



WORKFORCE PROFILE 2025



**ACT ALCOHOL, TOBACCO,
AND OTHER DRUG SECTOR**

Artist recognition

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Full report available on ATODA's website www.atoda.org.au



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About ATODA



The Alcohol, Tobacco and Other Drug Association ACT (ATODA) is the peak body for the alcohol, tobacco and other drug sector in the ACT.

We lead, strengthen and advocate for the ACT's high-quality treatment and harm-reduction sector, working to provide a broad range of alcohol, tobacco and other drug treatment options to the community.

We represent organisations and people throughout the ACT committed to reducing alcohol, tobacco and drug related harms.

Our work is informed and guided by our highly valued members who work in true partnership with their peak to enhance our sector and support the ACT community.

Acknowledgements



Acknowledgment of Traditional Custodians

ATODA proudly acknowledges the Ngunnawal people as Traditional Custodians of the land we work on and recognises all other peoples or families with connections to the ACT and region.

ATODA acknowledges, respects and celebrates the continuing cultures and contributions of Aboriginal and Torres Strait Islander peoples to the life of the ACT and region. We respect and value the contributions of Aboriginal and Torres Strait Islander peoples to the alcohol, tobacco and other drug sector.

Acknowledgment of people with lived and living experience

ATODA recognises the contributions of people with lived and living experience of substance use harms in progressing the objectives of ATODA and the alcohol, tobacco and other drug (ATOD) sector.

We are grateful for the insights and expertise of those with lived and living experience in their contribution to the ATOD and community sectors.

Acknowledgment of the workforce

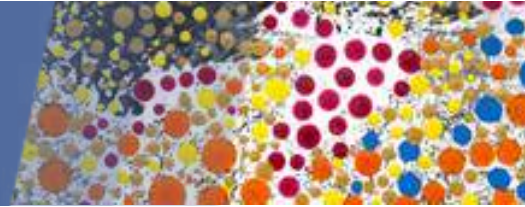
ATODA is grateful to the ACT ATOD workforce for their contribution to the Workforce Profile. We recognise the expertise, passion and dedication of those who work in this sector.

ATODA acknowledges the individuals and organisations that contributed to previous iterations of the Workforce Profile including David McDonald of Social Research & Evaluation Pty Ltd who developed the original surveys.

Survey design, implementation, data analysis and reporting of the *Workforce Profile 2025: ACT Alcohol, Tobacco and Other Drug Sector* was led by Dr Elisabeth Yar with the substantial support of Anke van der Sterren. Design support was provided by Jeanette Bruce.

Other current and previous ATODA staff contributed to various elements of the project, under the guidance of ATODA CEO Anita Mills.

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and to access appendices and additional material,
please scan the QR code below**



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Summary



42.9 yrs

Mean age of workers in the sector



75.2%

Percentage of respondents who identify as 'woman'

47.5%
PROPORTION OF WORKFORCE PARTICIPATING
190 WORKERS FROM 10 ORGANISATIONS



55.4%

Percentage of respondents who have a Bachelor's degree



69.9%

Percentage of respondents with some form of lived experience



82.6%

Percentage of respondents in direct client contact roles (some or more of week)



10.5%

Percentage of survey respondents who are in peer work roles



15.4%

Percentage of survey respondents who have a disability



7.6%

Percentage of survey respondents who identify as Aboriginal



21.1%

Percentage of survey respondents who identify as LGBTIQ+



21.9%

Percentage of respondents who identify as culturally / linguistically diverse



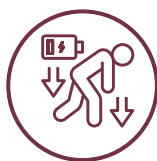
45.7%

Percentage of respondents who have caring responsibilities



89.3%

of respondents can recognise and respond to co-occurring mental health conditions



51.5%

of respondents are experiencing burnout somewhat, to a high degree or to a very high degree



44.4%

of respondents agree or strongly agree that "the ATOD sector is seen as less important than other medical fields or social services"

About the Workforce Profile

In 2009, the ACT alcohol, tobacco and other drug sector Executives' Group agreed to a regular survey of workers to map pay and conditions across the sector. Although initially just a survey of workers, in 2014 the Workforce Survey was expanded to include a survey of each organisation.

Across late 2024 and early 2025, ATODA collected data from organisations and workers. This formed the basis of the seventh ACT ATOD sector workforce profile report.



To view previous workforce profiles, please visit the ATODA website



The following organisations participated in the *ACT Alcohol, Tobacco and Other Drug Sector Workforce Profile 2025*:

- Alcohol and Drug Services, Canberra Health Services (ADS)
- Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)
- Directions Health Services (Directions)
- Family Drug Support (FDS)*
- Gugan Gulwan Youth Aboriginal Corporation (Gugan)*
- Karralika Programs (Karralika)
- Marymead CatholicCare Canberra & Goulburn (MCCG)
- The Salvation Army Australia (The Salvation Army)
- Ted Noffs Foundation ACT (Ted Noffs)
- Toora Women Inc (Toora)
- Winnunga Nimmitjyah Aboriginal Health and Community Services (Winnunga)⁺



Although several of these organisations also operate in other jurisdictions, only workers providing services within the ACT are in scope for the Workforce Profile.

*For logistical reasons, only the Organisation Survey was completed; ⁺Completed Workers' Survey only - estimate of total workforce numbers based on best knowledge.



Organisation Survey

45 questions

10 respondents

The Organisation Survey was circulated between December 2024 and January 2025. Executive Officers (or a delegate) from 10 organisations completed the survey.

Participation in the workforce profile is a contractual obligation for services receiving ATOD funding from the ACT Government.



Workers' survey

92 questions

190 respondents

47.5% response rate

The Workers' Survey was circulated between November 2024 and February 2025 and generated responses from 190 workers (representing 47.5 percent of those in scope) across nine organisations.

No individual worker is compelled to complete the survey. All responses were voluntary, any individual question could be skipped, and survey responses could be withdrawn prior to analysis.

Beyond the workforce in scope for the ACT Alcohol, Tobacco and Other Drug Sector Workforce Profile (that is, workers employed in services that receive funding for provision of ATOD treatment and harm reduction through the ACT Health and Community Services Directorate), there is a broader ATOD sector ecosystem, comprised of GPs, private practitioners, mental health providers, pharmacists, secondary needle and syringe programs (NSP)s, specialist health and allied sector services, researchers, and educators, amongst others. Workers in these roles provide valuable support to the ATOD sector but are not captured in the context of this workforce profile.



*Thank
you*

ATODA gratefully acknowledges the time and effort of all workers in the ACT alcohol, tobacco and other drugs sector who participated in this Workforce Profile. Your involvement in the project provides ATODA with data that allows us to better advocate for the sector and ensure that the workforce is supported to continue providing high quality, best practice treatment and harm reduction services.

ATODA is grateful for the ongoing funding of this project by the ACT Health and Community Services Directorate.

SECTION 1: THE ACT ALCOHOL, TOBACCO AND OTHER DRUG WORKFORCE



1.1 Overview of the ACT ATOD sector

The specialist alcohol, tobacco and other drug (ATOD) sector in the ACT is comprised of eleven government and non-government organisations that provide a wide range of treatment and harm reduction programs and services to a diverse population of service users.

