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The non-government alcohol and other drug workforce in Australia: Findings from a national survey

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Abstract

Introduction. *There is growing interest in the role of the non-government sector in the alcohol and other drug (AOD) service delivery system. This study examined the demographic profile of AOD workers in the non-government (NGO) compared to government sector, to ascertain their professional development needs, job satisfaction, retention and turnover.* ***Methods.*** *This study utilised cross-sectional data from an Australian AOD workforce online survey that assessed participants' demographics, employment profile, professional development needs and barriers. The sample comprised 888 workers in direct client service roles.* ***Results.*** *Binomial logistic regression analysis indicated that NGO workers were more likely to be younger (<35 years), have AOD lived experience and have an AOD vocational qualification. NGO workers were more likely to earn below the national average salary and report job insecurity; but nonetheless were more likely to feel respected and supported at work, believe their work was meaningful and be satisfied working in the AOD sector. Their top professional development barrier was personal financial cost. NGO workers were more likely to report employer financial costs as a professional development barrier, whereas government workers were more likely to report staff shortages.* ***Discussion and Conclusions.*** *AOD services in Australia rely increasingly on the NGO sector. Quality services and care pivot on the size, capability and maturity of the workforce. This study highlights the need for systemic interventions addressing structural issues, and the professional development and ongoing support needs of the NGO AOD workforce. Without such support, Australia's AOD services will be potentially jeopardised.* [Roche AM, Skinner N. The non-government alcohol and other drug workforce in Australia: Findings from a national survey. *Drug Alcohol Rev* 2021]

Key words: health workforce, non-government sector, professional development need, capacity building.

Introduction

There is increasing interest in the organisational and governance arrangements within the non-government (NGO) sector. Governments around the world invest substantial funds into the alcohol and other drug (AOD) sector [1]. Services are provided across a diverse array of settings, including hospitals, outpatient clinics, primary care settings, community and voluntary organisations. In Australia, the extent to which services are provided by government, non-government (NGO or not-for-profit) and to a lesser extent, private organisations, varies among jurisdictions. The configuration and balance of government to non-government services is of crucial importance and has implications for the workforces within these service delivery systems.

While the AOD workforce is of central importance to the functioning of the AOD service delivery sector globally [2], comparatively little is known about it and, in particular, the differences that might exist between workers in the various parts of the system [2]. However, it has become apparent that over time the NGO sector in Australia has steadily increased its share of the specialist treatment system, at least as measured in terms of episodes of care provided by specialist AOD services. This shift is illustrated in the number of closed episodes of care provided by non-government versus government services across all eight states and territories from 2009/2010 to 2018/2019 [3]. The proportion of episodes of care provided by the NGO sector increased incrementally from 61 to 71% from 2009/2010 to 2018/2019 [3]. In part, this trend may reflect the increased outsourcing of the provision of AOD services by the Australian Government to local commissioning bodies such as the Primary Health Networks [4].

Globally, NGOs have rapidly grown in size, scope and influence in recent decades [5]. They play an increasingly significant role in global governance [6],

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supplement shortfalls in supply of health care professionals in many parts of the world [7] and actively work to overcome structural constraints [8]. NGOs are often lauded for their strengths as innovative grassroots driven organisations with a desire and capacity to pursue participatory and people-centred forms of development and to fill service gaps left in meeting the needs of citizens [9].

The role of the NGO sector was highlighted in a Productivity Commission Research Report regarding the provision of support and capacity building arguing that this was a 'priority for those non-for-profit organisations engaged in delivery of government funded services' [10, p. 237]. These activities are also central to NGOs that provide AOD services. Diverse efforts have been subsequently directed to building the capacity of AOD workers in the NGO sector [4].

While the role of NGOs in civil society has grown substantially since the 1960s and now plays a key role in public policy and social service, their success depends on effectiveness and good governance [11]. NGOs haves been identified as important for political as well as economic reasons [12]. However, questions arise regarding the potential of NGOs and the extent to which they are capable of providing a comprehensive service delivery model able to shore up and even substitute for the efforts of government [5]. These roles are largely dependent on the composition and capabilities of their workforce.

