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Strengths, challenges, and future directions for the non-government alcohol and other drugs workforce

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ABSTRACT

Objective: To identify strengths and challenges faced by alcohol and other drug (AOD) non-government (NGO) workers in New South Wales (NSW), Australia to inform future workforce planning initiatives.
Methods: An online survey assessed workers' demographics, organizational characteristics, health and wellbeing.
Results: Respondents ($N = 294$) were mainly female (66.7%), 15.3% identified as lesbian, gay, homosexual, or queer, 8.4% identified as Aboriginal and/or Torres Strait Islander and 42.5% reported AOD lived experience. A third (34.4%) were ≥50 years, 40.3% had <5 years AOD-related experience, 42.0% had clinical supervision access, and half (55.1%) reported that their organization provided professional development support practices. Satisfaction working in the AOD NGO sector (66.0%) and work/life balance (58.5%) was high, as was turnover intention (31.4%), job insecurity (30.3%), and dissatisfaction with remuneration (67.8%). Most (76%) full-time workers earned below the national average wage.
Conclusions: Large proportions of older workers and young/inexperienced workers necessitate specific workforce planning and development action. Professional development and supervision access are priority areas for remediation. High turnover intention rates, potentially reflecting job insecurity or remuneration dissatisfaction, require strategies to increase workforce attraction, and retention in this sector.

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Introduction

Alcohol and other drug (AOD) use places a large burden on society's health and wellbeing. It is a major contributor to illness, disease, injury, and death, and the workforce plays a pivotal role in the prevention and amelioration of associated problems. In 2017, global AOD use disorders respectively caused 185,000 and 167,000 deaths (GBD 2017 Causes of Death Collaborators, 2018), and the loss of 44.7 million disability-adjusted life years (GBD 2017 DALYs and HALE Collaborators, 2018). Combined, alcohol and illicit drug use was responsible for 4.5% of all Australian deaths in 2011, and 6.7% of the total burden of disease and injury (AIHW, 2018). In Australia in 2016, >25% of those aged over 14 years exceeded risky drinking guidelines, and one in six used an illicit drug (AIHW, 2017). These trends have not abated over time, and may indeed increase in light of the COVID-19 pandemic, misuse of pharmaceutical opioids (Kovitwanichkanont & Day, 2018), risky AOD use among older adults (Kostadinov & Roche, 2017; Roche & Kostadinov, 2019), and the emergence of new drugs of concern (e.g., methamphetamine and carfentanil) (Bonomo et al., 2019).

The impact on the service delivery system is substantial. While AOD treatment services are provided by government and non-government (NGO) organizations who receive funding from the national and/or state governments, a disproportionately large burden is carried by the NGO sector. In 2017–18, approximately 210,000 AOD-related treatment episodes were provided to 130,000 people who sought treatment from 952 services, with NGOs accounting for 61% of treatment agencies and 70% of treatment episodes (AIHW, 2019).

An effective and agile workforce is essential to prevent and respond to the AOD impost on the health care system (Intergovernmental Committee on Drugs, 2014) and ensure provision of quality care and evidence-based practice. Recruitment, retention, and continuous improvement of skilled workers is imperative. Effective health workforce planning and workforce development is required to ensure that appropriate numbers of competent workers are available to meet current and future demand (Ritter et al., 2019). Such concerns are particularly salient in the Australian healthcare context, characterized by multiple complexities, reform efforts, aging practitioner and patient populations, unequal workforce distributions, and healthcare supply/mismatches (Gorman, 2015).

Workforce planning is hampered by limited data regarding AOD workers demographic and professional characteristics. No national, coordinated data collection efforts exist, resulting

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in a paucity of high-quality and up-to-date data on this workforce. This represents an important oversight. Appropriate policy and planning decisions require accurate and current data regarding AOD sector employees, the roles they perform, their professional development needs, and relevant organizational and structural factors. This study was therefore undertaken to ascertain the demographic composition, organizational characteristics, working conditions, and health and wellbeing of the AOD NGO workforce.

Materials and methods

A custom online survey was developed to assess participants' demographics, working conditions, organizational characteristics, health, and well-being. Full instrument details are available elsewhere (Roche et al., 2018). Ethics approval was obtained from Flinders University Social and Behavioural Research Ethics Committee. Responses were anonymous and treated confidentially, and participants were free to withdraw at any time.