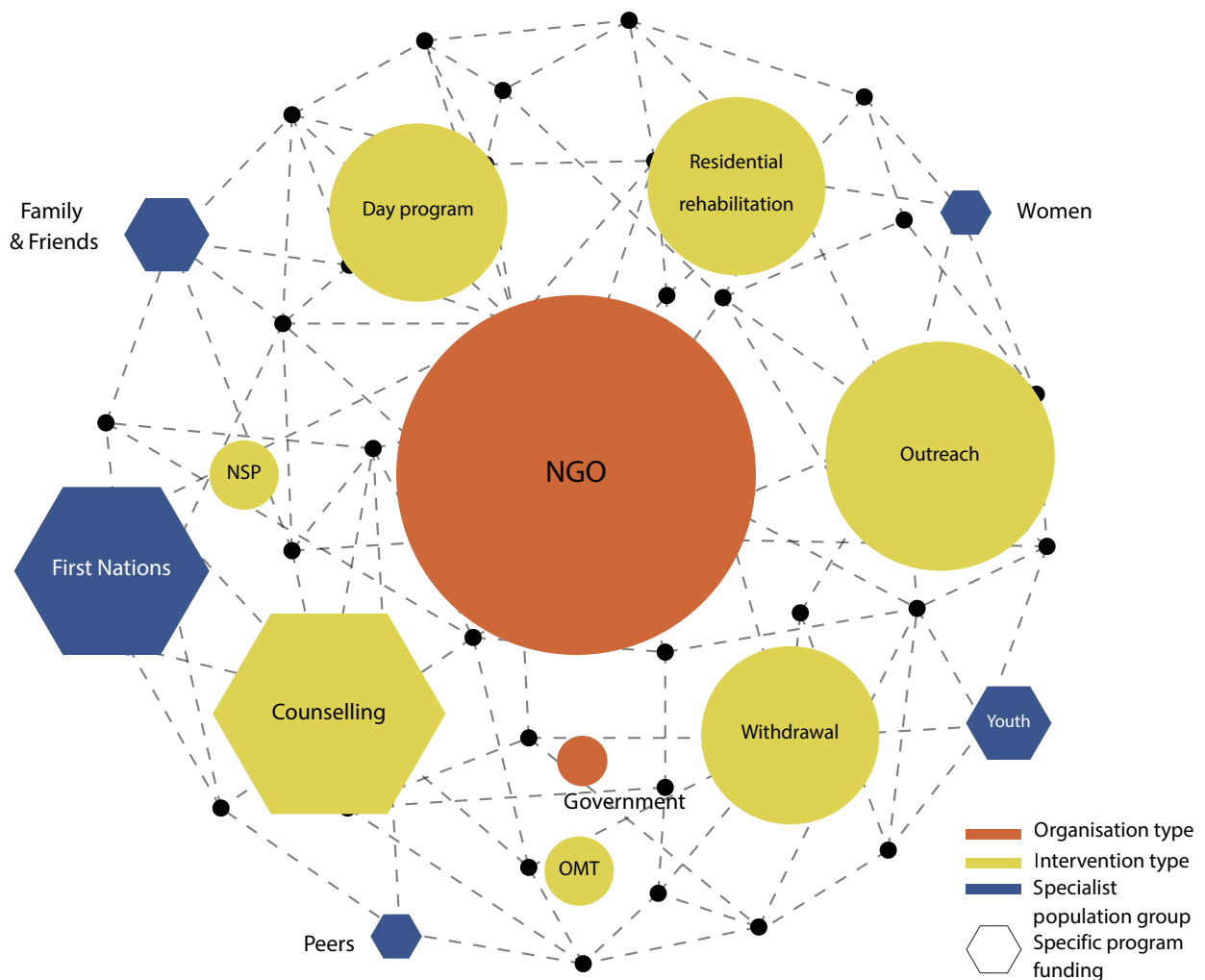


Diagram 1.1 Map of the sector 2025



To find out more about the ACT ATOD sector and the range of services and programs that are currently available, please visit the [ACT Alcohol, Tobacco and Other Drug \(ATOD\) Program Directory](#).

1



6000
episodes
of care¹
(in 2023-24)



3600
service
users¹
(in 2023-24)



400
sector
employees



287
FTE
positions

Between 2006 and 2025 the ACT ATOD workforce grew at a slightly faster rate than the ACT population.² However, demand for ATOD services continues to outstrip supply, with staffing being one of a complex interplay of factors that can limit the sector’s capacity to fully meet the needs of the community. The Organisation Survey showed that, across services, there was an estimated **shortfall of 86 workers** to address current demand.

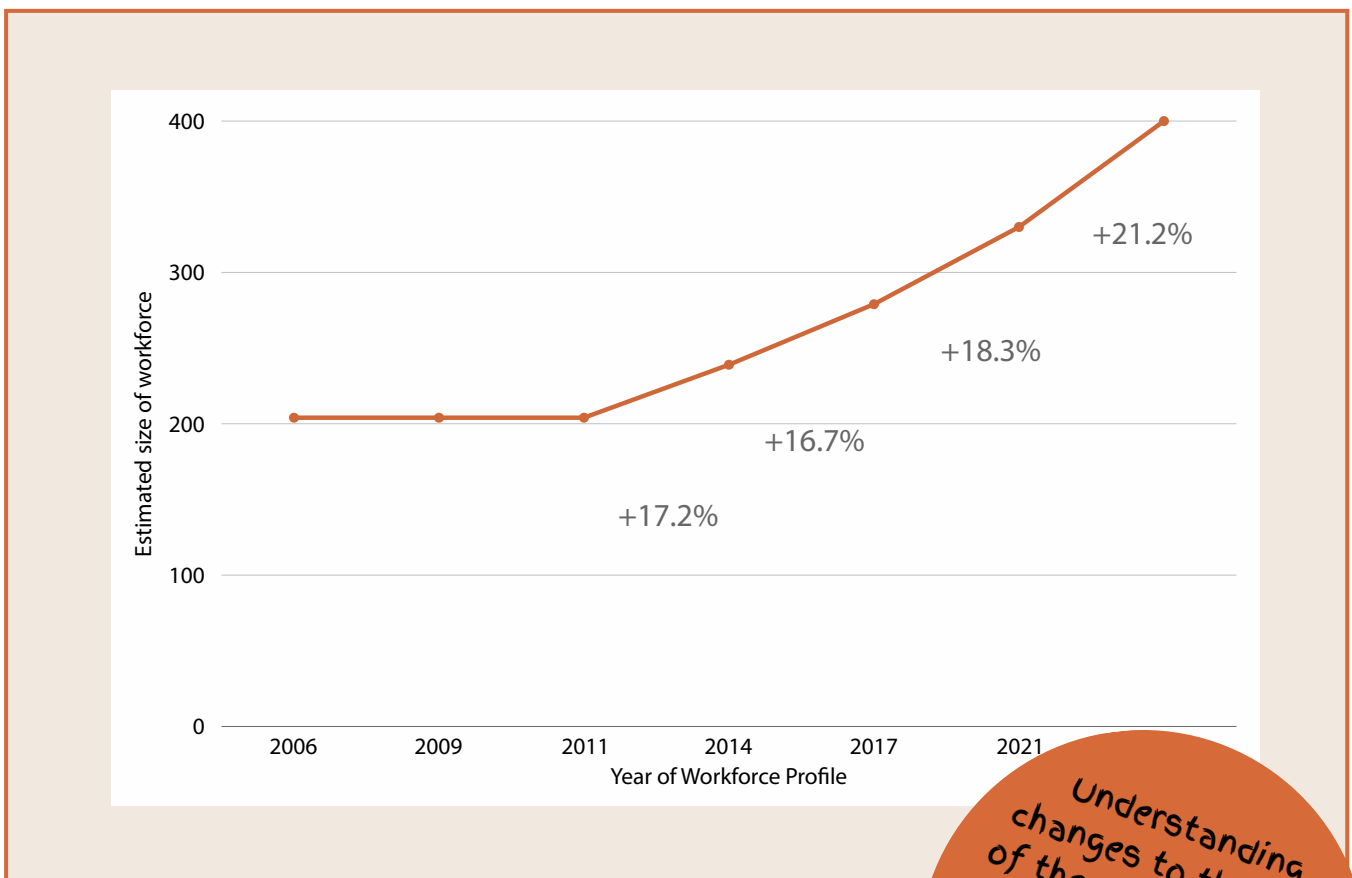
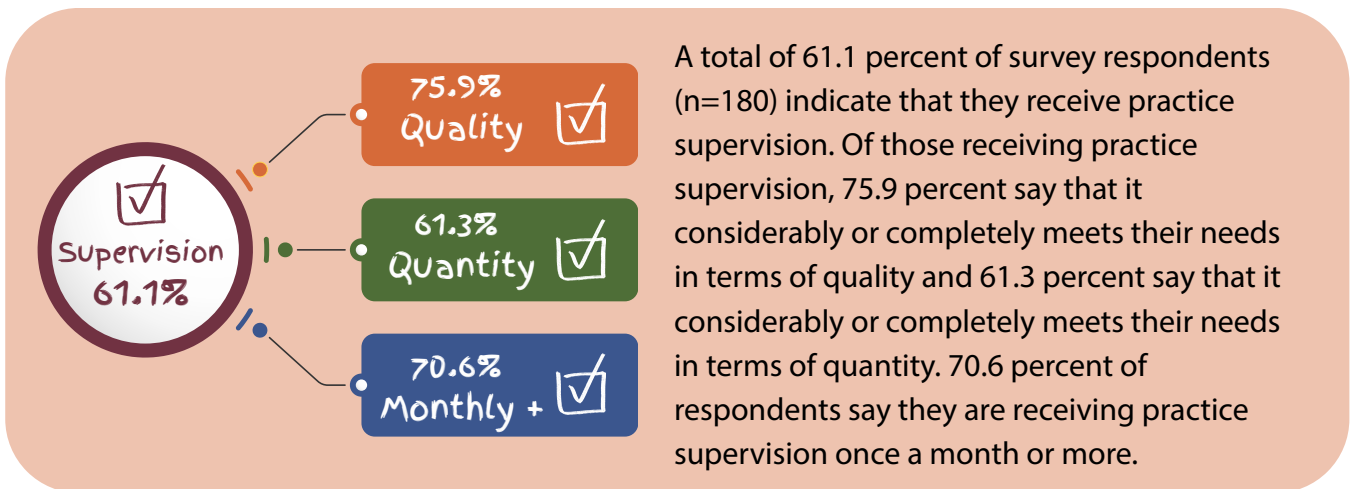