To date, comparatively little is known about the nature of the AOD NGO workforce, its strengths, weaknesses and capacity to fulfill the roles flagged above. Recent work in this area primarily comprises analyses of the NGO workforce in specific jurisdictions, which may to some extent reflect the unique service delivery systems and client profiles of particular geographic areas [e.g. 13-15]. This study builds on this work by: (i) offering a broader perspective with a national sample of AOD workers; (ii) including direct comparisons between NGO and government workers to more accurately identity unique characteristics of the NGO workforce; and (iii) including multivariate predictive analyses of key workforce development outcomes (job satisfaction, turnover intention) that directly impact the sustainability an effectiveness of the NGO workforce.

This study was undertaken to provide a closer examination of the demographic profile of AOD workers in the non-government sector compared to those in government and to ascertain their professional development needs, their interests and career aspirations and factors related to job satisfaction, retention and turnover.

The specific research questions addressed were:

1. What is the demographic profile of the AOD NGO workforce, and how does this profile differ from the AOD government workforce?
2. What are the professional development needs of NGO workers, and how do these needs differ from those of government workers?
3. Do government and non-government AOD workers differ in relation to job satisfaction and turnover intention, and the factors that predict these outcomes?

Methods

Survey method

A custom-designed cross-sectional survey was developed in consultation with an expert advisory group comprising 23 representatives from government and non-government sectors from policy, service delivery, research and consumer backgrounds. The survey comprised validated scales and items sourced from existing jurisdictional AOD workforce surveys, including those conducted in Victoria [16], New South Wales [17], the Australian Capital Territory [18] and Western Australia [19]. The survey target group comprised specialist AOD workers in client and non-client service roles and general health professionals who treated AOD clients. The current analyses focused on participants who provided direct client services in a specialist AOD service or a health/human services organisation. Respondents comprised workers from the NGO and government sectors across every Australian jurisdiction (Table 1).

The survey was promoted through AOD-related publications, conferences and social media. Industry stakeholders, peak representative bodies and government agencies promoted the survey. Data were collected from August 2019 to February 2020 through the online survey platform Qualtrics. Ethics approval was obtained from Flinders University Social and Behavioural Research Ethics Committee, Southern Adelaide Clinical Human Research Ethics Committee (under the National Mutual Acceptance Scheme) and jurisdictional research ethics and governance bodies.

Measures

The full survey addressed: demographics, employment and client characteristics, qualifications and professional development needs, working conditions, organisational characteristics, recruitment and retention, and health and wellbeing. The variables included in the present study are detailed below. Unless specified otherwise, all multi-item measures were recoded to bivariate variables based on a median split (0 = low; 1 = high). Single-item measures were recoded to bivariate variables based on the scale anchor (e.g. 0 = strongly disagree/disagree/neither agree nor disagree; 1 = agree,

Table 1. *Workforce demographic, employment and wellbeing profile*

	Government		NGO		All	
Jurisdiction	*n*	%	*n*	%	*n*	%
Australian Capital Territory	9	2.4	10	1.9	19	2.1
New South Wales	121	32.4	87	16.9	208	23.4
Northern Territory	16	4.3	3	0.6	19	2.1
Queensland	78	20.9	121	23.5	199	22.4
South Australia	41	11	43	8.4	84	9.5
Tasmania	7	1.9	3	0.6	10	1.1
Victoria	63	16.8	170	33.1	233	26.2
Western Australia	39	10.4	77	15	116	13.1
All	374	100	514	100	888	100
Social demographics		**%**		**%**		**%**
All		42.1		57.9		100
Sex: Female		73.4		69.1		70.9
Aboriginal and/or Torres Strait Islander: Yes*		4.4		8.1		6.6
*Age, years****						
18–34		15.6		26.5		22
35–49		39.8		38.2		38.8
50+		44.6		35.3		39.2
*Lived experience****						
Yes (any experience)		57.8		74		67.2
Personal experience**		41.3		56.3		50.9
Family/other experience**		84.1		69.6		74.8
Provide unpaid care to others: Yes		47.1		42.2		44.3
Qualifications and experience						
General tertiary qualification: Yes*		60.1		52.3		55.6
AOD tertiary or vocational qualification: Yes		47.8		46.7		47.2
Any AOD vocational qualification: Yes**		47.9		59.4		54.6
Enrolled in AOD qualification: Yes***		18.8		30.6		25.6
*Years in AOD sector****						
3 years or less		26		34.4		30.9
4–9 years		27.8		34		31.4
10+ years		46.2		31.6		37.7
*Years in current organisation****						
3 years or less		37.5		59.4		50.2
4–9 years		28.9		28.6		28.7
10+ years		33.6		12.1		21.1
Employment demographics						
Geographic location: Metropolitan		58.4		62.5		60.8
Permanent: Yes**		81.4		72.9		76.5
Full-time: Yes		59.1		59		59
Main work roles						
Management**		8.6		15.4		12.5
Administration/professional support*		20.9		27.4		24.7
Research/project work		9.1		12.8		11.3
Frequent overtime: Yes		34.7		38		36.6
*Any compensation for overtime: Yes***		69.1		79.6		75.2
Financial compensation		15.5		14.4		14.8
Time-related compensation***		54.7		69.5		63.2
*All workers salary****						
Below		31.3		49		41.6
Average		14.4		31.4		24.3
Above		54.3		19.6		34.1
*Full-time workers salary****						
Below		28.4		70.4		52.6
Average		39.4		26.4		31.9
Above		32.2		3.2		15.4

