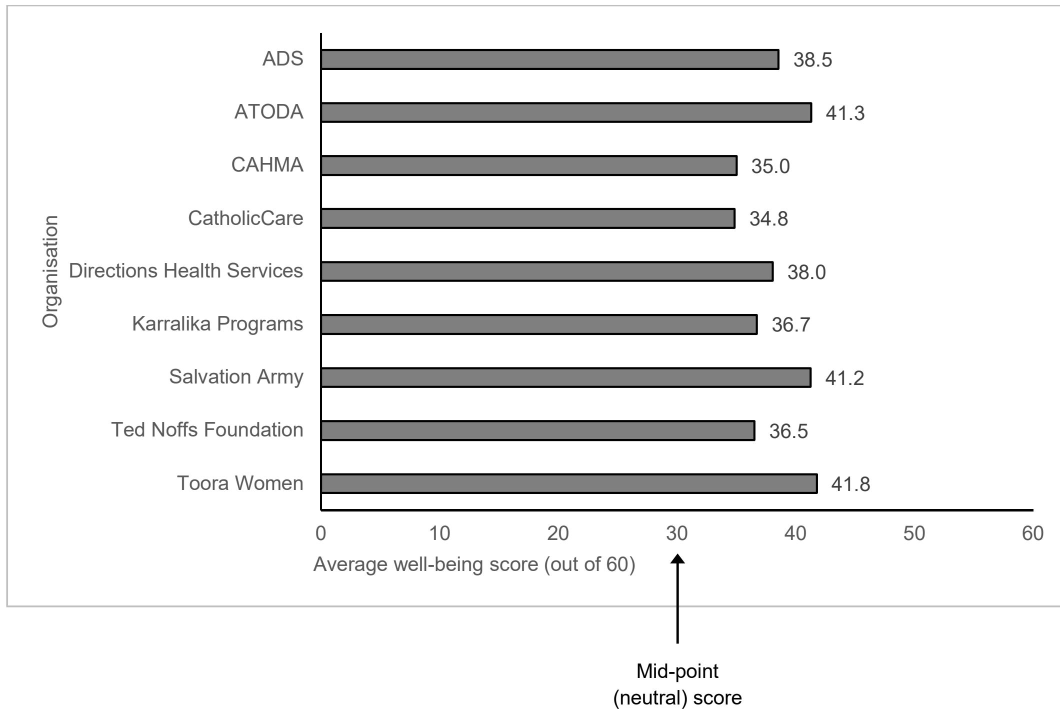
**Figure 40 Average scores for the burnout scale (Shirom-Melamed Burnout Measure—SMBM) for each job role compared to the cut-off point for burnout (5.5)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



### *3.15.6 Association between well-being measures and organisation*

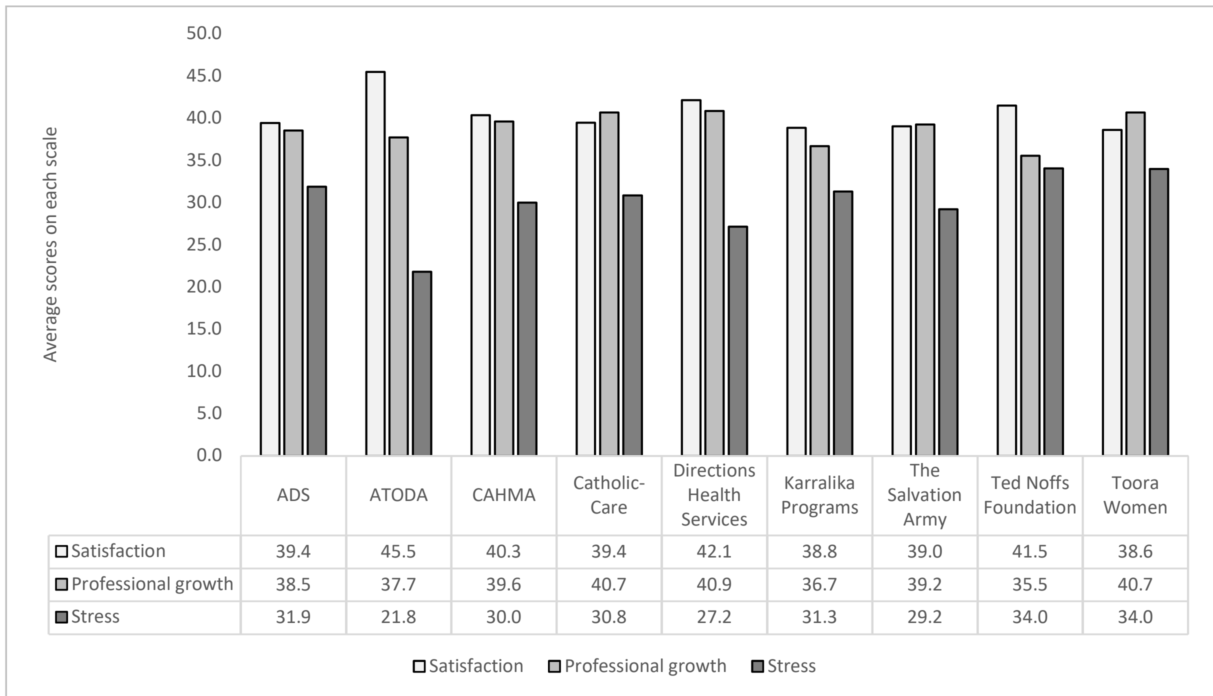
The differences in average well-being scores between organisations are not statistically significant (Figure 41), and all are above the mid-point (neutral) score of 30. Workers at Toora Women, ATODA and The Salvation Army reported the highest average well-being scores (41.8, 41.3 and 41.2 respectively).

**Figure 41 Average well-being scores (out of 60) for each organisation**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Similarly, while there were some differences in scores for job satisfaction, professional growth and stress across organisations, these differences were not statistically significant (Figure 42). Job satisfaction was highest at ATODA, Directions Health Services and Ted Noffs Foundation, but other organisations scored close to these, and all organisations scored well above the neutral mid-point of 30.

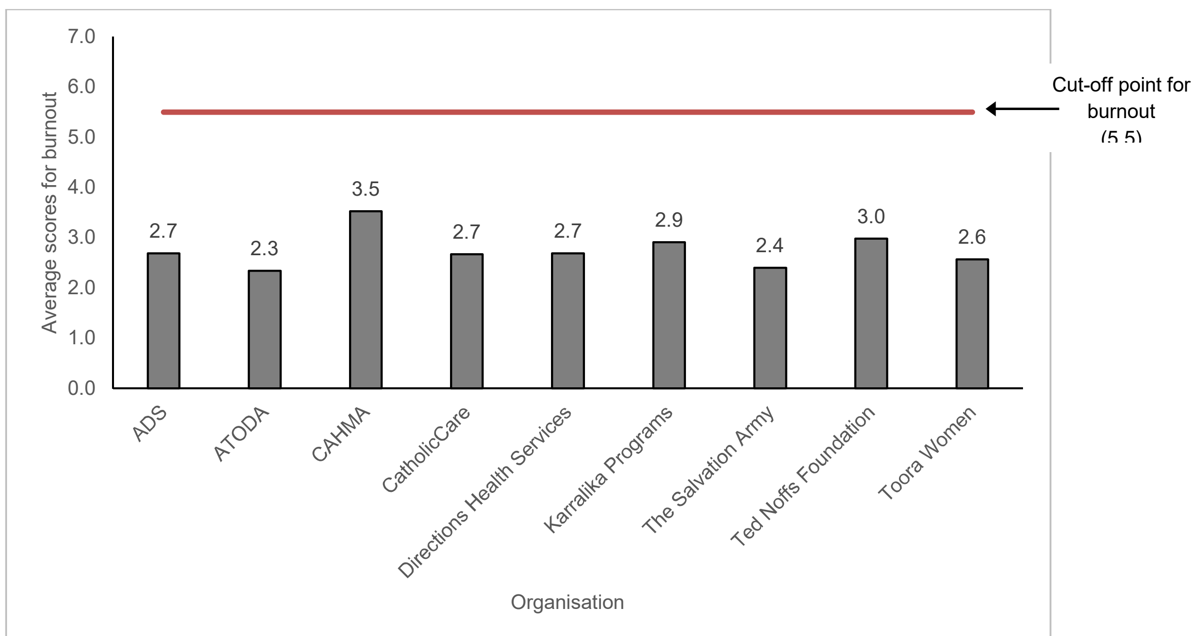
**Figure 42 Average scores for job satisfaction, professional growth and stress across organisations**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




| | ADS | ATODA | CAHMA | Catholic-Care | Directions Health Services | Karralika Programs | The Salvation Army | Ted Noffs Foundation | Toora Women |
|---|---|---|---|---|---|---|---|---|---|
| Satisfaction | 39.4 | 45.5 | 40.3 | 39.4 | 42.1 | 38.8 | 39.0 | 41.5 | 38.6 |
| Professional growth | 38.5 | 37.7 | 39.6 | 40.7 | 40.9 | 36.7 | 39.2 | 35.5 | 40.7 |
| Stress | 31.9 | 21.8 | 30.0 | 30.8 | 27.2 | 31.3 | 29.2 | 34.0 | 34.0 |

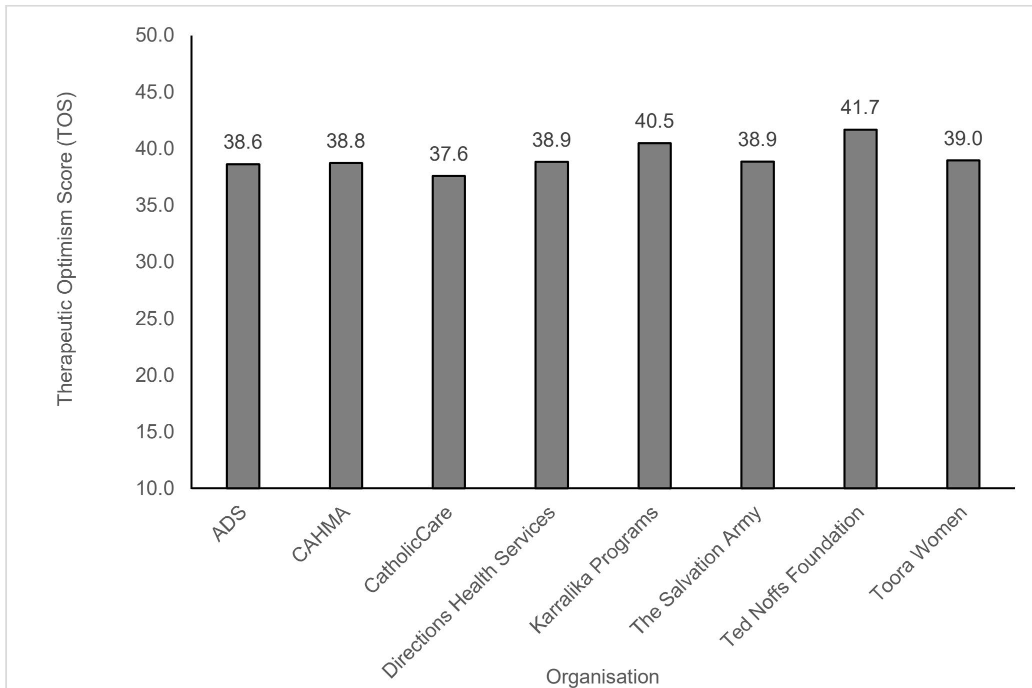
As seen in Figure 43, there was no significant difference in average burnout scores across organisations, and all organisations were well below the critical cut off point of 5.5 for burnout.

**Figure 43 Average scores for the burnout scale (Shirom-Melamed Burnout Measure—SMBM) for each organisation compared to the cut-off point for burnout (5.5)**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey



Therapeutic optimism was high at all organisations and did not differ significantly across these organisations (Figure 44).

**Figure 44** **Therapeutic optimism by organisation for workers with direct-client-contact**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Note: ATODA is not included in this chart as no workers at ATODA have direct-client contact

### *3.15.7 Association between well-being measures and direct-client-contact*

Table 14 shows the differences between scores for workers with direct-client-contact and non-client-contact; none of these differences are statistically significant.

**Table 14** **Comparison of well-being, satisfaction, professional growth, stress, and burnout scales between direct-client-contact and non-client-contact workers**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| Scale | Direct-client-contact worker (mean ± standard deviation) | Non-client-contact worker (mean ± standard deviation) |
|---|---|---|
| **Overall well-being** | 37.9 ± 11.7 | 39.6 ± 12.1 |
| **Job satisfaction** | 39.8 ± 6.7 | 41.7 ± 7.1 |
| **Stress** | 30.8 ± 9.0 | 28.3 ± 9.1 |
| **Burnout** | 2.7±1.0 | 2.8 ± 1.1 |
| **Professional growth** | 38.9 ± 7.7 | 38.4 ± 10.2 |

Note: The Therapeutic Optimism Scale does not appear in this table as it does not apply to non-client-contact workers.

### *3.15.8 Associations between well-being scales and other factors*

Associations were examined between the various well-being scales and a range of factors: age; gender; employment type; education; remuneration; weekly working hours; and time working in the sector.

*Age, remuneration, time working in the sector, weekly working hours*

Table 15 reports correlation coefficients (Pearson *r*) for the various well-being scales and age, remuneration (pre-tax base hourly rate), months in the ATOD sector, and average weekly working hours. Cohen's guidelines (1988) have been used to interpret the strengths of the associations (see Section 2.3), and asterisks indicate where these correlations are statistically significant.[15]

**Table 15 Correlations between well-being scale scores and age, remuneration, months in the ATOD sector and average weekly working hours**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | Overall well-being | Job satisfaction | Stress | Burnout | Professional growth | Therapeutic optimism |
|---|---|---|---|---|---|---|
| **Age** | 0.20* | 0.02 | -0.23** | -0.26** | -0.03 | 0.01 |
| **Pre-tax base hourly rate** | -0.01 | 0.06 | 0.19* | 0.03 | 0.08 | 0.12 |
| **Months in the ATOD sector** | -0.03 | -0.16 | 0.07 | 0.10 | -0.23** | -0.01 |
| **Average weekly working hours** | 0.09 | -0.00 | 0.08 | 0.04 | 0.01 | 0.19* |

Notes:
*. Correlation is significant at the 0.05 level (2-tailed)
**. Correlation is significant at the 0.01 level (2-tailed)
Using Cohen's guidelines (1988), correlations can be interpreted as: Small, r = 0.10 – 0.29; Medium, r = 0.30 – 0.49; Large, r = 0.50 – 1.00.
Only direct-client-contact workers are included in the analysis of therapeutic optimism.

Table 15 shows significant correlations for the following:

- a small positive correlation between age and well-being—as age increases, well-being also increases.
- a small negative correlation between age and stress and burnout—as age increases, stress and burnout decrease.
- a small positive correlation between pre-tax hourly rate and stress—as remuneration increases, stress increases.
- a small negative correlation between ATOD sector experience (months in the ATOD sector) and professional growth—as workers stay in the ATOD sector for longer, their professional growth scores decrease.

- a small positive correlation between average weekly working hours and therapeutic optimism—workers with greater average weekly working hours also have greater therapeutic optimism.

*Gender*

An independent samples t-test (two-tailed) was used to compare the various well-being scores for males and females. The only significant relationship was found between the professional growth scale and gender ($t$ (159) = -2.90; $p$ = .005). Females were significantly more likely to report higher scores on the professional growth scale—that is, to value and use opportunities for their own professional growth (females: $M$ = 40.0, $SD$ = 6.6; males: $M$ = 35.9, $SD$ = 9.0; where, $M$ is the mean, and $SD$ is the standard deviation).

*Employment type*

Associations between the well-being scales and current working arrangement were analysed by permanent-, fixed-term-, and casual- status. Analysis using the one-way analyses of variance (ANOVA) $F$ statistic found significant differences between these groups for stress scores ($F$ = 11.68, $p$ = .000), and burnout scores ($F$ = 3.83, $p$ = .024). Post-hoc comparisons show that the mean stress score for permanent workers ($M$ = 32.1, $SD$ = 8.8) was significantly different to that for fixed term workers ($M$ = 25.2, $SD$ = 7.9) and to that for casual workers ($M$ = 24.0, $SD$ = 7.4). There was no significant difference between fixed-term and casual workers. For the mean overall burnout score, there were significant differences between permanent ($M$ = 2.8, $SD$ = 1.0) and casual workers ($M$ = 2.2, $SD$ = 1.0), but not between fixed term workers ($M$ = 2.5, $SD$ = 1.1) and the other groups.

*Education*

While there were significant differences among highest education levels for mean stress ($F$ = 2.44, $p$ = .049) and burnout scores ($F$ = 2.59, $p$ = .038), the relationships were not linear (i.e. stress and burnout did not increase or decrease with highest education level). The only difference for the stress score was between the groups of workers with ‘Up to and including Year 12’ ($M$ = 24.8, $SD$ = 9.7) and ‘Bachelor’ ($M$ = 32.9, $SD$ = 9.3), and for the burnout score between the groups of workers with ‘Bachelor’ ($M$ = 3.0, $SD$ = 1.1) and ‘Graduate Diploma, Masters or Doctorate’ ($M$ = 2.3, $SD$ = 0.8).

### *3.15.9 Association between well-being measures*

An analysis of correlations among the various well-being-related scales shows the positive and negative correlations among these scales. Table 16 shows Pearson’s correlation coefficients among scale scores and sub-scale scores, indicating those with statistically significant correlations; Cohen’s guidelines (1988) have been used to interpret the strengths of the correlations. The significant correlations are summarized in Figure 45 with positive signs indicating positive correlations and negative signs indicating negative correlations.

