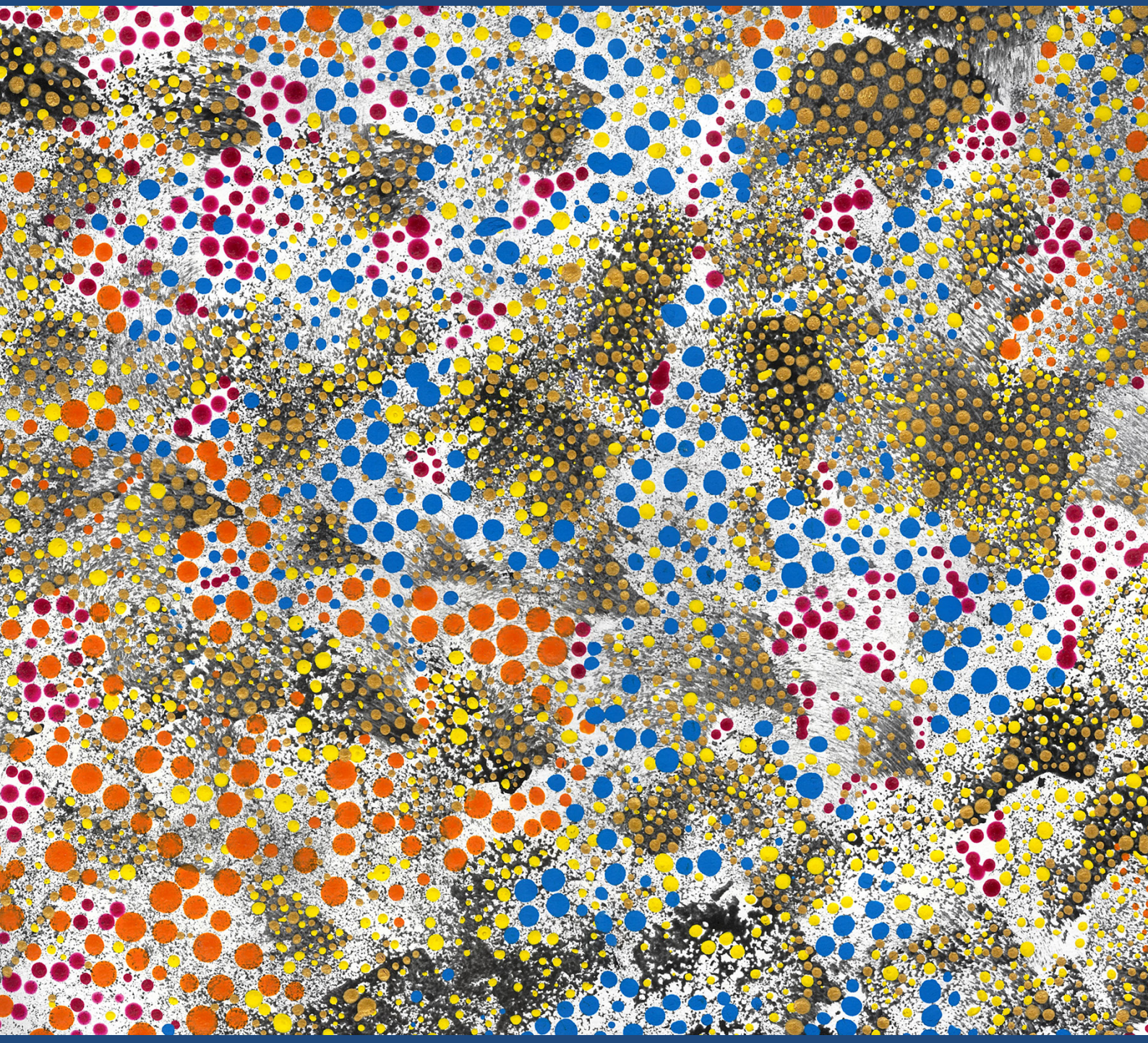
ATODA

Alcohol Tobacco & Other Drug Association ACT



ATODA Monograph Series, No. 10

ACT Alcohol and Other Drug Workforce Profile 2021: Qualifications, Renumeration and Wellbeing

ATODA Monograph Series

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PO Box 7187, Watson, ACT 2602

159 Maribyrnong Ave, Kaleen ACT 2617

T (02) 6249 6358

E info@atoda.org.au

W www.atoda.org.au

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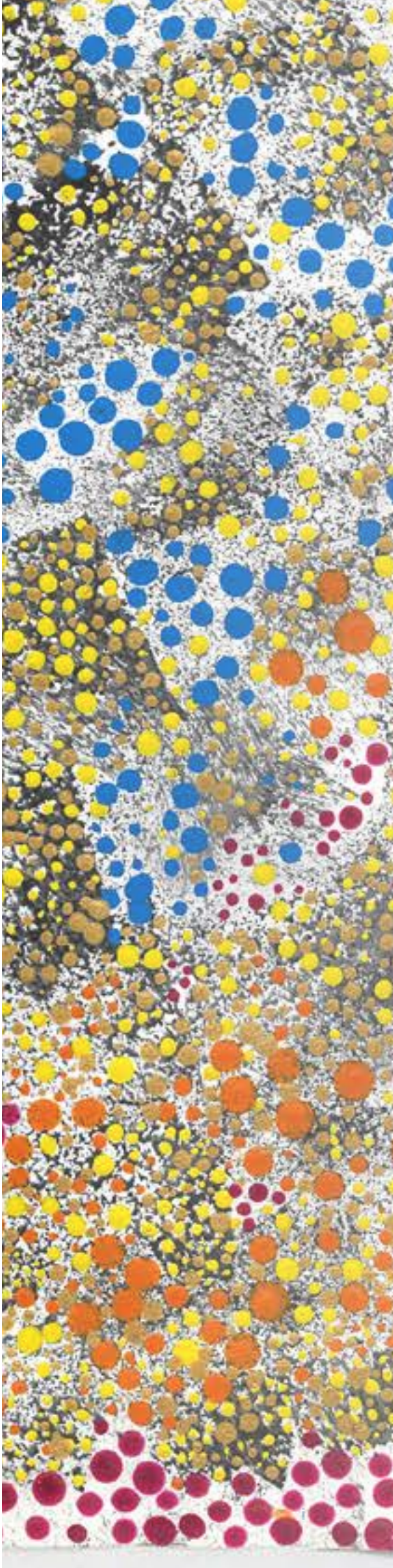
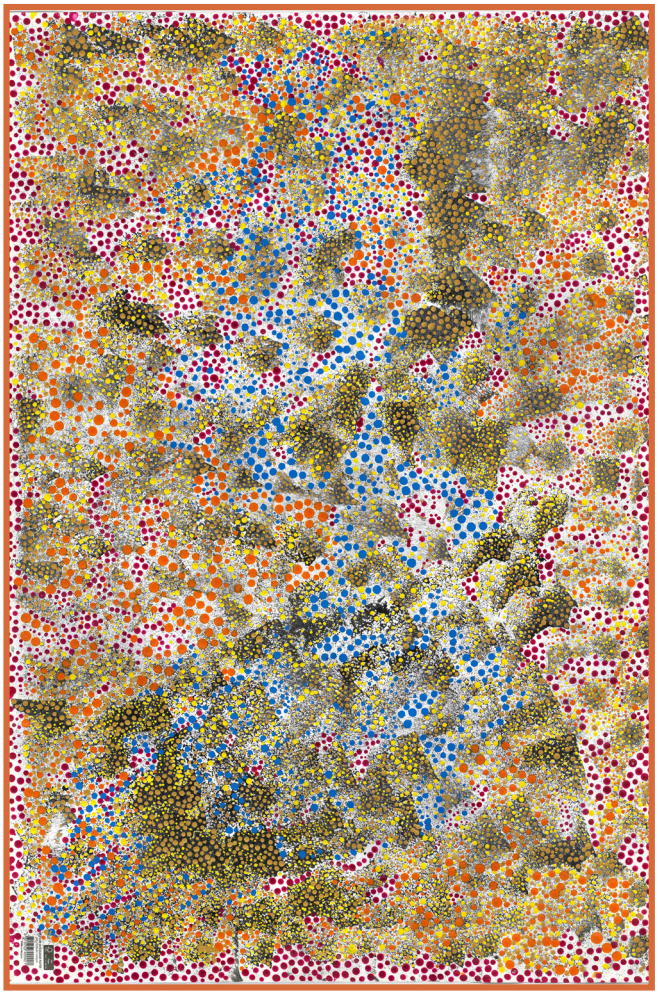




Unspoken History, Map of Pain
Artist: Sharon
Date: 2020

About the artist

Sharon is a Stolen Generation Aboriginal artist who spent many years tracing her origins. After a long journey she reunited with her family of the Noongar tribe (/ˈnʊŋɑː/), a constellation of peoples of Indigenous Australian descent who live in the south-west corner of Western Australia, from Perth on the west coast to Esperance on the south coast. At the age of 16 she married into the Ngunnawal tribe in Canberra where she has been living for the last 30 years. Her kids and grandchildren identify as Ngunnawal and many of them inherited her talent and are artists too.

About the artwork

While I was painting this, I was thinking about all layers of unspoken history that I will never get to know. Unspoken history of my family, my tribe and my Aboriginal peoples.

My mother belongs to the Stolen Generation, she was taken from her mother very early and sent to Gnowangerup Christian Mission for Aboriginal kids stolen from their parents located in the town of Gnowangerup in the Great Southern region of Western Australia. When she was 13 years old, she was placed in a white family to clean their house. I never found out what happened to her in that family, how she was treated or how deep the trauma of having been taken away from her mother was, because she never talked to me about that. However, based on the fact that she had serious alcohol dependence which was the reason her children were taken away from her tells me – she never really recovered from it.

So, I was taken away from her as a baby and placed in a white family. She didn't want to give me away. It was only then when I was able to, reflecting on my pain, start thinking what she must have gone through. Stories of abuse you cannot talk about because you feel too ashamed, too vulnerable and too unprotected… Stories that stay unspoken because their sentences and words hurt as much as the deeds done to you. Stories you cannot tell because you feel by telling them you will fall apart, break into a million pieces and no one and nothing will be able to pick them up and put them together again…

So… this painting is about everything I don't know but I feel – the pain, the sorrow, sadness and grief but also hope and rare moments of happiness that the hope
brings.

Sharon

Preface

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. These outcomes flow from initiatives in prevention, early intervention, harm reduction, treatment, peer services, and continuing care. ATODA provides 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 surrounding 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.

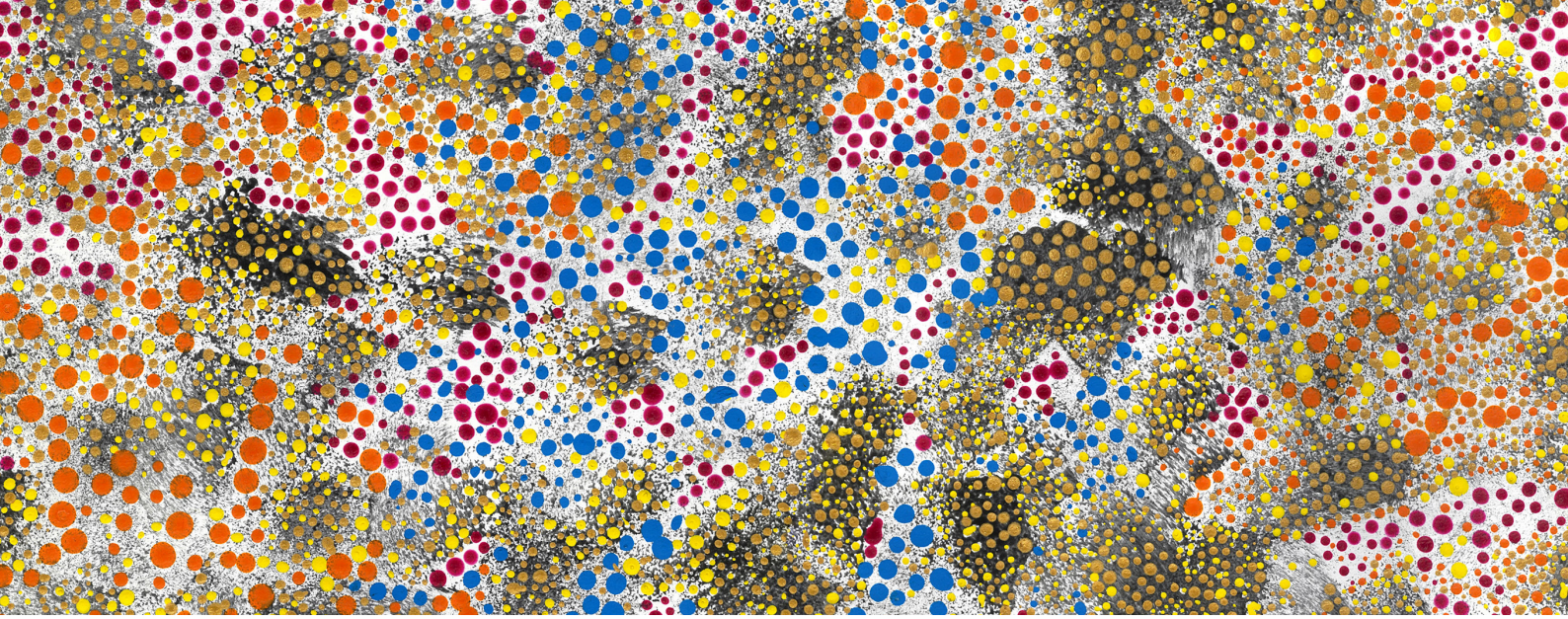
No 7. Secondary analysis of 2015–16 ACT Data reported to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS).

No 8. ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being.

No 9. Service Users' Satisfaction and Outcomes Survey 2018: a census of people accessing specialist alcohol and other drug services in the ACT.

This monograph comprises a rapid summary of results with brief interpretation and discussion. Where suitable ATODA may, in future, publish more extensive analysis in the peer reviewed literature. We hope this is a useful resource towards the sector's shared goal of a healthy, well and safe ACT community.

Dr Devin Bowles
Chief Executive Officer, ATODA



Acknowledgments

ATODA acknowledges the Traditional Custodians of the lands of the ACT and region and pays its respects to the Elders, past, present and emerging. ATODA is committed to advancing self-determination and reconciliation between Aboriginal and Torres Strait Islander peoples and other Australians.

ATODA acknowledges its members and stakeholders for their ongoing contributions to our community and our organisation.

The *ACT Alcohol and Other Drug Workforce Profile 2021: Qualifications, Remuneration and Wellbeing* (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
- 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 188 staff.

For the 2021 survey, data analysis and report write up was undertaken by Anke van der Sterren and Elisabeth Yarbakhsh. Julie Robert was involved in the design and implementation of the survey, in particular assisting with the online survey format. Dr Devin Bowles contributed to the survey design and data interpretation. The final draft was reviewed by Dr Anna Olsen, Associate Professor, ANU Medical School, College of Health and Medicine, The Australian National University.

This report builds on the work undertaken for the previous Workforce Profiles (2006, 2009, 2011, 2014 and 2017). ATODA acknowledges the contributions of David McDonald, Dr Ray Lovett and Dr Mieke Snijder to previous profiles and reports, which influence this report.

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

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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
ATDC	Alcohol, Tobacco and other Drugs Council
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
CBT	cognitive behavioural therapy
CEO	Chief Executive Officer
COVID-19	coronavirus disease of 2019
EO	Executive Officer
ERO	Equal remuneration order
FTE	full time equivalent
LGBTIQ	lesbian, gay, bisexual, transgender, intersex and queer
NCETA	National Centre for Education and Training on Addiction
NGO	non-government organisation
NSW	New South Wales
QS	Qualifications Strategy
SMBM	Shirom-Melamed Burnout Measure
SPSS	Statistical Package for the Social Sciences
SUSOS	(ACT AOD) Service Users' Satisfaction and Outcomes Survey
TCU-ORC	Texas Christian University Organizational Readiness for Change
TOS	Therapeutic Optimism Scale
WHO	World Health Organization

Executive Summary

Every two to four years, ATODA collects information from alcohol and other drug (AOD) workers and executives about the AOD workforce in the Australian Capital Territory (ACT). In 2021, ATODA received funding from the ACT Health Directorate to complete the sixth AOD Workforce Profile in cooperation with AOD services. Data were collected from nine of the ACT's 11 specialist AOD services, including ATODA. Cumulatively these nine services were delivering 35 programs in 2021. The Workers' Survey was completed by 188 workers in the participating specialist AOD services.

Two surveys were administered. This included a Workers' Survey, for which all workers at participating services were eligible to complete about themselves. It also included an Organisation Survey, completed by an Executive Officer (EO) or delegate to provide an overview of workforce issues for the whole of that specialist AOD service.

The total AOD workforce in participating organisations was about 340 staff, inclusive of 10 vacant positions. The Aboriginal and Torres Strait Islander community-controlled organisations are likely to have at least seven AOD positions, bringing the total to 347 staff. This is an increase from about 300 staff in 2017, and continues an upward trend since 2012.

Almost two-thirds of people in the AOD workforce were female, just under a third were male, and a small number identified as non-binary. The average worker was 44 years old, with most workers aged between 30 and 54 years. Five or less workers identified as Aboriginal, while 16% spoke a language other than English at home. Twelve percent of workers identified as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) or pansexual. In comparison to people who use AOD services in the ACT, the workforce is proportionately more female, and may be more culturally and linguistically diverse. A similar proportion of workers and clients are LGBTIQ, but a much lower proportion of workers are Aboriginal or Torres Strait Islander despite Aboriginal and Torres Strait Islander recruitment being prioritised by many services.

Over a quarter of workers identified as smokers, while about one-third identified as having personal lived experience with AOD. Most of these had disclosed their lived experience at the workplace. There is a growing literature about the role of lived experience in AOD treatment, with increasing appreciation of the peer workforce.

Just over half of the respondents were AOD workers, with 13% employed as nurses/nurse practitioners. Between 80% and 88% of workers were direct-client-contact workers. These workers in turn spent 81% of their time on direct-client-contact activities.

Most staff were permanent, but the proportion of casual staff employed had increased from 2017. Extra hours and overtime were common, with over one in three workers indicating it occurred at least a few times a week. People employed in the AOD workforce tend to make less than or around the ACT average salary, and AOD workers earn the least. The AOD sector has difficulty recruiting workers, but the overall workforce shortage is partly alleviated by high retention rates.

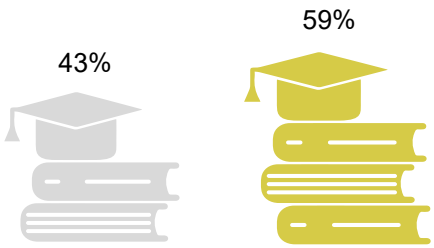
Almost three in four people in the AOD workforce possessed AOD-specific qualifications. The overall level of education has increased, and notably this was related to bachelor's degrees and other study, not the AOD Skill Set/Certificate IV. The proportion of the relevant workforce meeting the AOD Skill Set/Certificate IV portion of the Qualifications Strategy in 2021 (73%) was similar to the proportion in 2017. However, the proportion who held a current Provide First Aid Certificate had declined from about 8 in 10 to about 7 in 10. Most respondents agreed that a Certificate IV was an appropriate minimum level of qualification for those working with clients. One in three were undertaking further study or training at the time of the survey.

Additional professional development priorities were routinely identified by both workers and executives, including enhancing skills with specific client cohorts and areas of work practice across a range of advanced clinical skills. Seven out of eight organisations with staff having direct-client-contact provided access to external AOD practice supervision for staff.

The workforce had high levels of wellbeing and job satisfaction, and low levels of work-associated stress and burnout. This is notable in a pandemic, and some survey comments suggest that worker wellbeing programs implemented in response to COVID-19 helped. About half of workers indicated there were not enough workers at their program to meet client needs, but only about one in five indicated that workers had inadequate time to spend with clients. Combined with recruitment difficulties, relatively low pay for the health sector and the fact that around 80-90% of the workforce has direct-client-contact, this suggests a highly lean sector that is strongly focused on clients in the face of inadequate resources.

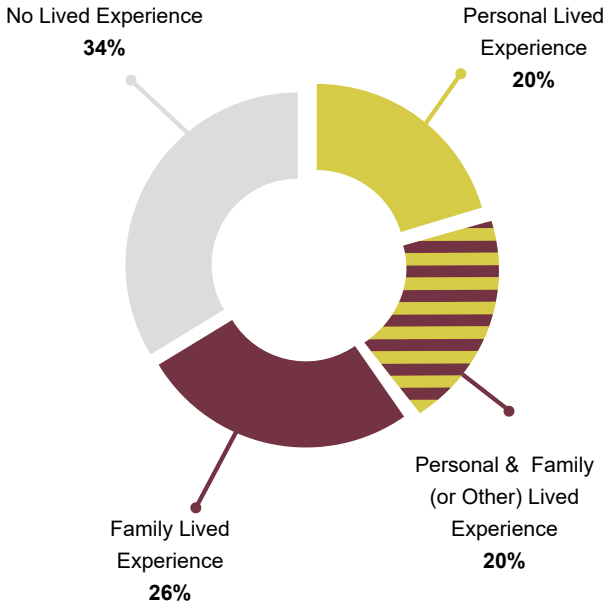
Size of workforce (excluding vacancies)

Percentage of workforce with a bachelor's degree or higher

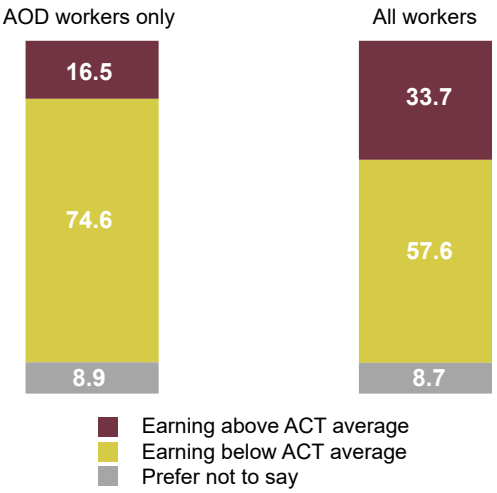


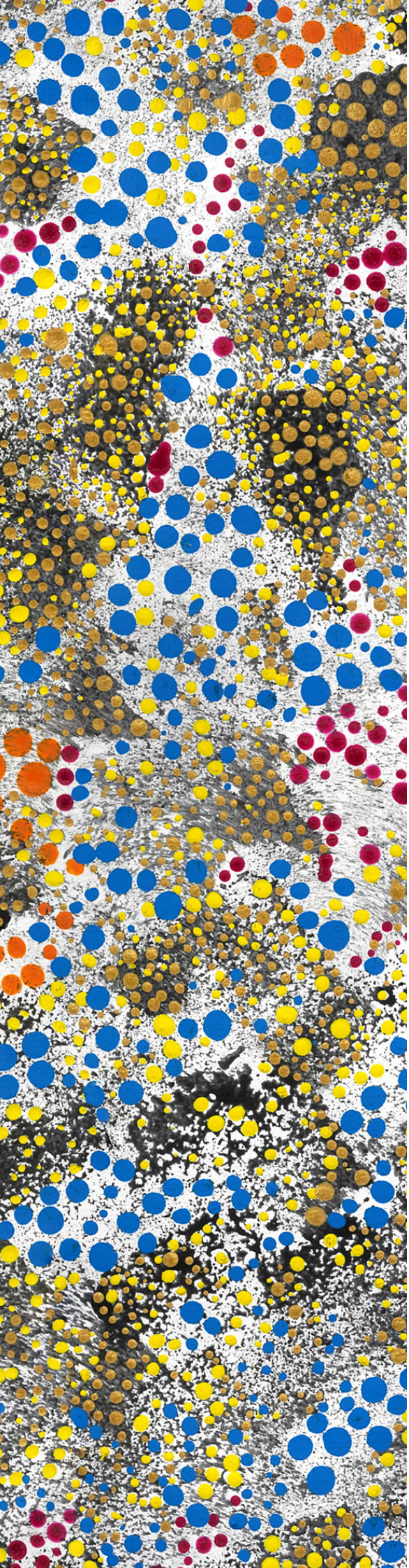
Workforce wellbeing

Lived experience



Average weekly income





ATODA Monograph Series, No. 10

1 | Introduction

This report presents the results from the sixth Australian Capital Territory (ACT) Alcohol and Other Drug (AOD) Workforce Profile conducted in 2021.[a, b] 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.

All 11 specialist AOD services in the ACT were invited to participate in the 2021 Workforce Profile—two services, each delivering an AOD program, chose not to participate. In total, nine services, delivering 35 programs, took part in administering the two surveys that comprise the Workforce Profile. These surveys were:

- a Workers' Survey administered to workers in participating specialist AOD services; and
- an Organisation Survey completed by an EO 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 the AOD sector as a whole, and for individual organisations;
- inform the enhancement of capacity of the AOD 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 wellbeing;
- 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 harm reduction and treatment outcomes; and
- monitor the impact of the application of workforce strategies, awards and legislation on remuneration and other conditions of employment in the AOD sector—e.g. the ACT AOD Qualifications Strategy (QS), the Equal Remuneration Order (ERO).

[a] 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 wellbeing), the Profile was 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).

[b] The ACT AOD Workforce Profile has been conducted between two- and four-yearly since 2006. The gap between this 2021 survey and the previous 2017 survey was four years due to the COVID-19 pandemic—the original intention had been to implement the survey in 2020.

1.1 Background of the Workforce Profile

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

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, 2014 and 2017—are available on the ATODA website: www.atoda.org.au.

1.2 Why conduct Workforce Profiles?

The *National Alcohol and Other Drug Workforce Development Strategy 2015–2018*[c] 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:[1]

- addressing recruitment and retention issues;
- identifying commonly understood AOD workforce capabilities, and matching capabilities to roles
- enhancing the capacity of the AOD workforce to respond to the complexity of service user needs, including as these needs 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; and
- 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 Alcohol and Other Drug 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.