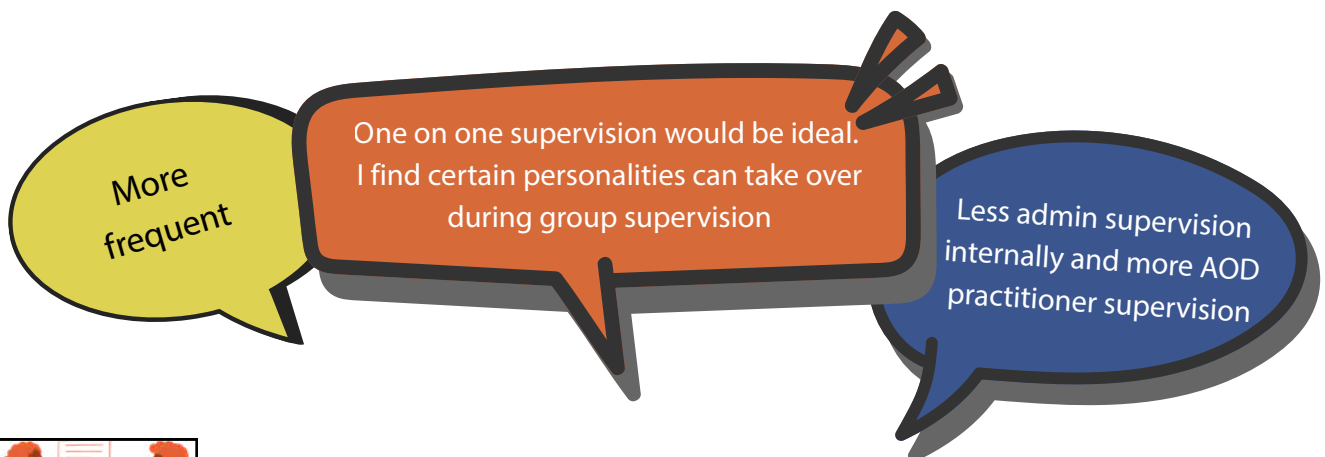
Diagram 1.2 Changes to the size of sector 2006 - 2025

Understanding changes to the size of the workforce over a period of years helps ATODA to better advocate on behalf of the sector

The ACT ATOD sector enjoys some unique benefits due to its relatively small size and geographic containment. Collaboration across the sector is particularly noteworthy. However, there are challenges related to economies of scale that adversely impact access to practice supervision and training.* ATODA seeks innovative ways to ensure that the size of the sector does not inhibit access to professional development.



The most cited improvement that is needed to current supervision arrangements is **increased frequency**. Other issues that were raised include the need for one-on-one and face-to-face supervision, and a preference for external supervisors with specialist ATOD practice expertise.



A total of 22 survey respondents **provide** practice supervision within or outside their organisation.

*ATOD practice supervision (sometimes referred to as clinical supervision) is distinguished from other forms of supervision by greater confidentiality and clear separation from the functions of line management. It involves reflective discussion of the worker's practice for the purposes of supporting wellbeing and developing skills, knowledge, professional identity, accountability and best practice.

Workers with direct client contact have minimum qualification requirements under the ACT Alcohol, Tobacco and Other Drug Qualifications Strategy and may face distinct risks and pressures, such as increased risk of exposure to vicarious trauma.



We asked

Most people employed in the alcohol, tobacco and other drug (ATOD) sector undertake a mix of different activities including direct client contact and non-client contact activities. Please indicate how much of an average working week is spent on direct client contact activities: all or almost all; most (approximately three-quarters of a week); about half; some (approximately one-quarter of a week); none or almost none.

In the context of the Workforce Profile, direct client contact is determined by the response to this question and cross-checked by way of reference to a person's stated job role and tasks.