Recruitment and data collection

All AOD workers employed in the NSW NGO sector were eligible to participate. Invitations were disseminated via the Network of Alcohol and other Drug Agencies' member and stakeholder communication networks, sector training events, and online forums. A snowball sampling method was utilized with participants encouraged to promote the survey. SurveyMonkey hosted the survey for three months.

Measures

Demographics

Demographic characteristics of interest were age (continuous data recoded as: 20–29, 30–39, 40–49, 50–59, and 60+ years) gender, country of birth (Australia or other), Aboriginal and/or Torres Strait Islander identity, sexual orientation (straight/heterosexual or lesbian/gay/homosexual/queer), lived experience of AOD use (no, yes) and disclosure to workplace (disclosed or undisclosed), and highest AOD (nil, accredited short course/Certificate I–IV/Diploma/Advanced Diploma, or undergraduate/postgraduate degree) and non-AOD qualifications (school, Certificate I–IV/Diploma/Advanced Diploma or undergraduate/postgraduate degree).

The SF-36 global health status item assessed participants' health (Ware & Sherbourne, 1992), with responses dichotomized as good/very good/excellent and fair/poor.

Employment characteristics

Respondents nominated their current work location (urban or regional/rural/remote), employment contract type (permanent or fixed term/casual), occupancy type (full-time or part-time), gross annual salary (AUD 20,000-40,000, AUD 40,001-60,000, AUD 60,001-80,000 or AUD 80,001+) and type of work performed (direct client services, management, administration or other). Gross annual salary was only included for respondents contracted to work 35+ hours per week.

Respondents indicated years worked in their current role, current organization, the AOD sector, and the workforce in total. Continuous values were coded as ≤1 year, 1–5 years, and ≥5 years for experience in current role, organization and AOD field. Years of experience in the workforce were coded as <10 or ≥10 years.

Respondents indicated professional affiliations/practitioner registration against 14 professional bodies (including other) (yes), or 'no professional registration/affiliation' or 'don't know'.

Supervision

Access to and frequency of supervision (internal clinical supervision, external clinical supervision, line management, peer supervision, mentoring/coaching, and cultural supervision) was assessed. Frequency of access responses were recoded as fortnightly or more/every month, every three to six months and once per year or less. Perceived quality of each supervision type was recorded on a four-point scale (poor – excellent). Internal and external clinical supervision were collapsed (clinical supervision) as was peer supervision and mentoring/coaching (peer supervision/mentoring).

Work-related factors

Workload, work/life balance, perception of support, satisfaction, turnover intention, job security and negative workplace experiences were examined as follows.

Three items (Cammann et al., 1983) measured perceptions of workload ('*I have too much work to do everything well*', '*I never have enough time to get everything done*' and '*The amount of work I am asked to do is fair*') on a five-point Likert scale (strongly agree – strongly disagree). The third item was reverse scored, then summed with the other two items to generate a total workload score (Cronbach's α = 0.86). Workload scores were categorized as low (3–8), neither low nor high (9) and high (10–15).

Work/life balance was assessed with two items (Best et al., 2016) '*Please indicate how often you a) take work home and b) are interrupted by work at home*' (rarely/never and sometimes/often/always), and a global item developed for this survey: '*Overall, how satisfied or dissatisfied are you with the balance between your work and other aspects of your life (such as time with your family or leisure)?*' (satisfied/very satisfied and neither satisfied nor dissatisfied/dissatisfied/very dissatisfied).

General perception of support was assessed with a single item '*In general, do you feel supported to undertake your role?*' (yes/no). The social support subscale of the English version of the Brief Job Stress Questionnaire (Shimomitsu et al., 2000) assessed degree of perceived support from supervisors (Cronbach's α = 0.97) and coworkers (Cronbach's α = 0.98). Level of perceived support was indicated (1: extremely – 4: not at all) across three items for both support types. Summed scores for each support type were then categorized as high (9–12) and not high (3–8). Respondents were also asked to identify whether their employer provided practices or initiatives to support their professional development.

Satisfaction with working in the AOD NGO sector was measured with a single item: '*How satisfied are you working in the non-government AOD sector?*' (satisfied/very satisfied or neither satisfied nor dissatisfied/dissatisfied/very dissatisfied).