In 2019–2020, the National Centre for Education and Training on Addiction (NCETA) conducted a national AOD workforce profile; prior to that, a national profile had not been undertaken since 2005.[2] Other jurisdictions in Australia have also undertaken AOD workforce profiles, with many having conducted multiple profiles over several years. The most recently undertaken surveys include:

- Australia's Alcohol and Other Drug Workforce: National Survey Results 2019–2020[2]
- State of the Workforce 2020: Mapping the alcohol and other drug (AOD) nursing workforce in Australia and New Zealand[3]
- AOD Workforce Study: NGO Insights 2021 (New South Wales and Victoria—in publication)[4]
- The Tasmanian Community Sector ATOD Workforce: Characteristics and Challenges, Results from the 2020 ATDC [Alcohol, Tobacco and other Drugs Council] Workforce Survey[5]
- Victorian Alcohol and Other Drugs Workforce Survey 2019[6]
- Alcohol and Other Drugs Workforce Development Assessment 2017: Summary report to Northern Territory Primary Health Network[7]
- 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)[8]
- Characteristics & wellbeing of the NSW non-government AOD workforce (2018)[9]

Several of these workforce profiles have been used to inform the 2021 ACT AOD Workforce Profile, in particular to inform the wording of some questions and/or answer options, and in the incorporation of wellbeing-related questions (see Appendix C.3).

[c] At the time of publication of this monograph, a new National AOD Workforce Development Strategy was in development, but had not yet been published.

1.2.1 ACT AOD health services planning and commissioning

Past ACT AOD Workforce Profiles have provided important data, both to individual services and to the AOD sector, to inform workforce development, to support the implementation of the QS, to understand the needs of the AOD workforce, and to match the AOD workforce to the alcohol and drug treatment needs of the ACT community. These data will be of value to the ACT Government to inform AOD sector planning, commissioning and evaluation activities in the coming years.

The ACT AOD sector is currently engaged in an intensive process of AOD health services planning that will inform the delivery of AOD health services over the upcoming years, and will guide the commissioning of AOD services in the near future. Among other data sources, the ACT AOD Workforce Profile provides valuable data for this planning, and will serve to monitor the implementation of sector reforms. Key planning and evaluation questions that the Workforce Profile could contribute to answering include:

- How do we continue to attract and retain a suitable workforce for the AOD service system?
    - Issues affecting supply, reasons for workers to stay in or leave the AOD sector
    - Particular types of workers that are difficult to recruit and/or retain, and reasons for this
    - Strategies needed to keep workers in the AOD sector
- What workforce is needed to properly staff an adaptable AOD service system that "delivers the right staff with the right skills" to meet the treatment and support needs of service users when and where they need it?
    - Size and growth of workforce
    - Cost of properly staffed services, appropriate remuneration of workforce
    - Types of workers matched to intervention types
- What clinical and other skills and qualifications are needed to maintain evidence-based practice, match the interventions being delivered, and meet the needs of service users?
    - Skills gaps and workforce development needs matched with current and future scopes of practice
    - Re-skilling or redeployment of workforce to adapt and respond to changing sector and client needs
    - Appropriate investment in professional development

1.2.2 Measuring workforce wellbeing

There is a considerable body of literature documenting the benefits of maintaining a healthy workforce not only for its own sake (i.e. wanting staff 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*).[10] The wellbeing of healthcare workers has been found to influence patient outcomes. A 2017 study examined the impact of physician burnout on health care quality and safety, finding a moderate association between burnout and lower safety-related quality of care.[11] Similarly, a 2012 study found that healthcare workers who scored poorly on wellbeing measures were more likely to make errors and less likely to be responsive to patient needs.[12] Putting in place strategies to address the wellbeing needs of the AOD workforce is, therefore, recognised as important to the provision of quality services.[13] Wellbeing in this context refers to a broad definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[14]

The 2017 ACT AOD Workforce Profile was the first in the series of ACT AOD Workforce Profiles to include and report on workforce wellbeing. The 2017 data showed that:

- higher overall wellbeing in the workforce was correlated with higher job satisfaction and higher opportunities for professional growth; and lower levels of stress and burnout
- higher stress was correlated with higher burnout, and both of these were correlated with lower professional growth and lower job satisfaction
- higher job satisfaction was correlated with higher professional growth; and
- therapeutic optimism was correlated with job satisfaction and professional growth.[15]

The findings reinforced the theoretical interactions reported in the literature between wellbeing, job satisfaction, organisational commitment, and the absence of stress and burnout. As discussed in the 2017 ACT AOD Workforce Profile report, the causes of stress and burnout come from the interactions between multiple job demands and a lack of resources (or inefficiently or ineffectively placed resources) in the workplace. These conditions can lead to increased anxiety and frustration, and higher stress and burnout. Stress and burnout

affect client outcomes, worker health and wellbeing, and organisational functioning. They reduce job satisfaction, lower organisational commitment and increase turnover and absenteeism.[13]

Two significant events occurred during 2020 that had the potential to impact on workforce health and wellbeing: the 2019–2020 bushfires; and the COVID-19 pandemic. At the request of the ACT ATOD Executives Group and the ACT ATOD Workers Group, the 2021 survey (administered in May to July) included questions about the impacts of the bushfires and the COVID-19 pandemic on service delivery and on worker wellbeing. The inclusion of measures of worker wellbeing enabled both the on-going monitoring of wellbeing, but also a comparison before and after these significant events (for further discussion, see 2.16 of this report).

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 alcohol and other drug (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.[d] These specialist AOD services are supported by the ACT's peak organisation, ATODA.[e]

The following nine ACT specialist AOD organisations participated in the 2021 Workforce Profile:

- Alcohol and Drug Services, ACT Health (ADS)
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- CatholicCare Canberra & Goulburn
- Directions Health Services
- 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. In this 2021 Workforce Profile, 188 workers responded to the Workers' Survey, a response rate of 57% (Appendix C.6).

Information about the methods used in this study are provided in Appendix C.

[d] See the ACT ATOD Services Directory (version 17 updated April 2019) at: directory.atoda.org.au.

[e] See page iii for further information about ATODA.

2 | Results and discussion

The following results include data from both the Workers' and Organisation Surveys. Where it is not specified, it should be assumed that the data come from the Workers' Survey. Data tables can be found in Appendix D. Proportions have been calculated using the number of valid responses to each question.

2.1 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?' (Q11)
- '…indicate the FTE vacancies for each position type' (Q18).

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

The total workforce in the participating organisations was estimated to be 340 staff, which includes 10 positions vacant at the time of the survey's implementation—note that the total figure is a combination of actual staff numbers (staff currently employed in the organisation) and vacant full time equivalent (FTE) positions (current staff vacancies), and as such is potentially a slight underestimate of the size of the total workforce (Table D.1).

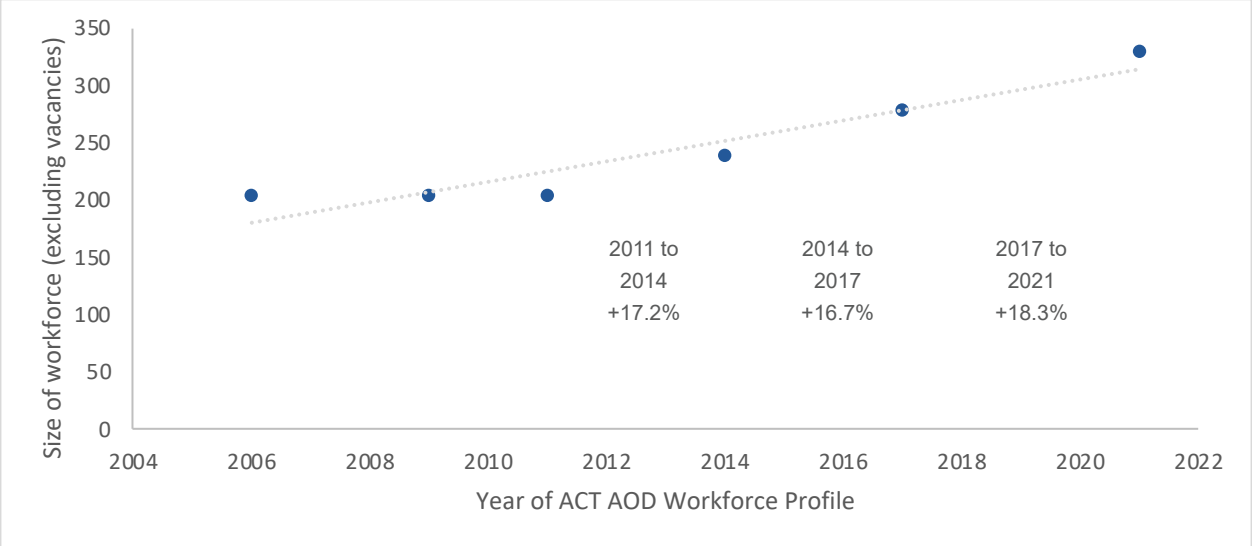
This figure does not include AOD positions in Aboriginal and Torres Strait Islander community-controlled services, where there were estimated to be a further seven AOD positions. Including these, brings the total estimated workforce to at least 347 staff in the ACT AOD sector.

The estimated workforce within participating organisations has therefore increased compared to the previous 2017 profile when the workforce was estimated to be 300 staff (including vacant positions). Between 2011 and 2021, there has been a consistent increase in the size of the workforce (actual employed staff numbers, excluding vacant positions), with a growth on average of 4.9% from year to year (Figure 1).

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 QS, full subsidies are provided for relevant workers to complete the AOD Skill Set, First Aid and the Certificate IV in AOD. Any increase in the size of the workforce has implications for increased resourcing of this training and other workforce development initiatives.

Figure 1

Size of the ACT AOD workforce (2006–2021)—actual employed staff number, excluding vacant positions—in each year of the Workforce Profile, showing percent increase from survey to survey
Sources: ACT AOD Workforce Profile—Workers' Survey, 2006, 2009, 2011, 2014, 2017, 2021



2.2 Demographics of the workforce

Respondents were asked about their age, gender, and cultural background. For the first time, workers were also asked about their sexual orientation, and lived experience with AOD.

2.2.1 Age group and gender

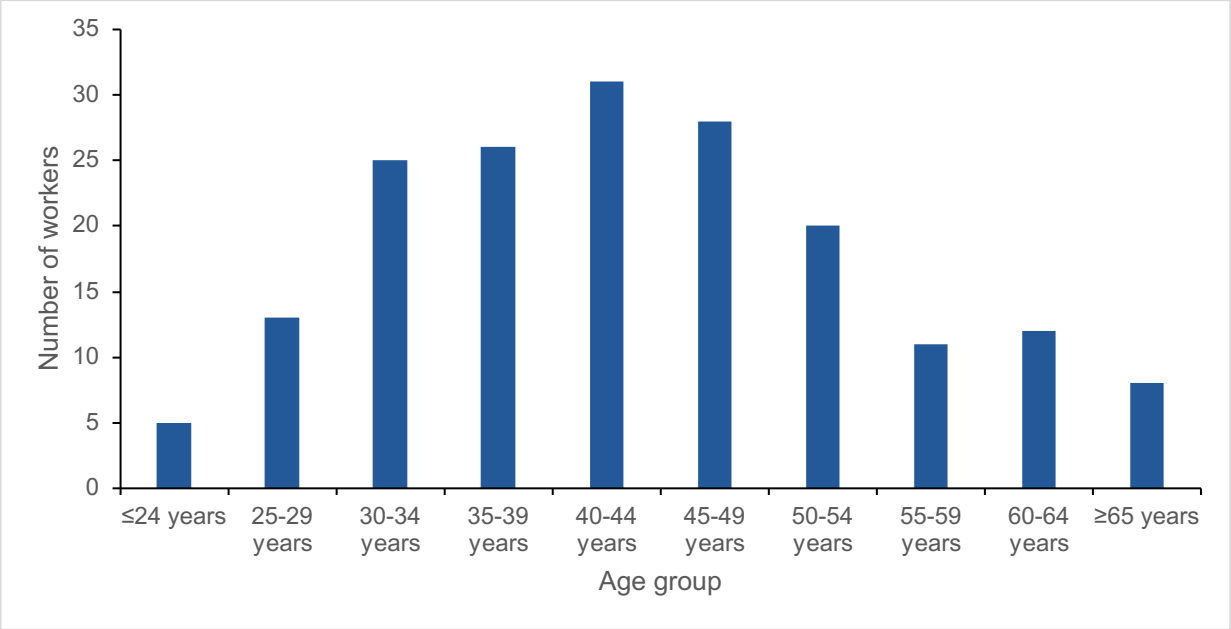
Of the respondents (n = 187), 119 (63.6%) were female and 60 (32.1%) male, and of the remaining respondents ≤ 5 workers identified as non-binary. This compares to the 2018 survey where 30.5% of respondents were male and 69.5% were female. According to the Organisation Survey, there were a total of 11 women-specific identified positions in ACT specialist AOD services in 2021 (all located in Toora Women).

While all role categories had more female than male workers, there were proportionately more male respondents in several categories when compared to previous workforce profiles. For example: in 2021, 56.3% of AOD workers who responded to the survey were female, compared to 62.3% in 2017; and 57.9% of managers who responded to the 2021 survey were female, compared to 88.9% in 2017.

The average age of the workforce was 43.7 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 slightly different for males and females, with the mean and median ages being higher for females than for males (mean: 44.1 compared to 43.5; median: 44.0 compared to 42.0). The mean ages of workers vary among organisations, with Ted Noffs Foundation and CatholicCare having the lowest average ages (38.5 years and 38.8 years respectively) and Directions Health Services, ATODA, CAHMA and the ADS the highest (47.1 years, 46.8 years, 46.2 years and 46.0 years respectively).

Figure 2

Age distribution of ACT AOD workforce (2021)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.2.2 Cultural and linguistic diversity

According to the Organisation Survey there were a total of nine Aboriginal and Torres Strait Islander and eight CALD identified positions in the participating specialist AOD services. As the two Aboriginal Community Controlled organisations did not participate, the number of Aboriginal and Torres Strait Islander positions is likely a substantial underestimate for the sector as a whole.

In the Workers' Survey, key characteristics of the cultural and linguistic diversity of the respondents were (Table D.2):

- Five or fewer workers identified as being of Aboriginal origin, with none identifying as Torres Strait Islander, or both Aboriginal and Torres Strait Islander (n = 187). Most of these were not employed in an Aboriginal and Torres Strait Islander identified position. As above, this figure represents an underestimate because of missing data from Aboriginal Community Controlled organisations.
- The majority of the survey respondents (n = 185), 125 (67.6%), were born in Australia, with 18 (9.7% of respondents and 30.0% of those born overseas) born in the United Kingdom.
- Twenty-nine (15.6%) spoke a language other than English at home (n = 186)—see list of languages in Table D.2.
- Thirteen (6.9%) workers stated that they use a language other than English for work purposes 'on occasion' or 'on a regular basis' (n = 188).

All services responded in the Organisation Survey that in the past twelve months they had used interpreter services either 'never' or 'once every 6 months', and most said either 'yes' or 'don't know' when asked if they would use interpreter services if they were available and resourced.

2.2.3 Sexual orientation

For the first time, in 2021, the Workforce profile asked respondents about their sexual orientation. The question wording and options were consistent with the ACT AOD Service Users' Satisfaction and Outcomes Survey (SUSOS), which was developed with advice from Meridian ACT (formerly AIDS Action Council ACT) and the ACT AOD Workers Group. The majority of the workforce identified as heterosexual, with 12.4% of respondents identifying as LGBTIQ or pansexual and 7.0% preferring not to say (Table D.3).

2.2.4 Comparison of the AOD workforce to service users of AOD services

With reference to the profile of service users accessing specialist AOD services as measured in the 2018 SUSOS, a comparison can be made between the demographic profiles of the ACT AOD workforce and service users (Table D.4).

As observed in previous surveys, the relative proportions of female and male workers (approximately two-thirds female, one-third male) is in direct contrast to the profile of AOD service users where male service users are more heavily represented (approximately 60:40).[16] The workforce is only slightly older on average than the service user group, and similar proportions identify as LGBTIQ—12.3% and 11.3% respectively; although it is worth noting that the proportion of workers who preferred not to say was higher than the proportion of service users who preferred not to say.[16] There are considerable differences between the workforce and service users in cultural background, with the workforce being under-representative in terms of Aboriginal and Torres Strait Islander background (≤2.7% vs 17.9%), and over-representative by culturally and linguistically diverse background (32.4% vs 9.5%—although note that these were measured differently in each survey).

2.3 Lived experience with alcohol, tobacco and other drugs

Just over one-quarter (27.8%) of respondents to the 2021 Workforce Profile (n = 187) identified as smokers—17.1% as 'current daily smokers', and 10.7% as 'occasional smokers' (Table D.5). This is up slightly from the 2017 survey when 26.2% identified as smokers (with exactly the same proportion of current daily smokers).

Similar to the 2017 survey, compared to ex- and never-smokers, being a worker who is a smoker (daily and occasional) was significantly associated with: being an AOD worker (compared to other clinical and non-clinical roles); and lower levels of education (Table D.6).

For the first time, the ACT AOD Workforce Profile survey included questions about the lived experience of workers in the AOD sector. The survey did not provide a definition of 'lived experience', and this should be kept in mind when interpreting the results.[f] According to the Organisation Survey, 15 workers are employed specifically as Peer Workers—that is, they are "specifically employed by their organisation to use their lived experience to inform their work". This is different to being employed as an AOD professional and having lived experience of AOD use, however, clearly there is an overlap, and Peer Workers are included in this reporting of lived experience.

Nearly two-thirds (63.8%) of all respondents indicated that they had some type of lived experience of AOD. Of those with lived experience, most responded in one of the following categories: 'personal lived experience only' (31.1%), 'family lived experience only' (39.5%) or both 'personal and family lived experience' (22.7%) (Table D.7). Just over one-third (35.1%) of all respondents indicated having personal lived experience of alcohol or drug problems.

Of those with lived experience, most (70.9%) indicated that they had disclosed this in the workplace. Of those that had not disclosed this (n = 34), over three-quarters (76.5%) indicated that they had no desire or need to discuss it, and just over one-third did not disclose it because 'it is not relevant to my job'. Similar proportions chose not to disclose due to judgment (23.5%), stigma (20.6%) or privacy (29.4%) concerns (Table D.8). About one-third of the respondents who chose not to disclose their lived experience in their workplace (11 of 34) indicated at least one of these three options.

The contributions of workers with lived experience of AOD use (and particularly of problematic AOD use) is increasingly recognised as integral to the sector. The 2021 survey included an opportunity for workers to explain how their lived experience with AOD has influenced their work with clients (Question 14). Details of responses will be reported in a future publication.

[f] The survey asked workers: 'Do you identify as having lived experience in relation to alcohol or other drug issues?', with the options including: 'Personal experience of alcohol or other drug problems (past or present)'; 'Family member who has experienced alcohol or drug problems (past or present)'. The response options provided were intended to elicit responses from workers with lived experience of problematic AOD use, rather than those with experience of AOD use more generally.

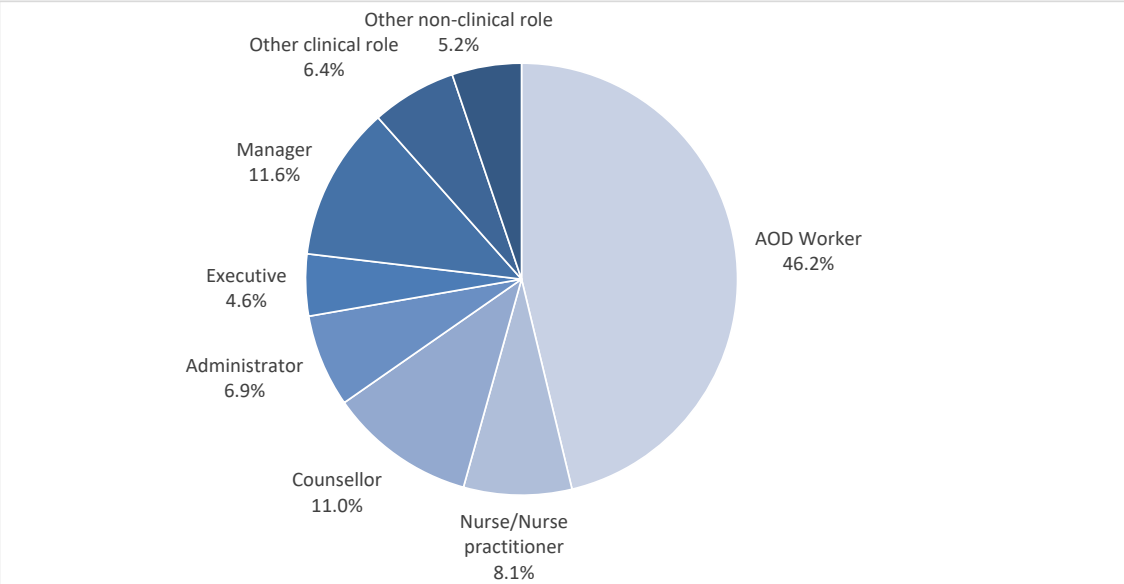
2.4 Job roles

In the Organisation Surveys, more than half of the workforce was identified as AOD Workers (50.6%), with 13.0% Nurse/Nurse Practitioners, and 8.2% in Other Clinical Roles (Table D.9). As shown in Figure 3, almost half (46.2%) of the Workers' Survey respondents were identified as AOD Workers, with 11.6% Managers, 11.0% Counsellors, and 8.1% Nurse/Nurse practitioners. In contrast to the 2017 Workforce Profile, respondents included clinical AOD practitioners in the categories 'General Practitioner', 'Addiction Medicine Specialists', and 'Other Medical Practitioner' categories.

Thirty (17.2%) workers (n = 174) reported being in roles that required them to be registered with the Australian Health Practitioner Regulation Agency (AHPRA).[g]

Figure 3

Main roles of the Workers' Survey respondents (n = 173)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Note: To maintain anonymity where response numbers are low, 'other clinical role' includes 'general practitioner', 'addiction medicine specialist', 'other medical practitioner', 'other psychologist', 'social worker', and 'other role clinical'; and 'other non-clinical role' includes the response categories of 'researcher/policy officer/ project officer' and 'other role non-clinical'.

[g] AHPRA is the agency that supports the National Boards that regulate their corresponding medical professions. Under the National Regulation and Accreditation Scheme, health practitioners who wish to call themselves any of the 'protected titles' are required to be registered with their corresponding National Board. 'Protected titles' include: medical practitioner; nurse; registered nurse; nurse practitioner; pharmacist; psychologist. See www.ahpra.gov.au.

2.4.1 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 (n = 176), 141 (80.1%) were categorised as direct-client-contact workers and 35 (19.9%) were non-client-contact workers. The proportion of direct-client-contact workers was higher in the Organisation Survey (88.2%—Table D.10)—this difference may reflect differing methods of defining client-contact roles (between CEOs/Managers completing the Organisation Survey and individual workers completing the Workers' Survey), or better capacity for non-client facing roles to participate in the survey.

Most people employed in the AOD sector undertake a mix of direct-client-contact and non-client-contact activities. Workers with direct-client-contact roles spent, on average, 81.0% of their time on direct-client services (54.3%) or client-related administration tasks (26.7%), and 18.9% of their time on other tasks that do not involve providing treatment and support to clients (Table D.11). Previous ACT AOD Workforce Profiles did not distinguish between direct-client service delivery and activities that related to clients, but that were client-related administration tasks—a significant portion of time, on average about one-quarter of the total, is dedicated to these types of activities. In 2017, direct-client-contact workers indicated that they spent 64.0% of their time on direct-client-contact activities, and it was unclear whether workers included client-related administration tasks as part of direct-client-contact or non-client-contact tasks.

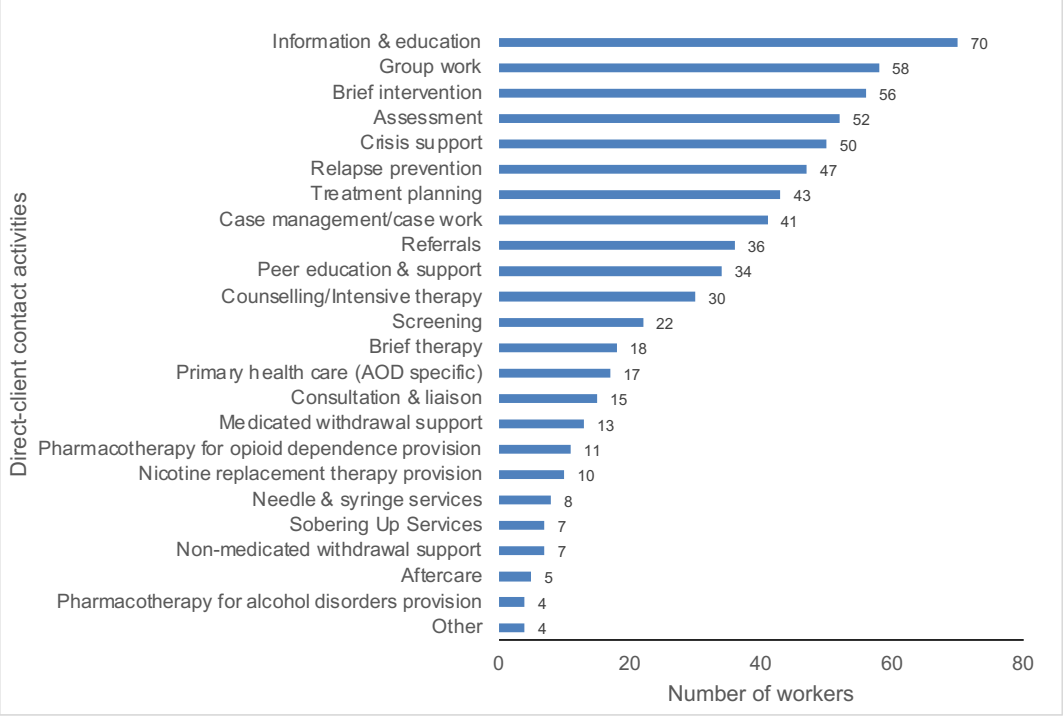
Of the 141 workers who were categorised as direct-client-contact workers, Figure 4 shows the direct-client-contact activities in which they were engaged as part of their roles. The highest numbers reported the following activities:

- Information and education (70)
- Group work (58)
- Brief interventions (56)
- Assessment (52)
- Crisis support (50)
- Relapse prevention (47)

Note that this reflects activities that the most workers nominated as part of their role; it does not provide a hierarchy of relative proportions of time spent on each activity.

Figure 4

Numbers of direct-client-contact workers undertaking each type of direct-client-contact activity
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Direct-client-contact workers reported spending, on average, 18.9% of their time on non-client-contact activities with the highest number of workers reporting the following activities (Figure 5):

- Undertaking your own professional development (46)
- Data entry (40)
- Meeting attendance (39)
- Other organisational processes (29)
- Compilation of data for reporting purposes (21)

Professional development and data entry are the most cited non-client-contact activities by workers with direct-client-contact. This is consistent with the commitment observed in the ACT AOD sector towards delivering evidence-informed and high quality AOD treatment and support.