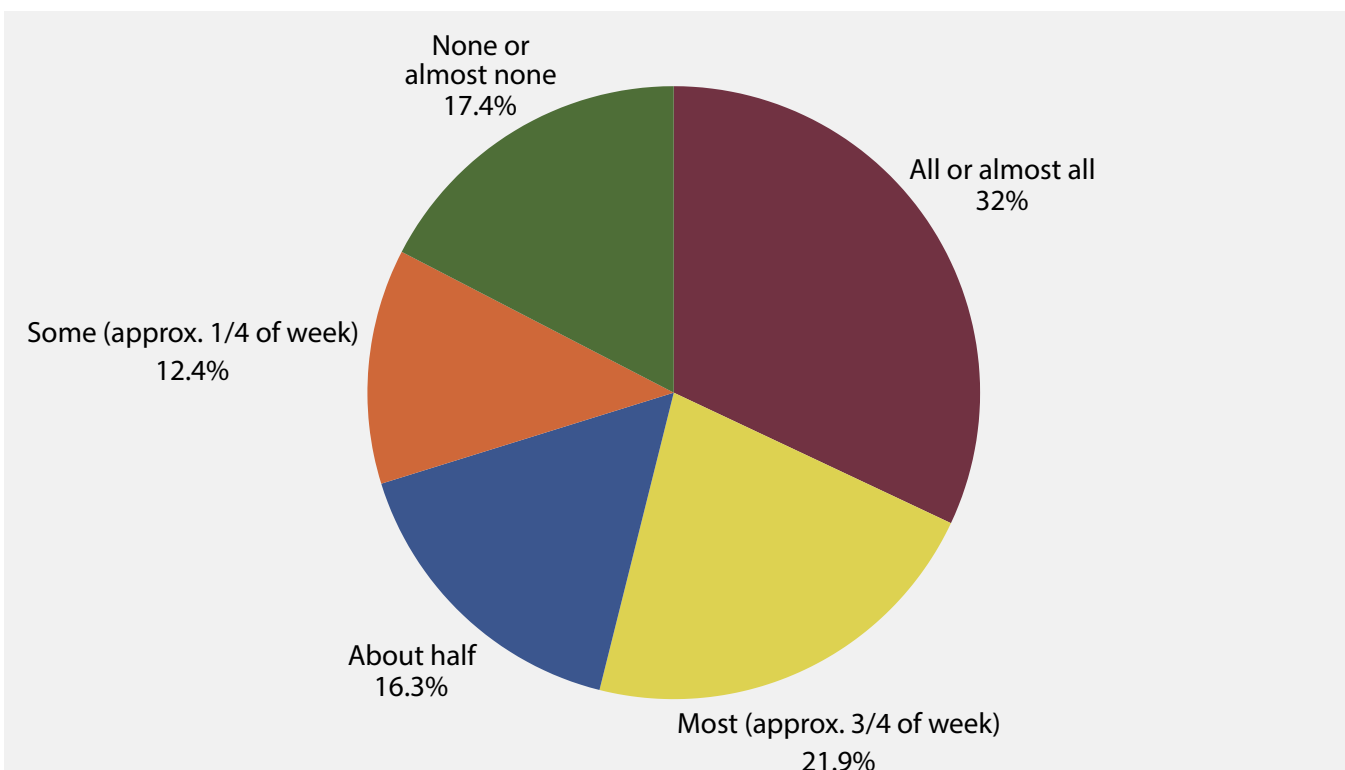


Diagram 1.3 Proportion of working week spent on direct client contact activities as reported in Workers' Survey (n=178)



In the Organisation Survey it was estimated that 78.9 percent of the workforce provides direct client services.



- The ACT ATOD sector employs approximately 400 people (287 FTE).
- 70.2 percent of respondents to the Workers' Survey indicate that they spend about half or more of their week on direct client contact activities.



1.2 Who is the 'average' worker?



42.9 yrs

Mean age of
workers in the sector

Age

The average age of workers in the sector (n=152) is 42 years and 11 months (42.9 years). The median age is 43 years. This is older than the median age of 35 for workers across the ACT.³

An older workforce may indicate greater experience and is often associated with workforce stability and lower rates of turnover. However, it can also signify a difficult recruitment environment.⁴ An aging workforce in the context of poor recruitment can lead to significant workforce pressures, as those leaving the sector by natural attrition are not replaced.



In 2023, the median age of service users was 40, up from 35 in 2009.⁵



75.2%

Proportion of
respondents who
identify their gender
as 'woman'

Gender

The Organisation Survey data shows that women make up 71 percent of the workforce, while men make up 28 percent. In the Workers' Survey, 75.2 percent of respondents (n=157) identify their gender as 'woman', while 24.4 percent identify their gender as 'man'. The number of workers who identify as non-binary or who use another term is <5.

Australia's health and community sector workforces are comprised predominantly of women (74 and 84 percent respectively).⁶ There are a number of issues that tend to arise in workforces that have significant gender imbalances. Health and care occupations are sometimes treated as an extension of women's domestic and unpaid work.⁷ This gendered expectation devalues health and caring work, which results in persistent underinvestment in these sectors.



The gender split of service users accessing ATOD services is 61.7 percent men to 36.2 percent women.⁵

Aboriginal and Torres Strait Islander

Survey respondents (n=157) were asked if they identify as Aboriginal and/or Torres Strait Islander. A total of 12 respondents (7.6 percent of survey respondents) indicate that they identify as Aboriginal (with none identifying as Torres Strait Islander).

The Organisation Survey shows that 17 workers are in specific Aboriginal and/or Torres Strait Islander identified positions. Drawing on data from the Workers Survey and Organisation Survey, ATODA estimates the Aboriginal and Torres Strait Islander workforce, across both Aboriginal Community Controlled Organisations (ACCOs) and other services, comprises 6.5 percent of the total workforce (n=400).

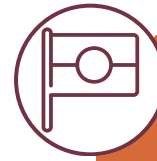
Recruitment of Aboriginal and Torres Strait Islander workers to the ACT ATOD sector may be particularly beneficial in supporting the health and wellbeing outcomes of First Nations peoples. Under the ACT Drug Strategy Action Plan 2022–2026, Aboriginal and Torres Strait Islander peoples constitute a population requiring special consideration.⁸

Cultural and linguistic diversity

Survey respondents (n=155) were asked if they identify as a person from a culturally and linguistically diverse (CALD) background. A total of 34 respondents (21.9 percent) indicate that they identify as having a CALD background. Identifying as having a CALD background is, unsurprisingly, strongly correlated with using a language other than English at home, with 25 respondents (15.3 percent; n=164) indicating they use a language other than English on occasion (3.7 percent) or on a regular basis (11.6 percent).



There are potential barriers to accessing ATOD treatment and harm reduction services for people from some migrant and refugee backgrounds.⁹ Less than 10 percent of ATOD service users in the ACT identify as having a CALD background.⁵ The proportion of workers identifying as having a CALD background is slightly lower than the general CALD population of the ACT.³



7.6%

Percentage of respondents who identify as Aboriginal



*21.9 percent of **service users** identify as Aboriginal and/or Torres Strait Islander.⁵*



21.9%

Percentage of respondents who identify as a person from a CALD background



21.1%

Percentage of survey respondents that identify as LGBTQIA+

Sexual orientation

Survey respondents (n=152) were asked how they describe their sexual orientation (heterosexual/straight, lesbian, gay, bisexual, queer, I prefer not to say, or I use a different term). For reporting purposes these categories have been collapsed into two: heterosexual/straight; LGBTQIA+ (with the category of I prefer not to say excluded from analysis). A total of 32 respondents (21.1 percent) identify as LGBTQIA+, with the largest proportion identifying as bisexual.



*In the ACT, 5.7 percent of adults in the **general population**,¹⁰ and 14 percent of **ATOD service users** identify as LGBTQIA+.⁵*



15.4%

Percentage of survey respondents who indicate that they have a disability

Disability

A total of 15.4 percent of respondents (n=162) indicate that they identify as a person with a disability. In the context of a) an aging workforce and b) efforts to incorporate lived experience, it is all the more incumbent to recognise and accommodate disability, including physical, sensory, cognitive and social/emotional disabilities, as well as various forms of neurodivergence. Doing so will add valuable diversity to the workplace and will provide greater opportunities for workers to contribute fully to the functioning of their organisations.



45.7%

Percentage of the workforce that identify as having caring responsibilities

Caring responsibilities

Survey respondents (n=162) were asked if they provide unpaid care to another person outside of work hours (a child or children, older person, person with a disability or other person requiring care). A total of 74 respondents (45.7 percent) indicate that they do have caring responsibilities, with the vast majority indicating that they are caring for a child or children.

Workers who are women were more likely to have caring responsibilities (47.9 percent of workers who identify as women have caring responsibilities, compared to 38.5 percent of those who identify as men). Those with caring responsibilities are only slightly more likely to be working part-time (47.8 percent) compared to full-time (44.6 percent) and are just as likely to be frequently working overtime than those with no caring responsibilities (49.1 percent compared to 50.9 percent).

Full-time or part-time status

More than half of the sector (59.6 percent) works full-time (n=188). Across the sector what constitutes a full-time working week varies from 35 hours up to 38 hours.