Satisfaction with salary ('*To what extent do you think you are paid enough for the work that you do?'*) was measured on a four-point scale (Van Veldhoven & Meijman, 1994) (satisfied (always/often) or dissatisfied (sometimes/never)).

A four-item scale (O'Driscoll & Beehr, 1994) addressed participants' intention to leave their current job, with the final item modified to refer specifically to the AOD field ('*I intend to search for a new job outside the AOD field*') (Cronbach's α = 0.89) (1: strongly disagree – 5: strongly agree). A total turnover intention score was calculated by averaging responses. Scores were then categorized as low (1.00–2.50), moderate (2.75–3.25) and high (3.50–5.00). Individual scale item responses were also dichotomized into agree (strongly agree/agree) or do not agree (neither agree nor disagree/disagree/strongly disagree).

Job insecurity was assessed with a single item from the New Zealand Survey of Working Life (Pacheco et al., 2016): '*In the next 12 months, what is the chance that you could lose your job for a reason that is beyond your control?*'. Responses were dichotomized into low (almost no chance/low chance) and moderate/high (a medium chance/high chance/almost certain).

Experience of workplace discrimination, bullying and/or harassment was coded as yes (occasionally/regularly) or no (never).

Analysis

Raw data were exported into SPSS Statistics version 25. Scores for validated scales were calculated according to relevant scoring manuals. Participants' responses were excluded from scales if they missed any scale item. Frequency analyses were conducted to examine the proportion of participants who endorsed each response category. Frequency analyses and significant testing were undertaken to determine group differences regarding perceptions of work-related factors for participants new to the AOD sector (less than 5 years' experience) and those who were more experienced (5 or more years' experience working in the AOD sector).

Results

Demographics

A total of 294 surveys were obtained. As the AOD NGO workforce in NSW comprises approximately 1,000 workers (Network of Alcohol and other Drugs Agencies, 2014) responses represent over one-quarter of that workforce.

Most respondents were female (66.7%) with a mean age of 43.4 years (SD 11.8). A third (34.4%) were aged ≥50 years, a quarter each were 40–49 (26.4%) and 30–39 years (23.6%), and 15.6% were <30 years (Figure 1). Approximately a quarter (23.5%) were born outside Australia, 8.4% identified as Aboriginal and/or Torres Strait Islander and 15.3% identified as lesbian, gay, homosexual or queer. Just under half (42.5%) reported having lived experience of problematic AOD use. Self-rated health was generally good/very good/excellent (81.4%) (Table 1).

Experience and qualifications

While 78.6% had been in the workforce for >10 years, almost half (43.8%) had worked in the AOD sector for less than five years, and substantial proportions had <1 year experience in the AOD sector (16.4%), their current organization (25.6%) or current role (37.5%) (Table 1). Less than half (43.9%) had professional affiliations/practitioner registration.

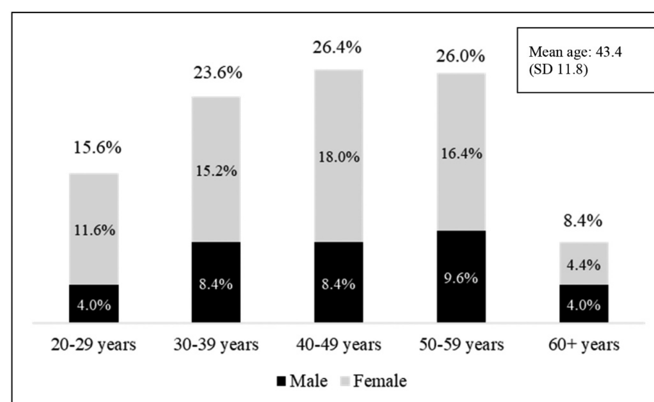

Figure 1. Age and sex profile of NSW AOD NGO workers.

Approximately one quarter (27.4%) possessed an undergraduate or postgraduate AOD-specific degree. The majority held AOD certificate/diploma qualifications or accredited short courses (54.4%) and one in five workers (18.1%) did not possess an AOD qualification. Overall, 41.9% held university level qualifications and a further 45.9% held non-AOD-related certificates/diplomas (Table 1).

Employment stability and salary

Most respondents were permanently employed (81.4%), in a full-time capacity (72.1%), within urban organizations (52.9%) and provided direct client services (87.8%). Among full-time workers (≥35 hours per week), 75.8% earnt AUD 80,000 or less per annum, with AUD 81,755 being the national average salary in 2017 (ABS, 2018).