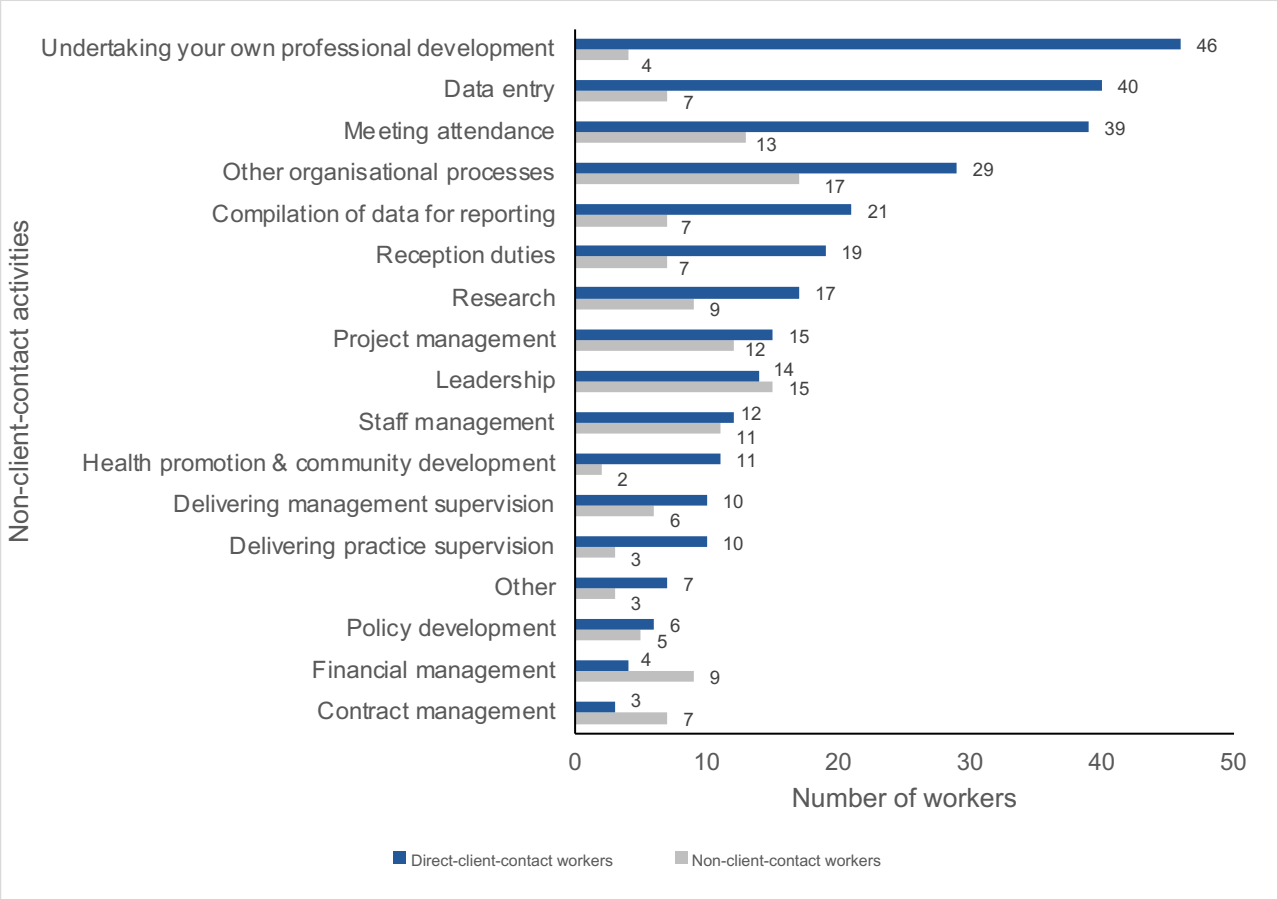
Among those workers who were categorised as non-client-contact workers (n = 35), a handful of workers identified undertaking some direct-client-contact activities, such as screening, information and education, consultation and liaison, and referrals. Figure 5 shows the non-client-contact activities of these workers, with the highest numbers reporting the following activities (Figure 5):

- Other organisational processes (17)
- Leadership (15)
- Meeting attendance (13)
- Project management (12)
- Staff management (11)

As above, this list reflects activities that the most workers nominated as part of their role; it does not provide a hierarchy of relative proportions of time spent on each activity.

Figure 5

Numbers of direct-client-contact workers and non-client-contact workers undertaking each type of non-client-contact activity
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.5 Employment status

In the Organisation Survey it was reported that 46.3% of staff were employed in permanent full-time positions and 2.1% in fixed-term full-time positions; 25.2% were employed in permanent part-time positions and 4.2% in fixed-term part-time positions; and 22.1% in casual positions (Table D.12). The proportion of workers in permanent positions is similar in the 2017 and 2021 Organisation Surveys (72.6% and 74.2% respectively).

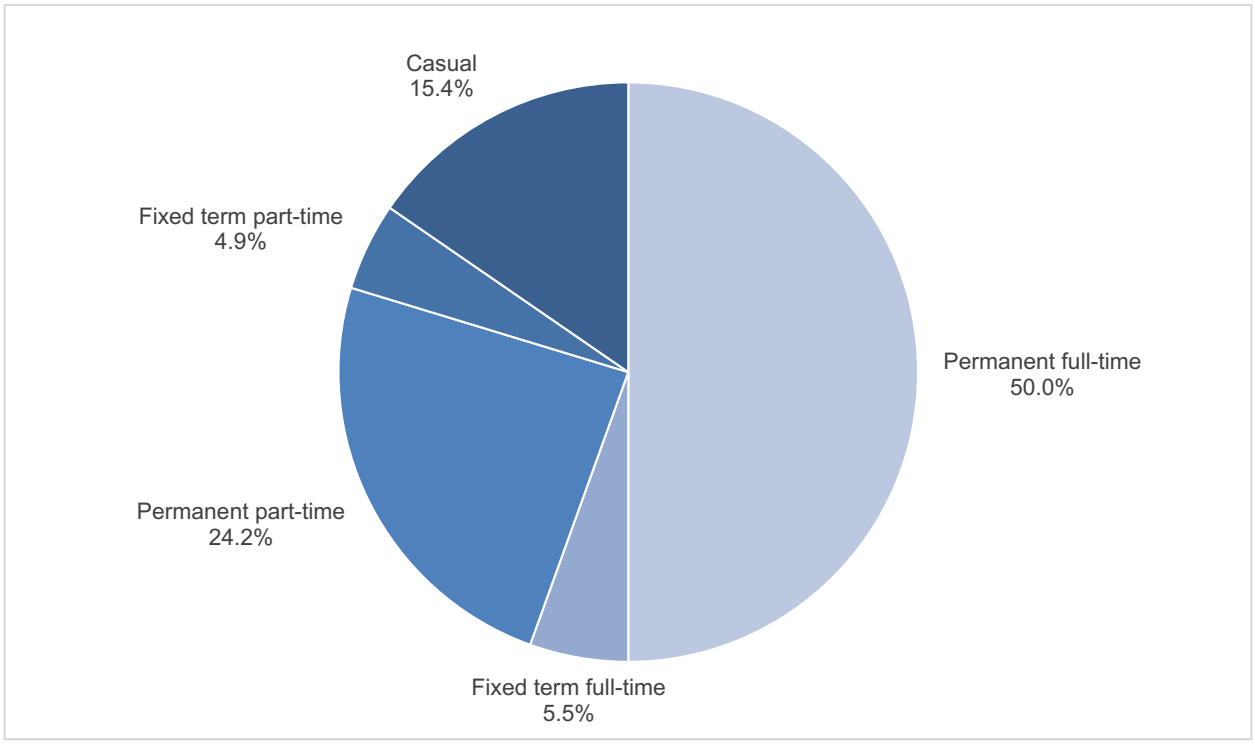
In the Workers' Survey, more than half (55.5%) of the respondents (n = 182) indicated that they were full-time employees—50.0% permanent full time and 5.5% fixed term full time; 29.1% worked part time—24.2% permanent part time and 4.9% fixed term part time; and 15.4% were casual workers (Figure 6).[h] The relative proportion of casual workers is higher in 2021 (15.4%) compared to 2017 (10.6%), which is likely due to the higher proportional representation of workers participating in the AOD workforce through the CAHMA volunteer employment program. For fixed term contract employees, the average total duration of their contract was 17.4 months (compared to 13.5 months in 2017).

Of workers responding to the question (n = 174), higher proportions of female workers indicated they were employed part time than male workers (31.6% vs 19.3%, respectively)—this is similar to the 2017 profile (34.8% for female workers and 21.6% for male workers).

For AOD workers, the role with the highest proportion of respondents, 45.5% of workers were employed full time, 27.3% part time, and 27.3% were employed casually (Table D.13). Most managers (95.0%) and all executives were employed full time, while nearly three-quarters of nurses/nurse practitioners were employed part time.

Figure 6

Proportions of workers employed in full-time, part-time and casual positions (as reported in Workers' Survey, n = 182)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



[h] Fewer than 5 casual workers were full time; most were part time. Note that casual workers include workers engaged in casual paid-volunteer positions.

2.6 Hours worked

In the Organisation Survey, the EOs reported between 35 to 40 hours per week as their organisations' full-time hours depending on the employment award(s) of their workers (see Box 1). Respondents of the Workers' Survey indicated that they worked an average of:

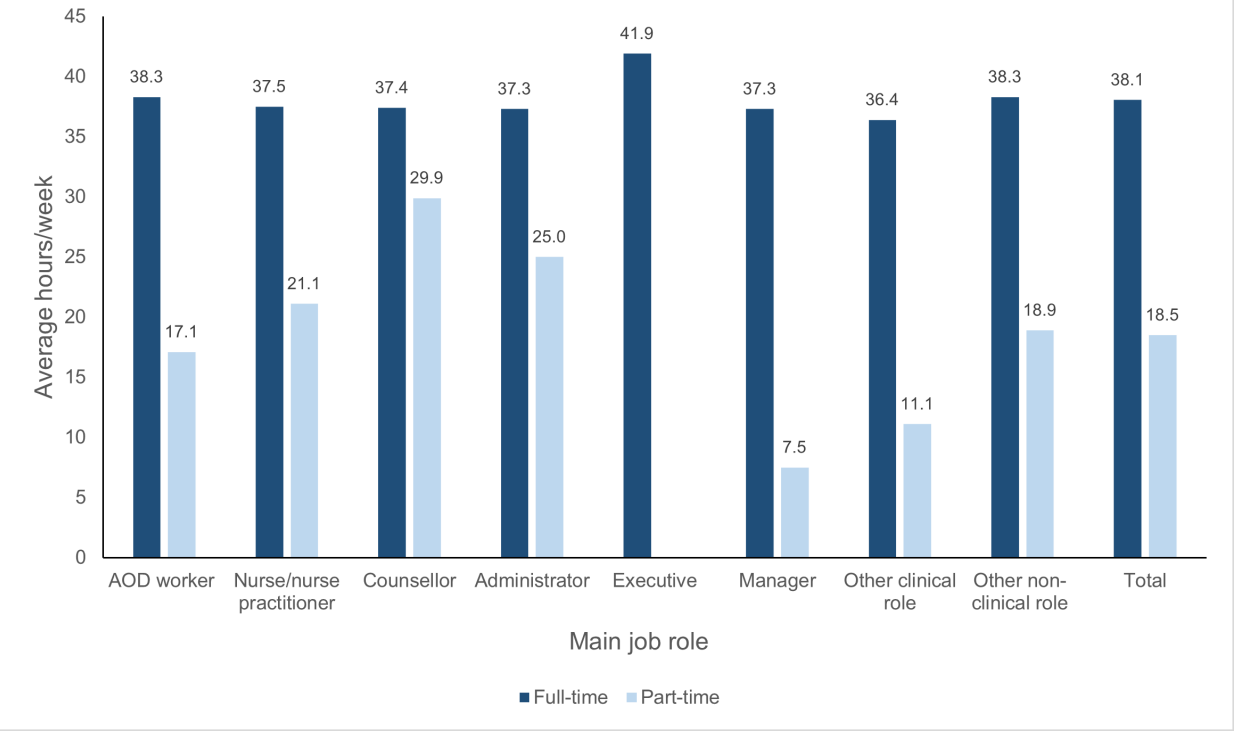
- 38.1 hours for full-time workers (permanent, fixed-term and casual)
- 18.3 hours for part-time workers (permanent, fixed-term and casual)

The average for all workers was 29.6 hours per week, which is lower than reported in the previous Workforce Profiles (34.5 hours per week in 2017; 33.6 hours per week in 2014; 34.5 hours per week in 2011). The median hours per week are similar for 2017 and 2021: 36.75 hours and 36.00 hours respectively. The difference in average hours might be partly accounted for by the larger proportion of casual workers (most of whom are part-time) participating in the survey than in previous survey years. However, the increase in casual workers cannot fully account for the magnitude of this decrease.

As demonstrated in Figure 7, executives work the longest hours in the workforce, averaging more than 41.9 hours per week (all were full time). Of part-time workers, counsellors (29.9 hours/week) and administrators (25.0 hours/week) worked the most hours.

Figure 7

Average weekly working hours by main job role, full-time and part-time workers
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

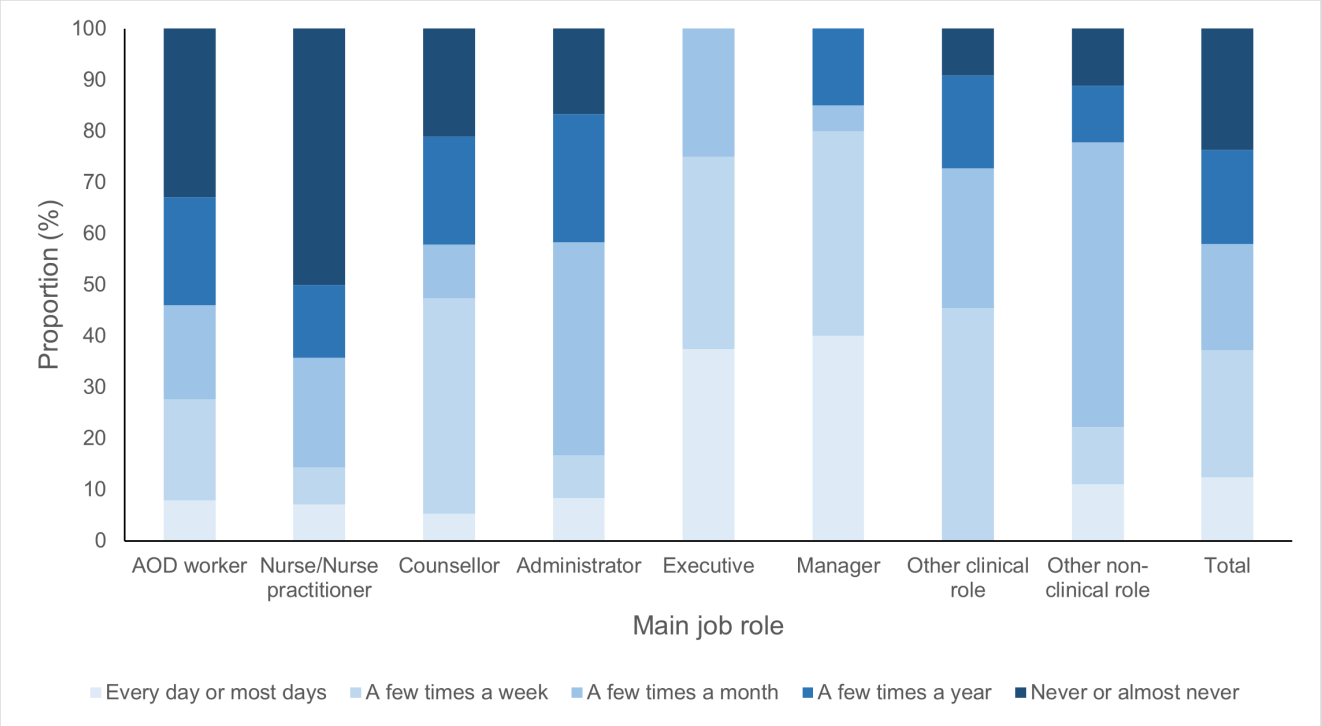


Note: To preserve anonymity where response numbers are low, 'other clinical role' includes 'general practitioner', 'addiction medicine specialist', 'other medical practitioner', 'other psychologist', 'social worker', and 'other role clinical'; and 'other non-clinical role' includes the response categories of 'researcher/policy officer/project officer' and 'other role non-clinical'.

When workers (n = 180) were asked how often they worked extra hours or overtime, 11.7% stated that they worked overtime ‘every day or most days’, and 24.4% stated ‘a few times a week’. About one-quarter also stated that they ‘never or almost never’ work overtime (24.4%). Executives and managers had the greatest proportions working overtime ‘every day or most days’ or ‘a few times a week’ (75.0% for executives and 80.0% for managers). About two in five Counsellors (42.1%) and workers in Other clinical roles (45.5%) worked overtime ‘a few times a week’ (Figure 8).

Figure 8

Frequency of working overtime, by main job role (n = 169)
Source: 2021 ACT AOD Workforce Profile—Workers’ Survey



About 73% of workers (n = 180) stated that they were satisfied with how they are compensated for their overtime. A small number who were not satisfied provided additional comments (six respondents), most of which related to a preference for overtime pay rather than time in lieu.

Most workers—86.7% (n = 181)—were satisfied with their flexible working arrangements. Commonly cited causes for a lack of satisfaction with flexible work arrangements include insufficient shifts and the lack of stability and certainty that comes with casual work arrangements.

2.7 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 1.

Box 1

Employment awards used in ACT specialist AOD services
Source: 2021 ACT AOD Workforce Profile—Organisation Survey

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

In contrast to previous Workforce Profile surveys, the 2021 survey asked workers to nominate their income category, rather than to state their base hourly rate of remuneration. It was hoped that this would increase the response rate for this question as workers would prefer the relative anonymity of the question—however, the changed method did not significantly increase the response rate (87.0% in 2017; 88.3% in 2021).

Figures 9 and 10 show the proportions of workers in each earnings category based on their employment type, and compares this to the average weekly earnings in the ACT (May 2021).[19] Figure 9 presents data for all workers—full time, part time and casual—and Figure 10 presents data for full-time workers only. Both figures show that most workers in the AOD sector are paid less than the average ACT worker:

- Up to two-thirds of all workers in the AOD sector (in all role-types) earn below the ACT average weekly total earnings (May 2021) of $1,500.30.
- At least three-quarters of AOD workers earn below the ACT average weekly total earnings (May 2021) of $1,500.30.
- At least half of all full-time workers in the AOD sector (in all role types) earn below the ACT average weekly full-time earnings (May 2021) of $1,908.60.
- At least two-thirds of full-time AOD workers earn below the ACT average weekly full-time earnings (May 2021) of $1,908.60.

Figure 9

Average pre-tax weekly income of workers in the AOD sector of all employment types (full time, part time, casual), comparing all workers (all role-types, n = 172) and AOD workers only (n = 79)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

ACT average weekly total earnings, adults (May 2021) $1,500.30

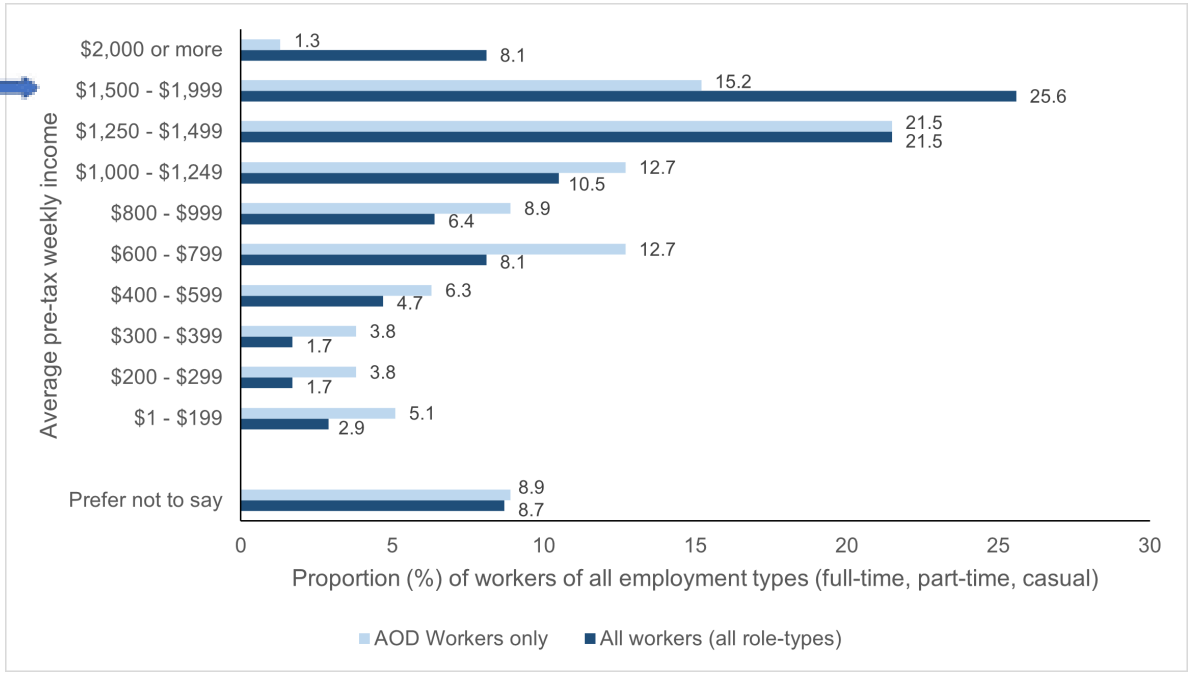
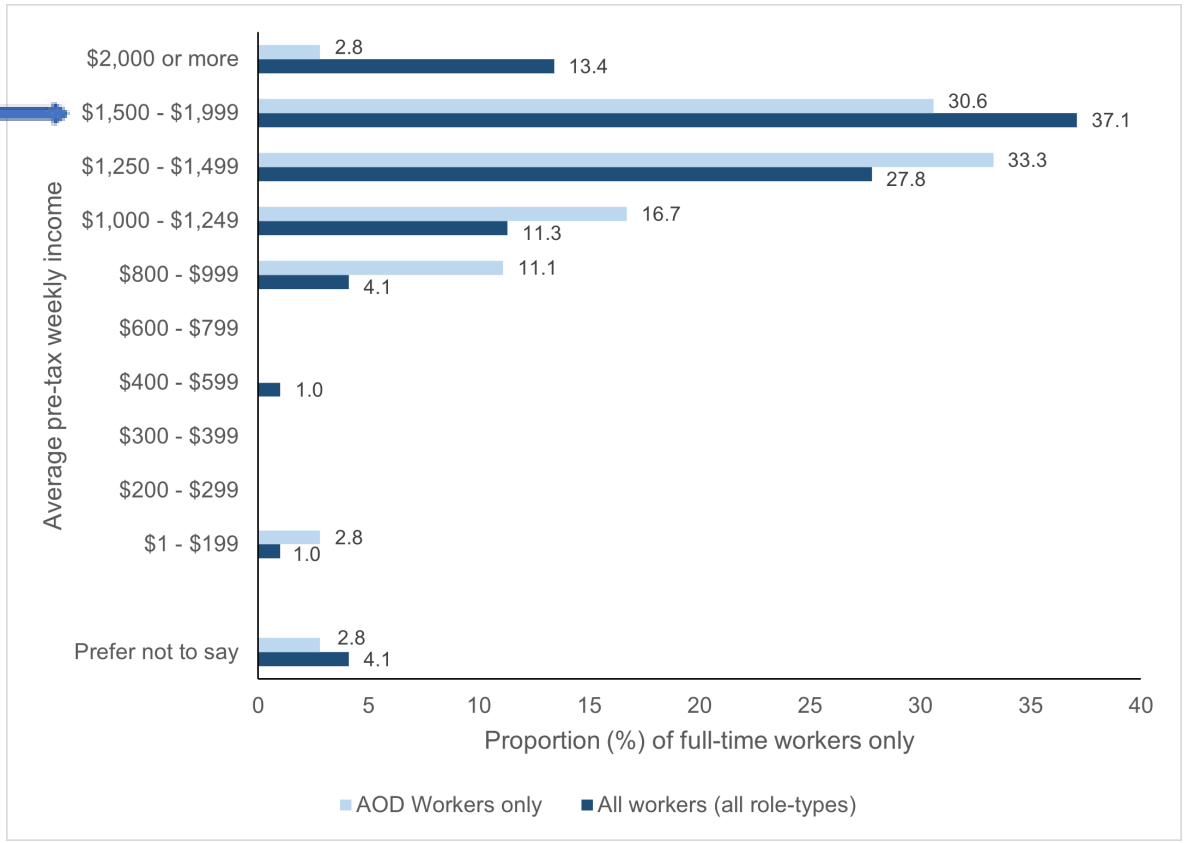


Figure 10

Average pre-tax weekly income of full-time workers in the AOD sector, comparing all workers (all role-types, n = 97) and AOD workers only (n = 36)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

ACT average weekly ordinary time earnings, full time, adults (May 2021) $1,908.60



2.7.1 Entitlements

Those completing the Organisation Survey were asked to identify the additional entitlements offered by their organisation, outside of any employment award (see Box 1). Box 2 show examples of the types of benefits that are offered to employees (not all are available in each organisation). Considering that remuneration provided to workers in specialist AOD services is generally lower than the average ACT weekly earnings, the range of non-remuneration based employee entitlements and benefits available to workers is potentially important in attracting and retaining employees in the short to medium term.

Box 2

Additional entitlements offered to employees of specialist AOD services
Source: 2021 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
- 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 kilometres travelled
- Salary sacrifice to superannuation
- Study assistance
- Study leave (paid)
- Study leave (unpaid)
- Time in lieu or paid overtime
- Travel allowance
- Unpaid leave provisions
- Work Health and Safety allowance

2.8 Work history

While the average years working in the AOD sector (anywhere) was 7.4 years, about half of respondents to the Workers' Survey had been working in the AOD sector for approximately 5 years or less (Table D.14). About one-fifth of workers (20.9%) have been in the AOD sector for fewer than two years, and 9.9% for 20 years or more (Figure 11).