**Table 16** **Correlations among overall well-being, job satisfaction, stress, burnout, professional growth and therapeutic optimism scales (and their subscales) showing significant correlations (shaded cells) and the magnitudes of these correlations**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | **Overall well-being** | Physical health | Psychological health | QOL | **Job satisfaction** | **Stress** | **Burnout** | Physical fatigue | Cognitive weariness | Emotional exhaustion | **Professional growth** | **Overall therapeutic optimism (TOS)** | TOS general | TOS Personal | TOS Pessimism |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Overall well-being** | 1 | .86** | .89** | .93** | .37** | -.43** | -.65** | -.65** | -.61** | -.30** | .25** | .16 | .21* | .08 | .04 |
| Physical health | | 1 | .59** | .69** | .26** | -.29** | -.49** | -.49** | -.49** | -.18* | .14 | .06 | .10 | .01 | -.01 |
| Psychological health | | | 1 | .80** | .38** | -.43** | -.63** | -.63** | -.60** | -.32** | .26** | .15 | .18 | .09 | .08 |
| Quality of life | | | | 1 | .37** | -.42** | -.63** | -.63** | -.58** | -.32** | .28** | .21* | .29** | .14 | -.00 |
| **Job satisfaction** | | | | | 1 | -.37** | -.49** | -.50** | -.38** | -.37** | .35** | .33** | .34** | .22* | .20* |
| **Stress** | | | | | | 1 | .49** | .50** | .40** | .30** | -.15* | -.08 | -.14 | -.08 | .08 |
| **Burnout** | | | | | | | 1 | .92** | .92** | .68** | -.27** | -.17 | -.20* | -.10 | -.07 |
| Physical fatigue | | | | | | | | 1 | .75** | .45** | -.20** | -.10 | -.15 | -.06 | .00 |
| Cognitive weariness | | | | | | | | | 1 | .54** | -.27** | -.17 | -.18* | -.09 | -.12 |
| Emotional exhaustion | | | | | | | | | | 1 | -.23** | -.20* | -.22* | -.14 | -.08 |
| **Professional growth** | | | | | | | | | | | 1 | .33** | .40** | .22* | .08 |
| **Overall therapeutic optimism (TOS)** | | | | | | | | | | | | 1 | .85** | .82** | .66** |
| TOS general | | | | | | | | | | | | | 1 | .50** | .35** |
| TOS Personal | | | | | | | | | | | | | | 1 | .41** |
| TOS Pessimism | | | | | | | | | | | | | | | 1 |

**. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Only direct-client-contact workers are included in the analysis of therapeutic optimism.

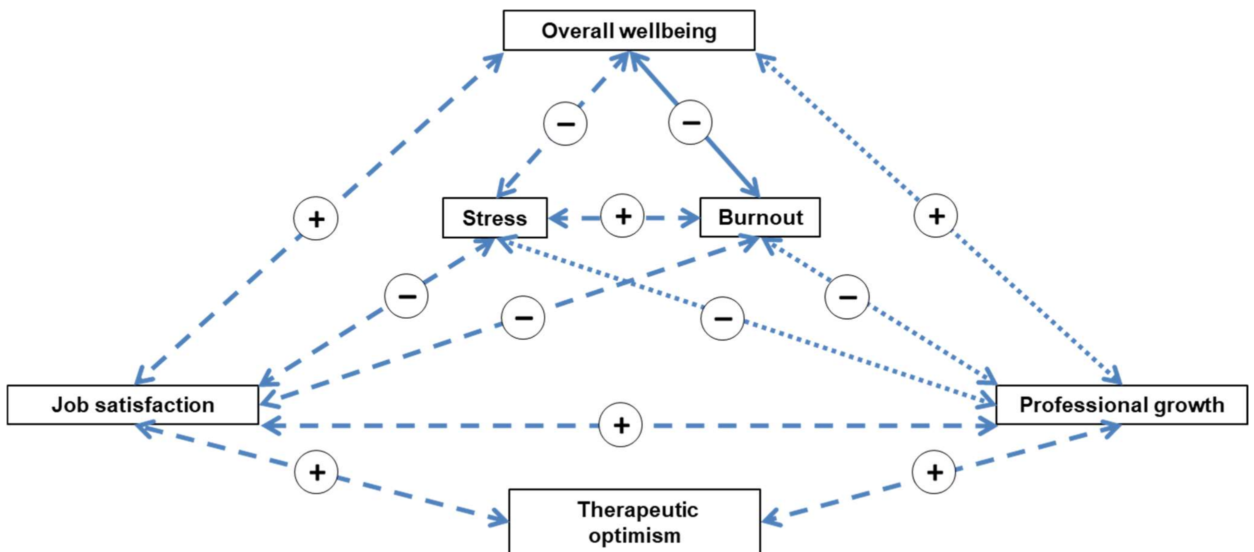
Using Cohen's guidelines (1988), correlations can be interpreted as: Small, r = 0.10 – 0.29; Medium, r = 0.30 – 0.49; Large, r = 0.50 – 1.00.

Table 16 and Figure 45 show:

- higher overall well-being in the workforce is correlated with:
    - higher job satisfaction (medium correlation)
    - higher opportunities for professional growth (small correlation)
    - lower levels of stress (medium correlation)
    - lower levels of burnout (large correlation)
- higher stress is correlated with higher burnout (medium correlation)
- both higher stress and higher burnout are correlated with:
    - lower professional growth (small correlation)
    - lower job satisfaction (medium correlation)
- higher job satisfaction is correlated with higher professional growth (medium correlation)
- therapeutic optimism is correlated with job satisfaction and professional growth (medium correlation)

**Figure 45 Significant correlations among key well-being-related scales for AOD workers—showing magnitudes of correlations and the directions of the relationships**

Source: 2017 ACT AOD Workforce Profile—Workers' Survey




Key:

| | |
|---|---|
| + | Indicates a positive correlation between variables (statistically significant) |
| - | Indicates an inverse (negative) correlation between variables (statistically significant) |
| ◄·········► | Indicates small correlations (r = 0.10 – 0.29) |
| ◄- - -► | Indicates medium correlations (r = 0.30 – 0.49) |
| ◄——► | Indicates large correlations (r = 0.50 – 1.00) |

### *3.15.10 Supporting well-being*

EOs/Managers completing the Organisation Survey were asked to identify what their organisation currently provides to support the well-being of workers outside of the conditions of their employment awards. Examples of the types of supports provided included (number of mentions are indicated in parentheses):

- Workplace policies (e.g. deliberate diversified tasks and caseloads; working set hours; short leaves of absence to support individual needs/appointments without use of leave; annual stress survey) (6)
- Access to nicotine replacement therapy and smoking cessation supports (5)
- Free immunisations (4)
- Employee Assistance Program (4)
- Team activities (including shared meals) (4)
- Health screens/checks (3)
- Employee reimbursement/financial support for well-being activities (e.g.subsidised gym memberships) (3)
- Specific well-being activities (e.g. massages, yoga, mini courses) (3)
- Free consumables (e.g. fruit, food, toothpaste) (3)

When asked what other well-being activities or strategies they would like to make available to their workers, EOs/Managers made the following responses:

- Provision of specific services or activities
    - on-site gym; meditation/relaxation groups
    - space where workers could access computers, and be able to have sick children with them at work
    - subsidised fitness activities
    - providing a well-being fund to staff
    - developing the staff social club
- Organisational policy/practice changes
    - access to benefits by all staff, including casuals
    - being responsive to issues raised in staff surveys
    - reinvigoration of Healthy Workplace Activities – split between work- and personal-time is a shared responsibility
    - developing a Workforce Development Strategy with input from staff
- Addressing workloads and caseload diversity
    - having properly resourced projects that reflect the full costs and inputs so that the work isn’t cross-subsidised
    - moving through roles in different programs to keep people fresh, develop their skills and network with others
- Changing work practices (e.g. walking meetings)
- Improving the physical working environment

# 4 Discussion

## 4.1 A growing AOD workforce—implications for resourcing

Since the completion of the last profile in 2014, the AOD workforce in specialist AOD services has grown by around 17%, as estimated by responses to the Organisation Survey. For this 2017 survey, it has been possible to estimate the size of the entire workforce in specialist AOD services as data was collected on both staff currently employed and the number of current staff vacancies.

Using this data, the total AOD workforce in the participating organisations has been estimated to be 300 staff. This figure does not include the specialist AOD workers in the Aboriginal and Torres Strait Islander services, where there were estimated to be a further seven ATOD positions (at the time of the survey). The total AOD workforce in the ACT is, therefore, estimated to be at least 307 workers.

The growth of the AOD workforce has important implications for resourcing, professional development and organisational infrastructure in the AOD sector. Clearly, AOD services require on-going resourcing to retain this increased workforce in terms of actual salaries, oncosts and infrastructure (e.g. desk space, computers, clinical practice rooms). In addition, organisations require resourcing and capacity to provide adequate and appropriate AOD practice supervision to these positions, and to provide access to training and qualifications. Under the Qualifications Strategy (QS), full subsidies are provided for relevant workers to complete the AOD Skill Set; First Aid and the Certificate IV in AOD – the increase in the size of the workforce clearly has implications for increased resourcing of this training and other workforce development initiatives (see Section 4.9 for further discussion of the QS).

## 4.2 Collaborative methods result in a high response rate

The Workers' Survey was completed by 61.3% of the workforce, a higher participation rate than those achieved in the two previous profiles (55% in 2011 and 52% in 2014), and higher than most comparable workforce profiles. ATODA expected high participation rates in the Workforce Profile due to the methodology and methods used in the implementation of the survey.

The development of the survey, and the administration and collection of the data, are undertaken collaboratively by ATODA and the specialist AOD services that participate. The topics and questions asked are shaped through discussions with the Executive Officers of the specialist AOD services and the ACT ATOD Workers' Group, and through extensive meetings held in the year leading up to the survey to negotiate survey content and methods. Through these forums, specialist AOD services are involved in shaping the collaborative nature of the process, and are able to discuss the utility of the data in shaping workforce development, planning and advocacy.

Further, the method of the 2017 survey implementation involved a concerted effort to improve participation through targeted recruitment strategies negotiated with each participating specialist AOD service. This included, for instance: regular communication with a nominated service (or site) Contact Person responsible for the survey's implementation; attendance by ATODA workers at staff meetings where the value of participation could be further discussed;

and, in some cases, administration of the survey “on the spot” to maximise participation (see section 2.2).

## 4.3 The need for specific strategies to improve participation among some sub-groups

The 2017 survey included a larger number of consistent standardised questions across both the Workers’ and Organisation Surveys that could be compared to assess the extent to which the responses to the Workers’ Survey were representative of the actual AOD workforce. Unfortunately, the Organisation Survey was only able to capture information about 230 workers (of 279 – 82.4%) and so provides a limited basis for comparison of the sample to the entire workforce. Acknowledging this limitation, the two groups were broadly comparable by gender and time worked at the organisation (i.e. “less than 12 months” and “more than 12 months”). Similar to previous surveys, full time workers had higher representation among Workers’ Survey respondents than stated in the Organisation Survey (58% of Workers’ Survey respondents worked full time compared to 42% in the Organisation Survey), and there was lower proportional representation of part-time and casual workers. In addition, similar to the 2014 survey, there were no survey responses from General Practitioners, Addiction Medicine Specialists, Other Medical Specialists and Psychiatrists.

As the profile and needs of some sections of the AOD workforce—e.g. part-time and casual workers and particular job categories—are being under-represented, this introduces a potential response bias. The implementation of the next workforce profile could include an investigation into the causes of this lower participation in some employment categories, and specific strategies to address these. Strategies to improve participation from Aboriginal and Torres Strait Islander workers should also be considered.

In order to maintain high response rates across all categories of workers, the design of the next survey will also need to carefully balance opportunities to gain detailed information on which to base systematic reporting with the need to ensure survey completion is not unnecessarily onerous or lengthy.

## 4.4 Age, gender and cultural diversity of the AOD workforce

Similar to previous workforce profiles, the 2017 profile continues to show that nearly 70% of the workforce is female. This is in direct contrast to the profile of service users where 66% are male.[18] This potentially presents unique dynamics around the provision of care to service users.

The average age of the workforce has increased slightly over time, but not significantly, and as in previous Workforce Profiles the highest number of workers are concentrated in the 40 – 49 year old age group. Workforce ages also differ predictably among organisations—for example, the youth-targeted service (Ted Noffs Foundation) has a younger than average workforce (33 years), while The Salvation Army has an older than the average workforce (50 years).

Although fewer than five respondents identified as Aboriginal and/or Torres Strait Islander, ATODA estimates that, based on knowledge of the sector, there are at least ten Aboriginal and/or Torres Strait Islander workers in participating specialist AOD services in the ACT (i.e.

over and above the workers in Aboriginal and Torres Strait Islander community controlled services). This is not significantly different to the 2014 survey where six respondents identified as Aboriginal and/or Torres Strait Islander, and seven workers were identified through the Organisation Survey.[u]

Some limited data was gathered on the cultural and linguistic diversity of the AOD workforce – 27.6% were born outside Australia, and 11% (18) spoke a language other than English at home—similar figures to the 2014 survey. Little is currently known about whether the AOD workforce matches the cultural and linguistic needs of the service users (other than for Aboriginal and Torres Strait Islander service users). Questions about the cultural and linguistic diversity of the client population were included in the 2018 ACT AOD Service Users' Satisfaction and Outcomes Survey (SUSOS), and may provide some insight into this.[19]

There are opportunities to obtain further information on workforce diversity in the next Profile, including assessing, for example, people in the AOD workforce who have a disability.

## 4.5 Split of direct-client-contact and non-client-contact activities

Not surprisingly, the majority of the workforce in the participating specialist AOD services are in AOD worker roles, or are administrators, Executive, managers or other roles with a secondary responsibility as an AOD worker—a total of just over 57% of the AOD workforce (consistent in both the Organisation and Workers' surveys). This is broadly similar to the proportions of AOD workers, identified in the 2014 Workforce Profile (although the definitions used were slightly different).

A significant proportion of the job activities of direct-client-contact workers (on average, 36%) includes non-client-contact activities such as data entry, meeting attendance, undertaking professional development, other organisational processes, and compilation of data for reporting purposes. Neither list of direct-client-contact nor non-client-contact activities specifically included activities such as writing up case notes and/or referral letters and booking appointments. Several respondents identified these activities as part of their role under 'other' non-client-contact activities; however, other workers may have assumed these to be part of their direct-client-contact activities. The 64:36 split between direct-client-contact and non-client-contact activities for workers in a direct-client-contact role is, therefore, a broad estimate of this activity split. This requirement of workers to be both proficient clinicians and administrators has implications for workforce recruitment; professional development and resourcing.

Also of note, is the clear commitment by direct-client-contact workers to the collection and entry of data in relation to their service users—'data entry' and 'compilation of data for reporting purposes' are among the most reported non-client-contact activities of these direct-client-contact workers. The recognition in the AOD workforce of the importance of quality data in the ATOD sector has been steadily growing over the past 10-years, and the dedication of on-the-

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[u] Note that the total figures were arrived at differently for each survey. Unlike the 2014 survey, the 2017 survey did not ask CEOs/Managers completing the Organisation Survey to identify the Aboriginal and/or Torres Strait Islander status of their workers—the total figure was instead arrived at through an estimate based on ATODA's knowledge of the AOD sector.

ground workers, supported by their managers and CEOs, to collecting this data is a key factor in this quality.

## 4.6 Supporting a peer workforce

As in the 2014 survey, the 2017 profile incorporated questions about identified peer worker positions. As per the recommendations of the 2014 survey, questions were changed in an attempt to clarify the definition and improve the validity of the data. 'Peer worker' was removed as a 'job role' category from relevant questions, and was instead specifically asked as separate questions:

- In the Organisation Survey: "Is the staff member a peer worker?"
- In the Workers' Survey: "Are you a peer worker?"

Both questions included a definition in explanation of the question:

> *Peer workers are defined as those who are specifically engaged to utilise their lived experience to inform their work*

The results of these questions have not been reported as it became clear that the question may have been interpreted differently between several workers (in the Workers' Survey) and Executives/managers (completing the Organisation Survey)—several appear to have responded with reference to having lived experience of AOD use, rather than whether they were specifically employed in a position that is defined by having lived experience of AOD use with a specific set of skills for working with people with lived experience of AOD use.

Further refinement of the explanation and the questions asked will be needed for the next Workforce Profile, as monitoring the changes in the peer workforce is important for considering how the needs and growth of this workforce is supported over time, and for assessing the capacity of the ATOD sector to respond to the needs of service users.

## 4.7 Supporting casual workers

The 2017 Organisation Survey shows that 15.5% of workers are employed in casual positions. As in previous surveys, this points to the need for a greater consideration of the unique needs of the casual workforce in the ATOD sector, and the unique ways in which casual workers are utilised by services. A future Workforce Profile may consider exploring these specific issues related to the casual AOD workforce in greater detail (for example, through a set of specific additional questions and a concerted effort to improve the response rate of casual employees).

## 4.8 Remuneration and non-remuneration entitlements

As seen in Table 17, this 2017 Workforce Profile shows that based on a 38-hour week, the average annual salary for an AOD Worker was $61,058.40. In 2017, 'AOD workers', along with administrators, earned the lowest average pre-tax income of all of the job roles. Although role category definitions differ between the 2014 and 2017 surveys, this can be broadly compared to the 2014 average annual salary for ATOD workers (Clinical and Non-Clinical) of $57,541.12 ($29.12/hour), showing a 6.11% increase between 2014 and 2017 (for AOD workers).

**Table 17 Pre-tax annual income (based on 38 hours/week) for 'AOD workers only' and for all workers in the participating specialist AOD services**
Source: 2017 ACT AOD Workforce Profile—Workers' Survey

| | AOD workers only* | | All survey respondents from participating AOD services (includes Executives) | |
|---|---|---|---|---|
| | Average pre-tax base hourly rate | Average pre-tax annual income | Average pre-tax base hourly rate | Average pre-tax annual income |
| **2014** | $29.12/hr | **$57,541.12** | n/a | n/a |
| **2017** | $30.90/hr | **$61,058.40** | $35.07 | **$69,298.32** |

* The category of 'AOD workers' was used in the 2017 Workforce Profile, and was categorised as Clinical and Non-Clinical ATOD Workers in the 2014 Workforce Profile.

According to the Australian Bureau of Statistics reporting on Average Weekly Earnings, May 2017, the average weekly total earnings for all employees[v] in the ACT was $1,393.10 per week, translating to an average pre-tax annual amount of $72,441.20 (based on a 38-hour week). This compares to an average pre-tax annual salary of $69,298.32 in 2017 for all survey respondents from participating AOD services (Table 17). This means that, on average, workers in specialist AOD services in the ACT are earning $3,142.88 per annum less than the average worker in the ACT.

Considering the comparatively low remuneration provided to workers in specialist AOD services, the range of non-remuneration based employee entitlements and benefits available to workers in specialist AOD services are potentially important in attracting and retaining employees in the short to medium term. This is particularly true, for instance, in organisations with lower average hourly rates (see Figure 11). It also highlights the critical importance of incorporating workforce planning within future AOD health services planning to ensure there is a structured approach to explore current and future AOD workforce needs and costs, and analyse the improvements required to meet them.

## 4.9 Qualifications and the Qualifications Strategy (QS)

The data from this 2017 Workforce Profile indicates that the ATOD sector has a well-qualified workforce (just over half of respondents had a bachelor or above qualification) that is becoming increasingly well-qualified over time (Figure 23). The potential value of these qualifications to individual workers is clear, as average pre-tax base hourly rates of pay increase as education level increases (Figure 15). There is also potentially a value to the quality of service provision within specialist AOD services and treatment outcomes for clients, although the evidence in the literature for the latter is mixed.[20]

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[v] Average weekly total earnings for all employees refers to the weekly ordinary time earnings calculated before taxation and any other deductions plus weekly overtime earnings of employees. This measure was chosen as it also includes part-time and casual employees—who make up a significant proportion of the workforce in specialist AOD services—in the estimate of the average weekly earnings.