Professional development opportunities

Access to all forms of supervision was relatively low; with 42.0% reporting access to clinical supervision, 40.1% to line management supervision, 32.5% to peer supervision/mentoring, and 4.0% to cultural supervision (Table 2).

Most workers who accessed clinical supervision, line management or peer supervision/mentoring did so at least once per month and perceived supervision to be good/excellent. Cultural supervision was infrequently accessed and 37.5% considered it to be of poor quality (Table 2). Line management supervision was assessed as poor quality by 17.6% of respondents.

Approximately half (55.1%) indicated that their employer provided practices or initiatives to support their professional development (e.g., study leave, paying fees, conference attendance) (Table 3).

Work conditions

Workloads were perceived as high by 38.8% of respondents. Most rarely or never took work home (56.4%) or were interrupted by work at home (66.5%). Overall, 58.5% were satisfied with their

Table 1. Demographic and professional profile of respondents.

Demographics	n	%
Country of birth: Australia	205	76.5
Aboriginal and/or Torres Strait Islander: Yes	23	8.4
Sexuality: Straight/Heterosexual	221	84.7
Lived experience of problematic AOD use[1]		
Yes (disclosed to workplace)	78	29.1
Yes (undisclosed to workplace)	36	13.4
Highest AOD qualification		
Nil	41	18.1
Accredited short course/certificate/diploma	123	54.4
Undergraduate/postgraduate degree	62	27.4
Highest non-AOD qualification		
School or less	27	12.2
Certificate/diploma	102	45.9
Undergraduate/postgraduate degree	93	41.9
Health status: Good/very good/excellent	162	81.4
Employment characteristics		
Location of workplace: Urban	139	52.9
Employment type: Permanent	214	81.4
Full time equivalency: Full time	176	72.1
Annual gross salary[2]		
AUD 20,000-40,000	3	1.9
AUD 40,001-60,000	53	33.8
AUD 60,001-80,000	63	40.1
AUD 80,001	38	24.2
Role involvement[3]		
Direct client services	208	87.8
Management	84	35.4
Administration	113	47.7
Other	23	9.7
Experience in current role		
≤ 1 year	87	37.5
1 – < 5 years	79	34.1
Experience in current organization		
≤ 1 year	58	25.6
1 – < 5 years	69	30.4
Experience in AOD field		
≤ 1 year	37	16.4
1 – < 5 years	62	27.4
Experience in workforce: ≥ 10+ years	180	78.6
Professional affiliation/practitioner registration: Yes	101	43.9

[1]Lived experience refers to personal experience of problematic AOD use for which treatment or support may or may not have been sought. [2] Full time employees (working ≥35 hours per week) only. Currency is in Australian dollars. The average annual income in November 2017 (trend data) for full-time workers (ordinary time earnings) was approximately AUD 81,755 (Australian Bureau of Statistics, Average Weekly Earnings, Australia, Nov 2017, 6302.0. 2018, Canberra, Australia). [3] Respondents could select more than one option.

work/life balance. The majority felt supported to undertake their role (85.1%) and most perceived supervisors and co-workers to be highly supportive (53.5% and 71.0%, respectively). Although most (66.0%) were satisfied working in the NGO AOD sector, a quarter to a half experienced discrimination (22.6%), bullying (45.0%), or harassment (23.9%) (Table 3).

Two thirds (67.8%) were dissatisfied with their pay. A substantial proportion planned to look for a new job within 12 months (30.0%), either within (18.4%) or outside (20.1%) the AOD field (Table 3). Overall, 55.4% of workers had moderate to high intentions to leave and approximately 30.3% thought they had a medium/high chance of losing their job in the next 12 months (Table 3).

Table 2. Availability, frequency of access, and perceived quality of supervision, by type of supervision.