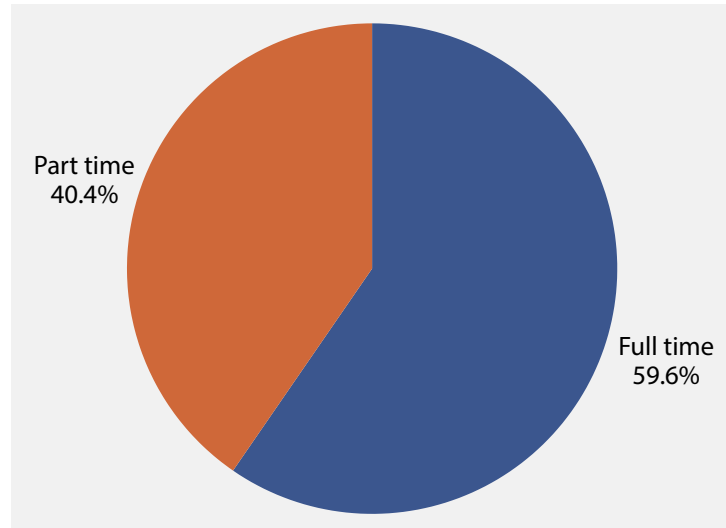


Diagram 1.4 Proportion of workforce in full time or part time roles (n=188)

Position status

The majority of the workforce (n=188) is employed in a permanent capacity (80.3 percent). Just over 10 percent (11.7 percent) of the sector is employed on a casual basis. The data may suggest a shift away from casualisation (down from 15.4 percent in 2021). However, longer term trends suggest that casual rates are relatively stable at around 10 percent of the workforce. Those employed on a casual basis are, unsurprisingly, significantly more likely to be working part-time. A persistent issue for data collection is that casual workers are less likely to complete the survey, meaning that there may be an undercount of these employees.

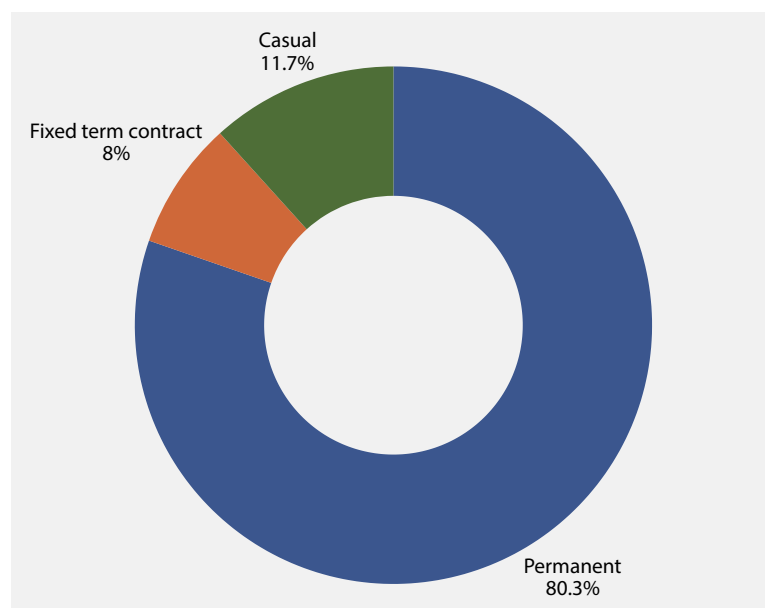


Diagram 1.5 Proportion of workforce in permanent, fixed term and casual roles (n=188)

Overtime

Survey respondents (n=185) were asked how often they work overtime. One-third (33.0 percent) indicate that they work overtime every day to a few times a week. Just over a third (37.8 percent) indicate that they never work overtime or only work overtime a few times a year. The remainder (29.2 percent) indicate that they work overtime a few times a month.

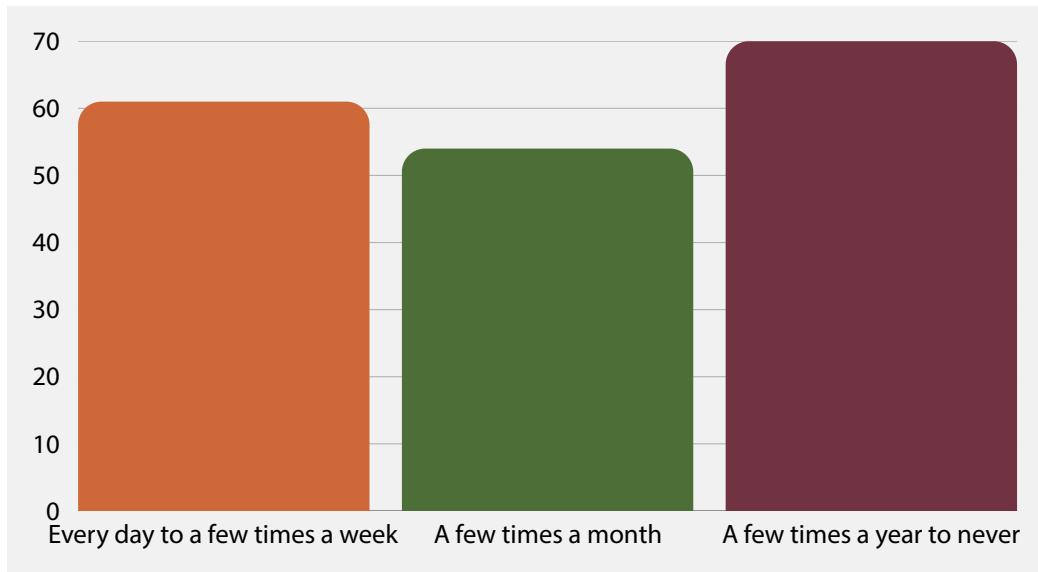


Diagram 1.6 Number of workers working overtime from everyday to never (n=185)

Income

The average weekly income for full-time workers (in any role) in the sector falls between \$1,500-\$1,999. The average weekly income for full-time AOD workers (including peer workers) is between \$1000-\$1,499. Earnings in the sector are, on average, lower than the ACT population-wide average full-time weekly earnings of just over \$2,230 in May 2025.¹¹

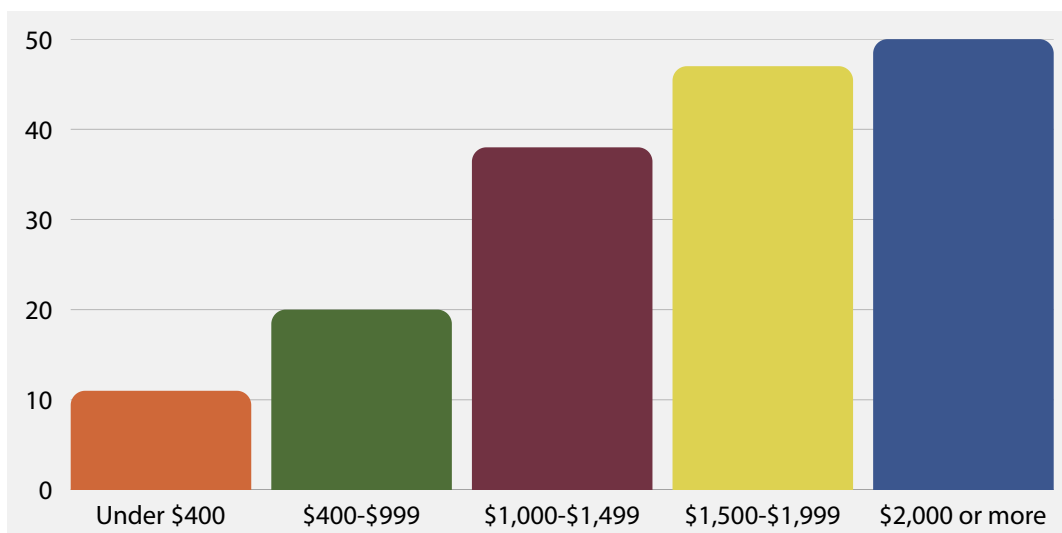


Diagram 1.7 Number of workers in different income categories (n=166)

Main role in organisation

We asked what best describes the main role or capacity the respondent (n=185) is employed in.*