Figure 11

Time in the AOD sector (anywhere and ACT), in their current organisation, and in their current position—proportions of the AOD workforce in each time period category
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

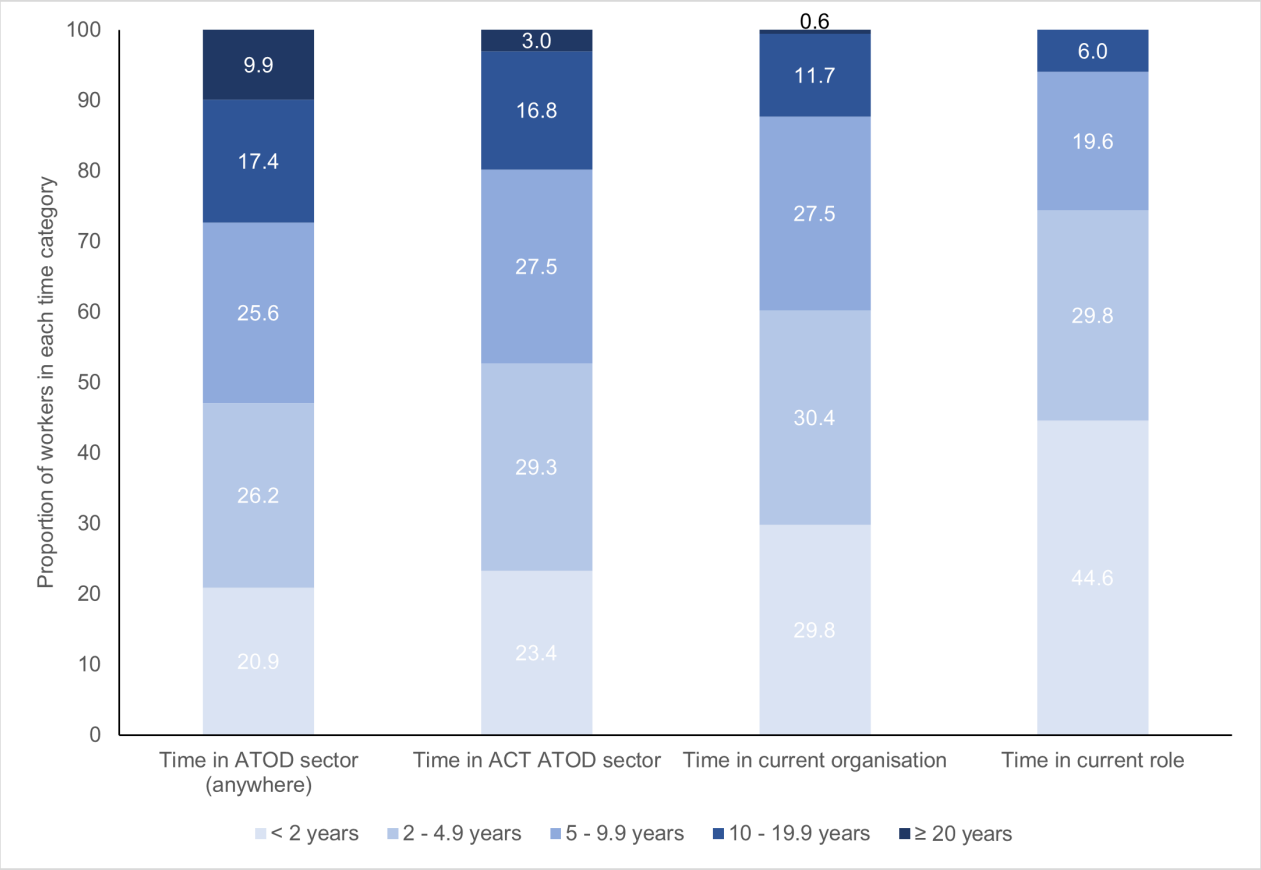
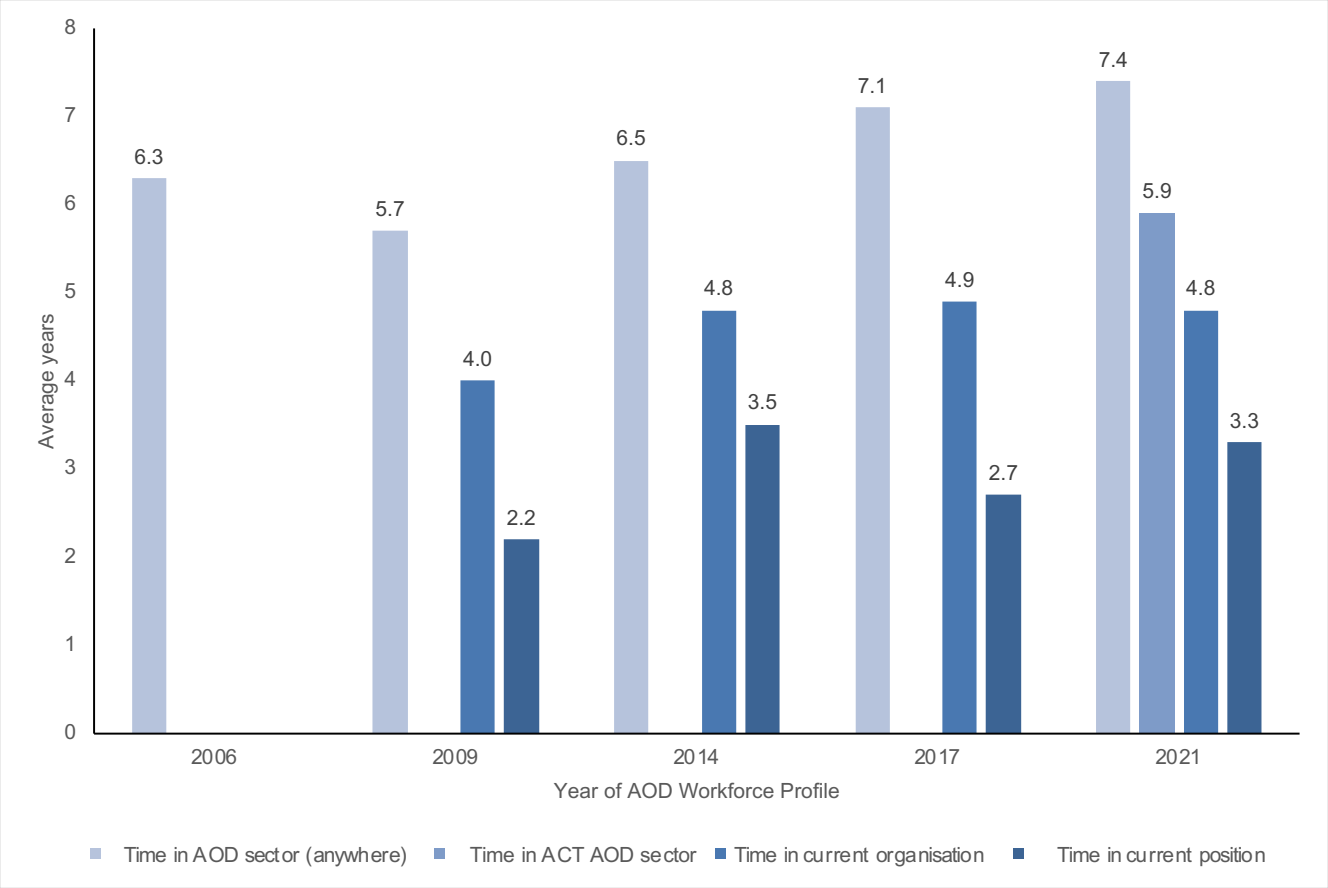


Figure 12 shows that there has been slight increase over time in the average years that workers are in the AOD sector, while the average years in their current organisation has been stable since 2014.

Figure 12

Workers' average years in the AOD sector (anywhere and in the ACT), in their current organisation, and in their current position—change over time
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

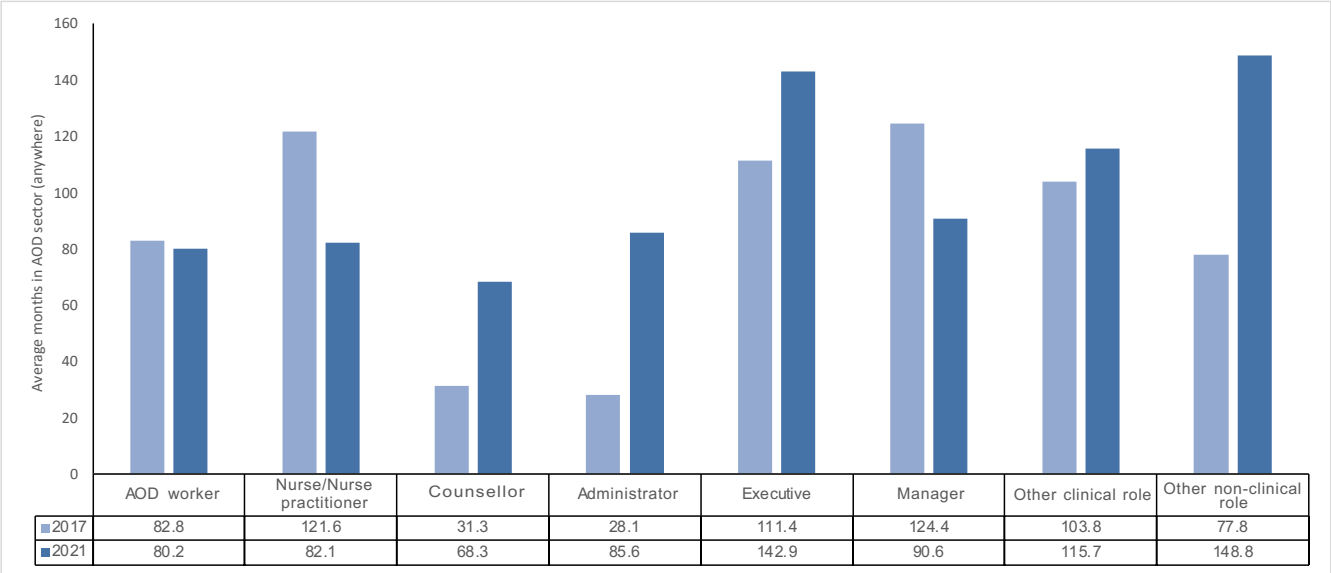


Note: These data are not available for the survey conducted in 2011. The 2006 Workforce Profile did not report specifically on years in current organisation and years in current position. The 2021 Profile is the only survey reporting 'Time in ACT AOD sector'.

On average workers who are currently in 'other non-clinical roles', executives, and 'other clinical roles', have been in the AOD sector for the longest duration (Figure 13). Counsellors have been in the AOD sector for the shortest period of time, possibly due to the recruitment to new counselling programs funded since the last Workforce Profile. Since the 2017 Profile, there has been a large increase in the average time in the AOD sector for administrators, and a large decrease for nurses/nurse practitioners. Note that this analysis relates to the current role of workers—they may have held other positions at other times in their careers.

Figure 13

Average length of time (months) in the AOD sector (anywhere), by current main job role, 2017 and 2021
Sources: 2021 ACT AOD Workforce Profile—Workers' Survey; 2017 ACT AOD Workforce Profile—Workers' Survey



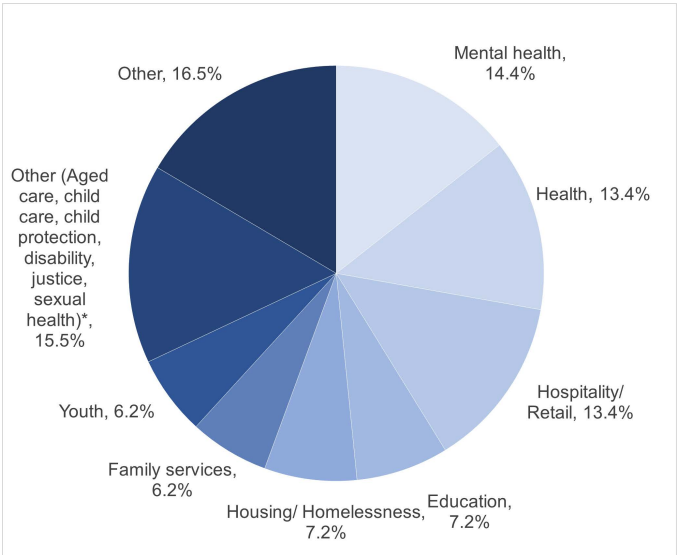
	AOD worker	Nurse/Nurse practitioner	Counsellor	Administrator	Executive	Manager	Other clinical role	Other non-clinical role
2017	82.8	121.6	31.3	28.1	111.4	124.4	103.8	77.8
2021	80.2	82.1	68.3	85.6	142.9	90.6	115.7	148.8

Workers were asked where they had worked immediately prior to their current role: just over half (52.2%) responded 'working outside the AOD sector', while 25.0% had worked in the same organisation, and 12.8% had worked within the AOD sector in another organisation. Of those whose immediate prior position had been outside the AOD sector (n = 94), 44.7% had worked in non-government settings, 24.5% in government or public sector settings, and 24.5% in the private sector.

When examined by sector, respondents whose last position was outside the AOD sector (n = 97) reported having been employed in the mental health (14.4%), health (13.4%), hospitality/retail (13.4%), education (7.2%), housing/homelessness (7.2%), family services (6.2%), and youth (6.2%) sectors (Figure 14).

Figure 14

Workers' reported last paid employment position if outside the AOD sector (n = 97)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

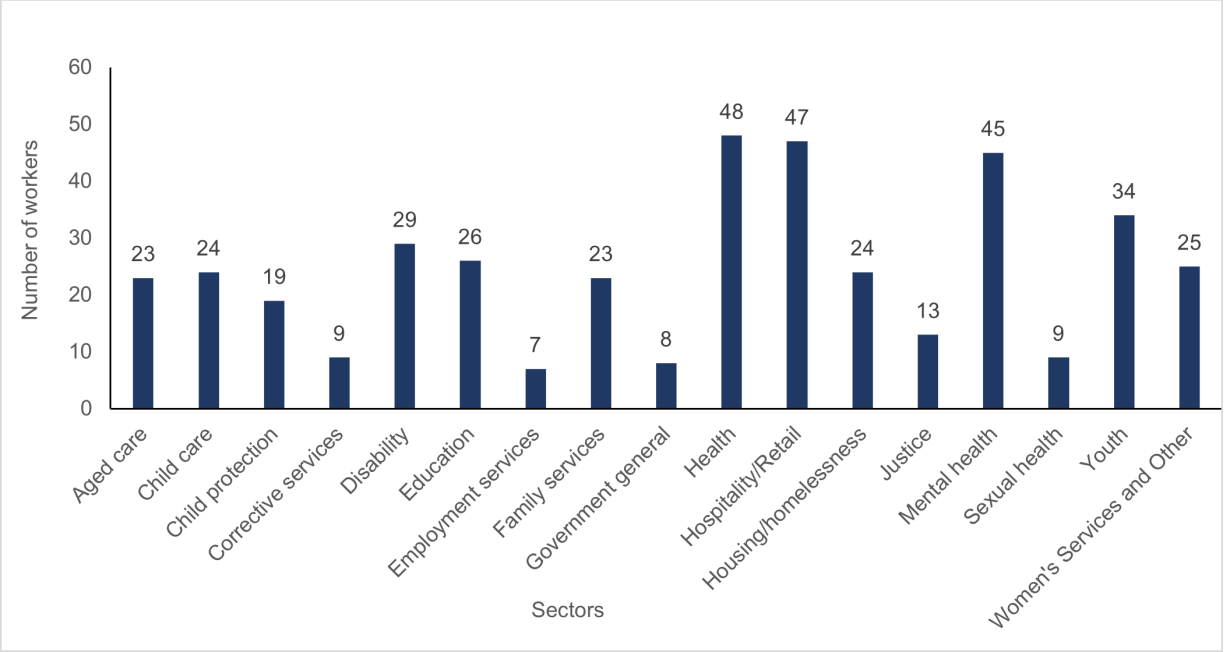


* For the category 'Other (aged care, childcare, child protection, disability, justice, sexual health)', there were five or fewer responses for each sector category. In order to maintain anonymity of respondents, these sectors have been grouped together.

Workers were also asked which other sectors they had ever had experience working in before joining the AOD sector—workers could indicate multiple responses. The highest numbers of workers reported having had previous employment in the health (48 workers), hospitality/retail (47 workers) and mental health (45 workers) sectors, followed by the youth (34 workers) and disability (29 workers) sectors. Other sectors (25 workers) included, for example: women's service (≤5 workers); building and construction; information technology; transportation and logistics; and general community services (Figure 15).

Figure 15

Other sector(s) in which survey respondents have worked
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.9 Qualifications

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 (n = 172):

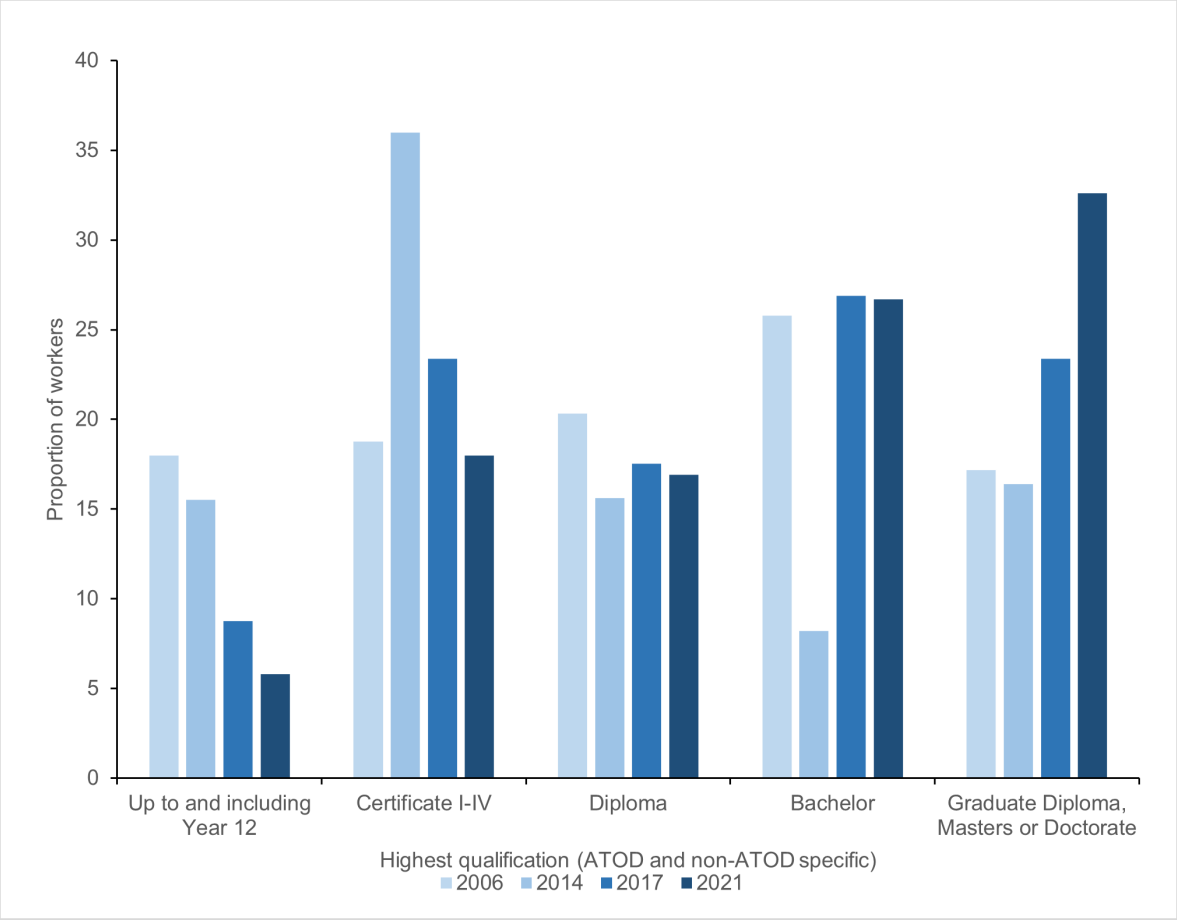
- Almost three-quarters (72.7%) had qualifications in an AOD-specific area;
- 70.3% had qualifications in a non-AOD health/social/behavioural sciences area; and
- 35.5% had a qualification in other areas of study (i.e. non-AOD and also not in the health/social/behavioural sciences areas).

Over half (59.3%) of the respondents had a bachelor's degree or above (Table D.15). The highest qualifications among AOD workers were (n = 77): a bachelor's degree or higher (40.3%); a Diploma (23.4%); or a Certificate I–IV (29.9%).

As seen in Figure 16, the trend over time has been towards an increasingly qualified workforce. For instance, the proportion of workers attaining a graduate diploma, masters or doctorate has increased by about 90% between 2006 and 2021. This has potential implications for the quality of care delivered, the capacity of the sector to retain staff, and for employment costs.

Figure 16

Highest education qualifications of the survey respondents over time (comparing 2006, 2014, 2017 and 2021 surveys)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Note: 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 these data which relate to all qualifications.

These data show that the ACT AOD sector is well-qualified. Almost 60% of respondents have a qualification at bachelor's level or higher. This compares to 50.3% in the 2017 Workforce Profile and is consistent with the increasing professionalisation of the AOD workforce and the commitment to delivering evidence-informed AOD treatment and support, and improved treatment outcomes for clients.

About one-third (33.9%) of respondents were undertaking study or training at the time of the survey (n = 171). Of those doing study or training (n = 58):

- 21 (36.2%) were undertaking AOD-related subjects;
- 31 (53.4%) were undertaking study in a non-AOD health, social or behavioural science area; and
- 6 (10.3%) were studying another subject area (e.g. business, management).

2.10 Qualifications Strategy

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

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

ACT Health provides funding to support the development and implementation of the QS through ATODA,

including the provision of full training subsidies to eligible workers. Appendix E includes a full description of the ACT AOD Qualifications Strategy (QS).

Of the valid survey responses (n = 176), 35 were non-client-contact workers and 141 were direct-client-contact workers—12 workers could not be assigned to a direct-client or non-client category (see Appendix E). As the QS only applies to workers with direct-client-contact, only those 141 workers with direct-client-contact were considered in the subsequent analysis. Figure 17 shows Workers' Survey respondents' progress against the QS, both completed and in progress:

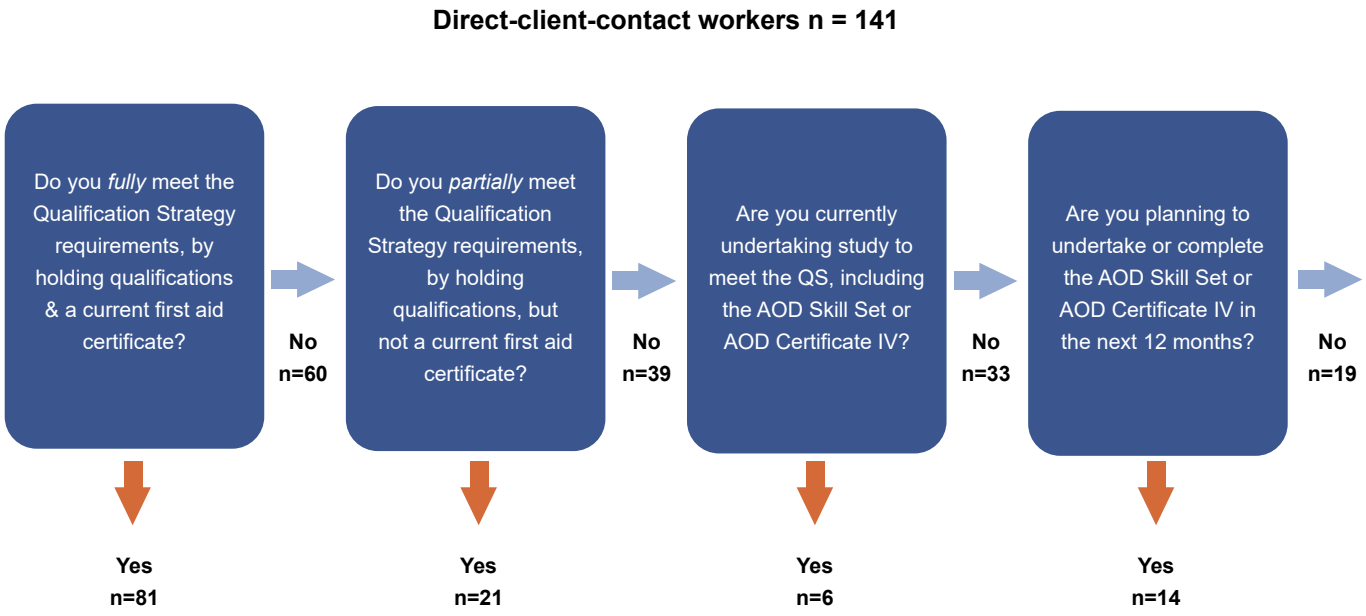
- Of the 141 workers, 81 (57.4%) fully met the QS requirements (requirements 1 and 2 listed above)
- Of the 60 workers who did not completely meet the QS requirements,
  - 21 had completed the AOD training / qualifications requirements of the QS, but did not have a current First Aid Certificate.
  - 6 workers were currently undertaking the AOD Skill Set units
- Of the 33 who had not yet attained or were not yet undertaking any AOD Skill Set units, 14 were planning to commence or complete this training in the next 12 months
- 19 workers were neither currently meeting, undertaking nor planning to undertake the AOD Skill Set and/ or Certificate IV remaining units in the next 12 months (13.5% of the 141 workers).

Most (70.2%) of the survey respondents classified as having direct-client-contact indicated they had a current Provide First Aid Certificate or equivalent.

When compared to the 2017 Workforce Profile, similar proportions of workers completely or almost completely met the QS requirements: 70.5% in 2017 (n = 129); 72.3% in 2021 (n = 141). In addition, similar proportions were neither currently meeting, undertaking, nor planning to undertake the training towards the QS: 10.1% in 2017; 13.5% in 2021. A higher proportion of workers reported holding a current Provide First Aid Certificate or equivalent in 2017 (80.3%) compared to 2021 (70.2%). This may be due to the more limited opportunities to access First Aid training during the COVID-19 pandemic.

Figure 17

Survey respondents' progress against the Qualifications Strategy
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



* For details of the analysis for this figure, please refer to Appendix E.