The data shows that 61.2% of direct-client-contact workers self-identified that they fully met the Qualifications Strategy, with a further 9.3% meeting the qualification/AOD Skill Set requirement, but not holding a *current* First Aid Certificate—note that the question does not differentiate between those who have previously completed a First Aid Certificate (but have not renewed it) and those who have *never* completed it. A further 8.5% of workers were currently undertaking the AOD Skill Set. Therefore, a total of 79% of direct-client-contact workers had either attained or were working towards holding an AOD-specific qualification or the AOD Skill Set. Similar to the 2014 survey, about half of workers who had not yet attained or were undertaking the minimum Certificate IV requirement were planning to do so in the next 12 months.

The data around the proportions of workers who meet the Qualifications Strategy were analysed slightly differently in previous surveys as they were based on responses from *all* workers, not just direct-client-contact workers. However, the figures appear to be broadly stable between the 2014 and 2017 surveys—i.e. the proportions of workers meeting the QS was between 65.6% (Workers' Survey) and 75.4% (Organisation Survey) in 2014, and between 61.2% (Workers' Survey) and 79.4% (Organisation Survey) in 2017.

According to the 2017 Workers' Survey, about one in five direct-client-contact workers did not have a current First Aid Certificate. Workers need to renew their qualifications in *HLTAID001 Provide cardiopulmonary resuscitation* annually, and *HLTAID002 Provide basic emergency life support* and *HLTAID003 Provide first aid* every three years. This points to the on-going need to regularly offer subsidised First Aid Certificate training to AOD workers so that they can maintain their currency and continue to meet the Qualifications Strategy.

Most workers agreed that the Certificate IV equivalent is adequate for the ATOD sector as it seems to strike a balance between enabling workers without experience in studying to still achieve a qualification (although some thought that it was still too difficult for some workers to attain), and enabling workers to have sufficient knowledge to work with clients with complex AOD needs, acknowledging that some areas of AOD work (e.g. psychosocial activities) need more advanced qualifications and/or experience. Several workers commented on the value of having lived experience as a 'qualification' for the type of work that is undertaken, and others noted the need for on-going professional development beyond simply the Certificate IV level.

The 2017 Workforce Profile has found that employees tend to stay within the AOD workforce for an average of 7.1 years, with half the workforce being in the ATOD sector for about 5 years or more. However, they change organisations and positions more often (i.e. average 4.9 years in their current organisation, and 2.7 years in their current position). This reinforces the benefit of having a Qualifications Strategy available collectively to the entire workforce in the ATOD sector. Because of the likelihood that an AOD worker will stay within the sector, investment in training this worker through the ATOD Qualifications Strategy has a benefit that extends across the entire sector, not just to a single organisation.

While there is significant retention within the AOD workforce, data from the Workers' Survey also clearly indicates that over half of the AOD workforce (56.8%) held their last positions outside the ATOD sector, and 71% of workers have a qualification in a non-ATOD health/social/behavioural sciences area. This highlights the importance of continuing the delivery of the Qualifications Strategy, including the AOD Skill Set, as there are constantly

people moving from other sectors into the ATOD sector who require training or upskilling in the minimum qualification. In response to demand from the ATOD sector, AOD Skill Set training frequency has been increased to meet the needs of workers coming from outside the ATOD sector. It is important to note that only limited AOD-specific training is available in the ACT, with many training and professional development opportunities being purchased from interstate providers. The significant challenges with accessing high quality local training, substantially increases the costs of delivering this training.

Further, while requiring a minimum Certificate IV qualification for new recruits could be a barrier to recruitment beyond the ATOD sector, offering minimum qualifications through the sectors' Qualifications Strategy could be viewed as an incentive to new potential recruits. The ATOD sector is the only community service sector in the ACT with a fully funded Qualifications Strategy, and this could continue to be better utilised as an incentive to attract people to the sector.

## 4.10 AOD practice supervision

The provision of AOD practice supervision to workers in specialist AOD services who have direct contact with clients continues to be a challenge for these services—cost, time and the limited availability of qualified people in the ACT to provide AOD-specific practice supervision are the main barriers. The low level of agreement by respondents to the statement 'my organisation allowed me to select my own AOD practice supervisor' likely points to the lack of options available for qualified AOD practice supervisors in the ACT. While several services have strategies to overcome the barriers listed, there are still a significant number of direct-client-contact workers who may not be receiving adequate practice supervision.

Practice supervision should ideally be provided regularly and by someone external to the organisation or, if provided internally, someone who is not also providing management supervision. An examination of the data shows that, among direct-client-contact workers receiving practice supervision, 38.8% were receiving this regularly (fortnightly or monthly) from someone outside the organisation. A further 25.0% were receiving regular (fortnightly or monthly) practice supervision from someone within their organisation, but at least some of this practice supervision was provided by someone who was not the same person as their line manager.

It is difficult to make direct comparisons between this 2017 supervision data and data from previous Workforce Profiles because of the different categorisations used for the workforce (e.g. Clinical and non-Clinical ATOD Workers vs AOD Workers and workers with direct-client-contact), and definitions of supervision (e.g. 'clinical' and 'non-clinical' supervision vs 'AOD practice' and 'management' supervision). However, if 'all respondents receiving clinical supervision' in the 2014 Workforce Profile are compared to 'all respondents receiving AOD practice supervision', then broadly there seems to have been an increase in:

- the proportions of respondents receiving clinical/AOD practice supervision at least monthly—from 75.5% in 2014 to 86.8% in 2017
- proportions of workers receiving clinical/AOD practice supervision external to their organisation (or a combination of internally and externally)—from 65.4% in 2014 to 78.8% in 2017

Satisfaction with clinical/practice supervision has probably remained more-or-less constant, although the questions asked in each survey between 2014 and 2017 are different. In 2014, 66.3% of workers receiving clinical supervision reported that they were 'very satisfied' or 'satisfied' with their clinical supervision. In 2017, 70.1% 'agreed' or 'strongly agreed' that the practice supervision they receive provides adequate support for working with clients, and 66.3% 'agreed' or 'strongly agreed' that it supported their own well-being in the workplace. While these statements do not directly reflect satisfaction, they indicate related concepts of being supportive of AOD practice and worker well-being.

In the 2014 Workforce Profile, 35.0% of non-clinical ATOD workers reported receiving ATOD-specific clinical supervision, something that was not necessary for their roles as non-clinical workers. Although categorisations and definitions have changed slightly between surveys, it appears that either AOD practice supervision is being applied in a more targeted way specifically towards direct-client-contact workers, or that workers have a better understanding of the differences between various types of supervision available to them—only 14.7% of non-client-contact workers reported receiving AOD practice supervision (and all of these reported that they were receiving this alongside management supervision).

It is difficult to find up-to-date recommendations on good practice in the provision of AOD practice supervision. The *NSW Drug and Alcohol Clinical Supervision Guidelines* (2006) suggest monthly private sessions or appointments of one hour's duration.[21] A resource kit developed by the National Centre for Education and Training on Addiction (2005) suggests that organisations develop a practice supervision program and policy which articulates the philosophy and purposes of supervision for that organisation, and the structure of and access to a supervision program for workers.[22] Considering the challenges faced by ACT specialist AOD services in providing practice supervision—in terms of cost, time and availability of qualified AOD practice supervisors—it would seem more relevant for individual specialist AOD services to develop (as some have) their own formal programs of practice supervision that address the needs of the workers within the constraints facing the organisation and the sector. The next Workforce Profile will benefit from questions that further explore the nature of practice and management supervision being received by workers, including for instance whether those workers not receiving practice supervision feel that they should be getting it.

## 4.11 Recruitment and retention in the AOD workforce

At the time of the 2017 survey, specialist AOD services indicated that they had 21 vacancies, and that they are taking about 3 months to fill these vacancies. The barriers to recruitment include low numbers of applicants, in particular those without adequate AOD experience or training and education. This points to the on-going need to be offering the Qualifications Strategy to ensure that new workers entering the AOD workforce can access AOD-specific training.

The data shows that administrators and counsellors have the shortest duration in their current positions, current organisation and in the ATOD sector. In the case of administrators, this seems to indicate high turnover in these positions—administrators also have the lowest average pre-tax base hourly earnings (see Figure 14), and lower average levels of education (Figure 22). However, they were also likely to indicate (at rates similar to other job roles) that

they planned to remain in their current role and/or seek promotional opportunities in the next 12 months.

At the time of this survey (mid-2017), a number of new counselling positions had been recently funded and appointed, thereby explaining the low years in ATOD sector, organisation and role for counsellors.

The data also shows that Executives and Managers are very experienced in AOD with these categories having a high average number of months in the ATOD sector.

The desire by almost one-fifth of the workforce (18.8%) to seek promotional opportunities within the ATOD sector points to the need to develop specific strategies to create these career pathways.

## 4.12 Recruiting and retaining an Aboriginal and Torres Strait Islander workforce

The employment of Aboriginal and Torres Strait Islander workers within specialist AOD services is acknowledged to improve the cultural security and accessibility of these services for Aboriginal and Torres Strait Islander clients. The Service Users Satisfaction and Outcomes Survey conducted in 2015 found that there were 90 people who identified as Aboriginal and/or Torres Strait Islander accessing *mainstream* specialist AOD services on the single census date (i.e. excluding service users accessing Aboriginal and Torres Strait Islander community-controlled services). The four Aboriginal and Torres Strait Islander- identified positions noted through the Organisation Survey are probably not sufficient to address the cultural security needs of Aboriginal and Torres Strait Islander people utilising mainstream specialist AOD services.

There appears to have been some improvement in the number of organisations having a formal and strategic commitment in place for the recruitment of Aboriginal and Torres Strait Islander workers within their organisations. Compared to the previous workforce profile, one additional organisation has an Indigenous Employment Strategy (from two in 2014 to three in 2017), but other organisations have specific unwritten strategies for trying to increase the employment of Aboriginal and Torres Strait Islander people.

It should be noted that since the 2017 Workforce Profile was implemented, there have been several further Aboriginal and Torres Strait Islander identified positions funded and appointed in specialist AOD services.

As discussed in the 2014 Workforce Profile, the ATOD sector would benefit from a strategic plan for improving recruitment, retention and development of a specialist AOD Aboriginal and Torres Strait Islander workforce. Such a plan should consider appropriate targets for Aboriginal and Torres Strait Islander AOD workers, how to best support them, and innovative approaches to enabling Aboriginal and Torres Strait Islander workers to better support clients within mainstream AOD services.

## 4.13 Worker well-being

This is the first ACT AOD Workforce Profile to measure the well-being of the workforce. The survey uses the scales from the Treatment Outcomes Profile (TOP) to rate psychological

health, physical health and quality of life on scales of 0 to 20, and a combined scale of 0 to 60. The TOP was developed for measuring treatment outcomes among clients of AOD services, with the three measured items correlating with general population measures such as the World Health Organization (WHO) Brief Quality of Life Scale and the Kessler Psychological Distress Scale.[12]

The measure on this scale shows that the well-being of the ACT AOD workforce is moderately high with 72% of workers scoring greater than the mid-point score of 30 indicating a tendency towards a descriptor between 'average' and 'the best you have ever felt'. The subscales also scored moderately well, with, for instance, 70.6% of workers scoring greater than the mid-point score (10) for quality of life. The lowest well-being score was for physical well-being (58.3% scoring greater than the mid-point), perhaps indicating the need for specific physical-well-being supports to continue to be offered to workers in specialist AOD services.

The TOP scale was also used in a study of 228 workers in specialist AOD services in Victoria which found average scores for that cohort of: 14.9 for psychological health; 14.1 for physical health; 15.3 for quality of life; and 43.7 for overall well-being.[12] These are higher scores than for our ACT cohort—12.6; 12.0; 13.6; and 38.3 respectively (see Figure 46).

Future ACT AOD Workforce Profiles could consider incorporating a well-being measure such as the Quality of Life measure used in the NSW non-government AOD workforce profile,[1] to enable further comparison across other jurisdictional AOD workforces.

The 2017 ACT AOD Workforce Profile shows that, similar to other workforce profiles and consistent with the literature (as shown in Figure 1), there is a positive correlation between well-being and job satisfaction and professional growth—see Figure 45. The moderately high score for well-being in this workforce profile is indicative of the existing supports being provided by specialist AOD services and more broadly within the ATOD sector—e.g. access to professional development activities and training/study opportunities, supportive supervision, and other specific well-being initiatives noted in Section 3.15.10.

While there were some variations, there were no statistically significant differences found between well-being (overall or the subscales) and job roles, specialist AOD organisations, and whether workers were 'direct-client-contact' or 'non-client-contact' workers. All scores for these factors were above the mid-point score of 30 (out of 60). Of other factors that were analysed (Section 3.15.8), age was the only one associated with well-being—that is, being older is associated with greater well-being. This is consistent with the study of workers in specialist AOD services in Victoria.[12]

The survey of Victorian specialist AOD workers also found a link between positive well-being and access to support systems (i.e. having a greater number of people with whom to discuss things that are important). A measurement of support systems could be considered for incorporation into the next ACT AOD Workforce Profile, either through a question such as, 'How many people do you discuss important things with?'—as used in the Victorian survey[12]—or a scale such as the Brief Job Stress Questionnaire (BJSQ) used in surveys conducted with the NSW non-government AOD workforce[1] and the New Zealand AOD workforce.[23]

**Figure 46 Summary of well-being measures, comparing the 2017 ACT AOD Workforce Profile with three other AOD workforce profiles**

| | | 2017 ACT AOD Workforce Profile | Workers in specialist AOD services in Victoria (2016)[12] | NSW non-government AOD workforce profile (2017)[1] | New Zealand AOD workforce (2017)[23] |
|---|---|---|---|---|---|
| **Well-being** | Average scores | | | n/a | n/a |
| **Psychological** | | 12.6 | 14.9 | | |
| **Physical** | | 12.0 | 14.1 | | |
| **Quality of Life** | | 13.6 | 15.3 | | |
| **Overall** | | 38.3 | 43.7 | | |
| **Job satisfaction** | Average score | 40.2 | 39.0* | 39.6 | 37.6 |
| | Proportion who 'agree' (i.e. score = 35.00 – 50.00) | 81.9% | n/a | 77.2% | 68.7% |
| **Professional growth** | Average score | 38.7 | 39.0* | 38.2 | 36.1 |
| | Proportion who 'agree' (i.e. score = 35.00 – 50.00) | 73.3% | n/a | 70.7% | 61.0% |
| **Stress** | Average score | 30.4 | 32.0* | 31.3 | 35.0 |
| | Proportion who 'agree' (i.e. score = 35.00 – 50.00) | 35.3% | n/a | 31.8% | 53.3% |
| **Burnout** | Proportion reporting they are 'burnt out' (i.e. score > 5.50) | 1.8% | n/a | 1.5% | 3.1% |
| **Therapeutic Optimism (overall)** | Average score | 39.4 | n/a | 34.4 | 34.8 |
| | Proportion who 'agree' (i.e. score = 35.00 – 50.00) | 84.3% | n/a | 48.9% | 53.9% |

*The average scores have been estimated based on a figure appearing in the article that reports these findings (Best, Savic and Daley 2016)

## 4.14 Job satisfaction

The 2017 Workforce Profile has found moderately strong job satisfaction among workers in ACT specialist AOD services—ninety percent of workers reported scores greater than the neutral mid-point of 30. As shown in Figure 46, the average score of 40.21 is slightly higher than then average job satisfaction scores reported among similar cohorts of workers in specialist AOD services in Victoria (around 39.0, n=228)[12] and NSW (39.6, n=202),[1] and higher than a cohort in New Zealand (37.6, n=246).[23]

Further, when scores were grouped according to their level of agreement, 81.9% indicated that they agree that they were satisfied with their job (i.e. scores between 35.0 and 50.0). This is higher than for cohorts of AOD workers in NSW (77.2% agreed) and New Zealand (68.7% agreed) (Figure 46).

In the 2014 ACT ATOD Workforce Profile, 89% of workers indicated that they were either 'satisfied' or 'very satisfied' with their jobs. As this was asked using a single question, it is not directly comparable to the 2017 figures, although it can be noted that the 2014 figure is of similar magnitude to the findings of the 2017 survey.

Although not necessarily directly related to job satisfaction, it is indicative that 71.2% of ACT AOD workers in this survey responded that they planned to remain in their current role in the next 12 months.

All scores for job satisfaction across job roles and specialist AOD organisations were well above the mid-point score of 30, and variations were not statistically significant. There was no associations found between job satisfaction and other factors examined in section 3.15.8 (e.g. age, remuneration, months in the ATOD sector, etc).

Similar to other workforce profiles[12] and consistent with the literature (as shown in Figure 1), this 2017 ACT AOD Workforce Profile shows a positive correlation between job satisfaction and overall well-being ($r = .37$, $p<0.01$) and professional growth ($r = .25$, $p<0.01$)—see Figure 45. Further, this data shows a significant (medium) correlation between job satisfaction and the therapeutic optimism scale (TOS) ($r = .33$, $p<0.01$), including the subscales of the TOS—in particular the subscale relating to treatment outcome expectancies (TOS general) (see Table 16).

## 4.15 Professional growth

The professional growth scale measured "the extent to which staff members value and use opportunities for their own professional growth".[24] The 2017 Workforce Profile has found moderately strong professional growth among workers in ACT specialist AOD services—86.1% of workers reported scores greater than the neutral mid-point of 30. The average score of 38.66 is about the same as the average growth scores reported among similar cohorts of workers in specialist AOD services in Victoria (around 39.0, n=228)[12] and NSW (38.2, n=222)[1], and slightly higher than a cohort in New Zealand (36.1, n=282)[23] (Figure 47).

The average score for professional growth can also be compared to a chart produced by the Texas Christian University (TCU) Institute of Behavioral Research (responsible for developing the Organizational Readiness for Change scales) that plots average scores from 2,031 completed surveys from previous research involving drug treatment program staff in a diverse

range of community AOD treatment programs (prior to 2004). The chart reports norm scores: an average growth score of 35.6, with the middle 50% falling between 32 ($25^{th}$ percentile) and 50 ($75^{th}$ percentile).[25] The average score of 38.7 for the 2017 ACT AOD Workforce Profile is therefore higher than the norm average score, and within the middle 50% of scores.

Further, when scores were grouped according to their level of agreement, 73.3% indicated that they agree that they have opportunities for professional growth (i.e. scores between 35.0 and 50.0). This is slightly higher than for cohorts of AOD workers in NSW (70.7% agreed) and higher than for a New Zealand cohort (61.0% agreed) (Figure 46).