(Continues)

Table 1. (Continued)

	Government	NGO	All
Job quality			
Satisfaction with current job: Yes***	72.4	84.4	79.4
Satisfaction with AOD sector: Yes**	67	77	72.8
Satisfaction with pay*	58.1	50.6	53.7
Satisfaction with career progress	64.7	70.1	67.8
Satisfaction with career opportunities*	38	45.5	42.4
Perceived job insecurity: Yes, insecure***	17.7	26.2	22.7
Respect/support: Yes***	43.2	59	52.4
Work intensity: Yes**	40.8	32.5	36
Work meaning: Yes***	51.2	66.1	59.9
Access flexibility: Yes***	46.5	65.1	57.3
Recruitment and retention			
Job turnover intention: Yes	46.6	41.8	43.8
Sector turnover intention: Yes	64.1	58.5	60.9
Challenging to recruit staff: Yes***	81.5	66.9	73
Challenging to retain staff: Yes***	67.5	48.9	56.7
*Prior sector of employment****			
Health/community services	63.5	29.7	44.1
Human services	10.8	19.2	15.6
Other	7.8	19.2	14.4
Services (hospitality, retail, construction)	5.4	13.8	10.2
Civil services (education, employment, housing, justice)	7	12.4	10.1
No prior sector (only AOD sector)	5.4	5.8	5.6
Health and wellbeing			
Professional confidence: Yes	76.2	70.8	73.1
Burnout: Yes	55.6	51.3	53.1
Engagement: Yes**	41.4	51.3	47.1
Health status: Very good/excellent	38.3	40.1	39.3

*$P \leq 0.05$; **$P \leq 0.01$; ***$P \leq 0.001$. AOD, alcohol and other drug; NGO, non-government organisation.

strongly agree). Bivariate coding of categorical variables is described below.

Social demographics. Demographic variables included sex, age, Aboriginal and/or Torres Strait Islander identity and provision of unpaid care (children, older person, others). Respondents identified whether they had lived experience of AOD issues personally, with a family member or another experience (multiple response item).

Qualifications and experience. Respondents indicated their highest general qualification (1 = undergraduate degree/masters/PhD/MBBS/medical fellowship), highest AOD specialist tertiary or vocational qualification (1 = AOD Certificate IV, Diploma, Advanced Diploma, undergraduate degree, graduate certificate, graduate diploma, Masters, PhD, Fellowship), attainment of any (one or more) AOD vocational qualifications (1 = AOD Skill Set, Certificate IV in AOD, Diploma of AOD) and current enrolment in tertiary or vocational AOD specialist training. AOD experience was assessed as years' experience in the AOD sector and respondent's current organisation.

Employment demographics. Measures addressing employment demographics comprised geographic location, employment contract (casual, fixed term, permanent), work hours (part time, full time), main work roles and three aspects of overtime hours comprising frequency (0 = a few times a month/a few times a year/never; 1 = everyday/a few times a week), compensation for extra hours (1 = yes) and form of compensation (financial, time-related). Participants selected a salary range that best matched their pre-tax income. Salary was recoded into two new variables to reflect the weekly national average income (all workers: $1257; full-time workers: $1658) [20].

Job quality. Satisfaction with various aspects of work and employment was assessed [21] (0 = neither unsatisfied nor satisfied/unsatisfied/completely unsatisfied; 1 = satisfied/completely satisfied). Single-item measures were used to assess satisfaction with current job, the AOD sector,

current pay, career progress to date and future career opportunities in the organisation (e.g. 'All in all, how satisfied are you with your job/the AOD sector?').