	Clinical [1]		Line Management		Peer/ Mentor [2]		Cultural	
Supervision	n	%	n	%	n	%	n	%
Access: Yes	159	42.0	110	40.1	89	32.5	11	4.0
Frequency of access								
Monthly or more often	130	77.8	91	66.4	79	76.0	3	10.0
Every 3–6 months	21	12.6	27	19.7	13	12.5	9	30.0
Once per year or less	16	9.6	19	13.9	12	11.5	18	60.0
Perceived quality								
Poor	14	8.4	25	17.6	11	10.1	12	37.5
Fair	31	18.7	30	21.1	20	18.3	9	28.1
Good	56	33.7	51	35.9	53	48.6	7	21.9
Excellent	65	39.2	36	25.4	25	22.9	4	12.5

[1]Internal and/or external clinical supervision. [2] Peer supervision and/or mentoring/coaching.

New vs experienced workers

New and experienced workers did not significantly differ in their perceptions of supports received; satisfaction with the NGO AOD sector and remuneration; turnover intention; chance of job loss; and experiences of discrimination and harassment (Table 3). Experienced workers however were

Table 3. Perceptions of work-related factors by all workers, new workers (<5 years) and experienced workers (5+ years)[1].

Work-related factors.	All workers[2] (n = 294).		New workers (n = 99).		Experienced workers (n = 127).		Significant difference (new vs experienced workers).
	n	%	n	%	n	%	
Workload							
Low	91	44.2	40	48.2	47	40.9	ns
Neither low nor high	35	17.0	17	20.5	15	13.0	ns
High	80	38.8	26	31.3	53	46.1	p =.04
Work/life balance							
Rarely/never take work home	115	56.4	50	61.7	59	51.8	ns
Rarely/never interrupted at home by work	135	66.5	65	79.3	64	57.1	p <.001
Overall satisfied with work/life balance[3]	121	58.5	47	56.0	67	58.3	ns
Support							ns
Feel supported to undertake role in general[4]	177	85.1	71	85.5	98	84.5	ns
High level of support from supervisors[5]	116	53.5	49	55.1	62	52.1	ns
High level of support from coworkers[5]	154	71.0	65	73.0	83	69.7	ns
Employer provided practices/initiatives to support professional development	151	55.1	63	63.6	82	64.6	ns
Satisfied with							
Working in NGO AOD sector[3]	132	66.0	51	61.4	73	67.6	ns
Pay[6]	84	32.2	26	26.3	47	37.6	ns
Turnover intention							ns
Q1 Thought about leaving job: Agree[7]	103	49.8	43	51.2	58	50.9	ns
Q2 Plan to look for a new job over the next 12 months: Agree[7]	62	30.0	30	35.7	31	27.2	ns
Q3 Plan to look for a new job within AOD field but outside current organization: Agree[7]	38	18.4	19	22.6	18	15.9	ns
Q4 Plan to search for a new job outside the AOD/addiction field: Agree[7]	41	20.1	18	21.4	22	19.8	ns
Total turnover intention[8]							
Low	91	44.6	35	41.7	49	44.1	ns
Moderate	49	24.0	21	25.0	28	25.2	ns
High	64	31.4	28	33.3	34	30.6	ns
Chance of job loss							
Low[9]	122	69.7	50	71.4	66	67.3	ns
Medium/high[10]	53	30.3	20	28.6	32	32.7	ns
Negative workplace experiences							
Discrimination: Yes[11]	49	22.6	14	15.4	34	29.1	ns
Bullying: Yes[11]	98	45.0	37	40.7	60	50.8	p =.02
Harassment: Yes[11]	52	23.9	20	22.0	32	27.1	ns

[1] Based on number of years' experience working in the AOD sector. [2] All workers include those who have not provided a response to the number of years they have worked in the AOD sector. [3] Proportion of respondents selecting satisfied or very satisfied. [4] Proportion of respondents selecting yes. [5] Proportion of respondents scoring 9–12 (high) on the Supervisor/coworker subscale of the Brief Job Stress Questionnaire. [6] Proportion of respondents selecting always or often. [7] Proportion of respondents selecting strongly agree or agree. [8] Proportion of respondents who scored low (1.00–2.50), moderate (2.75–3.25), and high (3.50–5.00). [9] Proportion of respondents selecting almost no chance or a low chance. [10] Proportion of respondents selecting a medium chance, a high chance or almost certain. [11] Proportion of respondents selecting occasionally or regularly.
ns = not significant

significantly more likely than new workers to have high workloads (new: 31.3%, experienced: 46.1%, p =.04) and to have experienced bullying in the workplace (new: 40.7%, experienced: 50.8%, p = .02). Compared to new workers, experienced workers were also significantly less likely to rarely/never be interrupted at home by work (new: 79.3%, experienced: 57.1%, p < .001).