Professional development is clearly a priority for workers in ACT specialist AOD services, as shown in the response to the statement "keeping your skills up-to-date is a priority for you" (average score of 4.3 out of 5.0), and the identification of areas of future professional development priorities. The priorities of workers and organisations overlapped.

The data show that female workers were significantly more likely to value and use opportunities for their own professional growth than male workers; and that workers who had been in the sector for longer were less likely to value and use opportunities for professional growth. It is possible that more experienced workers may feel they have less need for professional development opportunities—because of their level of experience—or may lack the time or opportunity because of their more senior roles and greater work responsibilities.

It should be noted that there is no AOD worker professional body to provide support to AOD workers seeking professional growth opportunities.

## 4.16 Staffing

It is notable that AOD workers feel that staffing levels are not sufficient to meet the needs of clients—almost half (46.6%) report that they strongly disagree or disagree that "there are enough AOD workers at our program to meet current client needs". This suggests the need for further resources and supports for specialist AOD services and the workforce. Despite this, most workers, however, feel that they are able to spend enough time with clients (42.2% agree or strongly agree that this is the case).

## 4.17 Stress and burnout

The stress scale measured "perceived strain, stress, and role overload",[24] while the burnout scale measured the extent to which a worker was experiencing "a crisis in [their] relationship with work".[17] The 2017 Workforce Profile has found moderate levels of stress among workers in ACT specialist AOD services. There was an even spread of workers above and below the neutral mid-point score of 30—46.5% of workers reported higher stress (i.e. scores greater than the mid-point of 30), while 43.5% reported lower stress (i.e. scores less than the mid-point of 30).

As shown in Figure 46, the average score of 30.4 is slightly lower than the average stress scores reported among similar cohorts of workers in specialist AOD services in Victoria (around 32.0, n=228)[12] and NSW (31.3, n=214)[1], and lower than a cohort in New Zealand (35.0, n=261).[23]

The average score for stress can also be compared to a chart plotting average scores from 2,031 completed surveys from previous research involving drug treatment program staff in a diverse range of community AOD treatment programs (prior to 2004). The chart reports norm

scores: an average growth score of 32.7, with the middle 50% falling between 25 (25th percentile) and 40 (75th percentile). The average score of 30.38 for the 2017 ACT AOD Workforce Profile is therefore lower than the norm average score, and within the middle 50% of scores.

Further, when scores were grouped according to their level of agreement, 35.3% indicated that they agree that they are stressed (i.e. scores between 35.0 and 50.0). This is higher than for cohorts of AOD workers in NSW (31.8% agreed) but lower than for a New Zealand cohort (53.3% agreed) (Figure 46).

The 2017 Workforce Profile has found low levels of burnout among workers in ACT specialist AOD services—1.8% of workers had scores greater than the cut-off point for burnout of 5.5. This means that 98.2% of workers could be classified as not burned out. As shown in Figure 46, this data is similar to the proportions of workers reporting burnout in similar cohorts of workers in specialist AOD services in NSW (1.5%),[1] and lower than a cohort in New Zealand (3.1%).[23]

Both stress and burnout were negatively correlated with age—as age increases, stress and burnout decrease. Increasing stress also correlated with increasing pre-tax hourly rates of pay, which is perhaps related to increasing job responsibilities as pay increases. Levels of stress and burnout were also higher among permanent workers compared to casual workers, possibly related to more working hours and greater responsibilities. While higher levels of stress and burnout were correlated with higher education levels, the relationship was not linear. So, for instance, workers with a Bachelor (highest) level of education were significantly more likely to be stressed than those with 'up to and including year 12' and had higher burnout than those with 'graduate diplomas, masters or doctorates'.

## 4.18 Therapeutic optimism

Therapeutic optimism measures how optimistic workers are that their clients can achieve positive outcomes, and incorporates measures of: clinicians' perceptions of how well treatment will work out for their clients; clinicians' confidence that they can help the client to achieve positive outcomes; and the tendency to anticipate or emphasise undesirable outcomes.[13]

Therapeutic optimism was high among this ACT AOD workforce with an average score of 39.4 (well above the midpoint of 30), and with 84.3% agreeing (i.e. scoring between 35.0 and 50.0) that they are generally optimistic about client outcomes. As seen in Figure 46, this is considerably higher than scores for cohorts in NSW (48.9%) and New Zealand (53.9%), although methods used in these surveys (including the nature of sample) may have been somewhat different.

## 4.19 Informing AOD service planning, quality frameworks and resourcing

Information contained within this profile of the workforce, and mapped across previous profiles, will provide a valuable data source for whole-of-Territory AOD health service planning including appropriate costing. In developing the next profile there would be benefit in collecting information on main treatment / intervention type provided by worker (rather than job role alone) and reviewing the Profile and survey tools in light of the opportunities to inform:

- Integration of workforce planning within broader health services planning activities

- Utilisation of workforce data to inform projections of workforce growth and associated costings of interventions more broadly
- Business and operational planning of the sector and services
- Planning, resourcing and targeting of workforce development and training initiatives (including working with education and training providers to forecast areas of need and growth)
- Ongoing quality improvement of AOD sector interventions
- Ongoing development or refinement of AOD sector scopes of practice and models of care
- Enhancement of the established quality framework of the ACT AOD sector.

# 5 Conclusion

This monograph presents a profile of the ACT alcohol and other drug workforce in 2017 with a focus on qualifications, remuneration and well-being. It builds on previous profiles and provides an examination of changes within the workforce between 2009, 2014 and 2017.

This Profile is the first in the ACT AOD sector to include and report on workforce well-being (in addition to the information reported previously on qualifications and remuneration). This provides useful information to inform strategies to address worker well-being as a critical consideration in the provision of quality AOD services.

The information presented in this profile provides a better understanding of the specialist AOD workforce in the ACT by monitoring and demonstrating outcomes relating to workforce capacity and identifying areas in need of further development and investment.

# Appendix A: 2017 ACT AOD Workforce Profile—Organisation Survey

## ACT ATOD Workforce Profile 2017: Qualification, Remuneration and Wellbeing

### *Organisation Survey*

Every three years workers in the ACT ATOD sector are asked to participate in the Workforce Profile. This is your opportunity to contribute to the narrative that describes the workforce—roles, qualifications and wellbeing—and inform professional development and retention strategies. In 2017, we are also undertaking a supplementary survey to monitor the range of tobacco management and smoking cessation activities within the ATOD sector.

**Background**
In 2009, the ACT ATOD Executive Directors Group agreed that a regular mapping of pay and conditions of the ACT ATOD sector would be conducted. This is the fifth Workforce Profile of the specialist ATOD sector. Previous profiles were undertaken in 2006, 2009, 2011 and 2014, and this is the second year a survey of organisations has been undertaken. The profiles are funded by ACT Health.

**About this survey**
The Workforce Profiles are administered by ATODA on behalf of ACT Health funded and delivered ATOD services to meet their reporting requirements against the ACT ATOD Qualification Strategy reflected in service contracts. The Workforce Profiles were successfully negotiated to replace previous annual reporting requirements to ACT Health.

The survey collects a range of information on the profile, qualifications and development, recruitment and retention, and wellbeing of staff employed in the ATOD sector.

**How will the information be used?**
The information collected via this survey will be used in conjunction with the Worker Survey to provide an overall profile of the ACT ATOD workforce and inform planning and development for the workforce in ACT Health funded and delivered ATOD services. In addition, the supplementary survey will provide a snapshot of where the sector is at and measure and record the ATOD sector's progress on tobacco control. Results of the surveys will be released in one or more reports and made publicly available on the ATODA website in late 2017. The report will present information at an organisational level.

**Instructions**
The Organisation survey should be completed by the Chief Executive Officer / Executive Director / Program Manager or other agreed representative. The survey consists of three components:

1. Organisation level information
2. Staff profiles (light blue section): Please complete individual forms for each staff member.
3. Workplace tobacco management and smoking cessation (Supplementary Organisation Survey)

Please retain all survey components in the folder provided for collection by an ATODA team member.

**Ethics**

Ethics approval for this project is received from the ACT Health Human Research Ethics Committee (ETHLR.14.113; approved on 13 June 2017).

**Further information**

If you have any questions, please contact Melinda Petrie or another member of the ATODA team:

Phone: (02) 6249 6358
Email: melinda@atoda.org.au
Visit: 11 Rutherford Street, Ainslie ACT
Web: www.atoda.org.au

If you have any concerns or queries about the way this study has been conducted and you do not feel comfortable communicating with the staff conducting this survey, please contact the Ethics Committee secretariat via ACT Health Research Office, Level 6, Building 10. Telephone: (02) 6174 7968. Email: acthealth-hrec@act.gov.au.

**Thank you for your participation in the survey!**

## Part A – General information

1. **Organisation name:**

2. **Contact person (i.e. the name of the person completing the survey):**

3. **Contact person role in organisation:**

- ☐ Executive Officer / CEO / Executive Director
- ☐ Operational Director / Coordinator
- ☐ Service Manager / Service Operations Manager
- ☐ Nursing / Clinical Manager
- ☐ Human Resource Manager
- ☐ Finance Manager
- ☐ Other, please specify:

4. **Under what enterprise agreement does your organisation operate?**

5. **What does your organisation consider to be a full-time working week?**

**hrs**

6. **How many staff does your organisation currently employ?**

## Part B – Staffing profile

7. **To enhance data quality and simplify the aggregation of information, individual forms for each staff member have been provided for completion (refer to light blue pages in the next section). Please return these with the remainder of the survey for your organisation.**

   **NOTE: The number of completed forms should correspond to your response to Question 6.**

Please complete one profile for each individual staff member. Exclude volunteers and student placements

**a. Organisation name:**

**b. Gender:**

- [ ] Male
- [ ] Female
- [ ] Other, please specify:

**c. Is the staff member in an identified position?**

- [ ] No
- [ ] Aboriginal and Torres Strait Islander
- [ ] Cultural and Linguistically Diverse
- [ ] Women specific
- [ ] Other, please specify:

**d. Is the staff member a peer worker?**

*(Peer workers are defined as those who are specifically engaged to utilise their lived experience to inform their work)*

- [ ] Yes
- [ ] No

**e. Does this staff member have direct client contact?**

- [ ] Yes
- [ ] No

**f. Employment status:**

- [ ] Permanent full-time
- [ ] Permanent part-time
- [ ] Fixed term full-time (e.g. contract)
- [ ] Fixed term part-time (e.g. contract)
- [ ] Casual

**g. Full-time equivalent status:**

*(For example, half-time = 0.5)*

**h. How long has the staff member worked at your organisation?**

- [ ] Less than 12 months
- [ ] More than 12 months

**i. Responses to this question will allow us to assess whether the staff member meets the Qualification Strategy requirements for specialist ACT ATOD services. In the table below, please indicate what qualifications the staff member has:**

*(Please provide a response against each qualification using a tick)*

| Qualification | Yes | No | N/A | Currently underway | Planned* |
|---|---|---|---|---|---|
| Provide First Aid (formerly Senior First Aid) | | | | | |
| AOD Skill Set (formerly 4 Core Competencies) | | | | | |
| Certificate IV in AOD | | | | | |
| Certificate IV or higher – AOD specific | | | | | |

* In the next 12 months

**j. Which of the following best describes the main role or capacity the staff member is employed in?**

*(Please tick only one of the following)*

- ☐ AOD worker only

| *For example:* | *Case worker* | *Intake worker* | *Support worker* |
|---|---|---|---|
| | *Case manager* | *Assessment officer* | *Harm reduction worker* |
| | *AOD practitioner* | *Youth AOD worker* | |

- ☐ Nurse only
- ☐ Nurse Practitioner only
- ☐ General Practitioner only
- ☐ Addiction Medicine Specialist only
- ☐ Other Medical Practitioner only
- ☐ Clinical Psychologist only
- ☐ Other Psychologist only
- ☐ Psychiatrist
- ☐ Social worker only
- ☐ Counsellor only
- ☐ Administrator
- ☐ Executive
- ☐ Manager
- ☐ Researcher / Policy Officer / Project Officer
- ☐ Other role, please specify, providing as much detail as possible about their main role:

**k. If the staff member is employed as an Administrator, Executive, Manager or Researcher / Policy Officer / Project Officer, please also indicate if they also have dual responsibilities as an:**

- ☐ AOD worker (refer to examples provided in Question j)
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ General Practitioner
- ☐ Addiction Medicine Specialist
- ☐ Other Medical Practitioner
- ☐ Clinical Psychologist
- ☐ Other Psychologist
- ☐ Psychiatrist
- ☐ Social worker
- ☐ Counsellor only
- ☐ Other role, please specify, providing as much detail as possible about their main role:

## Part C – Learning, training and professional development

**8. What proportion of your staff currently have individual professional development plans?**

[ %]

**9. Do you provide a professional development budget for each staff member?**

- ☐ No
- ☐ Yes, per person per year *(please note amount in dollars below)*
- ☐ Yes, as a proportion of staff wages *(please note the proportion below)*
- ☐ Other, please specify:

[ ]

[$ ] OR [ %]

**10. We would like to learn about the innovative ways you offer in-house training. Apart from access to ATOD Qualification Strategy training, what ongoing professional development mechanisms for staff are in place at your organisation?**

*(For example, forums, workshops, seminars, induction, access to resources, self-directed learning kits, etc. Please provide as much detail as possible).*

[ ]

**11. What do you forecast to be the top 3 training and professional development priorities for your staff over the next 3 years?**

1. ______
2. ______
3. ______

**12. What do you consider to be the top 3 challenges for the AOD workforce over the next 3 years?**

1. ______
2. ______
3. ______

## Part D – Staff recruitment and retention

**13. What method(s) does your organisation use to recruit staff and how effective are these methods?**

*(Please circle where 0 = do not use, 1 = not at all effective and 5 = highly effective)*

| | Do not use | Not at all | | | | Highly effective |
|---|---|---|---|---|---|---|
| Print (i.e. newspaper) | 0 | 1 | 2 | 3 | 4 | 5 |
| Online | 0 | 1 | 2 | 3 | 4 | 5 |
| Social media | 0 | 1 | 2 | 3 | 4 | 5 |
| Employment agency | 0 | 1 | 2 | 3 | 4 | 5 |
| Graduate programs | 0 | 1 | 2 | 3 | 4 | 5 |
| Secondments | 0 | 1 | 2 | 3 | 4 | 5 |
| Student placement – Certificate IV AOD | 0 | 1 | 2 | 3 | 4 | 5 |
| Student placement - Tertiary | 0 | 1 | 2 | 3 | 4 | 5 |
| Other, please specify: ____________________ | 0 | 1 | 2 | 3 | 4 | 5 |

**14. If you offer student placements, on average how many do you support per year in the following professions / fields?**

| Profession/field | Number |
|---|---|
| Certificate IV AOD | |
| Nursing | |
| Medicine | |
| Social work | |
| Psychology | |
| Other, please specify: | |

**15. What factors prevent you from achieving your desired recruitment outcomes?**

*(Please rank up to 6 factors, where 1 contributes the most to you not achieving your desired recruitment outcomes and 6 the least)*

| Category | Ranking |
|---|---|
| Not applicable – our organisation does not experience any difficulties | |
| Applicants have inadequate training and education | |
| Applicants do not have enough relevant AOD experience | |
| Applicants are not strongly aligned with the organisation's values | |
| Low number of applicants | |
| Insufficient remuneration | |
| Stigma associated with the AOD sector | |
| Other, please specify: | |

**16. What is the current number of staff vacancies in your organisation?**

☐

**17. Which positions/roles are currently vacant?**

*(Please provide details for all current vacancies)*

☐

**18. Are any of these vacancies identified positions?**

*(i.e. Aboriginal and Torres Strait Islander, Cultural and Linguistically Diverse, Women specific)*

☐ No
☐ Yes, please specify:

☐

**19. What particular roles or areas of expertise do you find difficult to recruit?**

☐

**20. What was the average time taken to fill staff vacancies at your organisation over the last 12 months?**

*(Please calculate from the date of advertising to the staff commencement date)*

☐ **yrs** ☐ **mths**

**21. What are the main reasons staff give for leaving your organisation?**

**22. Which of the following employee entitlements or incentives does your organisation offer?**

*(Please tick all that apply)*

- ☐ Access to professional development (during work hours)
- ☐ Above award payments
- ☐ Additional paid leave (e.g. between Christmas and New Year)
- ☐ Annual salary increments (other than as required by award)
- ☐ Bereavement leave
- ☐ Carers leave
- ☐ Cultural leave
- ☐ Childcare
- ☐ Christmas bonus
- ☐ Conference leave
- ☐ Domestic and family violence leave
- ☐ Employee Assistance Program
- ☐ Family leave
- ☐ First Aid allowance
- ☐ Flexible work practices
- ☐ Fringe benefits tax exemption / salary packaging
- ☐ Indexation
- ☐ Leave loading
- ☐ Maternity leave (paid)
- ☐ Maternity leave (unpaid)
- ☐ Paternity leave (paid)
- ☐ Paternity leave (unpaid)
- ☐ Private use of work phone
- ☐ Private use of work vehicle
- ☐ Purchase annual leave provisions
- ☐ Reimbursement of kilometers travelled
- ☐ Salary sacrifice to superannuation
- ☐ Study assistance
- ☐ Study leave (paid)
- ☐ Study leave (unpaid)
- ☐ Time in lieu (TOIL) or paid overtime
- ☐ Travel allowance
- ☐ Unpaid leave provisions
- ☐ Work Health and Safety allowance
- ☐ Don’t know
- ☐ Other, please specify:

**23. Does your organisation have an Indigenous Employment Strategy?**

☐ No

☐ Yes, please specify what the Strategy involves:

## Part E – Supervision and wellbeing

**AOD Practice supervision** (sometimes referred to as clinical supervision) is distinguished from management and other forms of supervision by its greater level of confidentiality and clear separation from the functions of line management. It involves discussion of a supervisee's practice for the purposes of supporting worker wellbeing, developing skills, knowledge, professional identity, accountability and best practice. In the context of AOD this includes reflective practice specific to AOD.