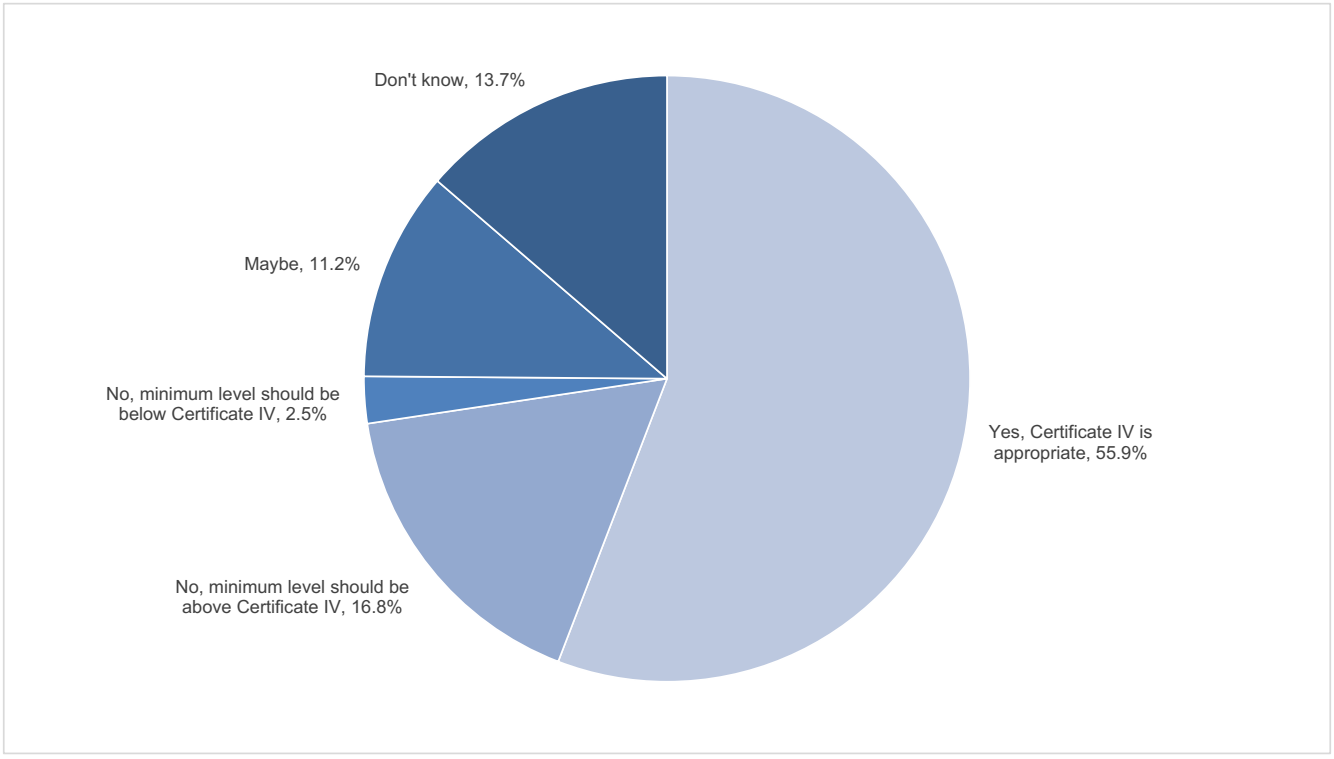
The data support the argument that a fully subsidised ACT AOD Qualifications Strategy (QS) significantly bolsters expertise throughout the sector. It is important to be able to offer fully subsidised training to support the low-paid AOD workforce. Such training may assist in attracting workers to, and retaining them within, the AOD sector. It may be particularly valuable in attracting and upskilling workers coming to the AOD sector from other non-AOD sectors—half (52.2%) of the survey respondents had come from outside the AOD sector, and most had non-AOD qualifications (70.3%). The average length of time workers had been in the AOD sector (7.4 years) indicates high retention within the sector. A QS that applies to and makes training available collectively to the entire workforce across the AOD sector supports workers to stay in the sector even when they move between AOD services for employment.

Survey respondents (n = 161) were asked to indicate if they thought a Certificate IV was an appropriate minimum level of qualification for the AOD workforce in the ACT. More than half (55.9%) of the respondents thought a Certificate IV was an appropriate minimum level of qualification; 16.8% thought the minimum level of qualification should be above the Certificate IV; 2.5% thought the minimum level of qualification should be below the Certificate IV; and the remaining respondents indicated ‘don’t know’ or ‘maybe’ (Figure 18).

Workers gave a number of reasons for their answers with the most consistent responses including: 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.

Figure 18

Survey respondents’ opinions regarding whether or not Certificate IV is an appropriate minimum qualification for the AOD workforce in the ACT
Source: 2021 ACT AOD Workforce Profile—Workers’ Survey



2.11 Professional development, training and support

EOs/managers completing the Organisation Survey indicated that:

- seven organisations have individual professional development plans for all or most of their staff
- six organisations provide a professional development budget specifically for each staff member (three as a proportion of their wages, one as a set amount per worker); for each team; or upon application

In the Workers' Survey (n = 156), the majority of workers (71.8%) indicated they had participated in some professional development opportunities offered by their organisation in the last 12 months (this compares to 66.2% in the 2017 survey).

A professional growth scale was included in the Workers' Survey and is reported at 2.15.2. 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; and
- 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 reported out of 5.0 (Table D.16). Keeping skills up-to-date is very important to workers in all organisations—the average score for all organisations was 4.4, with no organisation scoring lower than 4.2. Organisations are perceived to provide good to excellent encouragement and support for professional growth (average score 4.1, with an organisational score range of 3.4 to 4.7). Workers report that they regularly update and improve their skills (average score 4.0).

Scores for each question were higher in the 2021 Workforce Profile compared to the 2017 scores.

Workers were asked if they had experienced challenges or difficulties in accessing sufficient professional development for their work in the AOD sector (n = 167): 77.2% reported no or 'a little' difficulty; 18.6%, 'a moderate amount'; and 4.2% reported 'a lot' or 'a great deal' of difficulty accessing sufficient professional development.

2.11.1 Professional development priorities

Workers were asked to select the training and professional development gaps for themselves and for the ACT AOD sector in relation to particular client groups and particular areas of work practice. The top six training gaps (for themselves and for the ACT AOD sector) in relation to particular client groups were (Table D.17):

- Clients with acquired brain injury
- Forensic AOD clients
- Clients with co/multiple morbidities
- Clients from culturally and linguistically diverse backgrounds
- Older clients
- Clients with gambling problems

The top training gaps for themselves and for the ACT AOD sector combined in relation to particular areas of work practice were (Table D.18):

- Providing clinical supervision to others
- Responding to multiple and complex needs (e.g. dual diagnosis, trauma, family violence)
- Keeping up-to-date on alcohol or other drug issues (e.g. knowledge on AOD trends, treatments, services and policies)
- Clinical skills for counselling
- Specific interventions or therapies (e.g. Cognitive Behavioural Therapy [CBT], motivational interviewing, brief interventions)
- Managing risky behaviours (e.g. aggression, suicide, self-harm)
- Building and maintaining service partnerships
- Advanced clinical skills

Executives in the Organisation Survey were asked to nominate the top training and professional development priorities for staff over the next three years. Their top four items overlapped with those nominated by workers:

- Responding to multiple and complex needs (e.g. dual diagnosis, trauma, family violence) (6)
- Managing risky behaviours (e.g. aggression, suicide, self-harm) (6)
- Clinical skills for counselling (5)
- Specific interventions or therapies (e.g. CBT, motivational interviewing, brief interventions) (5)
- Keeping up-to-date on alcohol or other drug issues (e.g. knowledge on AOD trends, treatments, services and policies) (3)
- Leadership skills (3)

2.11.2 Student placements

Across the ACT AOD sector, organisations offer student placements to more than 73 students per year. Consistent with the types of treatment offered, all 28 placements for Certificate IV AOD students are in non-government specialist AOD services, while the majority of the 20 nursing and medicine student placements are in the government service. Social work and psychology students account for six placements each. New placements that have appeared in the 2021 survey are 'counsellors', and placements through a specific volunteer employment program.

2.11.3 Membership of professional bodies

A majority of survey respondents (104 of 188) specifically indicated that they were not members of any professional bodies, and 11.2% indicated they were a member of an 'other' association or group not listed in the answer options. Respondents who were members of a professional body indicated membership of: Australian Counselling Association (12); Australian Association of Social Workers (11); Nursing and Midwifery Board of Australia (9); Psychotherapy and Counselling Federation of Australia (8); Australian Nursing Federation (8); and Drug and Alcohol Nurses Association Australian (7).

2.12 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 four also providing practice supervision internally.

Workers were asked about the types of supervision they received, the frequency of supervision received, and who provided supervision (someone internal to the organisation, external to the organisation, or both) (Table D.19). Of the 106 people who indicated that they were receiving practice (clinical) supervision, 100 were workers with direct-client-contact. In other words, of the 129 workers with direct-client-contact who responded to the supervision questions, 77.5% (100/129) indicated that they were receiving practice supervision. For those receiving practice supervision, most (62.9%) were receiving it once a month and from someone external to the organisation (62.2%).

Most workers felt that their practice supervision moderately (26.9%), considerably (38.5%) or completely (23.1%) met their needs in terms of quality (n = 104), and 58.7% felt that their needs in terms of quantity of practice supervision were met considerably or completely (n = 104). Twenty-one workers (20.2%) felt that they were not getting enough supervision (responding that their needs were only being 'slightly' or 'not at all' met).

Similar to the previous 2017 Workforce Profile, barriers cited in the Organisation Survey to making AOD practice supervision available to staff were cost and time limitations on staff receiving supervision, but also the limited availability in the ACT of people to provide AOD-specific practice supervision. There is an identified need for suitable external supervision to cater for the specific needs of Peer Workers. Strategies that organisations used to engage and facilitate AOD practice supervision included:

- sourcing private clinicians, either locally or interstate;
- using a mix of face-to-face and online access; and a mix of group and individual supervision;
- engaging external experts under service agreements;

- providing in-house supervision more regularly, with external supervision provided less frequently;
- regular review of staff supervision needs to ensure good matches;
- developing communities of practice;
- utilising previous employees who now have private practices;
- working with other peer-based organisations to source supervision; and
- accessing supervision through the broader organisation (for services that operated in multiple jurisdictions).

2.13 Recruitment and retention

Those completing the Organisation Survey answered a series of questions about recruitment and retention issues in their services. Overall, services indicated that recruiting appropriate staff was challenging, but once hired there were fewer issues retaining staff.

Organisations have used a variety of methods to recruit staff, with the most common methods being: online (nine services); student placements—Certificate IV AOD (seven services) or tertiary (six services); employment agencies (six services); and social media (six services). Print, graduate programs, and secondments were not important methods. Two organisations also nominated 'other', listing 'word of mouth' and 'volunteer program' as important sources of recruitment for their organisations.

Of the most-used methods, the most successful were perceived to be: online (average rating of 4.0/5.0) and student placements—Certificate IV (3.7/5.0) and employment agencies (3.7/5.0), followed by student placements—tertiary (3.3/5.0). Graduate programs (3.0) and social media (3.2) were rated the least effective of these methods. Print is neither widely used, nor perceived as effective in recruitment. Other recruitment methods that had been each used by only one service—word of mouth and volunteer program—had been successful for the service using it.

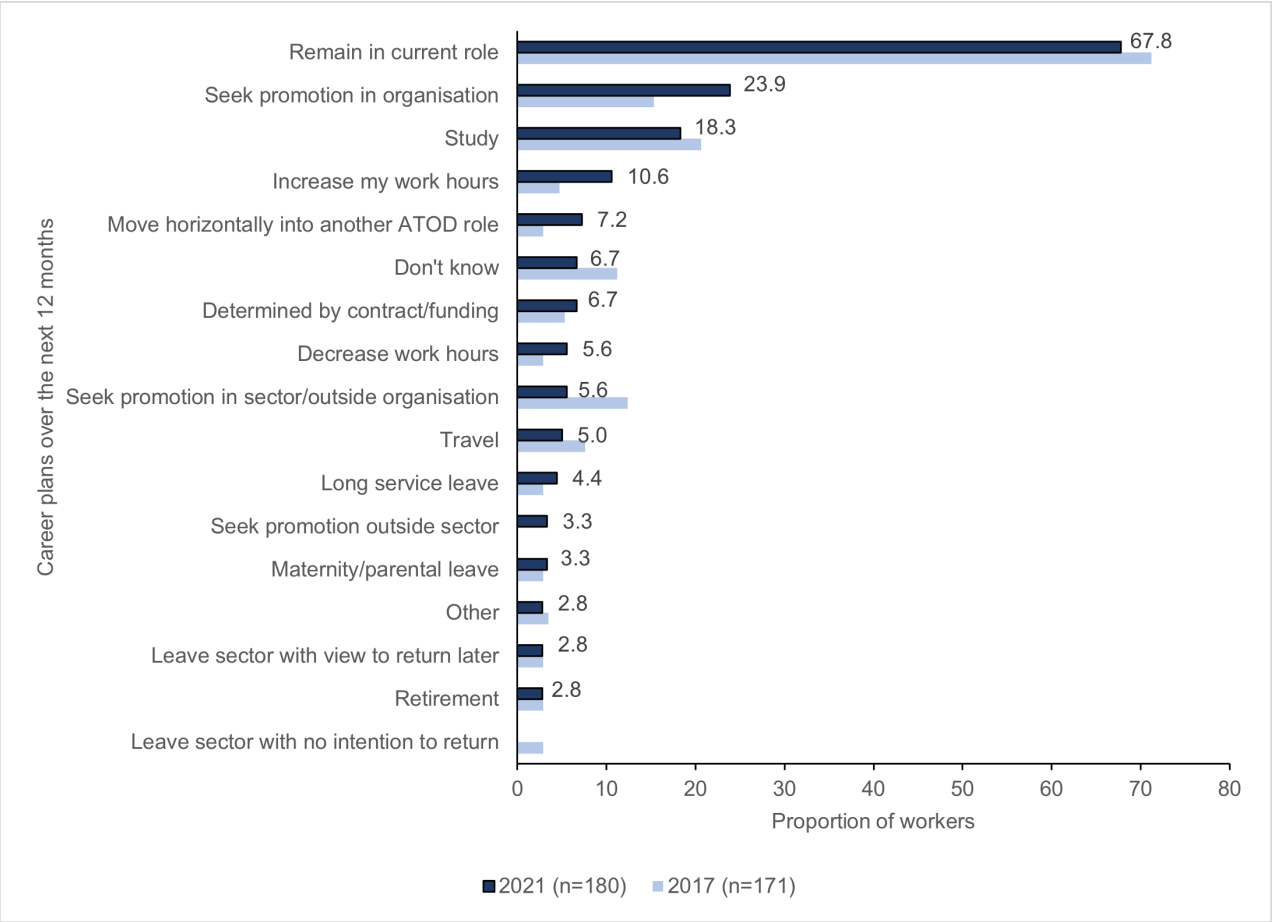
Three organisations have an Indigenous Employment Strategy, with others indicating that they have a specific (unwritten) strategy for increasing the employment of Aboriginal and/or Torres Strait Islander people.

Most organisations found it 'slightly' or 'not at all' challenging to retain staff, with one organisation reporting it to be 'moderately challenging' and one 'very challenging'. When respondents to the Organisation Survey were asked about their impressions of the main reasons for staff leaving, the most frequently cited response was 'high stress/burnout' (four responses), with other responses that appeared more than once being: differences between industrial awards; experience of difficult clients; insecure funding; lack of career opportunities; lack of job security/short-term employment contracts; low salary/poor benefits; and workload.

The reporting in the Organisation Survey that the retention of staff is only slightly or not at all challenging is consistent with the findings of the Workers' Survey. Survey respondents (n = 180) were asked 'What are your career plans over the next 12 months?', with the majority (67.8%) responding that they planned to 'remain in my current role' in the next 12 months (see Figure 19). This is lower than the proportion reported in 2017 (71.2%). Eighteen percent had plans to study in the next 12 months. Forty-eight workers (29.5%) planned to seek promotion opportunities within their organisation and/or within the sector (but outside their organisation).

Figure 19

Survey respondents' career plans over the next 12 months, 2021 (proportion values shown) compared to 2017
Sources: 2021 ACT AOD Workforce Profile—Workers' Survey; 2017 ACT AOD Workforce Profile—Workers' Survey

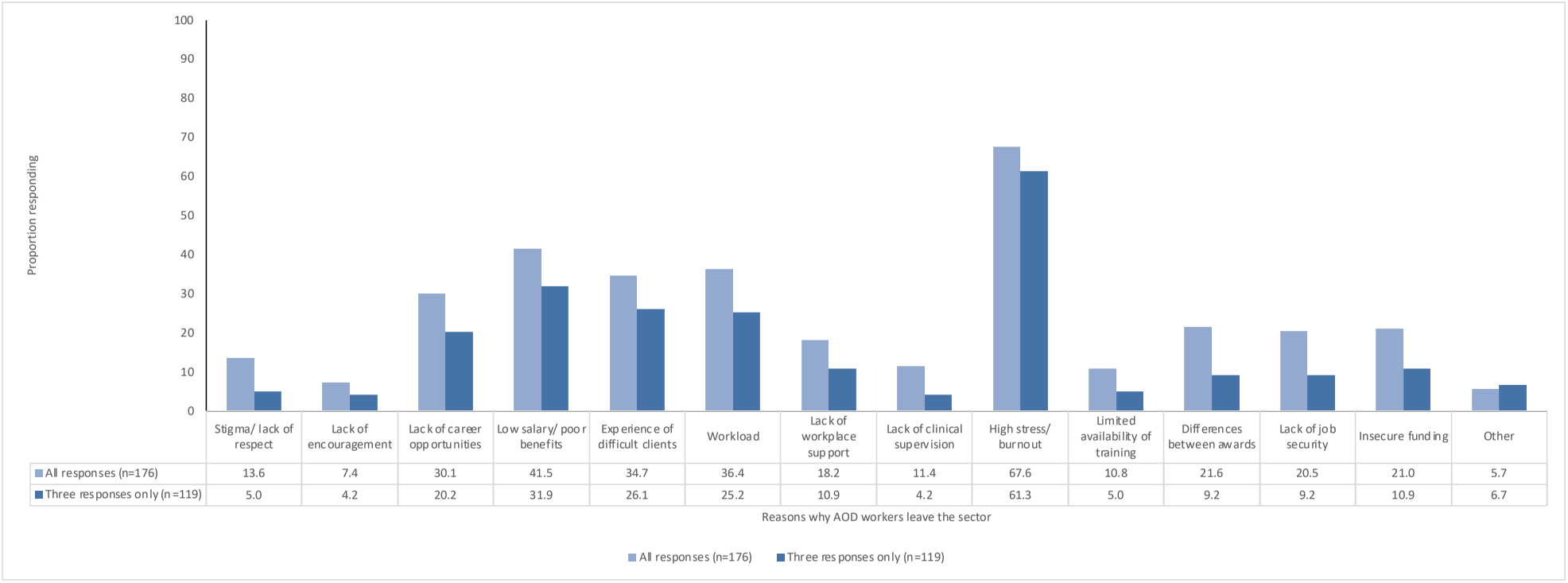


Note: Workers could indicate multiple responses. The number of responses for the 2021 survey (n = 180) does not include those workers (8) who did not progress beyond 30% into the survey, and therefore did not attempt this question. All categories with responses ≤5 have been reported as 2.8% for 2021 responses and 2.9% for 2017 responses. 'Seek promotional opportunities outside the sector' was not an option in 2017. An error on the 2021 online survey meant that the option 'Leave the sector with no intention to return' was excluded as an option. In the 2017 survey, this option recorded a response proportion of ≤2.9%, and so its exclusion would not be expected to greatly affect the relative proportions reported in 2021.

Respondents were asked to select up to three reasons why workers leave the AOD sector. Most workers who answered the question (n = 119) limited their responses to up to three reasons. A further 57 workers answered the question but indicated more than three reasons. The data has been analysed to both include and exclude those workers who gave more than three reasons (n = 176 and n = 119, respectively). Analyses of both sets of data show similar patterns, with the top five reasons given for why workers leave the AOD sectors being: high stress/burnout (over 60% in both analyses); low salary/poor benefits; experience of difficult clients; workload; and lack of career opportunities (see Figure 20).

Figure 20

Reasons why AOD workers leave the sector, 2021, showing proportions for workers who indicated up to three reasons (n = 119) and proportions for all workers who responded (n = 176)
Sources: 2021 ACT AOD Workforce Profile—Workers' Survey



	Stigma/ lack of respect	Lack of encouragement	Lack of career opportunities	Low salary/ poor benefits	Experience of difficult clients	Workload	Lack of workplace support	Lack of clinical supervision	High stress/ burnout	Limited availability of training	Differences between awards	Lack of job security	Insecure funding	Other
All responses (n=176)	13.6	7.4	30.1	41.5	34.7	36.4	18.2	11.4	67.6	10.8	21.6	20.5	21.0	5.7
Three responses only (n=119)	5.0	4.2	20.2	31.9	26.1	25.2	10.9	4.2	61.3	5.0	9.2	9.2	10.9	6.7

2.14 Upcoming challenges for the AOD workforce

Organisations were asked to list the top three challenges for the AOD workforce over the next three years. The responses given have been organised into themes: funding and policy issues; client complexity; and workforce pressures (Box 3).

Box 3

Upcoming challenges for the ACT AOD workforce
Source: 2021 ACT AOD Workforce Profile—Organisation Survey

Funding/policy issues

- Lack of certainty around funding, and related employment insecurity
- Inability to meet growing demand for quality treatment due to inadequate funding
- Low pay rates in the non-government sector
- Pressure on organisations without Equal Remuneration Order support
- Impact of policies, changes in government and priorities
- Ensuring flexibility in service delivery in the COVID-19 environment and into the future
- Increased reporting requirements

Client complexity

- Increasingly complex clients with co-morbid presentations and multiple needs
- Increasing need for integrated care co-ordination between discrete services
- Staff with little experience and knowledge regarding the complexity of the field

Workforce pressures

- Not enough staff
- Lack of appropriate AOD skills and/or qualifications in combination with practice expertise (specific clinical skills, working with particular populations, policy, etc)
- Recruitment of specialist health professionals (including counsellors, psychologists, nurses and addiction medicine specialists)
- Limited numbers of people attracted to working in AOD
- Lack of quality applicants in Canberra; finding people who want to do challenging work
- Managing wellbeing of workforce

2.15 Worker wellbeing measures

The Workers' Survey included validated scales to assess a number of wellbeing measures: overall wellbeing (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 C.3.

This section reports on each individual wellbeing measure. The scores for most scales are reported in relation to the mid-point score of each 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. Burnout scores have been categorised as 'burned out' (score above 5.5) and 'not burned out' (score below 5.5) (see Appendix C.3.3).

2.15.1 Overall wellbeing—physical and psychological health and quality of life

The majority of workers (73.1%) indicated 'better overall wellbeing' (Table D.21). Workers were asked to rate their wellbeing 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'. The mean score for overall wellbeing was 38.4 (the mean of the sums of the three sub-scales); and half of the workers scored their overall wellbeing at 39.5 or more (out of 60.0). The mid-point (or neutral) score for the overall wellbeing scale is 30 (i.e. half way between the minimum score of 0 and maximum score of 60). The average (mean) score (38.4) is above this mid-point (Table D.20—also shows the means [averages], medians and ranges for each of the subscales).

Wellbeing scores in 2021 are similar to those measured in the 2017 survey:

- means of 38.3 (2017) and 38.4 (2021)
- medians of 40.0 (2017) and 39.5 (2021)

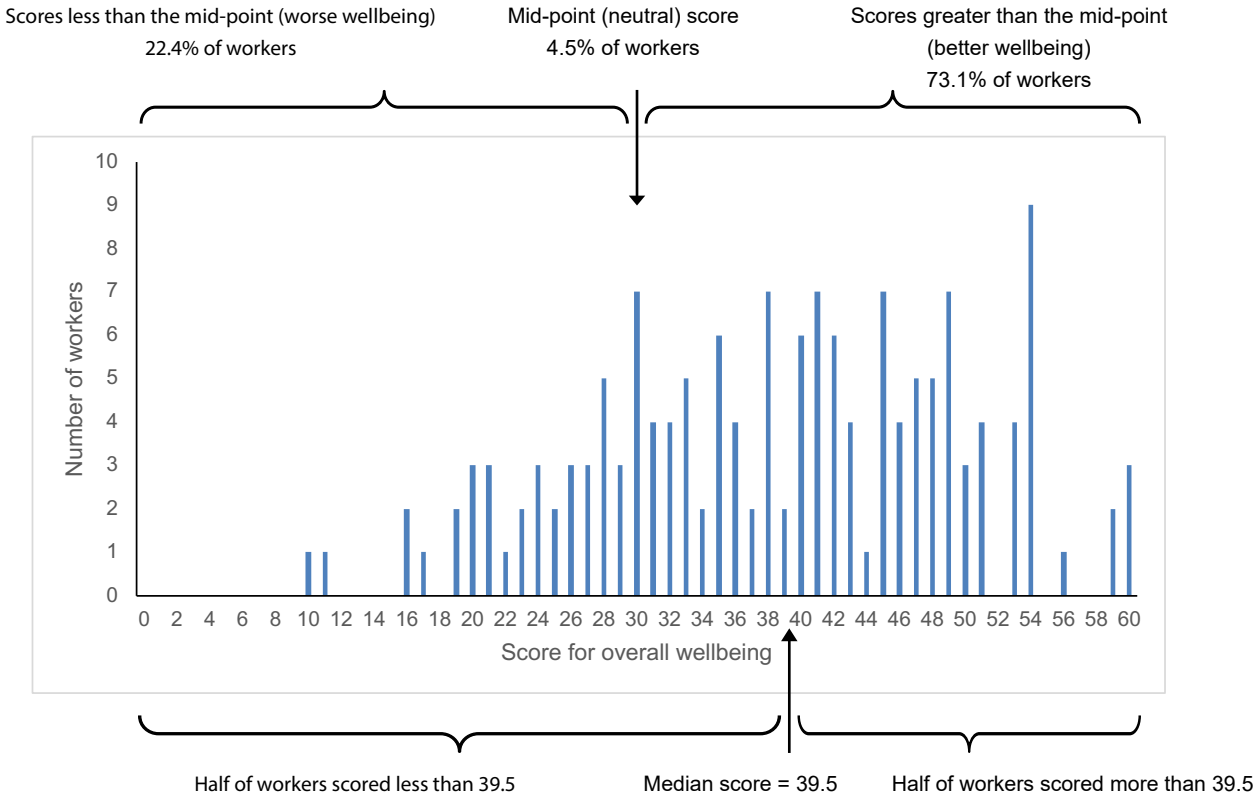
It should be noted that the response rates to these questions were higher in the 2017 survey compared to 2021 (over 97% compared to around 83%), but the reason for this is not clear.

Wellbeing 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 wellbeing and scores less than the mid-point (i.e. <30) indicating worse wellbeing. This is also shown graphically in Figure 21, where a higher proportion of overall wellbeing scores are spread above the mid-point of 30.