Discussion

As the Australian health care system is heavily impacted by problems associated with AOD use with no signs of abatement, and with potential for substantial increases, appropriately skilled and qualified workers are essential. Patients/clients seeking AOD-related treatment or advice are reliant on an optimal workforce. To inform future workforce planning efforts this study examined the demographic and employment characteristics of the AOD NGO workforce in NSW.

This workforce was predominately female and middle aged, as found in previous research (Gethin, 2008; Network of Alcohol and other Drugs Agencies, 2014). Encouragingly, a substantial proportion of the workforce identified as Aboriginal and/or Torres Strait Islander; attraction, support and retention of this group of AOD workers is essential to ensure provision of culturally appropriate care for the disproportionate level of AOD harm experienced by Aboriginal and/or Torres Strait Islander peoples (Shakeshaft et al., 2010). Substantial proportions of workers also identified as lesbian, gay, bisexual or queer; and may therefore be well placed to provide support for the higher prevalence of AOD problems experienced by this community (AIHW, 2020). A very large proportion of workers also had their own lived experience of problematic AOD use; a particularly important issue with significant workforce development implications (Chapman et al., 2020). These distinguishing characteristics of the AOD workforce require close consideration and carefully tailored workforce development responses.

In terms of the age, approximately one third of this workforce were 50 years or older, consistent with the aging of the health workforce in general (Buchan & Campbell, 2013). This finding suggests that succession planning strategies are

pressingly required to mitigate institutional knowledge loss when these workers retire. Mid-aged and older workers also have a range of needs that are particular to their life circumstances (e.g., additional carer roles and external demands on their time and resources) (Hill et al., 2014); organizations seeking to retain mid-career and older employees are encouraged to implement support strategies accordingly.

In contrast to the large proportion of older workers, there was also a substantial minority of young workers. These young (and most likely new) workforce entrants may require markedly different forms of support, professional development and mentoring than their older, more experienced counterparts. Correspondingly, appropriate organizational support strategies may be required to retain these individuals in the longer term and to support their career progression through the sector. Additional research is required to determine the unique needs and requirements of both older and younger AOD workers.

Given the limited experience noted among many workers (almost half of whom had <5 years' AOD-related experience, and more than a third had been in their current role for ≤1 year), judiciously selected professional development strategies are especially important. It is of concern that new workers received the same level of supports including professional development opportunities as their more experienced counterparts. While an influx of new and young workers is applauded, it may represent an inherent vulnerability in the workforce structure of the AOD sector. Too many young and/or inexperienced workers may undermine quality care if sufficient supervision and additional professional development supports are not provided; concomitantly, too many older workers may weaken continuity and stability within organizations and the sector overall.

These workforce profiles also highlight the need for concerted supervision and mentoring efforts to ensure implementation of evidence-based practice and adherence to high standards of quality care. It is also important that these workers receive appropriate support, given the demands of working in areas of high emotional labor (Ewer et al., 2015). There is also apparent scope to increase and improve the amount and quality of cultural supervision provided. It was concerning to find that only half the participants reported practices or initiatives were provided by their organization to support their professional development and many had limited access to supervision. Of those receiving supervision, a substantial proportion of workers indicated that the quality of their supervision was of only poor/fair quality. This was especially notable in relation to cultural supervision which received the poorest rating. Previous research has also emphasized the importance of clinical supervision and mentoring as central workforce development strategies, especially for workers with limited experience (Roche et al., 2007; Skinner et al., 2005). Organizations are encouraged to provide professional development support and enhanced supervisory opportunities for workers at all levels, with a particular focus on the needs of newer workforce entrants.

Encouragingly, participants reported high levels of satisfaction with their work/life balance and with working in the NGO AOD sector. They also perceived co-workers and supervisors to be highly supportive. However, despite these positive findings, a substantial proportion intended to look for a new job in the next 12 months. Factors that may contribute to high turnover intention include the level of job insecurity cited by many respondents, full-time salaries commonly below the national average, dissatisfaction with remuneration or the experiences of workplace discrimination, bullying and harassment. It is recommended that managers and policy makers seeking to improve attraction and retention focus their efforts on these areas in the first instance.