**24. Does your organisation provide access to AOD practice supervision for staff?**

☐ Yes
☐ No, please specify the reason for this, then skip to Question 28:

**25. How is AOD practice supervision provided in your organisation?**

☐ By someone who works at our organisation
☐ By someone who is external to our organisation
☐ Both *(i.e. internally and externally)*

**26. Do you experience any barriers or limitations in making AOD practice supervision available for staff?**

*(For example, cost, availability of AOD specific practice supervisors locally)*

**27. What strategies do you use to engage AOD practice supervision for your staff?**

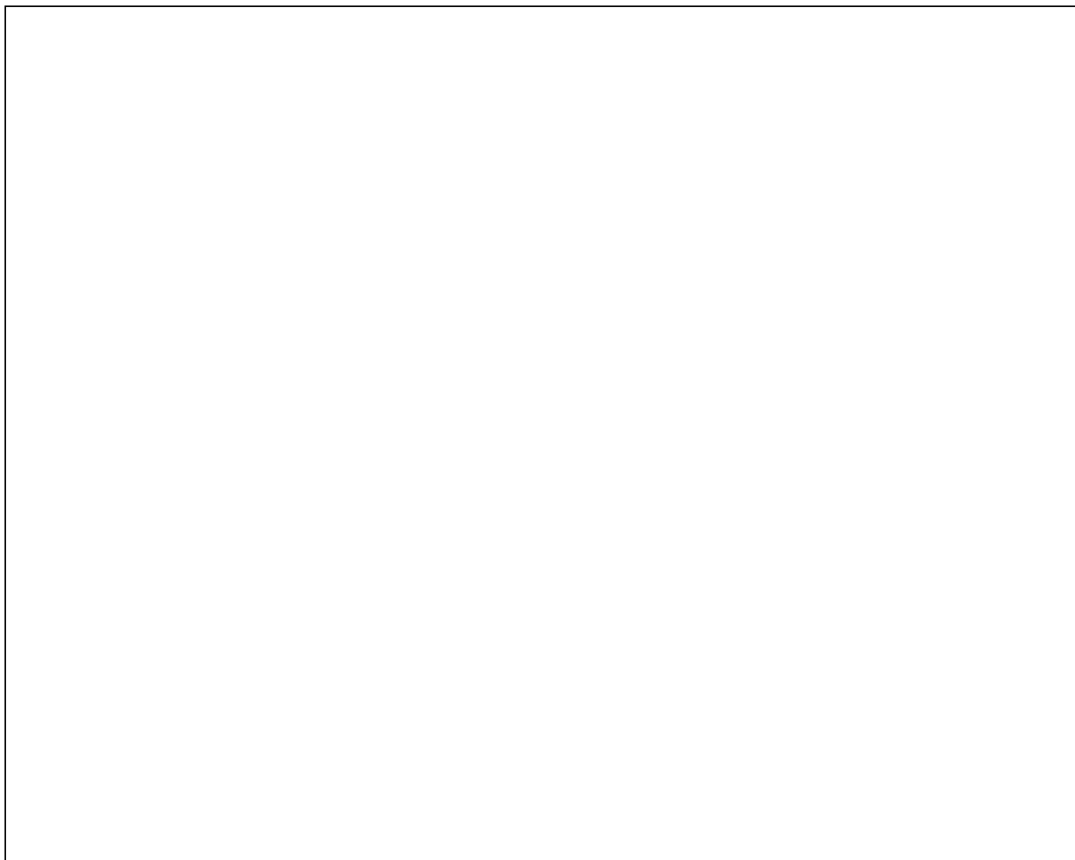
*(For example, engaging AOD clinicians from other services, interstate via skype)*

**28. At your organisation, outside of the conditions in your award, what is currently available to support the wellbeing of workers?**

*(For example, health screening, health treatments, health/fitness lunch-time activities, access to subsidised smoking cessation supports, diversified caseloads etc.)*

**29. What other wellbeing activities / strategies do you think could be made available to workers at your organisation?**

**30. Please provide any other comments you would like to make:**



# Appendix B: 2017 ACT AOD Workforce Profile—Workers' Survey

## ACT ATOD Workforce Profile 2017: Qualification, Remuneration and Wellbeing

### *Worker Survey*

Every three years workers in the ACT ATOD sector are asked to participate in the Workforce Profile. This is your opportunity to contribute to the narrative that describes the workforce—roles, qualifications and wellbeing—and inform professional development and retention strategies. In 2017, we are also undertaking a supplementary survey to monitor the range of tobacco management and smoking cessation activities within the ATOD sector.

**Background**

In 2009, the ACT ATOD Executive Directors Group agreed that a regular mapping of pay and conditions of the ACT ATOD sector would be conducted. This is the fifth Workforce Profile of the specialist ATOD sector. Previous workforce profiles were undertaken in 2006, 2009, 2011 and 2014. The profiles are funded by ACT Health, a reporting requirement of ACT ATOD service contracts and administered by ATODA.

Ethics approval for the conduct of this project is received from the ACT Health Human Research Ethics Committee (ETHLR.14.113; approved on 13 June 2017).

**About this survey**

Information provided in the survey will be treated confidentially and participation is voluntary.

The information collected via this survey will be used to provide an overall profile of the ACT ATOD workforce and inform planning and development activities for the workforce in ACT Health funded and delivered ATOD services. In addition, the supplementary survey will provide a snapshot of where the sector is at and measure and record the ATOD sector's progress on tobacco control. Results of the surveys will be released in one or more reports and made publicly available on the ATODA website in late 2017. Information will be presented at an organisational level, you will therefore not be individually identifiable.

**Instructions**

The survey will take approximately 30 minutes to complete. Once completed, please seal the survey in the envelope provided for collection by an ATODA team member.

**Further information**

If you have any questions about the Workforce Profile please contact Melinda Petrie or another member of the ATODA team:

Phone: (02) 6249 6358
Email: melinda@atoda.org.au
Visit: 11 Rutherford Crescent, Ainslie ACT
Web: www.atoda.org.au

If you have any concerns or queries about the way this study has been conducted and you do not feel comfortable communicating with the staff conducting the survey, please contact the ethics committee secretariat via ACT Health Research Office, level 6, Building 10. Telephone: (02) 6174 7968. Email: acthealth-hrec@act.gov.au.

## Part A – About you

**1. What's your age?**

[ ] yrs

**2. What's your gender?**

- [ ] Male
- [ ] Female
- [ ] I prefer not to say
- [ ] Other, please specify:

**3. Do you identify as being of Aboriginal and/or Torres Strait Islander origin?**

*(Please tick one only)*

- [ ] No
- [ ] Yes, Aboriginal
- [ ] Yes, Torres Strait Islander
- [ ] Yes, both Aboriginal and Torres Strait Islander

**4. In which country were you born?**

- [ ] Australia
- [ ] Other, please specify:

**5. Do you speak a language other than English at home?**

*(If more than one language, indicate the language that is spoken most often)*

- [ ] No, English only
- [ ] Yes, please specify:

## Part B – Your employment status

**6. At this organisation, <u>on average</u>, how many hours per week do you work?**

[ ] hrs

**7. Which of the following best describes your <u>current</u> working arrangement?**

*(Please tick one only)*

- [ ] Permanent full-time **Go to Question 9**
- [ ] Permanent part-time **Go to Question 9**
- [ ] Fixed term full-time *(e.g. contract)*
- [ ] Fixed term part-time *(e.g. contract)*
- [ ] Casual

**8. If you are on a fixed term contract, what is the total duration of your current contract?**

[ ] yrs [ ] mths

**9. What constitutes full-time hours per week at your organisation?**

[ ] hrs

**10. What is your normal (base) hourly rate of pay before tax?**

*(Please be as accurate as possible as this information is used to report on remuneration levels in the sector)*

$ [ ]

## Part C – Your work history

Responses to these questions will build our understanding of the workforce history of workers in the ATOD sector.

**11. For how many years/months have you cumulatively worked:**
*(i.e. total time in the workforce minus breaks)*

In the ATOD sector?

☐ yrs ☐ mths

In your current organisation?

☐ yrs ☐ mths

In your current position?

☐ yrs ☐ mths

If relevant, as an ATOD manager or team / program leader?

☐ yrs ☐ mths

**12. Prior to your current role, where was your last paid employment position?**

*(Please tick one only)*

- ☐ In the same organisation
- ☐ Within the ATOD sector in another organisation
- ☐ Outside the ATOD sector
- ☐ Returning to workforce
- ☐ Not applicable – this is my first paid position
- ☐ Other, please specify:

**13. If your last paid employment position was outside the ATOD sector, in what setting did you work?**

*(Please tick one only)*

- ☐ Not applicable
- ☐ Non-government
- ☐ Government
- ☐ Private
- ☐ Other, please specify:

**14. If your last paid employment position was outside the ATOD sector, in what sector did you work?**

*(Please tick one only)*

- ☐ Not applicable
- ☐ Aged care
- ☐ Disability
- ☐ Child protection
- ☐ Corrective services (including youth justice)
- ☐ Housing / Homelessness
- ☐ Mental health
- ☐ Youth
- ☐ Health
- ☐ Child care
- ☐ Education
- ☐ Hospitality / Retail
- ☐ Other, please specify:

**15. Which other sector(s) have you worked in?**

*(Please tick all that apply)*

- ☐ Not applicable
- ☐ Aged care
- ☐ Disability
- ☐ Child protection
- ☐ Corrective services (including youth justice)
- ☐ Housing / Homelessness
- ☐ Mental health
- ☐ Youth
- ☐ Health
- ☐ Child care
- ☐ Education
- ☐ Hospitality / Retail
- ☐ None – this is my first paid position
- ☐ Other, please specify:

**16. What are your career plans over the <u>next 12 months</u>?**

*(Please tick all that apply)*

- ☐ Remain in my current role
- ☐ Increase my working hours
- ☐ Decrease my working hours
- ☐ Leave the sector with a view to returning at a later time
- ☐ Leave the sector with no intention to return
- ☐ Move horizontally into another ATOD role
- ☐ Seek promotional opportunitites within my organisation
- ☐ Seek promotional opportunitites within the sector
- ☐ Long service leave
- ☐ Maternity / parental leave
- ☐ Will be determined by my contract and / or duration of funding
- ☐ Study
- ☐ Travel
- ☐ Retirement
- ☐ Don't know
- ☐ Other, please specify:

## Part D – Your AOD role

Responses to these questions will build on our understanding of the roles of workers in the ATOD sector.

**17. Which of the following best describes the <u>main role or capacity</u> you are employed in?**

*(Please tick only one of the following)*

- ☐ AOD worker only

| | | | |
|---|---|---|---|
| *For example:* | *Case worker* | *Intake worker* | *Support worker* |
| | *Case manager* | *Assessment officer* | *Harm reduction worker* |
| | *AOD practitioner* | *Youth AOD worker* | |

- ☐ Nurse only
- ☐ Nurse Practitioner only
- ☐ General Practitioner only
- ☐ Addiction Medicine Specialist only
- ☐ Other Medical Practitioner only
- ☐ Clinical Psychologist only
- ☐ Other Psychologist only
- ☐ Psychiatrist
- ☐ Social worker only
- ☐ Counsellor only
- ☐ Administrator
- ☐ Executive
- ☐ Manager
- ☐ Researcher / Policy Officer / Project Officer
- ☐ Other role, please specify, providing as much detail as possible about your main role:

**18. If you are employed as an Administrator, Executive, Manager or Researcher / Policy Officer / Project Officer, please also indicate if you have any dual responsibilities as an:**

- ☐ AOD worker (refer to examples provided in Question 17)
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ General Practitioner
- ☐ Addiction Medicine Specialist
- ☐ Other Medical Practitioner
- ☐ Clinical Psychologist
- ☐ Other Psychologist
- ☐ Psychiatrist
- ☐ Social worker
- ☐ Counsellor only
- ☐ Other role, please specify, providing as much detail as possible about your main role:

19. **Most people employed in the ATOD sector undertake a mix of direct client contact and non-client contact activities. During an average working week, what proportion of your time would you spend on:**

| | |
|---|---|
| Direct client contact activities | % |
| Non-client contact activities | % |
| Total | 100% |

20. **If you work in a direct client contact role, what are the top five activities that you spend the most time on:**

*(Please rank up to 5 activities, where 1 is what you spend most time on and 5 the least amount of time)*

- ☐ Not applicable
- ☐ Screening
- ☐ Assessment
- ☐ Treatment planning
- ☐ Brief intervention *(e.g. no more than 30 minutes of feedback on assessment & advice)*
- ☐ Brief therapy *(e.g. several sessions of CBT or other therapy)*
- ☐ Crisis support
- ☐ Information and education
- ☐ Peer education & support
- ☐ Case management / case work *(including clinical case management & brokerage)*
- ☐ Group work
- ☐ Intensive therapy / counselling
- ☐ Needle and syringe services
- ☐ Sobering Up services
- ☐ Medicated withdrawal support
- ☐ Non-medicated withdrawal support
- ☐ Pharmacotherapy for opioid dependence provision
- ☐ Pharmacotherapy for alcohol disorders provision
- ☐ Nicotine replacement therapy provision
- ☐ Primary Health Care *(AOD specific)*
- ☐ Consultation and liaison
- ☐ Relapse prevention
- ☐ Referrals
- ☐ Aftercare
- ☐ Other, please specify:

**21. If you undertake non-client contact activities, we are interested in the top five activities that you spend most time on.**

*(Please rank up to 5 non-client contact activities, where 1 is what you spend most time on and 5 the least amount of time)*

- ☐ Not applicable
- ☐ Leadership *(e.g. strategic planning, stakeholder management)*
- ☐ Financial management
- ☐ Contract management
- ☐ Meeting attendance
- ☐ Research
- ☐ Policy development
- ☐ Project management
- ☐ Data entry
- ☐ Compilation of data for reporting purposes *(e.g. NMDS)*
- ☐ Staff management
- ☐ Delivering practice supervision *(i.e. reflective practice)*
- ☐ Delivering management supervision *(e.g. day to day work)*
- ☐ Undertaking your own professional development / training
- ☐ Health promotion and community development
- ☐ Other organisational processes *(e.g. quality, service planning, reporting)*
- ☐ Other, please specify:

**22. Are you in an identified position?**

- ☐ No
- ☐ Aboriginal and Torres Strait Islander
- ☐ Cultural and Linguistically Diverse
- ☐ Women specific
- ☐ Other, please specify:

**23. Are you a peer worker?**

*(Peer workers are defined as those who are specifically engaged to utilise their lived experience to inform their work)*

- ☐ Yes
- ☐ No

**24. Are you required to be registered with the Australian Health Practitioner Regulation Agency (APHRA)?**

- ☐ Yes
- ☐ No

**25. Which, if any, professional bodies are you a member of?**

*(Please tick all that apply)*

- ☐ None
- ☐ Australian Association of Social Workers (AASW)
- ☐ Australasian Chapter of Addiciton Medicine (RACP)
- ☐ Australian Medical Association (AMA)
- ☐ Australian Nursing Federation (ANF)
- ☐ Australian Psychological Society (APS)
- ☐ Australian Counselling Association (ACA)
- ☐ Drug and Alcohol Nurses Association (DANA)
- ☐ Nursing and Midwifery Board of Australia (NMBA)
- ☐ Psychotherapy and Counselling Federation of Australia (PACFA)
- ☐ Other, please specify:

**26. Are you a member of any other association or group?**

- ☐ No
- ☐ Yes, please specify:

## Part E – Supervision

Responses to these questions will inform our understanding of workplace practice in relation to supervision.

Broadly, supervision can be defined as practices and relationships which provide workers' learning and support needs in relation to their work, and helps workers maintain appropriate boundaries. Here 'management supervision' and 'practice supervision' are defined separately:

- **AOD practice supervision** (sometimes referred to as clinical supervision) is distinguished from management and other forms of supervision by its greater level of confidentiality and clear separation from the functions of line management. It involves discussion of a supervisee's practice for the purposes of supporting worker wellbeing, developing skills, knowledge, professional identity, accountability and best practice. In the context of AOD this includes reflective practice specific to AOD.
- **Management supervision** is provided to a worker by their line manager, service coordinator or other senior member of the service and covers issues of performance and expectations of work role, education and administration.

**27. What type of supervision do you receive in your current role?**

*(Please tick one only)*

☐ None
☐ AOD practice supervision only
☐ Management supervision only
☐ Both AOD practice and management supervision
☐ Other, please specify:

**28. If you don't currently receive AOD practice supervision what is the reason for this?**

☐ Practice supervision not relevant to my current role
☐ Unable to access someone to provide practice supervision
☐ My organisation cannot afford to pay for it
☐ My organisation does not provide it
☐ Don't know/Unsure

Go to Part F if you don't currently receive AOD practice supervision

**29. If you currently receive AOD practice supervision, who do you receive it from?**

☐ Someone who works at my organisation
☐ Someone who is external to my organisation
☐ Both

**30. If you receive AOD practice supervision from someone who works at your organisation, is this person different to the person who provides your management supervision?** *(Please tick one only)*

☐ Yes
☐ No
☐ Not applicable *(i.e. I receive practice supervision from someone who is external to my organisation)*

**31. How often do you receive AOD practice supervision?**

*(Please tick one only)*

- ☐ Fortnightly
- ☐ Monthly
- ☐ Every 3 months
- ☐ Every 6 months
- ☐ Annually

**32. Following are a number of statements relating to your AOD practice supervision. Please circle the response that best describes your level of agreement with each statement.**

| | Strongly disagree | | | | Strongly agree |
|---|---|---|---|---|---|
| AOD practice supervision is important for my work with clients | 1 | 2 | 3 | 4 | 5 |
| My organisation facilitates / provides for AOD practice supervision | 1 | 2 | 3 | 4 | 5 |
| My organisation allowed me to select my own AOD practice supervisor | 1 | 2 | 3 | 4 | 5 |
| The AOD practice supervision I receive provides adequate support for working with clients | 1 | 2 | 3 | 4 | 5 |
| The AOD practice supervision I receive provides adequate support for my own wellbeing in the workplace | 1 | 2 | 3 | 4 | 5 |

**33. Overall, I am satisfied with the AOD practice supervision I receive:**

*(Please tick one only)*

- ☐ Yes
- ☐ No
- ☐ Unsure

**34. If you are not satisfied, or are unsure, how do you think your AOD practice supervision could be improved?**

## Part F – Training and qualifications

Responses to these questions will create a profile of the expertise within the ATOD sector and identify professional development pathways that might be needed.