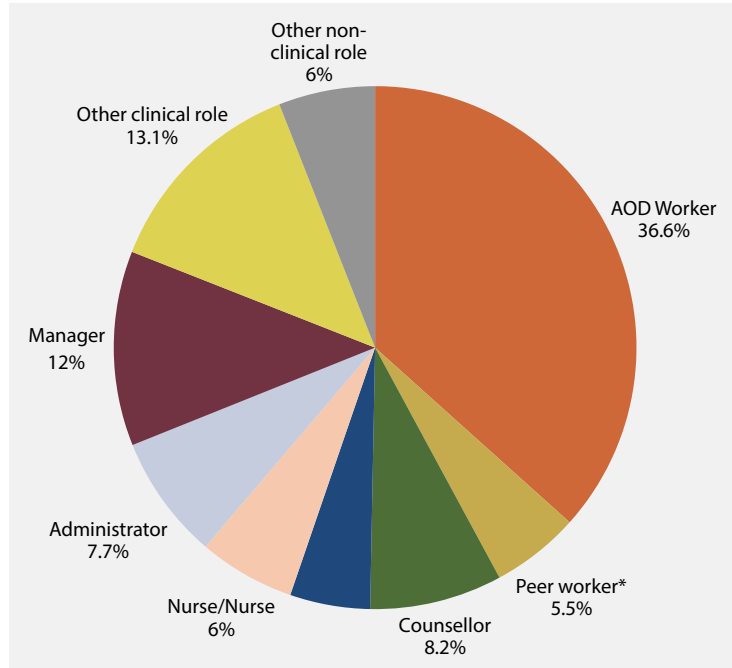


Diagram 1.8 Proportion of workforce in different main role (n=185)

Respondents who describe themselves as AOD workers make up 36.6 percent of the workforce. This is similar to the proportion of AOD workers identified in the Organisation Survey (36.0 percent).

*This is a self-described category. Elsewhere in this report, a different formula has been used to identify peer workers, who may here list their main role as AOD worker, Manager or Other role. This alternative formula, which includes secondary role, almost doubles the number of peer workers to 10.5 percent.

what defines an AOD worker?

An AOD worker is employed in a role where their main task is to provide specialist ATOD support.

AOD workers usually have an AOD qualification (e.g. a Certificate IV in AOD) and draw on knowledge and expertise acquired through training, workplace experience and - especially in the case of peer workers - their own lived experience of ATOD use.

AOD work is not registered under the AHPRA National Scheme or any other professional body but, in the ACT, AOD workers are required to meet the ACT Alcohol and Other Drug Qualifications Strategy.

Prior to current role

In their immediate prior role, 42.1 percent of respondents were working in the ATOD sector (in their own organisation or another organisation) while 41 percent were working outside the ATOD sector. Of those working outside the sector, the largest proportion (16.8 percent) came to their role from the mental health sector. Of the entire workforce, 24.2 percent had prior experience in the mental health sector. This wealth of mental health experience is noteworthy when we consider the interface of the ATOD and mental health sectors and the growing recognition of the importance of addressing co-occurring needs in the treatment and harm reduction space.

Length of time working in the sector

The average length of time working in the ATOD sector (n=167) for workers in any role is approximately six years and eight months (6.7 years). This is a decrease from the previous Workforce Profile, where the average length of time working in the ATOD sector was approximately seven years and five months (7.4 years). About half of the respondents to the Workers' Survey have been working in the sector for less than four years. About a quarter of respondents have been working in the sector for more than 10 years.

For those in an AOD worker role (including peer workers), the average length of time working in the sector is just over five years and nine months (5.8 years).

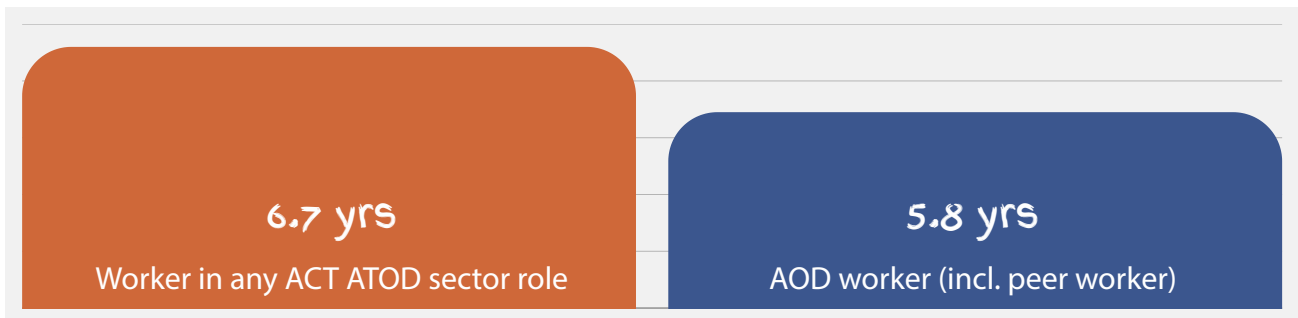


Diagram 1.9 Average length of time in sector for all workers and for AOD workers

Length of time in current organisation

The average length of time working in current organisation for workers in any role (n=188) is four years and five months (4.4 years). This is a slight decrease from the previous workforce profile where the average length of time in current organisation was approximately four years and ten months (4.8 years).

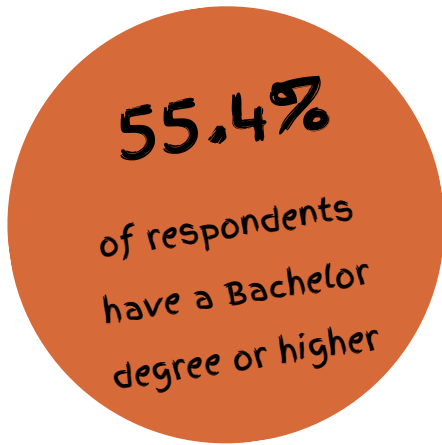
Length of time in current role

The average length of time working in current role is three years and two months. This is also a slight decrease from the previous workforce profile where the average length of time in current role was approximately three years and four months (3.3 years).



Highest level of education

Workers (n=175) were asked to indicate all qualifications that they had completed—many workers have multiple qualifications in different areas of study. Respondents described the levels and types of qualifications they had as follows:



- * Just over half (51.4 percent) have qualifications in an ATOD-specific area (e.g. Cert IV in AOD, Grad Cert in Addiction Studies but not including the AOD Skillset).
- * 21.7 percent do not have ATOD-specific qualifications but do have a qualification in health/social/behavioural sciences or community services (noting that, in some instances, ATOD-related content may make up a significant, although unspecified, portion of these qualifications).
- * 26.9 percent do not have ATOD-specific qualifications and do not have a qualification in the health/social/behavioural sciences or community services (this includes workers in non-client contact roles who may not be expected to have these qualifications).
- * Of workers in direct client contact roles, 55.6 percent have qualifications in an ATOD-specific area and 21.8 percent do not have ATOD-specific qualifications but do have a qualification in the health/social/behavioural sciences or community services.
- * Approximately 30 percent are currently studying.

The trend over time has been towards an increasingly qualified workforce. The proportion of workers attaining a graduate diploma, master's or doctorate has increased by approximately 50 percent between 2014 (36.8 percent) and 2025. This has potential implications for the quality of care delivered, the capacity of the sector to retain staff, and employment costs.