Job quality was assessed by a set of measures using five-point response scales (1 = strongly disagree, 5 = strongly agree). Perceived job insecurity was assessed by a four item scale (e.g. 'I feel insecure about the future of my job') [22]. Respect/support was measured by a five item scale (e.g. 'I experience adequate support in difficult situations') [23]. Work intensity was measured by a five item scale (e.g. 'I have constant time pressure due to a heavy workload') [23]. Work meaning assessed using a three item scale (e.g. 'The work I do is meaningful to me') [24]. Access to flexible work arrangements was assessed with a single item ('My working times can be flexible to meet my needs') [25].

Recruitment and retention. Turnover intentions with regard to respondents' current job and the AOD sector were assessed by two or three item measures (e.g. 'I frequently think about leaving my current job/the AOD sector') [26] using a five point response scale (1 = strongly disagree, 5 = strongly agree). Perceived challenge in recruiting and retaining employees in the organisation was assessed by two single-item measures (0 = not challenging at all/slightly challenging; 1 = moderately/very/extremely challenging) [27]. Prior sector of employment was assessed with a single item comprising 21 sectors, recoded into six categories.

Health and wellbeing. Professional confidence was assessed by a three-item scale (e.g. 'I am confident in my ability to do my job') [24] with a five point response scale (1 = strongly disagree, 5 = strongly agree). Burnout was assessed by a seven-item scale [28] comprising three items addressing burnout frequency (e.g. 'How often do you feel worn out at the end of the working day') (1 = never almost never, 5 = always) and three items addressing burnout intensity (e.g. 'To what degree is your work emotionally exhausting?') (1 = to a very low degree, 5 = to a very high degree). Engagement was assessed by a three-item scale (e.g. 'I am immersed in my work') (1 = never/almost never, 5 = always) [29]. General health was assessed using the SF-36 global measure of health [30] 'In general, would you say your health is?' (0 = poor/fair/good; 1 = very good/excellent).

Statistical analyses

All analyses were conducted in IBM SPSS Statistics 25.0 [31]. Group differences ($P \leq 0.05$) were explored on variables of interest via frequency statistics, χ^2 tests of independence and binary logistic regressions.

Results

Workforce demographics

The demographic profile of NGO workers was found to differ significantly from government workers on a number of indicators (Table 1). NGO workers were younger ($M = 43.8$) than government workers ($M = 47.6$), comprised a higher proportion of workers who identified as Aboriginal and/or Torres Strait Islander ($P < 0.05$) and who reported lived experience of AOD issues either personally and/or with a family member ($P < 0.001$). The proportion of female workers, and workers with care responsibilities, was equivalent between the sectors.

The NGO workforce had a higher proportion of younger workers (18–34 years), whereas the government workforce had a higher proportion of older workers (50 years or older) ($P < 0.001$).

Qualifications and experience

NGO workers were more likely to have an AOD vocational qualification (Certificate IV, Diploma or AOD skill set) ($P < 0.01$) compared to government workers who were more likely to have a general tertiary qualification (university degree or higher) ($P < 0.05$). NGO workers were also more likely to be enrolled in an AOD qualification ($P < 0.001$).

In regard to experience, NGO workers were more likely to have three or fewer years' experience in the AOD sector ($P < 0.001$) and in their current organisation ($P > 0.001$) compared to government workers.

Employment arrangements

Although rates of full-time employment did not differ between the sectors, government workers were more likely to have permanent employment contracts ($P < 0.01$). Reflecting this difference in contractual arrangements, NGO workers were more likely to perceive their jobs as insecure compared to government employees ($P < 0.001$). Rates of overtime/extra hours did not differ between the groups; however, NGO workers were more likely to be compensated for extra hours most commonly via time-related compensation ($P < 0.01$). Considering all workers and those working full-time, NGO workers were more likely to report income levels below the national average ($P < 0.001$). NGO workers were more likely to have diverse work roles, including management ($P < 0.01$) and administration/professional support roles ($P < 0.05$) in addition to providing direct client services. There was no difference

between NGO and government workers on the likelihood of being based in a metropolitan area.