**35. What qualifications have you completed in the following areas of study?**

*(Please tick all qualifications that you have completed. For certificate or higher, please also provide the name of the qualification)*

General schooling:

- ☐ Less than Year 10
- ☐ Year 10 / School certificate
- ☐ Year 12 / College certificate

| In ATOD: | **Name of completed qualification (include the field/specialisation)** |
|---|---|
| ☐ Certificate I – IV | |
| ☐ Diploma | |
| ☐ Advanced diploma / Associate degree | |
| ☐ Bachelor degree | |
| ☐ Graduate certificate / Graduate diploma / Bachelor degree with honours | |
| ☐ Masters degree | |
| ☐ Doctoral degree (PhD) | |
| ☐ Other, please specify: | |
| **In a non-ATOD health / social / behavioural sciences area:** | **Name of completed qualification (include the field/specialisation)** |
| ☐ Certificate I – IV | |
| ☐ Diploma | |
| ☐ Advanced diploma / Associate degree | |
| ☐ Bachelor degree | |
| ☐ Graduate certificate / Graduate diploma / Bachelor degree with honours | |
| ☐ Masters degree | |
| ☐ Doctoral degree (PhD) | |

| | |
|---|---|
| ☐ Other, please specify: | |
| In any other area of study: | **Name of completed qualification (include the field/specialisation)** |
| ☐ Certificate I – IV | |
| ☐ Diploma | |
| ☐ Advanced diploma / Associate degree | |
| ☐ Bachelor degree | |
| ☐ Graduate certificate / Graduate diploma / Bachelor degree with honours | |
| ☐ Masters degree | |
| ☐ Doctoral degree (PhD) | |
| ☐ Other, please specify: | |

**36. Are you currently undertaking any study or training?**

☐ No
☐ Yes, please provide the details below:

| | **Name of course / training** |
|---|---|
| ATOD | |
| Non-ATOD health / social / behavioural sciences | |
| Other area | |

**37. In the last 12 months, have you participated in any professional development opportunities offered by your organisation?**

☐ No
☐ Yes, please specify what these are:

| |
|---|
| |

**38. What other training, if any, have you undertaken in the last 12 months?**

| |
|---|
| |

**39. How do you feel about your professional growth?**

*(Please circle the response that best describes your level of agreement with each statement)*

| | N/A to my role | Strongly disagree | | | | Strongly agree |
|---|---|---|---|---|---|---|
| Your organisation encourages and supports professional growth | 0 | 1 | 2 | 5 | 3 | 4 |
| Keeping your skills up-to-date is a priority for you | 0 | 1 | 2 | 5 | 3 | 4 |
| You do a good job of regularly updating and improving your skills | 0 | 1 | 2 | 5 | 3 | 4 |
| You regularly read professional journal articles, books or other source material relevant to your job | 0 | 1 | 2 | 5 | 3 | 4 |
| You review new techniques and other information regularly | 0 | 1 | 2 | 5 | 3 | 4 |

**40. What do you consider your top 3 training and professional development needs will be over the next 3 years?**

1. ______________________________

2. ______________________________

3. ______________________________

## Part G – Qualification strategy

The following questions cover the sector's qualification strategy requirements. To meet the Qualification Strategy requirements all specialist ACT ATOD services (funded by ACT Health) require relevant staff to successfully complete: A qualification in ATOD or addiction studies which is equivalent to, or above, the Australian Qualifications Framework Certificate IV in AOD OR a health, social, or behavioural science related tertiary (university) qualification PLUS the AOD Skill Set (formerly the 4 Core Competencies) AND Provide First Aid Certificate (formerly Senior First Aid).

For more information please visit: http://www.atoda.org.au/projects/qs/

**41. Do you currently meet the ACT ATOD Qualification Strategy requirements?**

- [ ] Yes **(Go to Questions 45)**
- [ ] No
- [ ] I don't know

**42. If you have not already obtained the ACT ATOD Qualification Strategy requirements, do you have plans to commence them in the next 12 months?**

- [ ] Yes
- [ ] No
- [ ] Maybe

**43. Are you currently undertaking any of the following units from the AOD Skill Set?**

- [ ] No
- [ ] CHCAOD001: Work in an alcohol and other drugs context
- [ ] CHCAOD004: Assess needs of clients with AOD issues
- [ ] CHCAOD006: Provide interventions for people with AOD issues
- [ ] CHCAOD009: Develop and review individual AOD treatment plans

**44. Are you currently undertaking any additional / remaining units from the Certificate IV AOD work, not including the AOD Skill Set?**

- [ ] Yes
- [ ] No

**45. Do you have a current Provide First Aid Certificate or equivalent?**

- [ ] Yes
- [ ] No

**46. Through which registered training organisation (RTO) did you complete (or are undertaking) the AOD Skill Set?**

- [ ] Not applicable
- [ ] ReGen Uniting Care
- [ ] Turning Point Alcohol and Drug Centre
- [ ] Canberra Institute of Technology (CIT)
- [ ] Odyssey House Victoria
- [ ] Other, please specify:

**47. Do you think a Certificate IV is an appropriate minimum level of qualification for the ATOD workforce in the ACT?**

- ☐ Yes
- ☐ No – minimum level of qualification should be above the Certificate IV
- ☐ No – minimum level of qualification should be below the Certificate IV
- ☐ Maybe
- ☐ I don't know

**Please provide the reason for your answer:**

## Part H – Your wellbeing

Responses to these questions will build an understanding issues related to workplace wellbeing.

**48. For the following three questions, we ask that you think about your life in the last 4 weeks.**

*(Please circle where 0 = the worst you have ever felt, 10 = the average, and 20 = the best you have ever felt)*

**a. How would you rate your psychological health status in the past 4 weeks?**

| Worst | | | | | | | | | | Average | | | | | | | | | | Best |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |

**b. How would you rate your physical health status in the past 4 weeks?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**c. How would you rate your overall quality of life in the past 4 weeks?**
*(i.e. thinking about your work, family, social interactions, health, finances etc. overall)*

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**49. How strongly do you agree or disagree with each of the following statements?**

*(Please circle the number to indicate your level of agreement)*

| | N/A to my organisation | Strongly disagree | | | | Strongly agree |
|---|---|---|---|---|---|---|
| I am satisfied with my present job | 0 | 1 | 2 | 3 | 4 | 5 |
| I would like to find a job somewhere else | 0 | 1 | 2 | 3 | 4 | 5 |
| I feel appreciated for the job I do | 0 | 1 | 2 | 3 | 4 | 5 |
| I am under too many pressures to do my job effectively | 0 | 1 | 2 | 3 | 4 | 5 |
| I like the people I work with | 0 | 1 | 2 | 3 | 4 | 5 |
| There are enough AOD workers at our program to meet current client needs | 0 | 1 | 2 | 3 | 4 | 5 |
| Staff members at my program often show signs of stress and strain | 0 | 1 | 2 | 3 | 4 | 5 |
| The heavy staff workload reduces the effectiveness of my program | 0 | 1 | 2 | 3 | 4 | 5 |
| I give high value to the work I do here | 0 | 1 | 2 | 3 | 4 | 5 |
| Staff frustration is common where I work | 0 | 1 | 2 | 3 | 4 | 5 |
| I am proud to tell others where I work | 0 | 1 | 2 | 3 | 4 | 5 |
| AOD workers at my program are able to spend enough time with clients | 0 | 1 | 2 | 3 | 4 | 5 |

**50. How do you feel at work?**

*(Please indicate how often, in the last 4 weeks, you have felt each of the following feelings. Please circle where 1 = never or almost never, 4 = sometimes, and 7 = almost or almost always).*

| | Never or almost never | | | Sometimes | | | Always or almost always |
|---|---|---|---|---|---|---|---|
| I feel tired | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I have no energy for going to work in the morning | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel physically drained | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel fed up | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel like my ‘batteries’ are ‘dead’ | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel burned out | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| My thinking process is slow | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I have difficulty concentrating | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel I’m not thinking clearly | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel I’m not focused in my thinking | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I have difficulty thinking about complex things | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel I’m unable to be sensitive to the needs of coworkers and/or clients | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel I’m not capable of investing emotionally in coworkers and/or clients | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| I feel I’m not capable of being sympathetic to coworkers and/or clients | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**51. If you work in a direct client contact role, please circle the number that best describes your level of agreement with each of the following statements:**

| | Strongly disagree | | | | Strongly agree |
|---|---|---|---|---|---|
| AOD workers have a capacity to positively influence outcomes for people with AOD issues | 1 | 2 | 3 | 4 | 5 |
| There is little that can be done to help many people with AOD issues | 1 | 2 | 3 | 4 | 5 |
| My contribution to positive outcomes is insignificant in comparison to other treatments | 1 | 2 | 3 | 4 | 5 |
| I can make a positive difference to outcomes for most people with AOD issues | 1 | 2 | 3 | 4 | 5 |
| Positive outcomes are directly related to the quality of AOD worker skills and knowledge | 1 | 2 | 3 | 4 | 5 |
| There are always new skills and knowledge I can acquire to improve my work | 1 | 2 | 3 | 4 | 5 |
| The outcome of AOD problems is not significantly affected by AOD worker interventions | 1 | 2 | 3 | 4 | 5 |
| With my assistance most people with AOD issues will improve | 1 | 2 | 3 | 4 | 5 |
| Often there is little I can do to help people with their AOD issues | 1 | 2 | 3 | 4 | 5 |
| Even the most challenging clients can benefit from my interventions | 1 | 2 | 3 | 4 | 5 |

**52. Please provide any other comments you would like to make below:**

# Appendix C: Changes made to the surveys between the 2014 and 2017 Workforce Profiles

| 2017 Survey | | 2014 Survey | | Change or addition |
|---|---|---|---|---|
| 1 | What's your age? | 1 | | No change |
| 2 | What's your gender? | 2 | | No change |
| 3 | Do you identify as being of Aboriginal and/or Torres Strait Islander origin? | 3 | | No change |
| 4 | In which country were you born? | 4 | | Answer options added: Australia; Other, please specify |
| 5 | Do you speak a language other than English at home? | 5 | Do you speak any languages other than English at home? | Minor question rewording<br>Answer options expanded: No, English only; Yes, please specify |
| | | 6 | What's your organisation's and program's name? | Question removed |
| 6 | At this organisation, on average, how many hours per week do you work? | 10 | On average, how many hours per week do you work? | Minor question rewording<br>Answer option changed to specify hours |
| 7 | Which of the following best describes your current working arrangement? | 9 | Are you working full-time or part-time? | Questions combined<br>Answer options changed to: permanent full-time; permanent part-time; fixed term full-time; fixed term part-time; casual |
| | | 12 | Which of the following options best describe your current working arrangements? | |
| 8 | If you are on a fixed term contract, what is the total duration of your current contract? | 13 | If you are a contract worker (ticked contract in the previous question), what is the duration of your contract? | Minor question rewording<br>Answer option changed to specify years and months |
| 9 | What constitutes full-time hours per week at your organisation? | | | New question |
| 10 | What is your normal (base) hourly rate of pay before tax? | 8 | | No change |
| | | 11 | At what level are you employed? (e.g. MEA level 4.3) | Question removed |
| 11 | For how many years/months have you cumulatively worked: | 22 | Please fill in number of years you have worked for each: | Minor question rewording |
| | In the ATOD sector? | | ATOD workforce total | Minor question rewording |
| | In your current organisation? | | Current agency | Minor question rewording |
| | In your current position? | | Current role | Minor question rewording |
| | If relevant, as an ATOD manager or team/program leader? | 17 | If you undertake management duties, how long (in total) have you worked as a manager in the ATOD field? | Question reworded |

| | | | | |
|---|---|---|---|---|
| 12 | Prior to your current role, where was you last paid employment position? | 21 | Where was your last position? | Minor question rewording<br>Answer options changed to: in the same organisation; within the ATOD sector in another organisation; outside the ATOD sector; returning to workforce; not applicable – this is my first paid position; other, please specify |
| 13 | If your last paid employment position was outside the ATOD sector, in what setting did you work? | | | New question<br>Answer options provided: not applicable; non-government; government; private; other, please specify |
| 14 | If your last paid employment position was outside the ATOD sector, in what sector did you work? | | | New question<br>Answer options provided: not applicable; aged care; disability; child protection; corrective services (including youth justice); housing/homelessness; mental health; youth; health; child care; education; hospitality/retail; other, please specify |
| 15 | Which other sector(s) have you worked in? | 23 | Apart from ATOD, which other sector(s) have you worked in? | Minor question rewording<br>Answer options changed to: not applicable; aged care; disability; child protection; corrective services (including youth justice); housing/homelessness; mental health; youth; health; child care; education; hospitality/retail; none – this is my first paid position; other, please specify |
| 16 | What are your career plans over the next 12 months?<br>Options provided: remain in my current role; increase my working hours; decrease my working hours; leave the sector with a view to returning at a later time; leave the sector with no intention to return; move horizontally into another ATOD role; seek promotional opportunities within my organisation; seek promotional opportunities within the sector; long service leave; maternity/paternity leave; will be determined by my contract and/or duration of funding; study; travel; retirement; don’t know; other, please specify | | | New question |

| | | | | |
|---|---|---|---|---|
| 17 | Which of the following best describes the main role or capacity you are employed in? | 7 | What are you currently employed as? | Question rewording<br>Answer options changed to: AOD worker only (examples provided); nurse only; nurse practitioner only; general practitioner only; addiction medicine specialist only; other medical practitioner only; clinical psychologist only; other psychologist only; psychiatrist; social worker only; counsellor only; administrator; executive; manager; researcher/policy officer/project officer; other role, please specify, providing as much detail as possible about your main role |
| 18 | If you are employed as an Administrator, Executive, Manager or Researcher/Policy Officer/Project Officer, please also indicate if you have any dual responsibilities as an: | 15 | If you undertake management duties, what is your main work role? | Question changed<br>Answer options changed to: AOD worker; nurse; nurse practitioner; general practitioner; addiction medicine specialist; other medical practitioner; clinical psychologist; other psychologist; psychiatrist; social worker; counsellor only; other role, please specify, providing as much detail as possible about your main role |
| 19 | Most people employed in the ATOD sector undertake a mix of direct client contact and non-client contact activities. During an average working week, what proportion of your time would you spend on: Direct client contact activities; non-client contact activities | | | New question |
| 20 | If you work in a direct client contact role, what are the top five activities that you spend the most time on | 14 | What are the main tasks involved in your jobs? | Question split into direct client and non-client contact tasks.<br>Answer options included: not applicable; screening; assessment; treatment planning; brief intervention; brief therapy; crisis support; information and education; peer education and support; case management/case work; group work; intensive therapy/counselling; needle and syringe services; sobering up services; medicated withdrawal support; non-medicated withdrawal support; pharmacotherapy for opioid dependence provision; pharmacotherapy for alcohol disorders provision; nicotine replacement therapy provision; Primary health care (AOD specific); consultation and liaison; relapse prevention; referrals; aftercare; other, please specify |

| | | | | |
|---|---|---|---|---|
| 21 | If you undertake non-client contact activities, we are interested in the top five activities that you spend most time on | | | Answer options included: not applicable; leadership; financial management; contract management; meeting attendance; research; policy development; project management; data entry; compilation of data for reporting purposes; staff management; delivering practice supervision; delivering management supervision; undertaking your own professional development; health promotion and community development; other organisational processes; other, please specify |
| | | 16 | If you undertake management duties, on average, how many hours a week would you spend on non-managerial tasks? | Question removed |
| | | 18 | Which of the following entitlements and incentives can you access through your work? | Question removed |
| | | 19 | How many weeks annual leave do you receive? | Question removed |
| | | 20 | Do you have access to salary sacrificing? | Question removed |
| 22 | Are you in an identified position? | | | New question<br>Answer options: No; Aboriginal and Torres Strait Islander; Cultural and Linguistically diverse; women specific; other, please specify |
| 23 | Are you a peer worker? | | | New question<br>Answer options: yes; no |
| 24 | Are you required to be registered with the Australian Health Practitioner Regulation Agency (APHRA)? | | | New question<br>Answer options: yes, no |
| 25 | Which, if any, professional bodies are you a member of? | 41 | What professional associations, if any, are you a member of? | Question reworded and answer options given: none; AASW; RACP; AMA; ANF; APS; ACA; DANA; NMBA; PACFA; Other, please specify |
| 26 | Are you a member of any other association or group? | | | Question reworded |
| 27 | What type of supervision do you receive in your current role? | 44A | Do you:<br>1. Receive ATOD-focused clinical supervision | Question reworded and expanded.<br>Answer options changed: none; AOD practice supervision only; management supervision only; both |

| | | | | |
|---|---|---|---|---|
| | | | 2. Receive ATOD-focused clinical supervision at least moment [sic]<br>3. Receive clinical supervision from someone who works at your workplace<br>4. Receive clinical supervision from someone external to your workplace, within the ATOD sector | AOD practice and management supervision; other, please specify |
| 29 | If you currently receive AOD practice supervision, who do you receive it from? | | | Question reworded<br>Answer options changed: someone who works at my organisation; someone who is external to my organisation; both |
| 28 | If you don't currently receive AOD practice supervision what is the reason for this? | | | New question<br>Answer options: practice supervision not relevant to my current role; unable to access someone to provide practice supervision; my organisation cannot afford to pay for it; my organisation does not provide it; don't know/unsure |
| 30 | If you receive AOD practice supervision from someone who works at your organisation, is this person different to the person who provides your management supervision? | | | New question<br>Answer options: Yes; no; not applicable |
| 31 | How often do you receive AOD practice supervision? | | | New question<br>Answer options: fortnightly; monthly; every 3 months; every 6 months; annually |
| 32 | Following are a number of statements relating to your AOD practice supervision. Please circle the response that best describes your level of agreement with each statement. | | | New question<br>Scale from strongly disagree to strongly agree |
| | AOD practice supervision is important for my work with clients | | | |
| | My organisation facilitates/provides for AOD practice supervision | | | |
| | My organisation allowed me to select my own AOD practice supervisor | | | |
| | The AOD practice supervision I receive provides adequate support for working with clients | | | |

| | | | | |
|---|---|---|---|---|
| | The AOD practice supervision I receive provides adequate support for my own wellbeing in the workplace | | | |
| 33 | Overall, I am satisfied with the AOD practice supervision I receive | 44B | Generally speaking, how satisfied are you with the clinical supervision you receive? | Question reworded<br>Answer options changed from a scale to: Yes; no; unsure |
| 34 | If you are not satisfied, or are unsure, how do you think your AOD practice supervision could be improved? | | | New question |
| 35 | What qualifications have you completed in the following areas of study? | 24 | What is the highest level of education you have completed? | Questions have been restructured into a single table that collects information on the names of all qualifications achieved divided by: General schooling; In ATOD; In a non-ATOD health/social/behavioural sciences area; In any other area of study |
| | | 25 | For those with a certificate or higher, what field or area is the qualification in? | |
| | | 26 | List all the qualifications (Name of the qualification) you have completed | |
| | | 28 | What qualifications have you completed specifically in the addictions or alcohol, tobacco and other drugs area? | |
| | | 29 | Please list the qualifications completed specifically in the addictions or alcohol, tobacco and other drugs area (specific name of training/course) | |
| 36 | Are you currently undertaking any study or training? (Yes, please provide the details below) | 27 | List all the qualifications (name of the qualification) you are currently undertaking | Question reworded and reframed to collect information on the name of current study/training being undertaken by ATOD, non-ATOD health/social/behavioural sciences, other area |
| 37 | In the last 12 months, have you participated in any professional development opportunities offered by your organisation? | 32 | Are you currently undertaking any other training? | Two separate question developed |
| 38 | What other training, if any, have you undertaken in the last 12 months? | | | |
| | | 30 | Describe the procedure you would need to go through if you wanted to attend training outside your organisation. | Question removed |
| | | 31 | When you were hired for your current job, were you required to have any qualifications? | Question removed |