Although the current study has highlighted numerous strengths, there are also many challenges facing the AOD workforce. Of key relevance are the findings regarding turnover intention and limited years of experience and/or qualifications. These factors have important implications for the provision of high-quality client services and warrant immediate attention to forestall any future negative effects on service provision. Specifically, workforce planning strategies are needed to ameliorate the impact of potential staff losses and to support those workers with little formal experience or specialized training. As highlighted by Ritter et al. (2019), a comprehensive understanding of the AOD treatment service system, including the workforce, is essential for advanced planning efforts.

Limitations

Although this study's sample was relatively small and drawn from a single jurisdiction, the NGO component of the Australian AOD service delivery sector constitutes approximately 60% of the sector overall (AIHW, 2019), and hence the findings are potentially generalizable to more than half of the total sector nationally. Nonetheless, future studies would benefit from sampling from the entire Australian AOD workforce.

Conclusion

This study underscores the importance of contemporary and comprehensive workforce data to identify the particular needs of AOD workers. Given the composition of the workforce, nuanced workforce development and planning initiatives are needed to enhance and maintain high-quality service provision. Policy makers and managers are encouraged to ensure that relevant professional development and support strategies are in place to reduce potential negative consequences on service delivery associated with high numbers of staff approaching retirement, as well as the substantial proportions with limited experience.

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References

ABS. (2018). *Average weekly earnings, Australia, Nov 2017, 6302.0*. Australian Bureau of Statistics.

AIHW. (2017). *National drug strategy household survey 2016: Detailed findings*. Australian Institute of Health and Welfare.

AIHW. (2018). *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of disease study 2011. Australian Burden of Disease Study series no. 17. Cat. no. BOD 19*. Australian Institute of Health and Welfare.

AIHW. (2019). *Alcohol and other drug treatment services in Australia: 2017–18. Key findings. Cat. no. HSE 224*. Australian Institute of Health and Welfare.

AIHW. (2020). *Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221*. Australian Institute of Health and Welfare.

Best, D., Savic, M., & Daley, P. (2016). The well-being of alcohol and other drug counsellors in Australia: Strengths, risks, and implications. *Alcoholism Treatment Quarterly*, *34*(2), 223–232. https://doi.org/10.1080/07347324.2016.1148514

Bonomo, Y., Norman, A., Biondo, S., Bruno, R., Daglish, M., Dawe, S., Egerton-Warburton, D., Karro, J., Kim, C., Lenton, S., Lubman, D., Pastor, A., Rundle, J., Ryan, J., Gordon, P., Sharry, P., Nutt, D., & Castle, D. (2019). The Australian drug harms ranking study. *Journal of Psychopharmacology*, *33*(7), 759–768. https://doi.org/10.1177/0269881119841569

Buchan, J., & Campbell, J. (2013). Challenges posed by the global crisis in the health workforce. *BMJ: British Medical Journal*, *347*, f6201. https://doi.org/10.1136/bmj.f6201

Cammann, C., Fichman, M., Jenkins, G., jr., & Klesh, J. (1983). Assessing the attitudes and perceptions of organizational members. In S. E. Seashore, E. E. I. Lawler, P. H. Mirvis, & C. Cammann (Eds.), *Assessing organizational change: A guide to methods, measures and practices* (pp. 71–138). Wiley.

Chapman, J., Roche, A., Kostadinov, V., Duraisingam, V., & Hodge, S. (2020). Lived experience: Characteristics of workers in alcohol and other drug nongovernment organizations. *Contemporary Drug Problems*, *47*(1), 63–77. https://doi.org/10.1177/0091450919894341

Ewer, P., Teesson, M., Sannibale, C., Roche, A., & Mills, K. (2015). The prevalence and correlates of secondary traumatic stress among alcohol and other drug workers in Australia. *Drug and Alcohol Review*, *34*, 252–258. https://doi.org/10.1111/dar.12204

GBD 2017 Causes of Death Collaborators. (2018). Global, regional, and national age-sex-specific mortality for 282 causes of death in 195 countries and territories, 1980–2017: A systematic analysis for the global burden of disease study 2017. *Lancet*, *392*(10159), 1736–1788. https://doi.org/10.1016/s0140-6736(18)32203-7

GBD 2017 DALYs and HALE Collaborators. (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990–-2017: A systematic analysis for the global burden of disease study 2017. *Lancet*, *392*(10159), 1859–1922. https://doi.org/10.1016/s0140-6736(18)32335-3

Gethin, A. (2008). *NSW alcohol and other drug non government sector: Workforce profile and issues*. NADA.