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 wellbeing sub-scale, over half of workers indicated 'better wellbeing' (i.e. scoring above the mid-point)—63.1%, 58.3% and 71.3% for the psychological health, physical health and quality of life scales respectively (Table D.21). Physical health was lower than the other subscales for all measures of mean and median, and in comparison to the neutral mid-point. The observed proportions were similar between 2017 and 2021 (for example for overall wellbeing, 71.9% reported better overall wellbeing in 2017, compared to 73.1% in 2021).

Figure 21

Frequencies of scores for the overall wellbeing scale showing the spread of scores in relation to the mid-point score (30) and median score (39.5), n = 156
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.15.2 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) (Appendix C.3.2). This section also reports on two questions related to staffing. These questions come from a validated staffing scale (see Appendix C.3.5), but as they are two isolated questions, they must be considered independently.

The job satisfaction and professional growth scores were measured on a scale of 10 to 50, with a 'neutral' mid-point of 30. Respondents to the 2021 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 D.22).

Figures 22 and 23 show the spread of scores in relation to the neutral mid-point score of 30, and the spread according to whether they can be categorised as 'less than neutral' (i.e. < 30) or 'greater than neutral' (i.e. > 30).

- Figure 22 shows 90.4% of workers reporting scores greater than 30 (neutral mid-point), reflecting greater job satisfaction;
- Figure 23 shows 89.8% of workers reporting scores greater than 30 (neutral mid-point), reflecting greater opportunities for professional growth (Table D.22).

Job satisfaction and professional growth scores were slightly higher in 2021 compared to those in 2017, although not significantly different. Means for job satisfaction were 40.2 (2017) compared to 41.6 (2021); and means for professional growth were 38.7 (2017) compared to 40.1 (2021).

Figure 22

Number of workers reporting each score on the job satisfaction scale (TCU-ORC) and the spread relative to the mid-point (neutral) score of 30 (n = 157)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

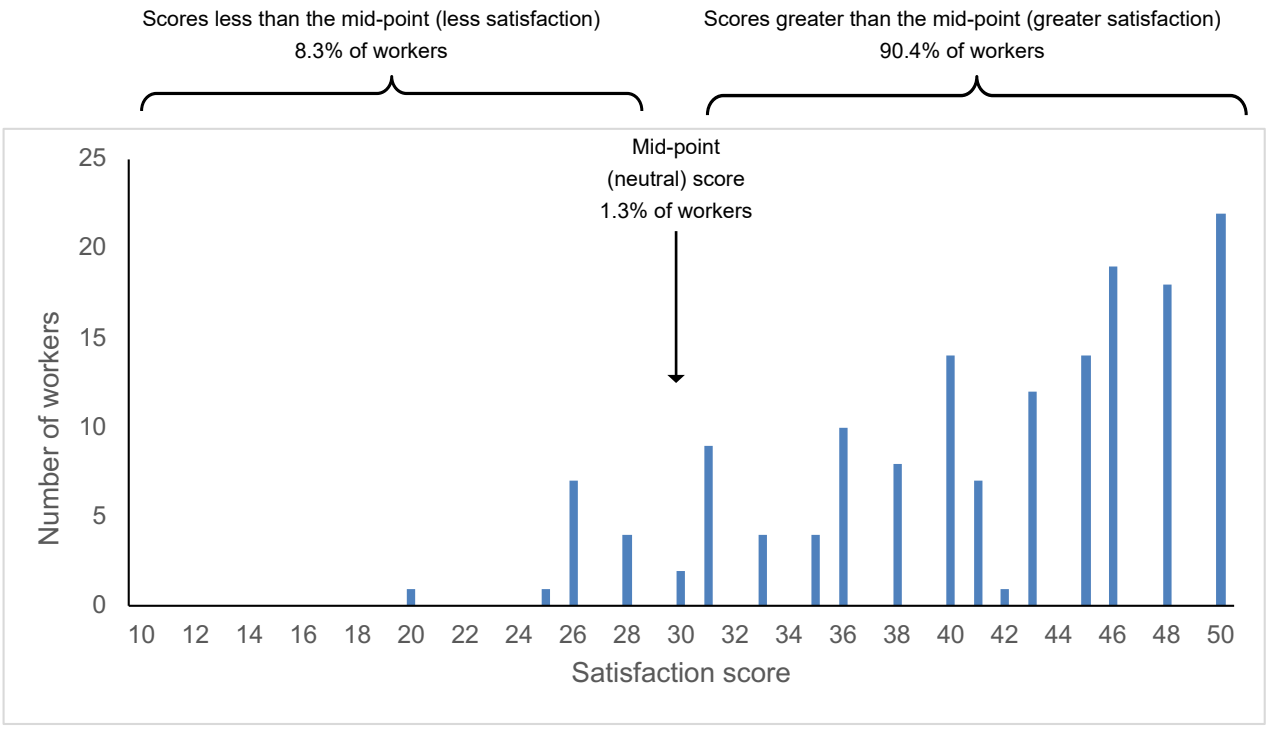
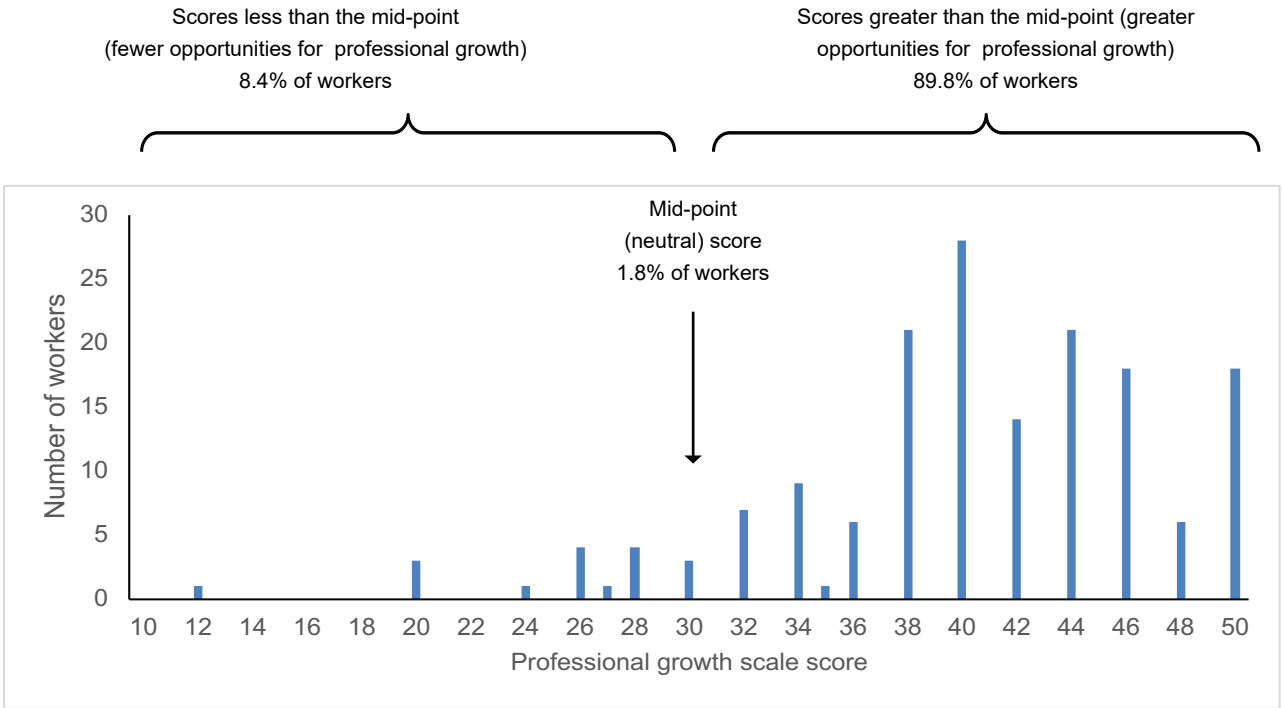


Figure 23

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 = 166)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

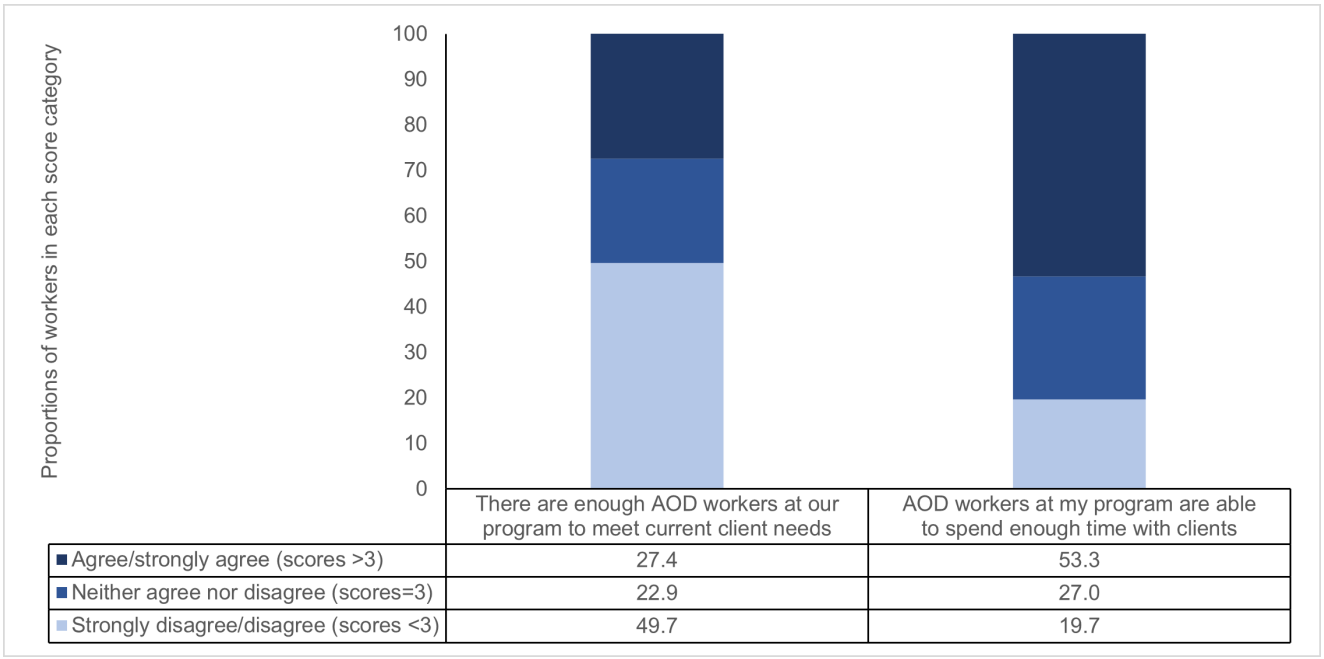


Workers were asked to rate two statements about staffing levels on a scale of 1 (‘strongly disagree’) to 5 (‘strongly agree’). Despite feeling that staffing levels are not sufficient to meet current client needs, most respondents felt that workers at their program were able to spend enough time with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

- Workers scored the statement, ‘There are enough AOD workers at our program to meet current client needs’, an average of 2.6 (out of 5.0). Figure 24 shows that almost half of workers (49.7%) ‘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 24 shows that 53.3% ‘agreed’ or ‘strongly agreed’ with this statement.

Figure 24

Levels of agreement by workers on two questions about staffing
Source: 2021 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)	27.4	53.3
Neither agree nor disagree (scores=3)	22.9	27.0
Strongly disagree/disagree (scores <3)	49.7	19.7

2.15.3 Stress and burnout

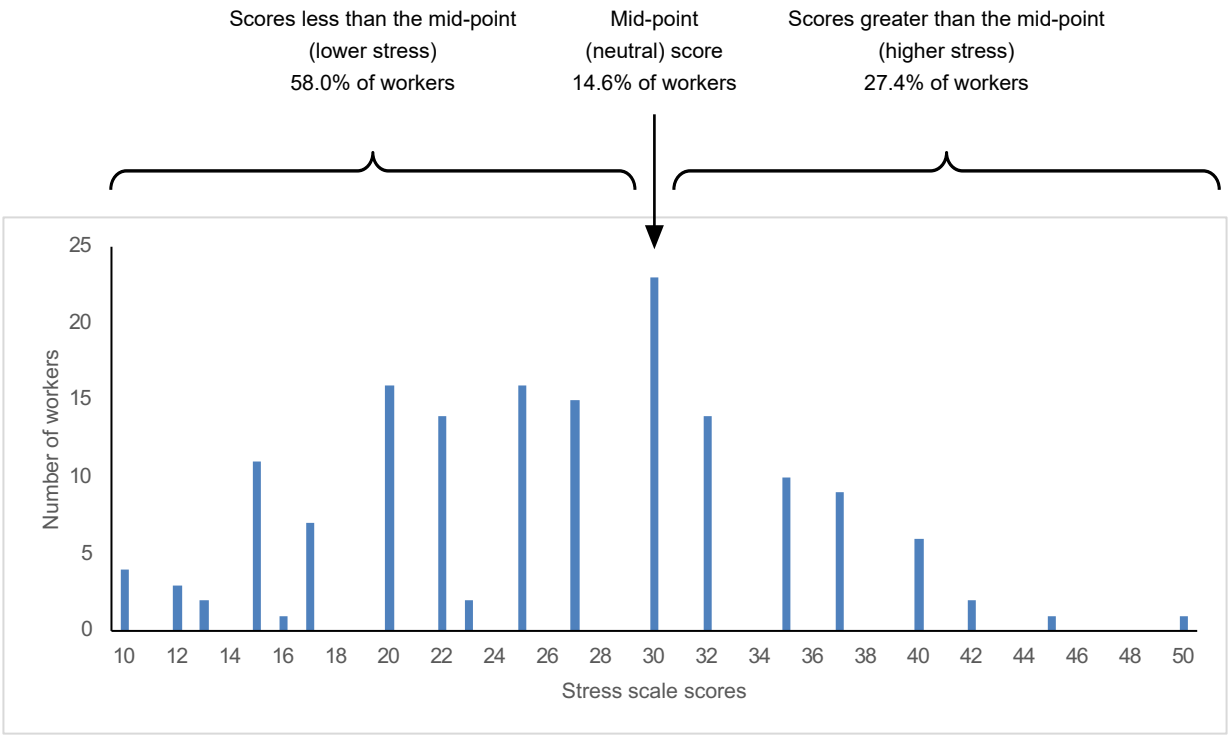
This section reports on the scores for stress and burnout. For a description of the scales used, and how these are calculated and interpreted, please see Appendices C.3.2 and C.3.3. The stress scores were measured on a scale of 10 to 50, with a 'neutral' mid-point of 30; scores above 30 indicate greater stress.

Respondents of the ACT AOD Workforce Profile reported moderate levels of stress. The mean score (26.5) is below the neutral mid-point of 30 (Table D.23).

Figure 25 shows the spread of the stress scores in relation to the neutral mid-point (30). A lower proportion of workers reported higher stress (i.e. scores greater than 30) than lower stress (i.e. scores less than 30)—27.4% and 58.0% respectively.

Figure 25

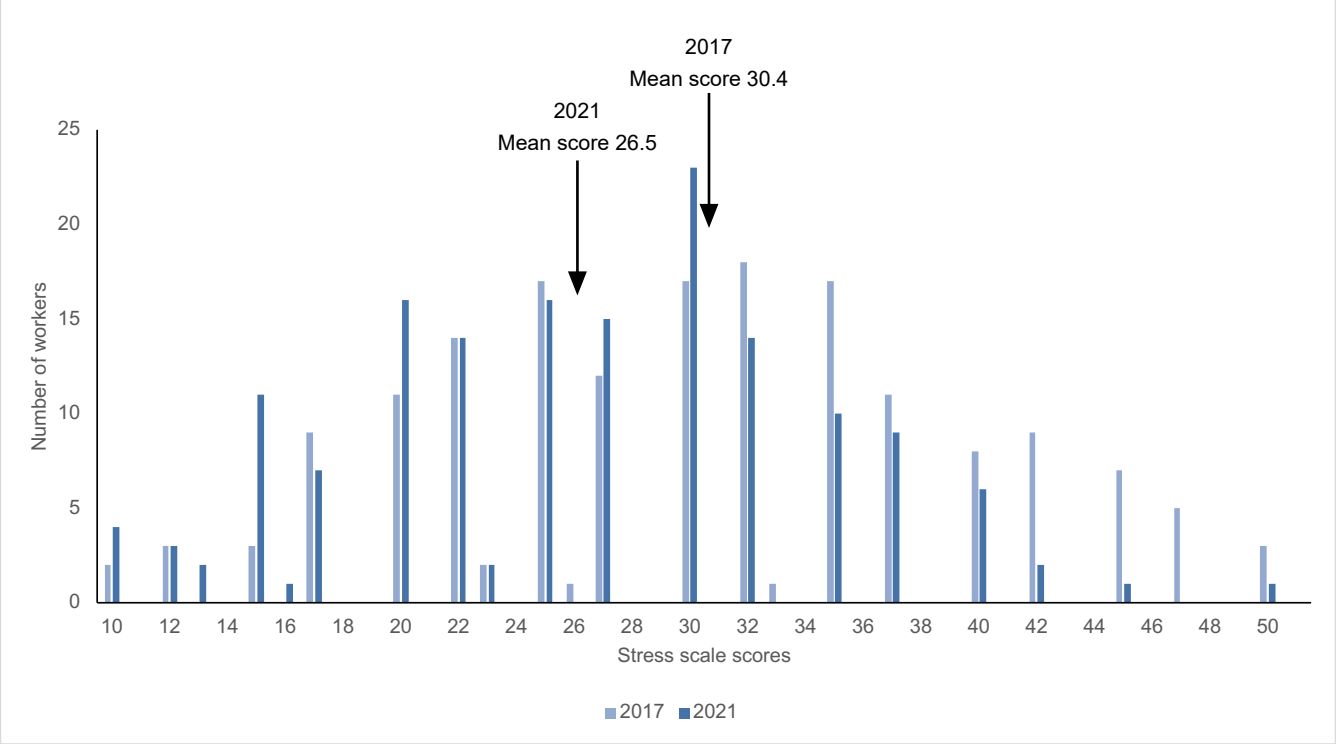
Number of workers reporting each score on the stress scale (from the TCU-ORC) and the spread relative to the mid-point (neutral) score of 30 (n = 157)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



There was a significant difference observed between the stress scores measured in 2017 and 2021. Figure 26 shows that the scores in 2021 are shifted further towards the left of the figure, indicating lower stress scores in 2021. When comparing the means, this difference is significant (i.e. not due to chance) (2021: Md = 27.5, n = 157; 2017: Md = 30.0, n = 171; U = 10261.5, z = -3.698, p<.001).

Figure 26

Comparison of stress scores between 2017 (n = 170) and 2021 (n = 157)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey; 2017 ACT AOD Workforce Profile—Workers' Survey



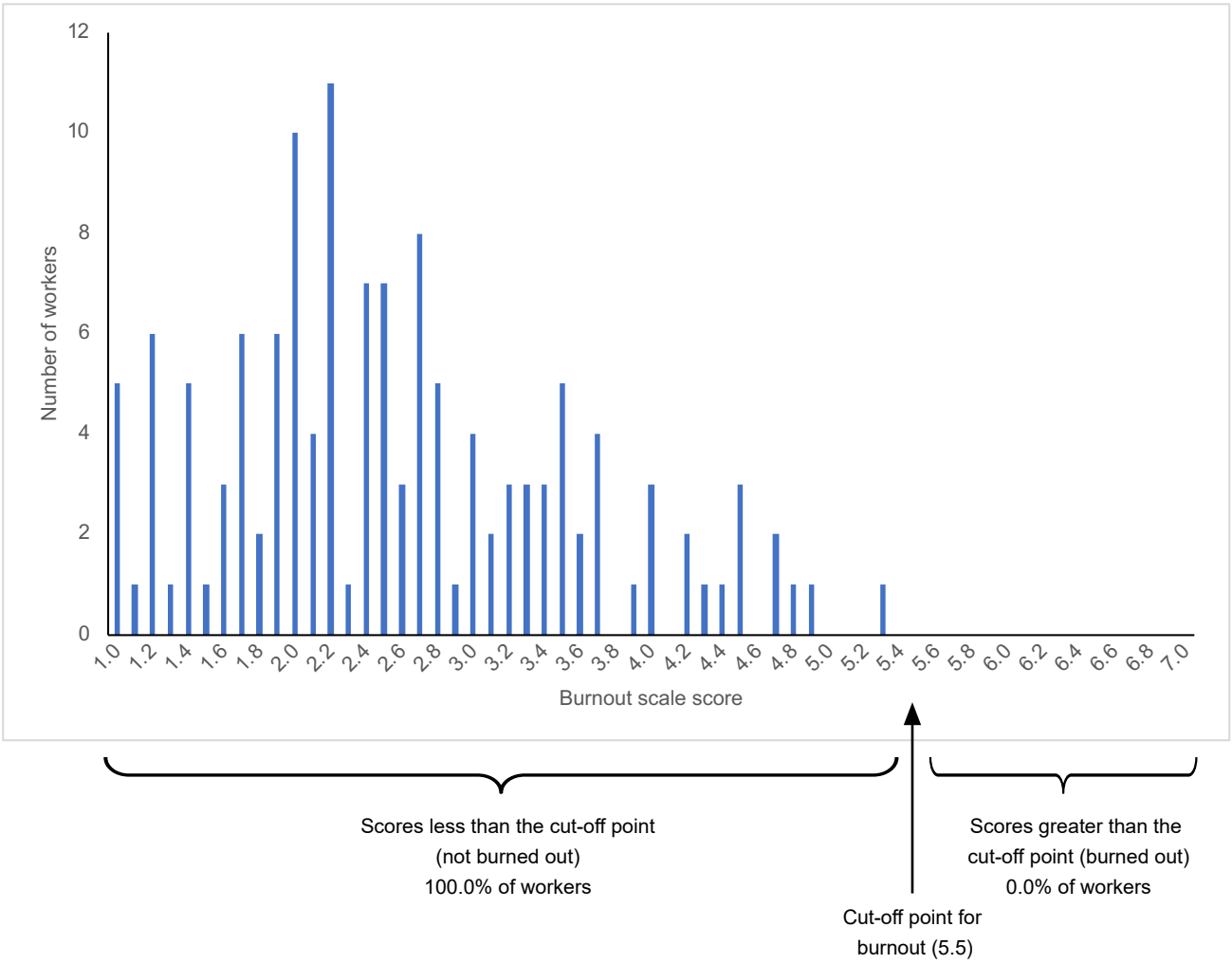
Burnout was measured using a 14-item measure (Shirom-Melamed Burnout Measure—SMBM) on a scale from 1 (almost never experiencing particular feelings) to 7 (almost always experiencing particular feelings). Workers could be categorised as burned out if they scored at least 5.5 on the scale; this cut-off 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"[20] (for more details, see Appendix C.3.3). 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 D.24).

As seen in Figure 27, the spread of burnout scores is distributed to the left of the graph (i.e. towards low burnout). When the scores are categorised according to whether they are burned out (score at least 5.5) or not, no scores can be classified as being burned out (i.e. experiencing symptoms of burnout more than 'quite frequently'). The difference in overall burnout between the two years of the survey was not significant (2021: Md = 2.43, n = 135; 2017: Md = 2.57, n = 171; U = 10883, z = -.858, p = .391).

Figure 27

Distribution of scores for the burnout scale (SMBM) between 1.0 and 7.0, showing the cut-off point for burnout (5.5) (n = 135)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.15.4 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:

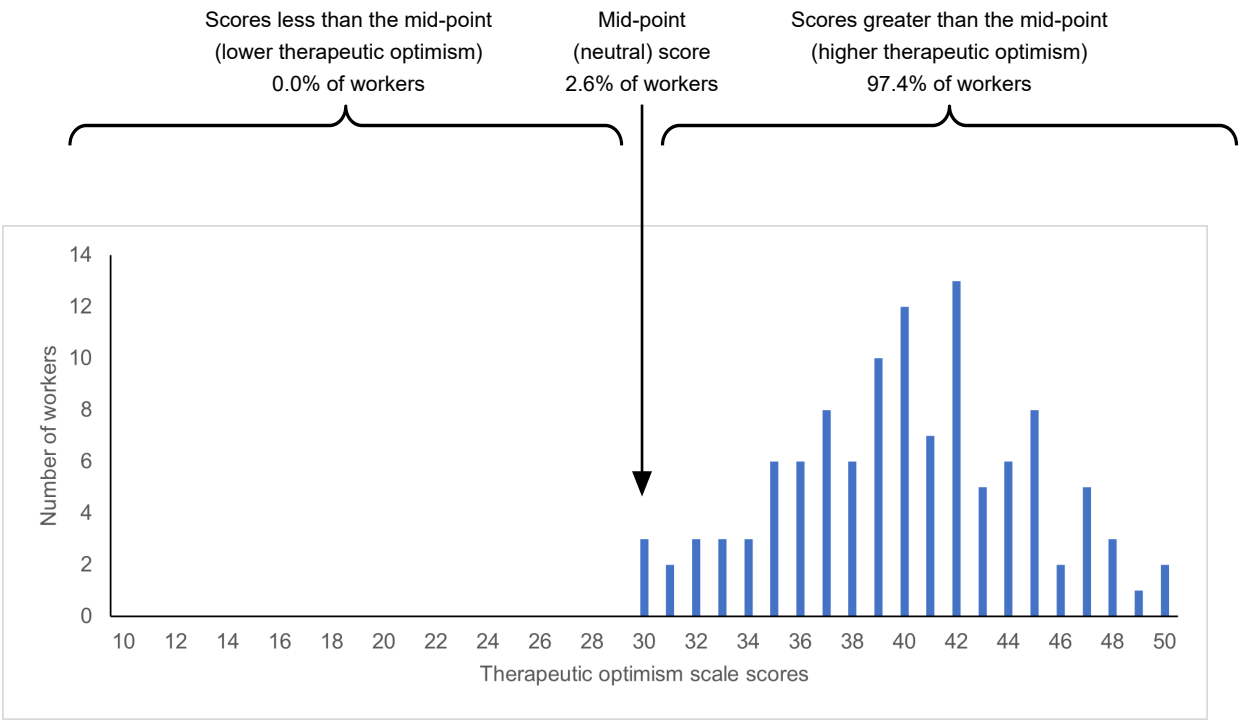
- General treatment outcome expectancy—clinicians' perception of how well treatment will work out for their clients; includes 5 items, and generates a score between 5 and 25;
- Personal treatment outcome expectancy—clinicians' confidence that they can help the client to achieve positive outcomes; includes 3 items, and generates a score between 5 and 15; and
- 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 both the mean score and the median score in this workforce profile are above this mid-point (Table D.25).