| | | | | |
|---|---|---|---|---|
| 39 | How do you feel about your professional growth? | | | New question<br>Scale from strongly disagree to strongly agree |
| | Your organisation encourages and supports professional growth | | | |
| | Keeping your skills up-to-date is a priority for you | | | |
| | You do a good job of regularly updating and improving your skills | | | |
| | You regularly read professional journal articles, books or other source material relevant to your job | | | |
| | You review new techniques and other information regularly | | | |
| 40 | What do you consider your top 3 training and professional development needs will be over the next 3 years? | 33 | What do you think are your top 3 training and professional development needs? | Question reworded |
| 41 | Do you currently meet the ACT ATOD Qualification Strategy requirements? | 34 | Do you currently reach the ACT ATOD sector minimum qualification requirements? | Question reworded |
| 42 | If you have not already obtained the ACT ATOD Qualification Strategy requirements, do you have plans to commence them in the next 12 months? | 35 | If you have not already obtained the ACT ATOD sector minimum qualification, do you have a plan to attain the ACT minimum qualification in the next three years? | Question reworded<br>Answer option 'maybe' added |
| 43 | Are you currently undertaking any of the following units from the AOD Skill Set? | 36 | Are you currently undertaking any of the following four core ATOD units of competence? | Question reworded<br>Answer options changed to reflect the new names of the units |
| 44 | Are you currently undertaking any additional / remaining units from the Certificate IV AOD work, not including the AOD Skill Set? | 37 | Are you currently undertaking any additional / remaining units from the Certificate IV AOD work, not including the four core units of competence? | Question reworded |
| 45 | Do you have a current Provide First Aid Certificate or equivalent? | 38 | Do you have a current Senior First Aid Certificate or a current Workplace level 2 First Aid Statement of Attainment? | Question reworded |
| 46 | Through which registered training organisation (RTO) did you complete (or are undertaking) the AOD Skill Set? | 39 | If applicable, through which training organisation did you complete (or are undertaking) the four core AOD units of competence? | Question reworded |

| | | | | |
|---|---|---|---|---|
| 47 | Do you think a Certificate IV is an appropriate minimum level of qualification for the ATOD workforce in the ACT? | 40 | | Question wording is the same<br>Answer options changed to include: no – minimum level of qualification should be above the Certificate IV; no – minimum qualification should be below the Certificate IV |
| 48 | For the following three questions, we ask that you think about your life in the last 4 weeks | | | New question<br>Scale from 0 (worst) to 20 (best) |
| | a. How would you rate your psychological health status in the past 4 weeks? | | | |
| | b. How would you rate your physical health status in the past 4 weeks? | | | |
| | c. How would you rate your overall quality of life in the past 4 weeks? | | | |
| 49 | How strongly do you agree or disagree with each of the following statements? | | | New question<br>Scale from strongly disagree to strongly agree |
| | I am satisfied with my present job | | | |
| | I would like to find a job somewhere else | | | |
| | I feel appreciated for the job I do | | | |
| | I am under too many pressures to do my job effectively | | | |
| | I like the people I work with | | | |
| | There are enough AOD workers at our program to meet current client needs | | | |
| | Staff members at my program often show signs of stress and strain | | | |
| | The heavy staff workload reduces the effectiveness of my program | | | |
| | I give high value to the work I do here | | | |
| | Staff frustration is common where I work | | | |
| | I am proud to tell others where I work | | | |
| | AOD workers at my program are able to spend enough time with clients | | | |
| 50 | How do you feel at work? (Please indicate how often, in the last 4 weeks, you have felt each of the following feelings) | | | New question<br>Scale from ‘never or almost never’ to ‘always or almost always’ |

| | | | | |
|---|---|---|---|---|
| | I feel tired | | | |
| | I have no energy for going to work in the morning | | | |
| | I feel physically drained | | | |
| | I feel fed up | | | |
| | I feel like my ‘batteries’ are ‘dead’ | | | |
| | I feel burned out | | | |
| | My thinking process is slow | | | |
| | I have difficulty concentrating | | | |
| | I feel I’m not thinking clearly | | | |
| | I feel I’m not focused in my thinking | | | |
| | I have difficulty thinking about complex things | | | |
| | I feel I’m unable to be sensitive to the needs of coworkers and/or clients | | | |
| | I feel I’m not capable of investing emotionally in coworkers and/or clients | | | |
| | I feel I’m not capable of being sympathetic to coworkers and/or clients | | | |
| 51 | If you work in a direct client contact role, please circle the number that best describes your level of agreement with each of the following statements: | | | New question<br>Scale from strongly disagree to strongly agree |
| | AOD workers have a capacity to positively influence outcomes for people with AOD issues | | | |
| | There is little that can be done to help many people with AOD issues | | | |
| | My contribution to positive outcomes is insignificant in comparison to other treatments | | | |
| | I can make a positive difference to outcomes for most people with AOD issues | | | |
| | Positive outcomes are directly related to the quality of AOD worker skills and knowledge | | | |

| | | | | |
|---|---|---|---|---|
| | There are always new skills and knowledge I can acquire to improve my work | | | |
| | The outcome of AOD problems is not significantly affected by AOD worker interventions | | | |
| | With my assistance most people with AOD issues will improve | | | |
| | Often there is little I can do to help people with their AOD issues | | | |
| | Even the most challenging clients can benefit from my interventions | | | |
| 52 | Please provide any other comments you would like to make below | | | New question |

Changes to the Organisation Survey between 2014 and 2017

| 2017 Survey | | 2014 Survey | | Change or addition |
|---|---|---|---|---|
| 1 | Organisation name | 1 | | No change |
| 2 | Contact person | 2 | | No change |
| 3 | Contact person role in organisation | 3 | | Answer options changed and expanded: Executive Officer/CEO/Executive Director; Operational Director/Coordinator; Service Manager/Service Operations Manager; Nursing/Clinical Manager; Human Resources Manager; Finance Manager; Other, please specify |
| 4 | Under what enterprise agreement does you organisation operate? | 4 | | No change |
| 5 | What does your organisation consider to be a full-time working week? | | | New question |
| 6 | How many staff does your organisation currently employ? | 5a | Number of fulltime equivalent staff | Question reworded |
| | | 5b | Total number of staff | |
| 7 | Staffing profile | A key change to the Organisation Survey was in the collection of information for the staff profiles. Managers completing the 2014 Organisation Survey were requested to estimate the number (or proportion) of staff in different categories. For the 2017 survey, an attempt was made to improve the accuracy of these estimates by asking those completing the Organisation Survey to fill out an information profile about *each* of the employees in their organisation. Proportions were generated during analysis from the data provided in an attempt to gain a more accurate estimate of these demographics. The 2017 information profile requested the same information as in 2014, as well as a number of additional items:<br>- gender of staff member<br>- whether they are a peer worker<br>- whether they have direct client contact<br>- whether they have worked at the organisation for less than 12 months or more than 12 months<br>As in past surveys, the 2017 Organisation survey asked whether the staff member meets the Qualification Strategy requirements, but—unlike the 2014 survey—did not ask about other qualifications. | | |
| 7a | Organisation name | | | New question |
| 7b | Gender | | | New question<br>Answer options: male; female; other, please specify |
| 7c | Is the staff member in an identified position? | 7a | Staff cultural diversity. Please indicate the number of staff in the following identified positions, or who identifies as the following. | Question changed to only ask about (all) identified positions, not about whether staff identify as Aboriginal and Torres Strait Islander and/or Culturally and Linguistically Diverse. |

| | | | | |
|---|---|---|---|---|
| | | | | Answer options: No; Aboriginal and Torres Strait Islander; Cultural and Linguistically Diverse; Women specific; other, please specify |
| 7d | Is the staff member a peer worker? | | | New question<br>Answer options: Yes; No |
| 7e | Does this staff member have direct client contact? | | | New question<br>Answer options: Yes; No |
| 7f | Employment status: | 6 | Staffing profile. Please state the number of staff in each category | Response options changed to: permanent full-time; permanent part-time; fixed term full-time; fixed term part-time; casual (‘Volunteer’ and ‘Temporary’ removed as options) |
| 7g | Full-time equivalent status (specify) | | | New question |
| 7h | How long has the staff member worked at your organisation? | | | New question<br>Answer options: Less than 12 months; more than 12 months |
| 7i | Qualification: Provide First Aid; AOD Skill Set; Certificate IV in AOD; Certificate IV or higher – AOD specific | 10 | Qualification strategy. What proportion of your staff reach the minimum qualification for the ACT ATOD sector? | Question asked differently between the surveys (see note under 7 above). 2017 survey asked about specific Qualification strategy categories and only about AOD specific qualifications (‘Certificate IV’ or ‘Certificate IV or higher’)<br>Answer options: Yes; No; N/A; Currently underway; Planned (in the next 12 months) |
| | | 9 | Staff qualifications. Please state how many staff have the following qualifications, counting only the highest level of qualification for each staff member | |
| 7j | Which of the following best describes the main role or capacity the staff member is employed in? | 8 | Job roles in organisation. Please state the number of full time equivalent staff currently employed in each role | Question asked differently between the surveys (see note under 7 above). Peer worker category removed and asked as a separate question (7d)<br>Job role answer options were revised to match those in the Workers’ Survey:<br>AOD worker only (examples provided); nurse only; nurse practitioner only; general practitioner only; addiction medicine specialist only; other medical practitioner only; clinical psychologist only; other psychologist only; psychiatrist; social worker only; counsellor only; administrator; executive; manager; researcher/policy officer/project officer; other role, please specify, providing as much detail as possible about their main role |

| | | | | |
|---|---|---|---|---|
| 7k | If the staff member is employed as an Administrator, Executive, Manager or Researcher/Policy Officer/Project Officer, please also indicate if they also have dual responsibilities as an: | | | New question.<br>Job role categories were revised to match those in the Workers' Survey: AOD worker; nurse; nurse practitioner; general practitioner; addiction medicine specialist; other medical practitioner; clinical psychologist; other psychologist; psychiatrist; social worker; counsellor only; other role, please specify, providing as much detail as possible about their main role |
| 8 | What proportion of your staff currently have individual professional development plans? | | | New question |
| 9 | Do you provide a professional development budget for each staff member? | 13 | Do you provide a professional development budget for each staff member? | Answer options changed to: no; yes, per person per year; yes, as a proportion of staff wages; other, please specify |
| 10 | Apart from access to ATOD Qualification Strategy training, what ongoing professional development mechanisms for staff are in place at your organisation? | 11 | What internal ATOD-specific learning and development activities does you organisation provide to further develop your staff? | Questions changed |
| | | 12 | How else does your organisation assist its staff to undertake professional development and training activities? | Question not included in 2017 |
| 11 | What do you forecast to be the top 3 training and professional development priorities for your staff over the next 3 years? | 14 | Do you have priority professional development needs for your staff that are not currently being met? What can be done to meet them? | Question reworded |
| 12 | What do you consider to be the top 3 challenges for the AOD workforce over the next 3 years? | | | New question |
| 13 | What method(s) does your organisation use to recruit staff and how effective are these methods? | 16 | Recruitment sources. Please rank the top 3 source categories for staff recruitment for your organisation. | Answer options changed: print (ie newspaper); online; social media; employment agency; graduate programs; secondments; student placement – Certificate IV AOD; Student placement – Tertiary; other, please specify<br>Effectiveness rated on scale of 0=do not use, 1 = not at all effective to 5 = highly effective |
| 14 | If you offer student placements, on average how many do you support per year in the following professions/fields? | | | New question<br>Answer options: Certificate IV AOD; Nursing; Medicine; Social Work; Psychology; Other, please specify |

| | | | | |
|---|---|---|---|---|
| 15 | What factors prevent you from achieving your desired recruitment outcomes? | | | New question<br>Answer options: Not applicable – our organisation does not experience any difficulties; Applicants have inadequate training and education; Applicants do not have enough relevant AOD experience; Applicants are not strongly aligned with the organisation's values; low number of applicants; insufficient remuneration; stigma associated with the AOD sector; other, please specify |
| 16 | What is the current number of staff vacancies in your organisation? | | | New question |
| 17 | Which positions/roles are currently vacant? | | | New question |
| 18 | Are any of these vacancies identified positions? | | | New question<br>Answer options: no; yes, please specify |
| 19 | What particular roles or areas of expertise do you find difficult to recruit? | | | New question |
| 20 | What was the average time taken to fill staff vacancies at your organisation over the last 12 months? | | | New question |
| 21 | What are the main reasons staff give for leaving your organisation? | | | New question |
| | | 17 | Do you have organisation-specific initiatives for staff retention? (If yes, please specify) | Not included in 2017 |
| | | 18 | Do you have ideas that could be implemented to improve recruitment and retention across the ATOD sector? | Not included in 2017 |
| 22 | Which of the following employee entitlements or incentives does your organisation offer? | 15 | Which of the following entitlements and incentives can your staff access? | Question slightly reworded, and some answer options changed.<br>Added/replaced: Above award payments; Domestic and Family Violence leave; Fringe benefits tax exemption/salary packaging (replaced 'Fringe benefits tax exemption'); Private use of work phone (replaced 'a work mobile phone'; private use of work vehicle (replaced 'Access to a work car'); salary sacrifice to superannuation; time in lieu (TOIL) or paid overtime (replaced 'time in lieu'); travel allowance (replaced 'per |

| | | | | |
|---|---|---|---|---|
| | | | | diem (daily allowance for when staff is travelling for work)')<br>Removed: mentoring; superannuation matching; I don't know what entitlements and incentives I can get |
| 23 | Does your organisation have an Indigenous Employment Strategy? | 19 | | No change |
| 24 | Does your organisation provide access to AOD practice supervision for staff? | 20.1 | Does your organisation provide ATOD-focused clinical supervision? | Wording and question/response format changed; term changed from 'clinical supervision' to 'practice supervision'<br>Response options: Yes; No, please specify |
| | | 20.2 | Does your organisation provide ATOD-focused clinical supervision at least monthly? | Not included in 2017 |
| 25 | How is AOD practice supervision provided in your organisation? | 20.3 | Does your organisation provide clinical supervision to staff through someone who works at your organisation? | Wording and question/response format changed; term changed from 'clinical supervision' to 'practice supervision'<br>Response options: by someone who works at our organisation; by someone who is external to our organisation; both |
| | | 20.4 | Does your organisation provide clinical supervision to staff through someone external to your organisation? | Wording and question/response format changed; term changed from 'clinical supervision' to 'practice supervision' |
| 26 | Do you experience any barriers or limitations in making AOD practice supervision available for staff? | | | New question |
| 27 | What strategies do you use to engage AOD practice supervision for your staff? | | | New question |
| 28 | At your organisation, outside of the conditions in your award, what is currently available to support the wellbeing of workers? | | | New question |
| 29 | What other wellbeing activities/strategies do you think could be made available to workers at your organisation? | | | New question |
| 30 | Please provide any other comments you would like to make. | 21 | Do you have any other comments? | Slight wording change |

# Appendix D: Well-being measures used in the Workers' Survey

The Workers' Survey included validated scales to assess a number of well-being measures:

- overall well-being (with subscales of psychological health, physical health, and quality of life)
- opportunities for professional growth
- stress
- burnout
- job satisfaction
- therapeutic optimism.

Appendix D describes each of these scales, the questions included in each, and how each is scored.

**Health and Well-being**

The health and well-being questions from Question 48 are from the Health and Social Functioning section of the Treatment Outcomes Profile (Public Health England). These have been validated for use with clients of AOD services, and the questions correspond with general population measures of well-being (such as the WHO Brief Quality of Life Scale and the Kessler Psychological Distress Scale).[9,12]

They ask:

- How would you rate your psychological health status in the past 4 weeks?
- How would you rate your physical health status in the past 4 weeks?
- How would you rate your overall quality of life in the past 4 weeks? (thinking about your work, family, social interactions, health, finances etc overall).

For each of these scales—psychological health, physical health, and quality of life—ratings occur on a scale of 0 ('the worst you have ever felt') to 10 ('average') to 20 ('the best you have ever felt'). This generates a score for each scale out of 20, with a neutral score of 10 (the midpoint).

A measure of overall well-being is achieved by adding together the scores for each of the scales—psychological health, physical health, and quality of life—to generate a score out of 60 (with 30 as the neutral midpoint).

Scores greater than the mid-points (10 for the sub-scales and 30 for the overall well-being scale) indicate 'better' health or well-being, while scores less than the mid-points indicate 'worse' health or well-being.

**Items from the Texas Christian University (TCU) Organizational Readiness for Change (ORC) measure**

Three scales were used from the Texas Christian University (TCU) Organizational Readiness for Change (ORC) measure (TCU-ORC): professional growth; job satisfaction; and stress. These scales come from a tool for measuring program functioning and readiness for change. Originally tailored for the drug treatment and health services fields, it has been adapted for use

in several other fields.[24] The questions have been adapted as noted below and come from the 4-Domain Assessments for Organizational Readiness for Change Version (TCU ORC-D4).[10] Items were scored by respondents on a scale of 1 to 5 (where 1=strongly disagree and 5=strongly agree). Respondents had the option of answering “not applicable to my role” (“0”).

These scales were scored as follows:

1. Remove respondents who left more than half of the items for any scale blank (i.e.no more than half of the items for any scale can be missing), so:
    - For the professional growth scale, at least 3 items should be completed for the respondent to be included
    - For the satisfaction scale, at least 3 items should be completed for the respondent to be included
    - For the stress scale, at least 2 items should be completed for the respondent to be included
2. Find and reverse the scoring for the reflected items (those designated with ® in the descriptions below)—this can be done by subtracting the response value (1 to 5) for this item from ‘6’ (e.g. if the response is ‘2’, the revised reversed score is ‘6’ – ‘2’ = ‘4’)
3. Sum the response values of all non-missing items for each scale
4. Divide the sum of item responses by the number of items included to get an average score
5. Multiply this average by 10 to rescale the score to range from 10 to 50

On these scales, 30 represents a neutral score (midpoint between 10 and 50), with scores over 30 indicating stronger levels of agreement and scores below 30 indicating stronger levels of disagreement.[26]

Scales have also been reported using an interpretation applied by the National Centre for Education and Training on Addiction (NCETA) where scores are equated to a level of agreement with the respective subscale as follows:[1,23]

- 10.00 – 24.99 Disagree
- 25.00 – 34.99 Neither agree nor disagree
- 35.00 – 50.00 Agree

Professional growth

The items about professional growth (Question 39) are adapted from the ‘Growth’ scale in the Staff Attributes Scales (TCU STFORCS) of the TCU-ORC-D4.