Lived experience

Do you identify as having lived/living experience in relation to alcohol and/or drug use?
(Please mark all answers that apply to your situation)



- I have personal experience of impacts from my own alcohol and/or drug use
- I have personal experience of engaging with a treatment or harm reduction service for my own alcohol and/or drug use
- I am a family member or close friend of someone who has experienced impacts from alcohol and/or drug use
- I have other past or present lived experience of alcohol and/or drug use not listed above (please specify)
- I do not identify as having lived experience of alcohol and/or drug use
- I prefer not to say

38.5 percent of the sector identify as having personal lived experience. This rises to 69.9 percent if we include those who indicate they are “a family member or close friend of someone who has experienced impacts from alcohol and/or drug use” or “have other past or present lived experience of alcohol and/or drug use”.

The diagram on the right shows overlap of experience, whereby for example, those with treatment experience (maroon) have complete overlap with personal experience (blue) and there is significant overlap between personal and family/other experience (yellow).

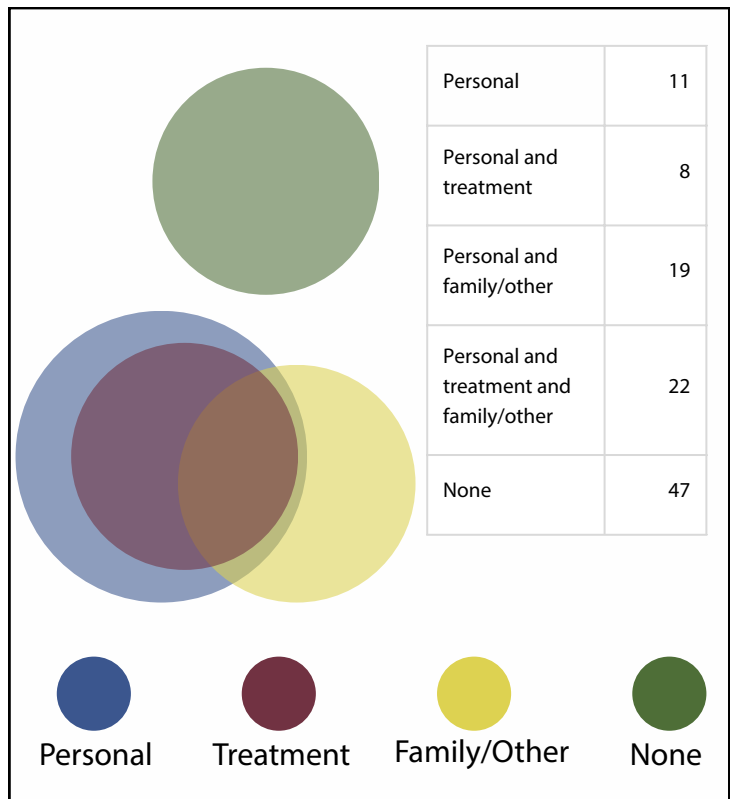


Diagram 1.10 Lived experience in the ATOD workforce

Smoking and vaping

16.2 percent of the workforce (n=167) indicate in the survey that they are a “current daily smoker”. This is higher than the general ACT population of daily smokers but significantly lower than the service user cohort. ATODA currently provides smoking cessation support, including provision of nicotine replacement therapies (NRT) to both service users and workers in ACT non-government ATOD services, through the Reducing Nicotine Harms project (see Section 6).

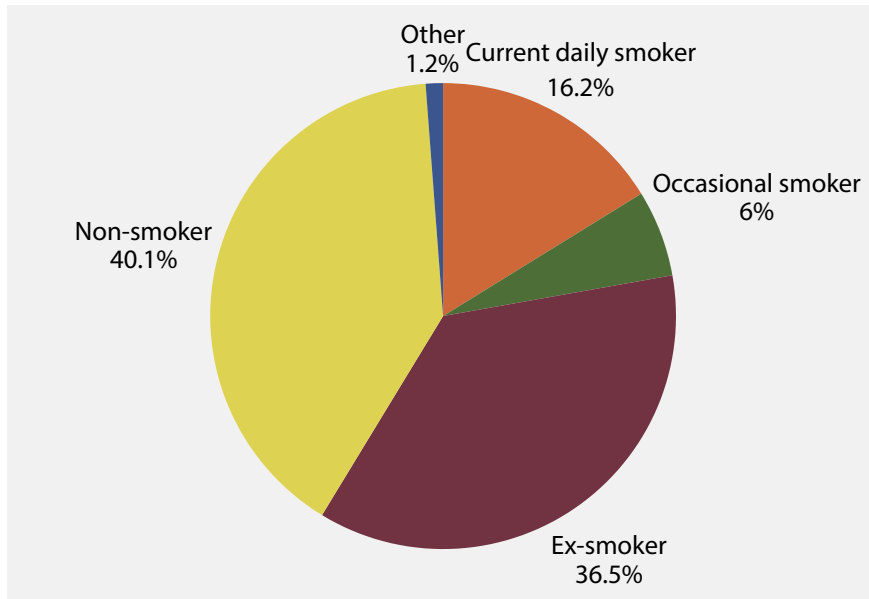


Diagram 1.11 Smoking status of workforce (n=167)

9.5 percent of survey respondents indicate that they use electronic cigarettes (vapes) on a daily basis. Evidence shows that electronic cigarettes may be effective in reducing smoking in some people and are likely to be less harmful than smoking tobacco products.¹² The evidence on vaping cessation is still emerging. However, there is no reason to believe NRT would not be effective in reducing or ceasing use of nicotine-containing electronic cigarettes.