Figure 28 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 (97.4%) of workers with direct-client-contact indicated a therapeutic optimism greater than neutral (i.e. > 30). This shows that the clear majority of workers felt that they could impact on the outcomes of their clients. There was no significant difference observed between the therapeutic optimism scores measured in 2017 and 2021.

Figure 28

Number of workers reporting each score on the Therapeutic Optimism Scale and the spread relative to the mid-point (neutral) score on 30 (n = 114)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



2.15.5 Association between wellbeing measures and job roles

While the statistical significance could not be assessed due to small numbers in some job role categories, an analysis of relationships between job role and various wellbeing measures found that there were observable differences among some job role categories.

For the overall wellbeing score (the sum of psychological wellbeing, physical wellbeing and quality of life), executives reported the highest average score (47.3), followed by nurses/nurse practitioners (39.6), counsellors (38.9), and AOD Workers (38.7) (Figure 29). All average wellbeing scores across all job roles are above the mid-point (neutral) score of 30 (indicating better overall wellbeing on average).

Similarly, there were observable differences in scores for job satisfaction, professional growth, stress, and burnout among job roles (Figures 30 and 31). Average job satisfaction was highest among executives and managers, while average professional growth scored highest among counsellors, executives and 'other clinical roles'. All job satisfaction and professional growth average scores were above the 'neutral' mid-point of 30 (Figure 30).

Average stress scores were highest among workers with 'Other clinical roles'—this category includes 'general practitioner', 'addiction medicine specialist', 'other medical practitioner', 'other psychologist', 'social worker', and 'other role clinical'. In contrast to the 2017 Workforce Profile, there were no job categories that reported average stress scores above the mid-point of 30 (Figure 30). There was not a notable difference in burnout scores among the different job categories. Burnout was low for all job categories and well below the cut-off point for burnout of 5.5 (Figure 31).

Figure 29

Average wellbeing scores (out of 60) for each job role
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

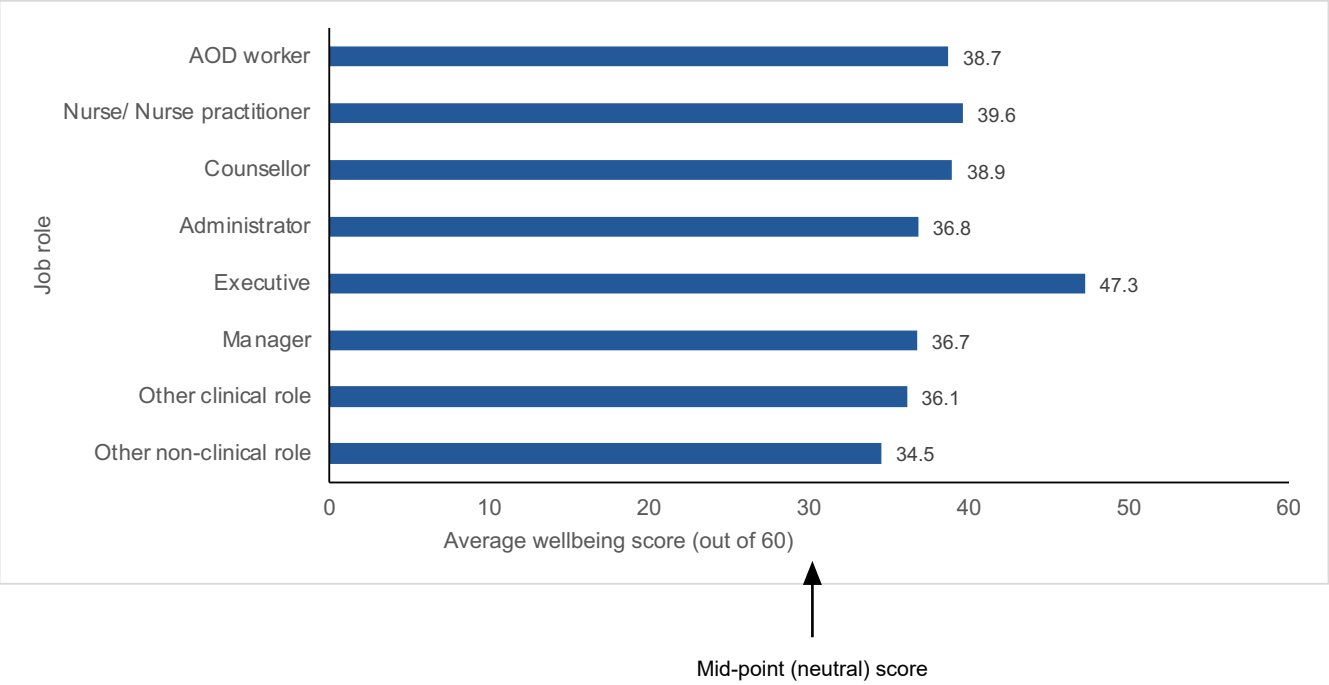
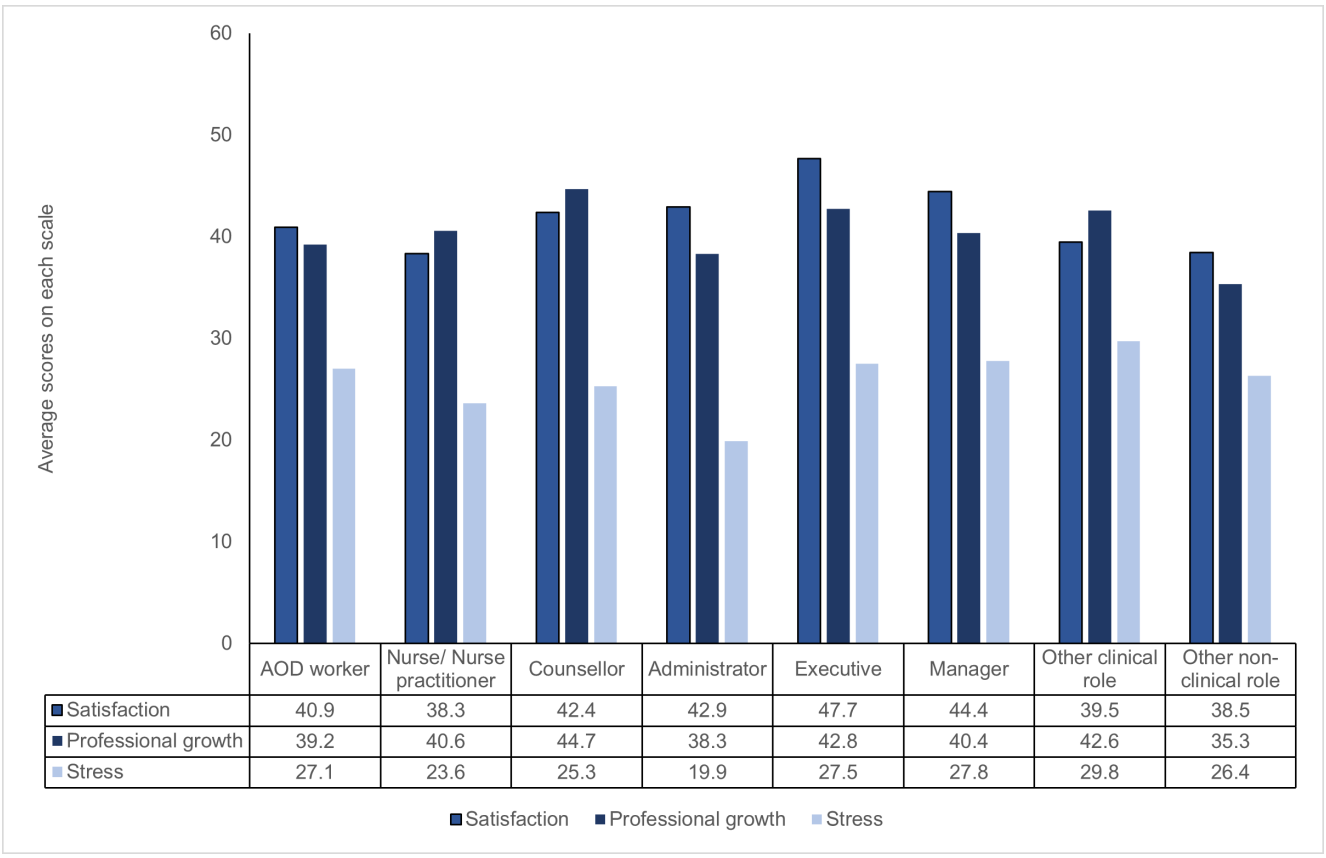


Figure 30

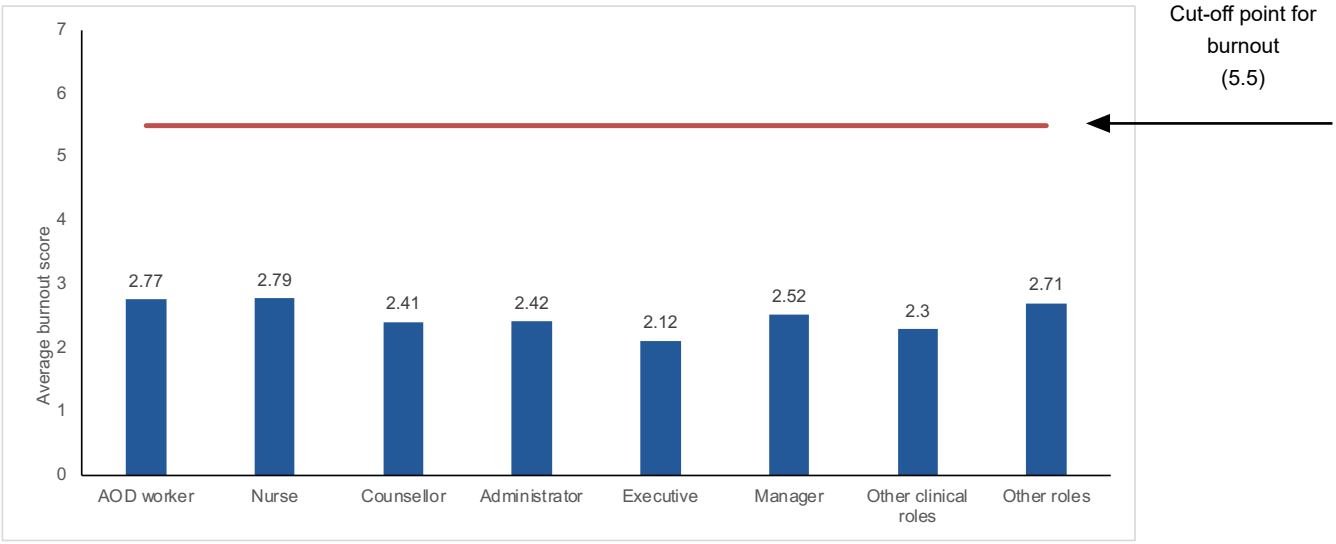
Average scores for job satisfaction, professional growth and stress across job roles
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



	AOD worker	Nurse/ Nurse practitioner	Counsellor	Administrator	Executive	Manager	Other clinical role	Other non-clinical role
Satisfaction	40.9	38.3	42.4	42.9	47.7	44.4	39.5	38.5
Professional growth	39.2	40.6	44.7	38.3	42.8	40.4	42.6	35.3
Stress	27.1	23.6	25.3	19.9	27.5	27.8	29.8	26.4

Figure 31

Average scores for the burnout scale (SMBM) for each job role compared to the cut-off point for burnout (5.5)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

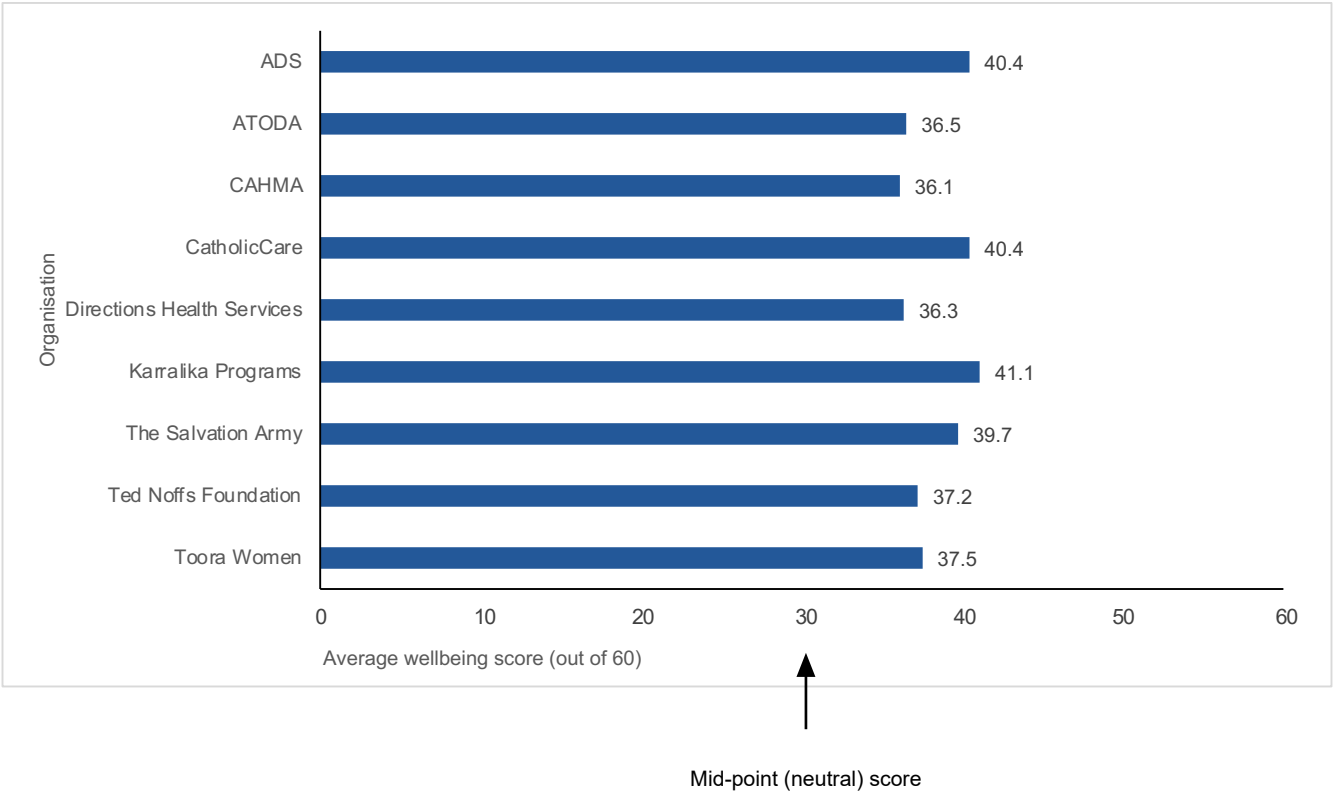


2.15.6 Association between wellbeing measures and organisation

The differences in average wellbeing scores between organisations are not statistically significant (Figure 32), and all are above the mid-point (neutral) score of 30. Workers at Karralika, CatholicCare and ADS reported the highest average wellbeing scores (41.1, 40.4 and 40.4 respectively).

Figure 32

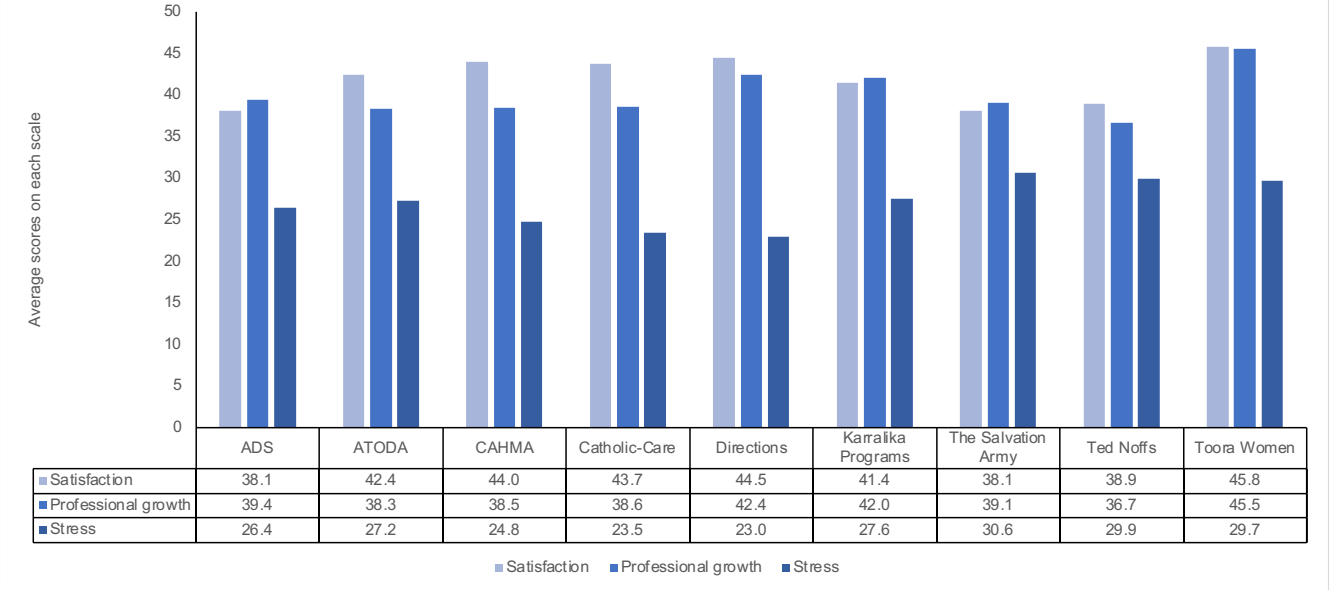
Average wellbeing scores (out of 60) for each organisation
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Similarly, while there were some differences in scores for job satisfaction, professional growth and stress across organisations, these differences were not statistically significant (Figure 33). Job satisfaction was highest at Toora Women, Directions Health Services and CAHMA, but other organisations scored close to these, and all organisations scored well above the neutral mid-point of 30.

Figure 33

Average scores for job satisfaction, professional growth and stress across organisations
Source: 2021 ACT AOD Workforce Profile—Workers' Survey

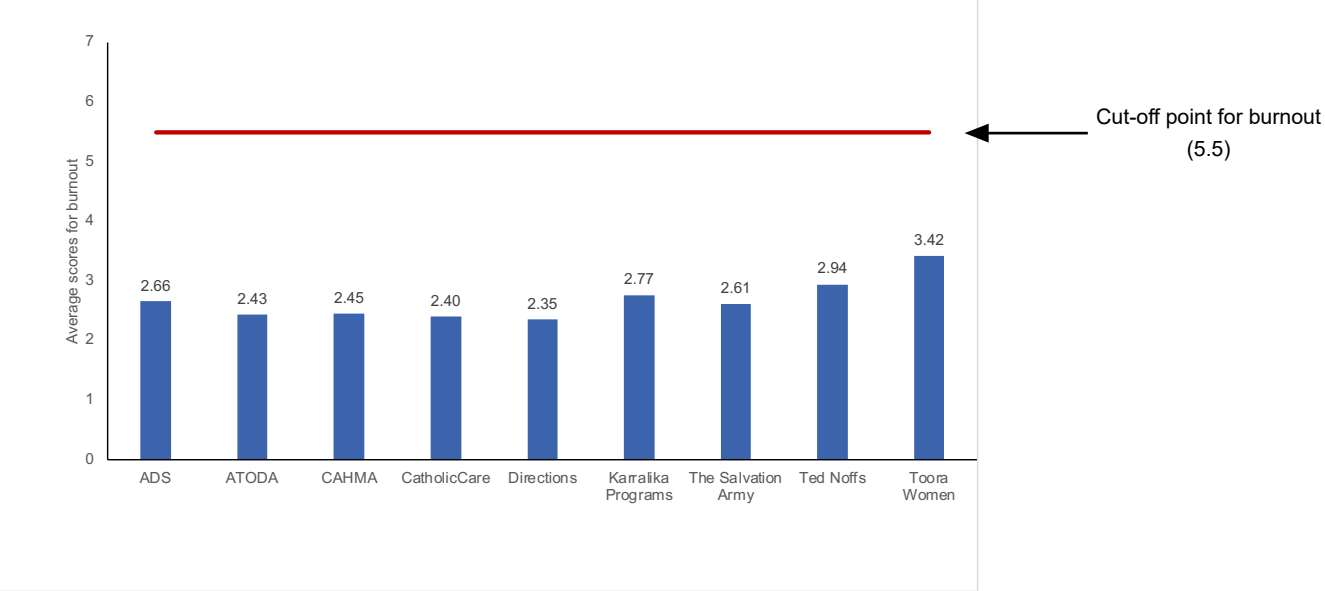


	ADS	ATODA	CAHMA	Catholic-Care	Directions	Karralika Programs	The Salvation Army	Ted Noffs	Toora Women
Satisfaction	38.1	42.4	44.0	43.7	44.5	41.4	38.1	38.9	45.8
Professional growth	39.4	38.3	38.5	38.6	42.4	42.0	39.1	36.7	45.5
Stress	26.4	27.2	24.8	23.5	23.0	27.6	30.6	29.9	29.7

As seen in Figure 34, 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.

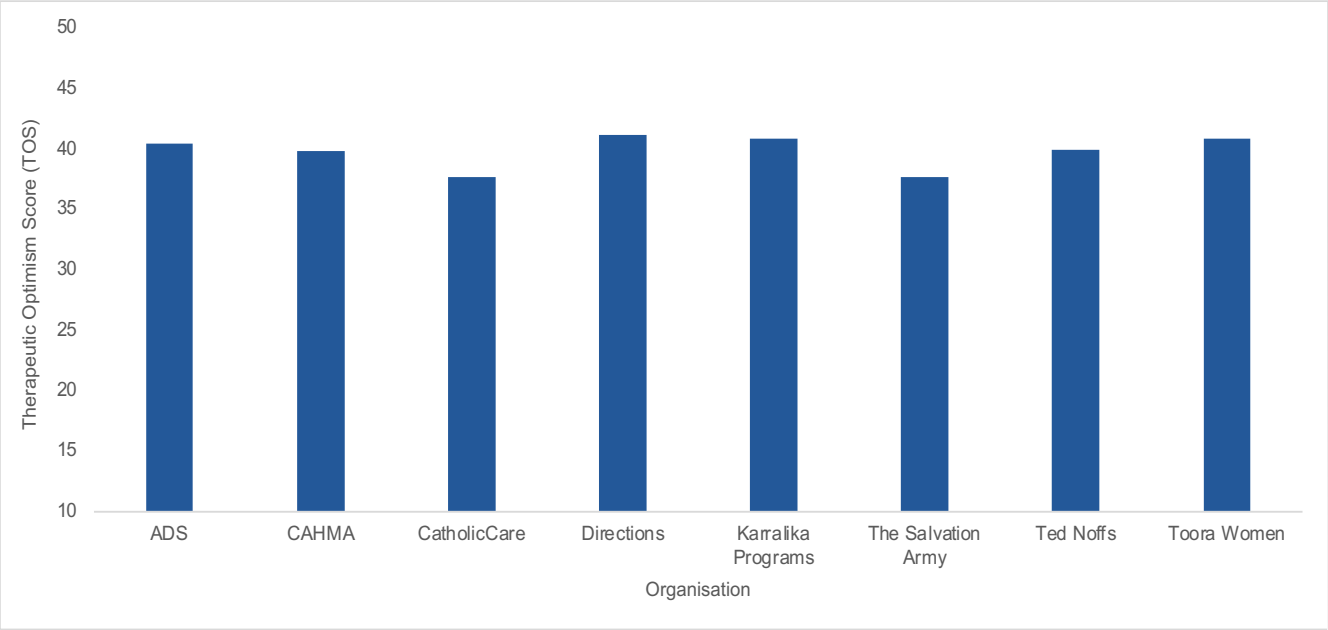
Figure 34

Average scores for the burnout scale (SMBM) for each organisation compared to the cut-off point for burnout (5.5)
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Therapeutic optimism was high and did not differ significantly across organisations (Figure 35).

Figure 35
Average scores for therapeutic optimism by organisation for workers with direct-client-contact
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



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

2.15.7 Supporting wellbeing

EOs/managers completing the Organisation Survey were asked to identify what their organisation currently provides to support the wellbeing 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):

- Access to subsidised smoking cessation supports (5)
- Access to work computers (e.g. dedicated room or laptops) (5)
- Diversified caseloads (4)
- Staff social club (3)
- Health screening (1)
- Health treatment (1)
- Health/fitness lunch-time or subsidised activities (1)
- Annual wellbeing initiative (1)
- Self care policy and allowance (1)

When asked what other wellbeing activities or strategies they would like to make available to their workers, EOs/managers made the following responses:

- Working from home
- More clinical supervision
- Continuation of wellbeing program (i.e. mindfulness, group personal training sessions) established during COVID-19 pandemic
- Employee Assistance Program with a wellbeing model that is holistic, with a broader range of support services across the mental health continuum, and with more flexible accessibility options

Notably these include options that have been raised in importance since the COVID-19 pandemic and response (e.g. working from home, and wellbeing programs implemented in response to COVID-19).

Respondents to the Workers' Survey were asked to identify what kinds of supports they could access through the workplace if needed. Of the 188 respondents, 39 (20.7%) did not identify any forms of support. The most frequently identified form of support was 'support from peers and colleagues' (126 responses), followed by

'regular debriefs with a suitable colleague' (111 responses) (Table D.26).

Respondents were asked to nominate what supports (if any) they would like to access through the workplace that weren't available at the time of the survey. Thirty-nine respondents from eight organisations provided answers. After discarding "none" (and its equivalent) and "n/a", there were 26 valid responses. In total, 27 suggestions for additional workplace supports were made (two respondents made two suggestions each and one respondent stated that they "don't know what is available").

Two answers were noteworthy for the frequency with which they appeared: desire for a wellness/chillout room and exercise-based support (or similar). It is worth noting that Question 60 asked respondents to pick from a list of currently available supports, amongst which was included 'wellness/chillout room' (30 responses, across seven organisations). As such, respondents were perhaps already primed to provide this answer. There was no prior mention of exercise-based support. There were six mentions of the need for wellness/chillout rooms, from four organisations. There were also six answers, from three organisations, that referenced exercise (or similar) support. There was a clear gender divide, with a split between yoga, meditation and massage (female respondents) and fitness programs/gyms (male or gender unspecified respondents). Five answers, from three organisations, called for improved supervision and training. In one instance, this was a call for very specific training in provision of medication. Four answers from three organisations suggested a need for improved peer support or managerial support systems. Two respondents proposed the need for better access to mental wellbeing supports.