Job quality

NGO workers were more likely to report being satisfied with their job ($P < 0.001$), the AOD sector ($P < 0.01$) and their career opportunities ($P < 0.05$). Conversely, government workers were more satisfied with their pay ($P < 0.05$) reflecting observed differences in average income levels. There were no differences between NGO and government workers on satisfaction with career progress. With regard to the everyday experience of work, NGO workers were more likely to report feeling respected and supported ($P < 0.001$), have access to flexibility ($P < 0.001$) and to experience their work as meaningful ($P < 0.001$). NGO workers were less likely to report high work intensity ($P < 0.01$).

Table 2. *Professional development barriers and needs*

Variable	Government ($n = 374$) %	NGO ($n = 514$) %	All ($n = 888$) %
Professional development/clinical supervision access			
Clinical supervision: Yes**	82.7	88.6	86.1
Line supervision: Yes***	50.2	69.1	61.6
Difficulty accessing professional development: Yes	45	39.7	42
Professional development barriers			
Financial cost to self	45.9	49.4	47.9
Financial cost to employer***	23.1	41.4	33.6
Insufficient time at work/outside work	50.4	45.6	47.6
Staff shortages***	29.9	17.5	22.8
Lack of support manager/organisation	24.3	20.6	22.1
Geographic constraints	25.7	22.2	23.7
Difficulty accessing relevant training	25.4	25	25.2
Professional development needs—client groups			
Clients with trauma	70.3	64.6	66.9
Clients with dual diagnoses/mental health	66.9	60.9	63.4
Clients with experience of family violence	52.6	54.1	53.5
Aboriginal clients	52.3	53.4	53
Forensic clients	54.2	49.6	51.5
Children/families	54.2	51.5	52.6
Clients with ABI*	53.6	45.1	48.5
Clients with gambling issues	46.7	44.8	45.6
CALD clients	45.2	49.4	47.7
Older clients	48.9	43.8	45.9
LBQTI clients	38.7	44.2	42
Professional development needs—skills			
Complex needs	63.1	62.4	62.7
Service delivery/partnerships/multi-disciplinary teams	56.5	61.9	59.7
Management/leadership	51.8	57.3	55.1
Specific therapies*	55.1	45.9	49.7
Clinical skills	50.2	47	48.3
Leadership and management	44.9	48.9	47.2
Training on risky behaviours	46.2	46.8	46.5
Advanced clinical skills**	51.8	39.9	44.8
Providing clinical supervision**	37.9	47.9	43.8
Evidence-based practice	44.9	41.5	42.9
Leadership skills	39.9	43.1	41.8
Training on AOD issues	42.5	37.6	39.6
Service delivery	35.9	40.6	38.7
Management skills	35.2	38.8	37.3
Service partnerships	35.2	37.2	36.4
Multi-disciplinary teams*	28.6	36.2	33.1

*$P \leq 0.05$; **$P \leq 0.01$; ***$P \leq 0.001$. AOD, alcohol and other drug; CALD, culturally and linguistically diverse; LBQTI, lesbian, bisexual, queer, transgender, intersexed; NGO, non-government organisation.

Table 3. *Binary logistic regression analyses*

		95% CI for odds ratio		
	B (SE)	Lower	Odds ratio	Upper
Employment and social demographics				
Constant	0.712		2.039*	
Sex (1 = female)	−0.314	0.513	0.730	1.039
Age (1 = < 35 years)	0.810	1.457	2.247***	3.464
Lived experience (1 = yes)	0.779	1.550	2.179***	3.062
General tertiary qualification (1 = yes)	−0.272	0.548	0.762	1.060
AOD vocational qualifications (1 = yes)	0.531	1.219	1.700**	2.370
AOD experience (1 = < 4 years)	0.286	0.908	1.331	1.953
Burnout (1 = yes)	−0.118	0.632	0.888	1.248
Engagement (1 = yes)	0.292	0.951	1.338	1.883
Working conditions				
Constant	−0.419		0.658	
Employment contract (1 = permanent)	−0.126	0.590	0.881	1.316
Income (1 = below national average)	0.652	1.369	1.919***	2.691
Satisfaction with AOD sector (1 = satisfied)	0.427	0.997	1.533*	2.355
Satisfaction with pay (1 = satisfied)	−0.669	0.358	0.512***	0.734
Satisfaction with career prospects (1 = satisfied)	0.090	0.750	1.095	1.597
Access to flexible work (1 = yes)	0.571	1.275	1.769**	2.455
Recruitment challenging (1 = yes)	−0.262	0.511	0.770	1.160
Retention challenging (1 = yes)	−0.608	0.382	0.545**	0.777
Difficulty accessing professional development (1 = yes)	0.105	0.788	1.111	1.567
Work intensity (1 = yes)	−0.204	0.577	0.816	1.153
Respected and supported (1 = yes)	0.407	1.048	1.503*	2.155
Work meaningful (1 = yes)	0.603	1.305	1.827***	2.558
Job insecure (1 = yes)	0.676	1.380	1.965***	2.799

* $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$. Outcome variable: 1 = non-government organisation; 0 = government. AOD, alcohol and other drug; CI, confidence interval.