Gorman, D. (2015). Developing health care workforces for uncertain futures. *Academic Medicine*, *90*(4), 400–403. https://doi.org/10.1097/acm.0000000000000644

Hill, E., Erickson, J., Fellows, K., Martinengo, G., & Allen, S. (2014). Work and family over the life course: Do older workers differ? *Journal of Family and Economic Issues*, *35*(1), 1–13. https://doi.org/10.1007/s10834-012-9346-8

Intergovernmental Committee on Drugs. (2014). *National alcohol and other drug workforce development strategy 2015–2018*. Australian Government Department of Health.

Kostadinov, V., & Roche, A. (2017). Bongs and baby boomers: Trends in cannabis use among older Australians. *Australasian Journal on Ageing*, *36*(1), 56–59. https://doi.org/10.1111/ajag.12357

Kovitwanichkanont, T., & Day, C. (2018). Prescription opioid misuse and public health approach in Australia. *Substance Use & Misuse*, *53*(2), 200–205. https://doi.org/10.1080/10826084.2017.1305415

Network of Alcohol and other Drugs Agencies. (2014). *Responding to alcohol and drug related harms in NSW: Mapping the NSW non government alcohol and other drugs sector*. NSW Australia.

O'Driscoll, M., & Beehr, T. (1994). Supervisor behaviors, role stressors and uncertainty as predictors of personal outcomes for subordinates. *Journal of Organizational Behavior*, *15*, 141–155. https://doi.org/10.1002/job.4030150204

Pacheco, G., Morrison, P., Cochrane, B., Blumenfeld, S., & Rosenberg, B. (2016). *Understanding insecure work*. New Zealand Work Research Institute.

Ritter, A., Mellor, R., Chalmers, J., Sunderland, M., & Lancaster, K. (2019). Key considerations in planning for substance use treatment: Estimating treatment need and demand. *Journal of Studies on Alcohol and Drugs*, (s18), 22–30. https://doi.org/10.15288/jsads.2019.s18.22

Roche, A., & Kostadinov, V. (2019). Baby boomers and booze: We should be worried about how older Australians are drinking. *Medical Journal of Australia*, *211*(8), 382–382.e381. https://doi.org/10.5694/mja2.50351

Roche, A., Kostadinov, V., Hodge, S., Duraisingam, V., McEntee, A., Pidd, K., & Nicholas, R. (2018). *Characteristics and wellbeing of the NSW non-government AOD Workforce*. National Centre for Education and Training on Addiction.

Roche, A., Todd, C., & O'Connor, J. (2007). Clinical supervision in the alcohol and other drugs field: An imperative or an option? *Drug and Alcohol Review*, *26*(3), 241–249. https://doi.org/10.1080/09595230701247780

Shakeshaft, A., Clifford, A., & Shakeshaft, M. (2010). Reducing alcohol related harm experienced by Indigenous Australians: Identifying opportunities for Indigenous primary health care services. *Australian and New Zealand Journal of Public Health*, *34*(s1), S41–S45. https://doi.org/10.1111/j.1753-6405.2010.00552.x

Shimomitsu, T., Haratani, T., Nakamura, K., Kawakami, N., Hayashi, T., Hiro, H., Arai, M., Miyazaki, S., Furuki, K., Ohya, Y., & Odagiri, Y. (2000). Final development of the brief job stress questionnaire mainly used for assessment of the individuals. In M. Kato (Ed.), *The ministry of labor sponsored grant for the prevention of work-related illness* (pp. 126–164). Tokyo Medical University.

Skinner, N., Roche, A., O'Connor, J., Pollard, Y., & Todd, C. (2005). *Workforce development TIPS (Theory into practice strategies): A resource kit for the alcohol and other drugs field*. National Centre for Education and Training on Addiction.

Van Veldhoven, M., & Meijman, T. (1994). *Questionnaire on the experience and assessment of work: VBBA—English version*. The Foundation for Quality in Occupational Health Care.

Ware, J., Jr., & Sherbourne, C. (1992). The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Medical Care*, *30*(6), 473–483. https://doi.org/10.1097/00005650-199206000-00002