2.16 Impact of bushfires and the COVID-19 pandemic

At the suggestion of workers and executives, the 2021 Workforce Profile included several questions about the impact of the bushfires and the COVID-19 pandemic on the AOD workforce.

2.16.1 Impact of the 2019/2020 bushfires

The ACT and south coast of NSW were greatly impacted by bushfires and heavy smoke during December 2019 and January 2020, in particular. The survey included open-ended questions asking workers to comment about how these bushfires and smoke had impacted on their general health and wellbeing, their health and wellbeing at work, and on their work practice. While twenty-nine workers specifically indicated that they had not felt much impact from the bushfires, sixty-four workers provided comments on their experiences. These included:

- impacts of the smoke on people's physical health (particularly for asthmatics, and others with underlying health conditions);
- mental health (self, family, friends, clients and wider community);
- concerns about climate change; and
- community connection.

Not surprisingly, the majority of these responses related to the impacts of the smoke on people's physical health (particularly for asthmatics, and others with underlying health conditions), and on their mental health. Workers identified high rates of anxiety centred on themselves, their families and friends, people accessing their services, other staff, and for the community more generally. Some workers expressed feelings of depression, isolation, stress, trauma and helplessness. This included feeling anxious and helpless about the impact of the destruction from the fires, and the broader and longer-term impact of climate change. Despite the reported negative effects, several workers commented on feeling supported by their workplace, colleagues and the community more generally during this time.

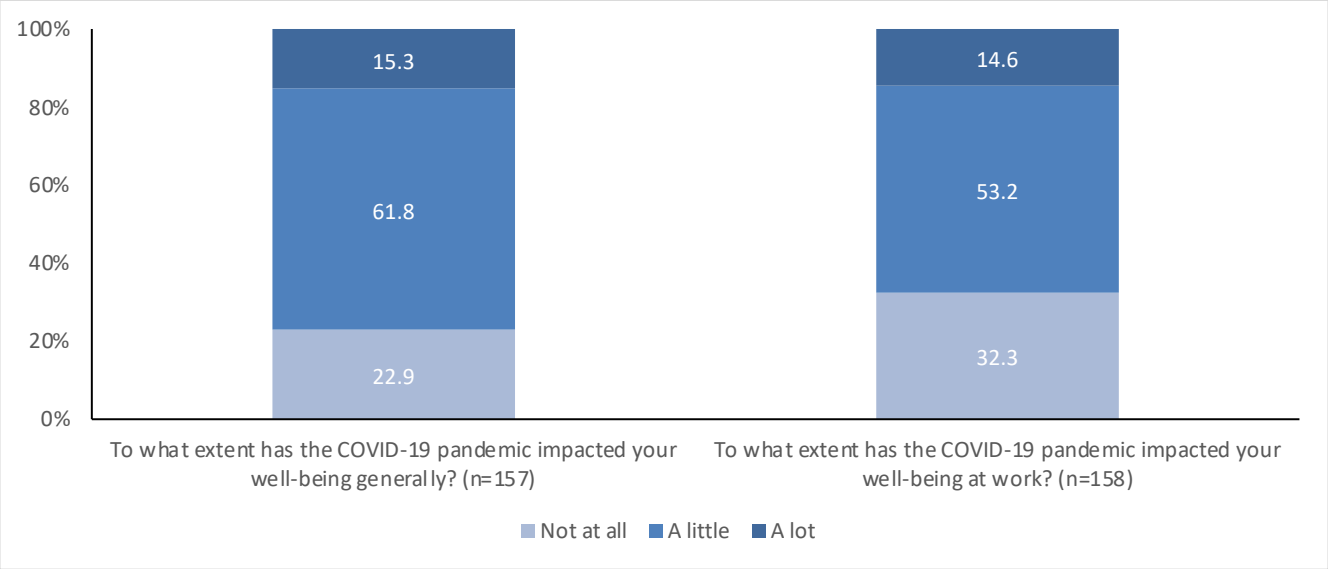
2.16.2 Impact of the COVID-19 pandemic

A number of questions related specifically to the experience of workers during the COVID-19 pandemic over the 12–18 months prior to the implementation of the Workforce Profile.

Most workers categorised the level of impact of the COVID-19 on their wellbeing both generally and at work as 'not at all' or 'a little' (Figure 36)

Figure 36

Level of impact of the COVID-19 pandemic on the wellbeing (generally and at work) of the AOD workforce
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Workers indicated that the pandemic had mostly led to a decrease in client numbers, and about equal proportions of workers felt that it had led to an increase or 'no change' in client complexity. About three-quarters felt that there had been no change to the amount of their work hours (Table D.27).

Working from home was not an option for about one-third (36.7%) of workers (n = 147). Of the 93 workers who indicated it was an option for them, most reported that the experience was neutral (neither 'good' nor 'not good' 41.9%) or 'was good for me' (38.7%). About one-in-five workers (19.4%) reported that the experience of working from home 'was not good for me'. Of workers who had used telehealth for their work (n = 79), more than half found it beneficial to their work (54.4%) and 15.2% found it detrimental to their work.

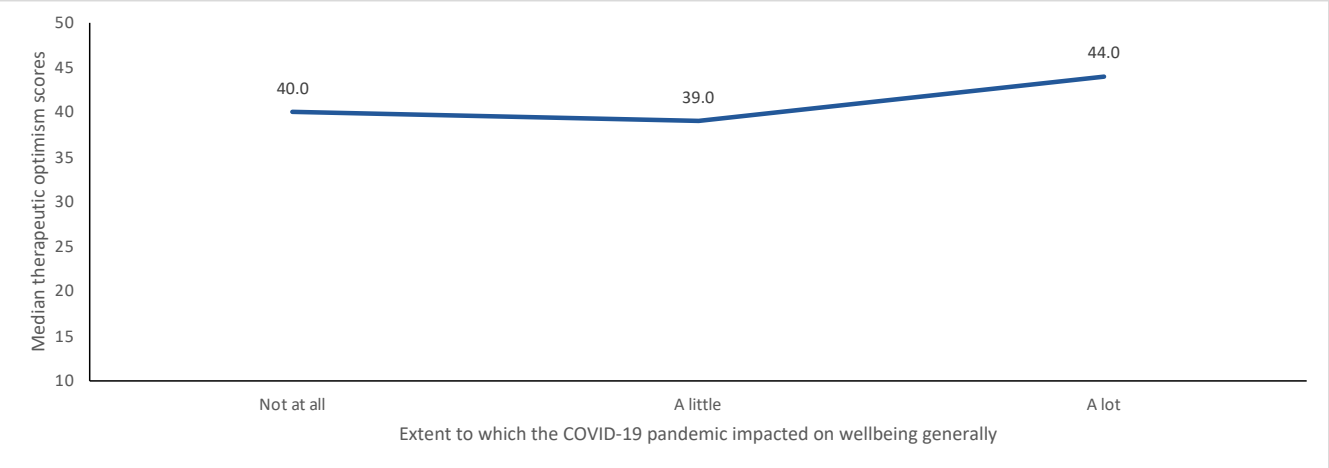
Small differences were found between the extent that workers felt the COVID-19 pandemic had impacted on their wellbeing generally and other wellbeing indicators. In general, workers who reported 'a lot' of impact from the COVID-19 pandemic had lower (worse) overall wellbeing and job satisfaction scores, and higher (worse) stress and overall burnout scores. However, none of these differences were significant.

A significant difference was noted in the therapeutic outcomes scale among workers reporting different levels of impact of the COVID-19 pandemic on their wellbeing generally (Figure 37) (x^2 (2, n = 113) = 13.61, p = .001). However, the differences did not occur in a linear relationship.

A significant difference was observed between workers reporting 'a little' impact from the COVID-19 pandemic on their general wellbeing and those reporting 'a lot' of impact. Those reporting 'a lot' of impact from the COVID-19 pandemic reported significantly higher therapeutic optimism than those reporting 'a little' impact. They also reported higher (but not significantly different) therapeutic optimism than those reporting 'no impact' from the COVID-19 pandemic on their general wellbeing ('A little' impact: Md = 39.0, n = 70; 'A lot' of impact: Md = 44.0, n = 17).

Figure 37

Median scores for therapeutic optimism for workers in ACT AOD services versus their perceived level of impact of the COVID-19 pandemic on their wellbeing generally
Source: 2021 ACT AOD Workforce Profile—Workers' Survey



Workers were asked open-ended questions to nominate what their organisations had done well, and not so well to support their work during the COVID-19 pandemic. Ninety-nine workers provided specific comments on what their organisations had done well, the most frequently cited of which were:

- Responsiveness;
- Flexibility;
- Continuity;
- Communication and connection; and
- Health and wellbeing initiatives.

Participants commented that their organisations had responded quickly and effectively to the situation, including quickly developing policies and procedures, and providing mechanisms for staff to contribute to these. Service provision was continued under difficult circumstances, and organisations changed and adapted services to meet client needs (e.g. moving to online service delivery).

Organisational flexibility was appreciated both in terms of maintaining services and responding to clients, and flexibility in responding to the needs of workers. Staff were kept in paid work through flexible work arrangements and paying casuals even when hours were reduced. Organisations enabled staff to work from home and provided information technology support.

Workers reported excellent communication about changes to pandemic circumstances and responses, and felt that their services provided a supportive work environment through excellent teamwork, frequent staff check-ins, and health and wellbeing initiatives. For example, staff were provided with time off if needed; were provided with access to protective equipment and infection control training; cleaning and safety procedures were put in place; and access to vaccinations arranged.

Twenty-nine workers made comments about what their organisation had not done so well during the COVID-19 pandemic. The most commonly reported issues were:

- lack of information technology support, particularly for working from home;
- an increase in demand from clients and in workload, including too many Zoom meetings;
- lack of information and failures in communications to staff;
- feeling that the COVID-19 strategies put in place were too strict, kept clients away, or were in place for too long;
- workers needing extra time off; and
- not having access to specific provisions that may have been available elsewhere, for example, not being able to work from home, not having the QR code or vaccinations available.

3 | Conclusion

This monograph presents a profile of the ACT alcohol and other drug (AOD) workforce in 2021 with a focus on qualifications, remuneration and wellbeing. It builds on previous Profiles conducted in in 2006, 2009, 2011, 2014 and 2017, and provides an examination of changes within the ACT AOD workforce.

The 2021 Workforce Profile was conducted at a critical moment for the sector. Faced with consecutive crises of bushfire and COVID-19 pandemic, the analysis of worker wellbeing took on new significance. This was the second time that questions about wellbeing have been incorporated into an ACT AOD Workforce Profile. The tracking of worker wellbeing across time is an invaluable resource for the sector as a whole and will help to inform strategies to address worker wellbeing as a key consideration in the provision of quality AOD services into the future.

Beyond wellbeing data, the 2021 Workforce Profile provides important snapshots of workforce demographics and changes in the AOD sector employment landscape. The 2021 ACT AOD Workforce Profile provides analysis of workforce trends that will be of interest to individual services and to the AOD sector as a whole. The information contained in this Workforce Profile will inform workforce development, support the implementation of the QS, provide improved understanding of the needs of the AOD workforce, and will be used alongside other resources to match the AOD workforce to the alcohol and drug treatment needs of the ACT community.

In 2021, the ACT AOD workforce had grown to number over 300 employees. While the sector is relatively successful in retaining workers, recruitment remains challenging. The AOD sector remains heavily female (although there is some movement towards a greater gender balance in the workforce) and is relatively diverse culturally and linguistically. While the sector is increasingly well-educated, it is also increasingly casualised. The implication of these trends and their possible impact on wellbeing may be more fully understood in future Workforce Profiles.

ACT AOD Workforce Profiles have been conducted every two to four years since 2006. It is anticipated that the next Workforce Profile will be undertaken in 2024. While the last few years have dealt some significant challenges, the ACT AOD workforce has shown remarkable resilience.

The landscape of AOD service provision is likely to shift considerably in the coming years. A diverse, educated, skilled and experienced sector that is fully funded to ensure adequate program delivery and appropriate remuneration of the workforce, will be best placed to address future challenges and to provide exemplary AOD services to the benefit of the ACT community.

References

1. Intergovernmental Committee on Drugs 2014. *National Alcohol and other Drug Workforce Development Strategy 2015–2018.* A Sub-strategy of the National Drug Strategy 2010–15. Canberra, ACT: Department of Health.

2. Skinner N, McEntee A and Roche A 2020. *Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020.* Adelaide, SA: National Centre for Education and Training on Addiction (NCETA), Flinders University.

3. Searby A and Burr D 2020. *State of the workforce 2020: Mapping the alcohol and other drug (AOD) nursing workforce in Australia and New Zealand*. Brisbane, QLD: Drug and Alcohol Nurses of Australasia (DANA).

4. Learning for Purpose 2021. AOD Workforce Study NGO Insights 2021, https://learningforpurpose.org/research/aod-workforce-study/.

5. Alcohol Tobacco & Other Drugs Council Tasmania 2021. *The Tasmanian Community Sector ATOD Workforce: Characteristics and Challenges.* Results from the 2020 ATDC Workforce Survey. Hobart, TAS: Alcohol Tobacco and other Drugs Council Tasmania (ATDC).

6. Victorian Department of Health. VIctorian Alcohol and Other Drugs Workforce Survey 2019. 2021. Melbourne, VIC: Victorian Government.

7. National Centre for Education and Training on Addiction 2018. *Alcohol and Other Drugs Workforce Development Assessment 2017.* Summary report to Northern Territory Primary Health Network. Adelaide, SA: National Centre for Education and Training on Addiction, Flinders University.

8. Western Australian Network of Alcohol and other Drug Agencies (WANADA) 2017. *Comprehensive Alcohol and other Drug Workforce Development in Western Australia.* Perth, WA: Western Australian Network of Alcohol and other Drug Agencies (WANADA).

9. Roche A, Kostadinov V, Hodge S, et al 2018. Characteristics and wellbeing of the NSW non-government AOD Workforce. Adelaide, SA: National Centre for Education and Training on Addiction, Flinders University.

10. Australian Capital Territory 2011. Work Health and Safety Act 2011. A2011-35. Canberra, ACT.

11. Dewa CS, Loong D, Bonato S, et al. 2017. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open* 7: e015141, doi:10.1136/bmjopen-2016-015141.

12. Aiken LH, Sermeus, W, Van den Heede, K, Sloane, D et al. 2012. Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal* 344.

13. Skinner N and Roche, A 2005. Stress and Burnout: *A Prevention Handbook for the Alcohol and Other Drugs Workforce.* Adelaide, SA: National Centre for Education and Training on Addiction (NCETA), Flinders University.

14. Preamble to the Constitution of World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948.

15. Alcohol Tobacco and Other Drug Association ACT (ATODA) 2019. *ACT Alcohol and Other Drug Workforce Profile 2017: Qualifications, Remuneration and Well-being*. Canberra, ACT: Alcohol Tobacco and Other Drug Association ACT (ATODA).

16. Alcohol Tobacco and Other Drug Association ACT (ATODA) 2020. S*ervice Users' Satisfaction and Outcomes Survey 2018: a census of people accessing specialist alcohol and other drug services in the ACT. Canberra, ACT*: Alcohol Tobacco and Other Drug Association ACT (ATODA).

17. Chapman J, Roche AM, Kostadinov V, et al. 2020. Lived Experience: Characteristics of Workers in Alcohol and Other Drug Nongovernment Organizations. *Contemporary Drug Problems* 47: 63–77, DOI: 10.1177/0091450919894341.

18. Lived Experience Workforce Strategies Stewardship Group 2019. *Strategy for the Alcohol and Other Drug Peer Workforce in Victoria.* Melbourne, VIC: Self Help Addiction Resource Centre (SHARC).

19. Australian Bureau of Statistics 2021. 6302.0 Average Weekly Earnings, Australia. Table 13H. Average Weekly Earnings, Australian Captial Territory (Dollars) - Original, https://www.abs.gov.au/statistics/labour/earnings-and-work-hours/average-weekly-earnings-australia/latest-release#state-and-territory.

20. Bianchi R and Schonfeld IS 2016. Burnout is associated with a depressive cognitive style. *Pers Individ Differ* 100: 1–5.

21. Best D, Savic M and Daley P 2016. The well-being of alcohol and other drug counsellors in Australia: strengths, risks, and implications. *Alcoholism Treatment Quarterly* 34: 223–32, DOI: 10.1080/07347324.2016.1148514.

22. Roche A, Kostadinov V, Braye K, et al 2018. *The New Zealand addictions workforce: Characteristics and wellbeing*. Adelaide, SA: National Centre for Education and Training on Addiction, Flinders University.

23. Public Health England 2018. Treatment Outcomes Profile. PHE TOP v2 July 2018 , https://www.gov.uk/government/publications/drug-and-alcohol-treatment-outcomes-measuring-effectiveness. Accessed 15 April 2019.

24. Institute of Behavioral Research 2009. *TCU Organizational Readiness for Change (ORC-D4)*. Fort Worth, TX: Texas Christian University, Institute of Behavioral Research, ibr.tcu.edu. Accessed 1 August 2019.

25. Shirom A and Melamed S 2006. A Comparison of the Construct Validity of Two Burnout Measures in Two Groups of Professionals *Int J Stress Manag* 13, 2: 176–200.

26. Byrne MK, Sullivan NL and Elsom SJ 2006. Clinician optimism: Development and psychometric analysis of a scale for mental health clinicians. AJRC 12(1): 11–20.

27. Ryan A, Holmes J, Hunt V, Dunlop A, Mammen K, Holland R, Sutton Y, Sindhusake D, Rivas G, Lintzeris N 2014. Validation and Implementation of the Australian Treatment Outcomes Profile in Specialist Drug and Alcohol Settings. *Drug Alcohol Rev 33*(1): 33-42.

28. Simpson DD and Flynn PM 2007. Moving Innovations into Treatment: A Stage-based Approach to Program Change. *J Subst Abuse Trea*t 33(2): 111–20.

29. Courtney KO, Joe GW, Rowan-Szal GA, et al. 2007. Using Organizational Assessment as a Tool for Program Change. *J Subst Abuse Trea*t 33(2): 131–37.

30. Bianchi R, Schonfeld IS and Laurent E 2015. Burnout-depression overlap: A review. *Clin Psychol Rev* 36: 28–41.

31. Cohen J 1988. Statistical power analysis for the behavioral sciences (*2nd edition*). Hillsdale,NJ: Lawrence Erlbaum Associates.

32. Bateman J, Henderson C and Hill H 2012. *Implementing Practice Supervision in Mental Health Community Managed Organisations in NSW.* Sydney, NSW: Mental Health Coordinating Council.

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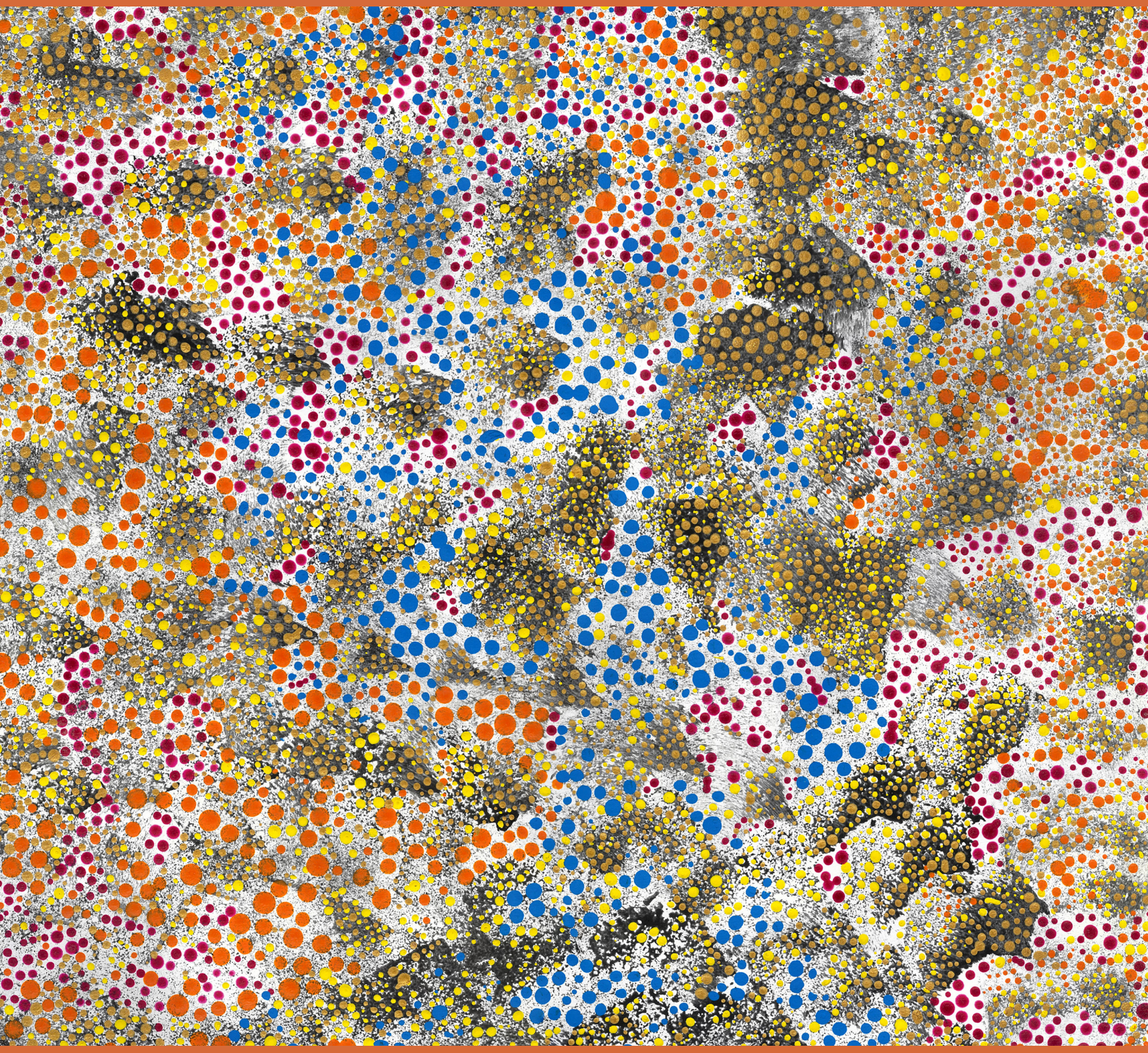
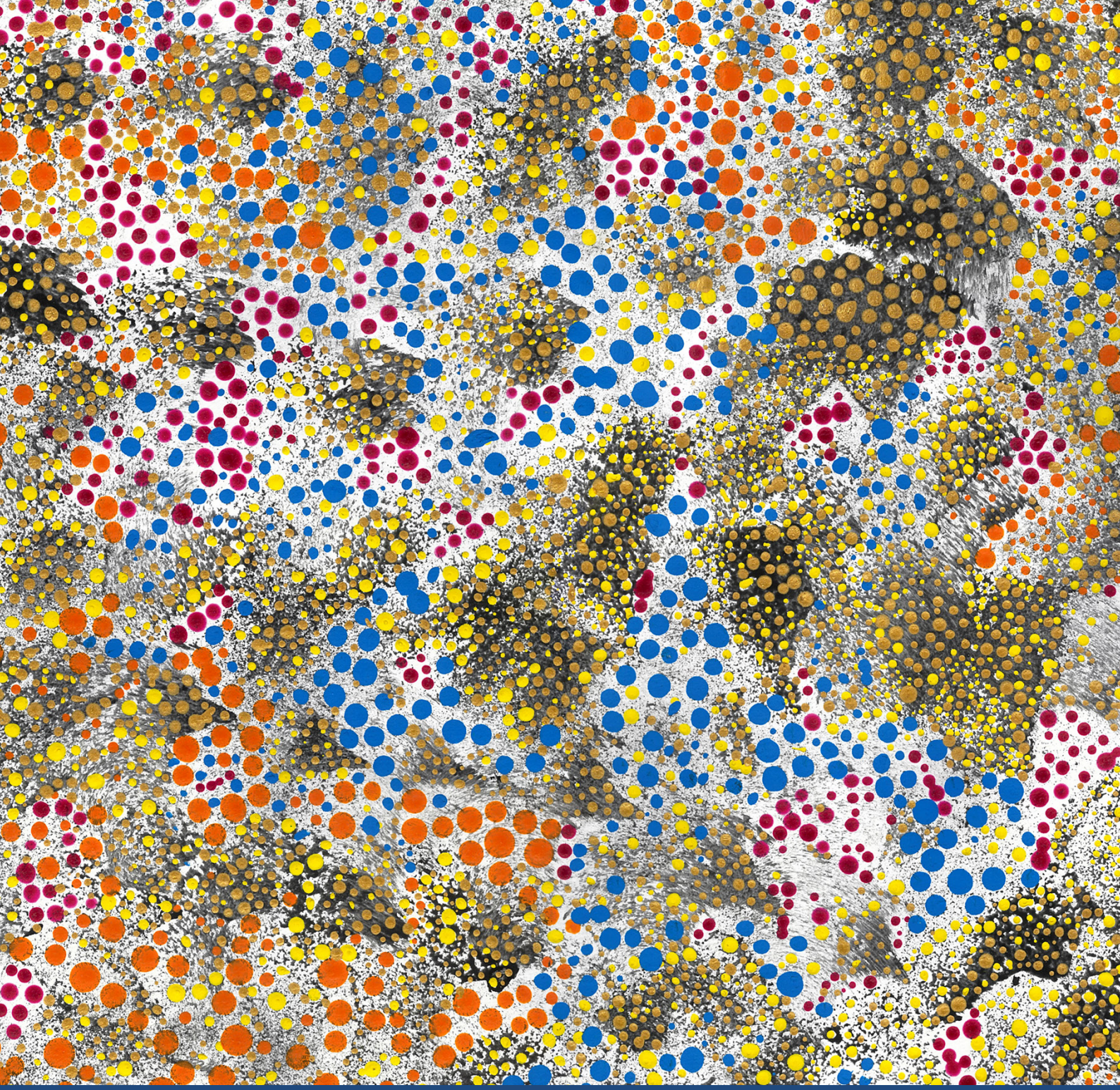


Appendices

ACT Alcohol and Other Drug Workfprce Profile 2021: Qualifications, Renumeration and Wellbeing

Access apendices at:
https://www.atoda.org.au/publications/research-publications/



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