None of the questions in this scale require reflected scoring (i.e. reversing the scores).

The questions for the professional growth scale are (where the item wording differs from the original, the original items are included in *italics*):

| | |
|---|---|
| Q39_1 | Your organisation encourages and supports professional growth *(Your program encourages and supports professional growth)* |
| Q39_2 | Keeping your skills up-to-date is a priority for you *(Keeping your counselling skills up-to-date is a priority for you)* |

| | |
|---|---|
| Q39_3 | You do a good job of regularly updating and improving your skills |
| Q39_4 | You regularly read professional journal articles, books or other source material relevant to your job *(You regularly read professional articles or books on drug treatment)* |
| Q39_5 | You review new techniques and other information regularly *(You review new techniques and treatment information regularly)* |

In this survey, the professional growth scale showed good internal consistency with a Cronbach alpha coefficient of .80.

Satisfaction

The items about satisfaction are adapted from the 'Satisfaction' scale in the Staff Attributes Scales (TCU STFORCS) of the TCU-ORC-D4. This scale forms part of the items for question 49.

In this scale, item Q49_2 requires reflected scoring (i.e. reversing the scores).

The questions for the satisfaction scale are (where the item wording differs from the original, the original items are included in *italics*):

| | |
|---|---|
| Q49_1 | I am satisfied with my present job *(You are satisfied with your present job)* |
| Q49_2 | ® I would like to find a job somewhere else *(You would like to find a job somewhere else)* |
| Q49_3 | I feel appreciated for the job I do *(You feel appreciated for the job you do at work)* |
| Q49_5 | I like the people I work with *(You like the people you work with)* |
| Q49_9 | I give high value to the work I do here *(You give high value to the work you do)* |
| Q49_11 | I am proud to tell others where I work *(You are proud to tell others where you work)* |

® Indicates items that need to be reversed

In this survey, the satisfaction scale showed good internal consistency with a Cronbach alpha coefficient of .78.

Stress

The items about stress are adapted from the 'Stress' scale in the Organizational Climate Scales (TCU CLMORCS) of the TCU-ORC-D4. This scale forms part of the items for question 49.

In this scale, none of the items require reflected scoring (i.e. reversing the scores).

The questions for the stress scale are (where the item wording differs from the original, the original items are included in *italics*):

| | |
|---|---|
| Q49_4 | I am under too many pressures to do my job effectively *(You are under too many pressures to do your job effectively)* |
| Q49_7 | Staff members at my program often show signs of stress and strain *(Staff members at your program often show signs of high stress and strain)* |
| Q49_8 | The heavy staff workload reduces the effectiveness of my program *(The heavy staff workload reduces the effectiveness of your program)* |
| Q49_10 | Staff frustration is common where I work *(Staff frustration is common where you work)* |

In this survey, the stress scale showed good internal consistency with a Cronbach alpha coefficient of .78.

**Burnout—Shirom-Melamed Burnout Measure**

Question 50 measures burnout using the 14-item Shirom-Melamed Burnout Measure (SMBM).[11,12]The scale encompasses 3 subscales: physical fatigue (6 items); cognitive weariness (5 items); and emotional exhaustion (3 items).

The question asked workers to indicate how often, in the last 4 weeks, they had felt each of the following feelings (on a scale from 1 = 'never or almost never' to 7 = 'always or almost always'):

*Physical fatigue*

| | |
|---|---|
| Q50_1 | I feel tired |
| Q50_2 | I have no energy for going to work in the morning |
| Q50_3 | I feel physically drained |
| Q50_4 | I feel fed up |
| Q50_5 | I feel like my 'batteries' are 'dead' |
| Q50_6 | I feel burned out |

*Cognitive weariness*

| | |
|---|---|
| Q50_7 | My thinking process is slow |
| Q50_8 | I have difficulty concentrating |
| Q50_9 | I feel I'm not thinking clearly |
| Q50_10 | I feel I'm not focused in my thinking |
| Q50_11 | I have difficulty thinking about complex things |

*Emotional exhaustion*

| | |
|---|---|
| Q50_12 | I feel I'm unable to be sensitive to the needs of coworkers and/or clients |
| Q50_13 | I feel I'm not capable of investing emotionally in coworkers and/or clients |
| Q50_14 | I feel I'm not capable of being sympathetic to coworkers and/or clients |

These items are all worded in the same way as the original tool, with the exception of replacing the word ‘customers’ with ‘clients’.

Scores for overall burnout, and for each of the sub-scales, was obtained by averaging the responses for the corresponding items of each scales (e.g. the overall burnout score was obtained by averaging the responses to all 14-items). No respondents needed to be excluded from the analysis, as all had answered at least half of the questions.

Workers were categorised as ‘burned out’ if they scored at least 5.5 out of 7.0 on the scale. This cut-off point was used by Bianchi and Schonfeld to correspond to experiencing burnout symptoms more than “quite frequently”, with burnout representing “a crisis in a person’s relationship with work”.[17] There is no consensus on diagnostic criteria for burnout, and Bianchi, Schonfeld & Laurent have recommended using conservative cut-off points that correspond to relatively high frequencies of symptoms.[27]

In this survey, the SMBM showed strong internal consistency with a Cronbach alpha coefficient of .95. There was also strong internal consistency for each of the sub-scales: Physical fatigue, Cronbach alpha = .92; Cognitive weariness, Cronbach alpha = .96; Emotional exhaustion, Cronbach alpha = .92.

**Therapeutic Optimism Scale**

The Therapeutic Optimism Scale (TOS) was designed to provide a reliable means of measuring mental health clinician optimism, including being able to evaluate the change in a clinician following an intervention to enhance optimism.

Items in Question 51 have been adapted from the items included by Best in his Worker Well-being survey (personal communication), which have in turn been adapted from the original Elsom Therapeutic Optimism Scale.[13] These items are scored on a scale of 1=strongly disagree to 5=strongly agree.

The TOS has been validated in mental health services in NSW, although 27% of the workers in the sample were treating patients with “drug and alcohol abuse”. Other studies that have validated the tool have done so in mental health settings.[13]

The TOS includes three subscales that measure: General Treatment Outcome Expectancy; Personal Treatment Outcome Expectancy; and Pessimism.

Scores are obtained by:

- reversing the scoring for reflected items (subtract the response value from 6—e.g. if the response is ‘2’, the revised score in ‘4’ (6-2=4)—the four reflected items are preceded by a ® in the table below.
- individuals with missing data are removed
- total scores are calculated and range between 10 (lower limit) and 50 (upper limit)

Similar to the TCU ORC-D4 scales described above, 30 represents a neutral score (midpoint between 10 and 50) on the Therapeutic Optimism Scale, with scores over 30 indicating stronger levels of agreement and scores below 30 indicating stronger levels of disagreement.

The TOS scores have also been reported using an interpretation applied by the National Centre for Education and Training on Addiction (NCETA) where scores are equated to a level of agreement with the respective subscale as follows:[1,23]

- 10.00 – 24.99 Disagree
- 25.00 – 34.99 Neither agree nor disagree
- 35.00 – 50.00 Agree

The questions for the Therapeutic Optimism Scale are (where the item wording differs from the original, the original items are included in *italics*):

Factor 1: General Treatment Outcome Expectancy

| | |
|---|---|
| Q51_1 | AOD workers have a capacity to positively influence outcomes for people with AOD issues *(Mental health clinicians have the capacity to positively influence outcomes for people with mental disorders)* |
| Q51_4 | I can make a positive difference to outcomes for most people with AOD issues *(I can make a positive difference to outcomes for most people with mental disorders)* |
| Q51_5 | Positive outcomes are directly related to the quality of AOD worker skills and knowledge *(Positive outcomes are directly related to the quality of mental health clinician skills and knowledge)* |
| Q51_6 | There are always new skills and knowledge I can acquire to improve my work |
| Q51_7 | ® The outcome of AOD problems is not significantly affected by AOD worker interventions *(The outcome of mental disorders is not significantly affected by clinician interventions)* |

® Indicates items that need to be reversed

Factor 2: Personal Treatment Outcome Expectancy

| | |
|---|---|
| Q51_8 | With my assistance most people with AOD issues will improve *(With my assistance most people with mental disorders will recover)* |
| Q51_9 | ® Often there is little I can do to help people with their AOD issues *(Often there is little I can do to help people with their mental illness)* |
| Q51_10 | Even the most challenging clients can benefit from my interventions *(Even the most challenging patients can benefit from my intervention)* |

® Indicates items that need to be reversed

Factor 3: Pessimism

| | |
|---|---|
| Q51_2 | ® There is little that can be done to help many people with AOD issues *(There is little that can be done to help many people with mental disorders)* |
| Q51_3 | ® My contribution to positive outcomes is insignificant in comparison to other treatments *(My contribution to positive outcomes is insignificant in comparison to other treatments, for example, medications)* |

® Indicates items that need to be reversed

In this survey, the Therapeutic Optimism Scale showed good internal consistency with a Cronbach alpha coefficient of .72.

#### Staffing

The items about staffing are adapted from the 'Staffing' scale of the Texas Christian University (TCU) Organizational Readiness for Change (ORC) measure. While this is a validated scale overall, only 2 items out of 6 have been included in our survey—therefore, these two items must be considered individually, not combined into a scale.[10] The items from this scale forms part of the items for question 49.

Scores are obtained by taking the average for each response (where 1=strongly disagree and 5=strongly agree).

Where the item wording differs from the original, the original items are included in *italics*.

| | |
|---|---|
| Q49_6 | There are enough AOD workers at our program to meet current client needs *(Your program has enough counsellors to meet current client needs)* |
| Q49_12 | AOD workers at my program are able to spend enough time with clients *(Counselors in your program are able to spend the time needed with clients)* |

Note: neither of these items is reversed.

Respondents had the option of answering "not applicable to my organisation" ("0"). Any missing or not applicable items are not included in the calculation of the average.

#### AOD practice supervision

The following questions (Question 32) related to practice supervision were taken from a Workforce Survey undertaken by the Alcohol Tobacco and Other Drugs Council of Tasmania (ATDC). They do not form a scale; questions should be analysed and interpreted individually.

| | |
|---|---|
| Q32_1 | AOD practice supervision is important for my work with clients |
| Q32_2 | My organisation facilitates/provides for AOD practice supervision |
| Q32_3 | My organisation allowed me to select my own AOD practice supervisor |
| Q32_4 | The AOD practice supervision I receive provides adequate support for working with clients |
| Q32_5 | The AOD practice supervision I receive provides adequate support for my own wellbeing in the workplace |

# Appendix E: Glossary of terms

The Workforce Profile incorporates a number of key concepts that require definition and explanation in order to understand how the data has been analysed and interpreted.

## ACT ATOD Qualification Strategy

The Workforce Profile supports the measurement of progress and implementation of the ACT ATOD Qualification Strategy (QS). The profile measures whether workers meet the requirements of the Qualification Strategy, or are currently undertaking, or plan to soon undertake, these requirements. This information is critical to measuring the degree to which the ACT is maintaining and supporting a competent and highly skilled ATOD workforce.

### About the Qualification Strategy

The ACT ATOD Qualification Strategy (QS) (formerly the Minimum Qualification Strategy) was introduced in 2006. The objectives of the QS are to ensure:

- the development and maintenance of a competent and professional ATOD workforce in the ACT; and
- that all ATOD workers in the ACT have a shared minimum knowledge and skill base.

Compliance with the QS is a performance expectation in all funding agreements between the ACT Health Directorate[w] and specialist alcohol and other drug treatment and support services. The QS is mandatory for all workers employed by specialist ACT AOD services funded by the ACT Health Directorate who directly provide AOD services to clients (e.g. assessment, counselling, group work, case work). Although the QS is not an entry requirement for employment, workers should either meet the minimum QS requirements or have an agreed plan and timeline with their agency to engage with the QS within 12 months of employment and completed within 3 years.

The QS supports workers to have accredited credentials specific to their field, and is based on nationally recognised standards through the provision of industry endorsed and delivered training. In order to meet the Qualification Strategy requirements, all specialist ACT AOD services (funded by the ACT Health Directorate) require relevant staff to successfully complete:

1. A qualification in ATOD or addiction studies which is equivalent to, or above, the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs (CHC43215).
   OR
   A health, social, or behavioural science related tertiary (university) qualification plus the 'Alcohol and Other Drug Skill Set':
   - CHCAOD001 Work in an alcohol and other drugs context
   - CHCAOD004 Assess needs of clients with AOD issues
   - CHCAOD006 Provide interventions for people with AOD issues

[w] From 1 October 2018, ACT Health was restructured into Canberra Health Services and the ACT Health Directorate. The new title is used here in line with the publication date of this workforce profile.

- CHCAOD009 Develop and review individual AOD treatment plans

AND

2. A First Aid qualification equivalent to the following units:
   - HLTAID001 Provide cardiopulmonary resuscitation
   - HLTAID002 Provide basic emergency life support
   - HLTAID003 Provide first aid

Further information on the QS is available on the ATODA website: www.atoda.org.au.
In the analysis for this survey, workers were assessed as either meeting, or not meeting, the Qualification Strategy. Workers were categorized as meeting the Qualifications Strategy either because they:

- self-reported having obtained a non-AOD health-, behavioural- or social-tertiary qualification (Question 35 of the survey), and self-reported meeting the QS (Question 41 of the survey), and indicated that they hold a current First Aid Certificate (Question 45 of the survey);

or

- self-reported having obtained an ATOD qualification (Question 35 of the survey), and indicated that they hold a current First Aid Certificate (Question 45 of the survey), even if they answered 'no' or 'don't know' to Question 41 of the survey.

## Direct client contact versus non-client contact

In previous surveys, workers were asked to define their employment status in terms of 'clinical' and 'non-clinical' ATOD workers. The definitions used in the survey lacked clarity, and this led to confusion, with workers who were unclear as to whether their activities should be categorised as clinical or not.

For the 2017 survey, the terminology and resulting categorisation of job roles has been changed to refer to direct-client-contact (regardless of whether the nature of the contact is 'clinical' or not) versus non-client-contact. This also aligns better with the Qualifications Strategy, whereby the QS is only mandatory for workers employed to directly provide AOD clinical and/or non-clinical services to clients.

Most workers will be undertaking both direct-client-contact and non-client-contact tasks.

Job roles with direct-client-contact, therefore, may include clinical and/or non-clinical tasks such as:

- screening
- assessment
- treatment planning
- brief intervention
- brief therapy
- crisis support
- information and education
- peer education and support
- case management/case work
- group work
- intensive therapy/counselling
- needle and syringe services
- sobering up services
- medicated withdrawal support
- non-medicated withdrawal support
- pharmacotherapy for opioid dependence provision
- pharmacotherapy for alcohol disorders provision
- nicotine replacement therapy provision
- primary health care (AOD specific)
- consultation and liaison
- relapse prevention
- referrals
- aftercare

Job roles with non-client contact may include tasks such as:

- leadership
- financial management
- contract management
- meeting attendance
- research
- policy development
- project management
- data entry
- compilation of data for reporting purposes
- staff management
- delivering practice supervision
- delivering management supervision
- undertaking your own professional development
- health promotion and community development
- other organisational processes

A number of questions in the Workforce Profile—for example, those related to the Qualification Strategy (QS) and Therapeutic Optimism Scale (TOS)—are only relevant to those workers engaged in direct client contact roles. This, therefore, required workers to be categorized accordingly using responses to questions about:

- self-reported proportion of their time that they spent on direct client contact and non-client contact task (Question 19);
- nature of the tasks they carried out as part of their roles divided into direct client and non-client contact activities, as listed above (Question 20 and Question 21);
- their job role (Question 17 and Question 18).

Detailed criteria for allocating workers as 'direct-client-contact' or 'non-client-contact' were as follows:

- Workers with 0% direct-client-contact (Question 19) were automatically assigned as 'non-client-contact'.
- Workers with more than 0% direct-client-contact (Question 19), who had also indicated that they undertake direct-client-contact tasks (Question 20) were assigned as 'direct-client-contact'.
- Workers with more than 0% direct-client-contact (Question 19), who had not indicated that they undertook direct-client-contact tasks (i.e. they left Question 20 blank, or only ticked 'not applicable'), we checked their job role (Questions 17 and 18) to assign them to 'direct-client-contact' or 'non-client-contact'.
- For workers who had answered neither Question 19 nor Question 20, we checked their indicated job role (Questions 17 and 18)—where their job role clearly placed them as 'direct-client-contact' (e.g. 'AOD Worker') or non-client-worker (e.g. 'Finance Officer'), they were assigned accordingly. If it was not possible to determine this from their job role, they were excluded from this categorisation and relevant analyses.

Once categorized as workers with either 'direct-client-contact' or 'non-client-contact', this information was utilized in the analysis of specific questions around the QS and TOS.

## Practice supervision

Since the 2014 Workforce Profile, there has been a further increase in recognition for practice supervision as an essential component of employment in the ATOD sector. Best practice requires all ATOD workers who have direct contact with clients to have some form of practice supervision, ideally provided regularly and externally to the organisation, and separately from line management functions.

Broadly, supervision can be defined as practices and relationships which provide workers' learning and support needs in relation to their work, and helps workers maintain appropriate boundaries. Here 'management supervision' and 'practice supervision' are defined separately:[28]

- *AOD practice supervision* (sometimes referred to as clinical supervision) is distinguished from management and other forms of supervision by its greater level of confidentiality and clear separation from the functions of line management. It involves discussion of a supervisee's practice for the purposes of supporting worker well-being, developing skills, knowledge, professional identity, accountability and best practice. In the context of AOD this includes reflective practice specific to AOD.
- *Management supervision* is provided to a worker by their line manager, service coordinator or other senior member of the service and covers issues of performance and expectations of work role, education and administration.

The Workers' Survey asked a series of practice supervision-related questions, including a series of items (Question 32) taken from the Workforce Survey undertaken by the Alcohol Tobacco and Other Drugs Council of Tasmania. They do not form a scale and so the questions are analysed and interpreted individually.[4]

## Peer worker

The 2014 Workforce Profile included, for the first time, 'peer worker' as an employment category. However, it was evident from the implementation and responses from the 2014 survey that there was some confusion about its definition. The 2017 survey has sought to clarify this by providing specific questions along with definitions of 'peer worker'. The description used is as follows: "Peer workers are defined as those who are specifically engaged to utilize their lived experience to inform their work". Workers were asked if they are a peer worker, and the Organisation Survey sought to identify the number of 'Peer Worker' positions. It is evident from the responses received that there is still some confusion over the meaning of the term (see Section 4.6 in the Discussion).

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