Recruitment and retention

NGO workers were less likely to perceive recruitment and retention as challenging, compared to government workers ($P < 0.001$). NGO workers reported a more diverse career history, with more NGO workers recruited into the AOD sector from non-health areas, such as human services, civil services and general services ($P < 0.001$). Turnover intentions regarding current job or the AOD sector did not differ between the two groups.

Health and wellbeing

While indicators of work-related wellbeing, such as professional confidence and burnout, did not differ between NGO and government workers, NGO workers were more likely to report being engaged by their work ($P < 0.01$).

Professional development needs and barriers

Clinical supervision ($P < 0.01$) and line supervision ($P < 0.001$) were more common for NGO workers (Table 2). Across a range of potentials barriers to professional development, cost to employers ($P < 0.001$) was more common for NGO workers, whereas staff shortages ($P < 0.001$) were likely to be reported by government workers. Similarly, across a broad array of potential professional development areas, only the need for support for working with clients with acquired brain injury was nominated more frequently by government workers ($P < 0.05$). For areas of skill development, NGO workers were more likely to indicate the need for upskilling in providing clinical supervision ($P < 0.01$) and working with multidisciplinary teams ($P < 0.01$). Whereas, government workers were more likely to nominate specific therapies ($P < 0.05$) and advanced clinical skills ($P < 0.01$).

Regression analyses

Binary logistic regression was used to identify the variables that most strongly differentiated workers in NGO and government organisations. Two regressions were conducted to predict group membership (NGO = 1, government = 0) from social and

employment demographics (n = 698) and working conditions (n = 747). Separate analyses were conducted to enable a sufficient ratio of predictor variables to cases to ensure reliability of estimates.

As Table 3 shows, four social and employment demographic factors best differentiated NGO and government workers (Model $\chi^2(8) = 62.83$, $P < 0.001$; Pseudo R^2 = 0.09 (Cox and Snell), 0.12 (Nagelkerke)). Workers were more likely to be employed in NGO organisations if they were younger (<35 years), had lived experience and had vocational AOD qualifications. Considering working conditions, a range of factors differentiated NGO and government workers (Model $\chi^2(13) = 117.50$, $P < 0.001$; Pseudo R^2 = 0.15 (Cox and Snell), 0.20 (Nagelkerke)). Respondents were more likely to be NGO workers if they reported an income level below the national average, were satisfied with their employment in the AOD sector and their pay, had access to flexible work arrangements, felt respected and supported at work, perceived their work as meaningful and their jobs as insecure. NGO workers were less likely to perceive that their organisation had challenges with staff retention.

Discussion

As the NGO sector now provides most episodes of care in the AOD sector [3], the composition, needs and longevity of the NGO workforce are of particular salience with implications for future workforce development initiatives and the security and stability of the service delivery system overall. The traditional flexibility and comparative independence of the NGO sector affords its scope to undertake a range of roles that may not be possible, or that are severely curtailed, within the government services.

This study provides unique insights into the NGO workforce, its demographic profile, professional development needs and factors impacting on sustainability. Comparison with government workers provides new insights into the unique characteristics of the NGO workforce from a national perspective, extending previous work conducted within single jurisdictions [e.g. 13-15] and offering findings applicable to both national and jurisdictional workforce development initiatives. Given the recent global expansion of NGOs [5,6] and their increasingly important roles in innovative health care in many parts of the world [7,9], these findings have resonance beyond the AOD sector and the confines of Australia.

NGO workers were found to differ from government workers in several important respects. They were younger, less formally qualified and had less AOD experience (i.e. higher proportions of NGO workers had less than 3 years' experience), highlighting both the opportunity and imperative for mentoring, support and tailored professional development for this segment of the AOD workforce. Inexperience in the AOD sector also alerts us to several important considerations: that is, high levels of inexperience largely equated with being younger, and this in turn equates to greater vulnerability to stress, burnout and turnover—experiences to which early career workers are more susceptible [32,33]. While these potentially vulnerable attributes of NGO workers may be offset by their higher levels of job satisfaction, respect, sense of meaning derived from their work and appreciation of their flexible working conditions, they nonetheless underscore the importance of addressing specific support requirements. As a young workforce in the segment of the service delivery sector providing most occasions of service, NGO workers hold enormous value as both a workforce and sector resource. The significantly higher level of job insecurity and workforce retention challenges reported by NGO workers stands in stark contrast to the growing need for a larger, stable and skilled NGO workforce.

NGO workers also reported higher levels of AOD lived experience—an issue only relatively recently explored and one that also has implications for worker retention and wellbeing [34]. Workers with lived experience may also benefit from enhanced mentoring, stress management and other forms of workplace support.

Given differences identified between NGO and government workers, and changes in service delivery load distribution, there is an increased role for NGO peak bodies in supporting capacity building to ensure national consistency in evidence-informed approaches to treatment and workforce development more generally [4]. To this end, for instance, the recent NSW NGO Service Treatment Specifications resource [35] was developed as part of an organisational agreement between funders and service providers to provide a common understanding of performance, competence and skill sets. The Treatment Service Specifications aim to offer guidance regarding the principles and key elements of different types of AOD treatment and facilitate consistency of contemporary high-quality, evidence-based service delivery by NGOs. In doing so, it also helps define the roles and competencies required of the workforce.

This study has also highlighted the need for greater investment in multidisciplinary team skills, mentoring/supervision and basic leadership. These attributes are especially needed among the workforce in the NGO sector, a finding that has also been identified in other countries, such as New Zealand [36]. However, as

found in this study the greatest barrier to professional development for NGO workers was the financial cost to employers. Ensuring that budgets for NGO services address this issue is therefore vital.

While the NGO sector has a long history of engagement with AOD treatment, it appears to be on an upward growth trajectory. It has been argued that the NGO sector is perhaps better placed than government or private organisations to respond to complex social concerns, such as AOD issues [37]. Further, it has been asserted that NGOs can build community capacity by acting as intermediaries between government and citizens, providing opportunities for civic participation, reaching diverse populations, treating problems holistically, generating trust, working with compassion and commitment, providing a voice to the marginalised and bringing about social change [37]. Conversely however, in state-centric systems there may be limitations to what NGOs can achieve. Limitations may derive from perceptions of the NGO sector as a source of controversy, even irritation, for government [38, p. 4]. Lack of adequate funding to address the workforce needs of the NGO sector may reflect these tensions.

At a wider level, NGO developments are among several trends that are disrupting traditional funding sources [39]. NGOs are subject to unpredictable budget cuts with many attempting to revise fixed-term funding models and the associated challenges of perennial funding renewal. However, alternative funding models may require greater transparency and accountability to investors, with impact investing progressively driven by measurable results and subject to payment by results, potentially changing the nature of social impact bonds and necessitating reflection on what NGOs want to achieve, how they will achieve it and with which population groups [39]. It is within this dynamic context that the role of the NGO worker and their needs is jockeying to receive the attention and resourcing required to ensure a highly skilled, competent and secure workforce. Without directing sufficient and appropriate attention to the workforce, the NGO sector may be subject to increasing and ever more complex demands that are unmatched by commensurate support.

The current study offers valuable insights regarding the non-government AOD workforce. It should be acknowledged, however, that due to a lack of valid and reliable national and jurisdictional sampling frames and workforce population estimates, it was not possible to confirm sample representativeness. Nevertheless, the sample was drawn from all jurisdictions and was typical of the AOD workforce with regard to demographic, educational and employment characteristics [15,40,41].

Conclusion

The contribution of the NGO sector has received limited attention and less than might be warranted. This study aimed to provide a more nuanced understanding of the role of the NGO sector, and the NGO workforce in particular. Addressing the unique attributes of the NGO workforce identified here is of growing importance given the trend towards a higher proportion of AOD service provision being supplied by the NGO sector and the apparently decreasing role played by government services [3]. At present, the NGO sector appears to comprise over two-thirds of the AOD service delivery system in Australia, jurisdictional variations notwithstanding. As such, closer consideration of the unique needs of the NGO workforce is warranted, together with a critical examination of how these needs, which differ from those of government workers, may be appropriately supported.

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