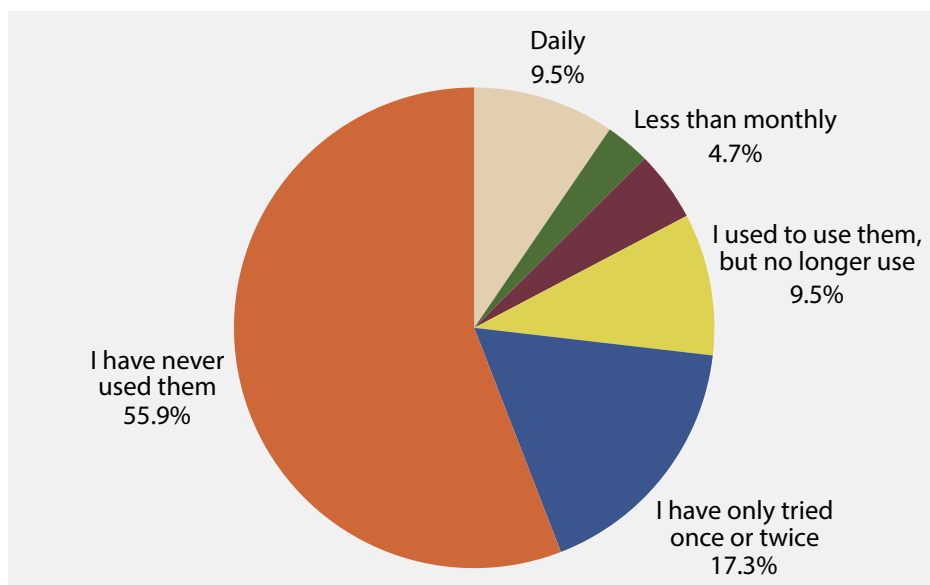
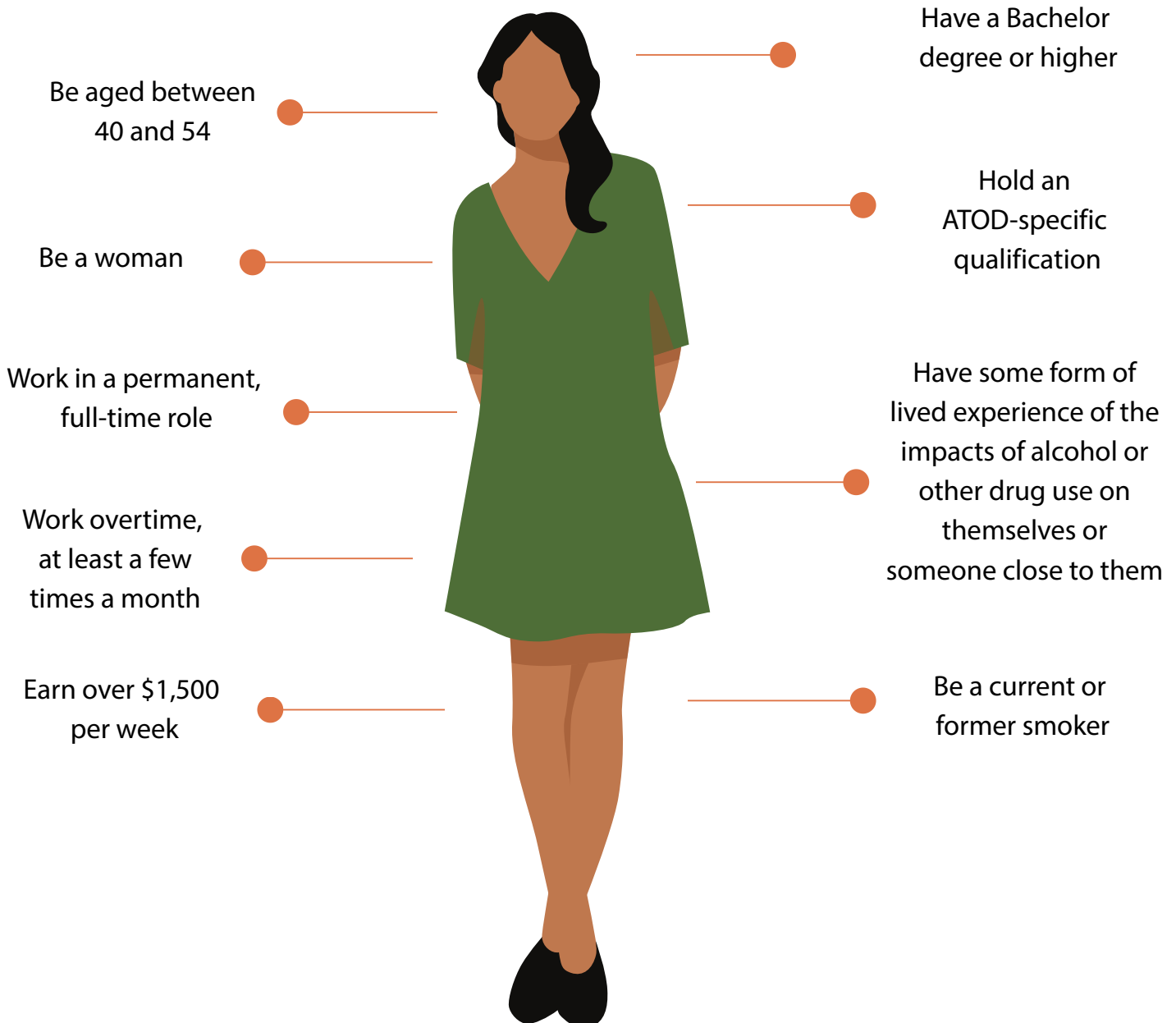


Diagram 1.12 Vaping status of workforce (n=169)



A randomly selected worker in the sector is more likely* to...



*In this context, 'more likely' indicates more likely than not (i.e. >50 percent of respondents)

SECTION 2: RECRUITMENT AND RETENTION

The viability and sustainability of the alcohol, tobacco and other drugs (ATOD) sector depends on the capacity of organisations to both retain existing workers and recruit new workers. Since the first profile of the ACT ATOD workforce was undertaken in 2006, a key objective has been to understand the recruitment and retention landscape, with the broader aim of supporting and promoting sector sustainability.

Recruitment and retention are widely held to be particularly challenging in the ATOD space.¹³ Globally, there is recognition of the need for national and sub-national workforce development strategies to address a range of workforce challenges and to promote the development of a sustainable sector.¹⁴ A lack of suitably experienced and qualified applicants is compounded by relatively poor remuneration against the backdrop of funding challenges; highly complex work environments; a lack of clear pathways to and within the sector; a broader context of stigma around ATOD use; and competition between services and sectors in the context of an aging workforce and burgeoning healthcare needs in the general population.^{15,16}

Data collected about the ATOD workforce in the ACT through the 2025 Workforce Profile, documents the resilience of the sector in the face of significant challenges and looks at the turnover intention of staff. It shows that while recruitment is a significant and ongoing challenge, retention of ATOD workers in the ACT is relatively robust.



2.1 Recruitment



we asked

Over the past 12 months, what method(s) has your organisation used to recruit staff and how effective have these methods been?



Organisations are most likely to utilise online advertising or word-of-mouth to recruit new staff.

Where organisations have recruited via Certificate IV in AOD placements or volunteer programs, these methods were assessed as **highly effective**.

Most organisation (80 percent) indicate that recruitment of new staff is moderately challenging or very challenging.

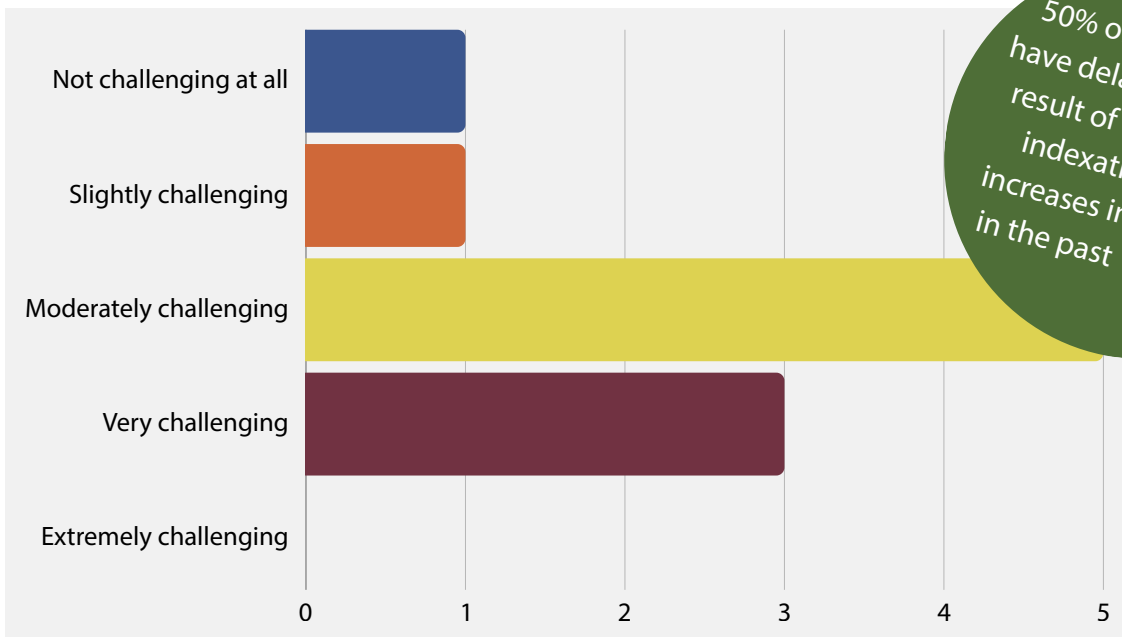


Diagram 2.1 How challenging is it to recruit new staff?

Organisations were provided with a list of possible recruitment challenges and asked to indicate how strongly these impacted their organisation. The highest ranked responses include:

1. *Uncertainty about future of program*
2. *Competitive recruitment environment*
3. *Insufficient applicants*
4. *Insecure funding*
5. *Applicants are not strongly aligned with the organisation's values*
6. *Applicants do not have enough relevant ATOD / other experience*
7. *Applicants have inadequate training and education*



we asked

If funding were not a consideration, how many additional staff would you need to meet anticipated demand in the next 12 months?

Across the sector, it was estimated that there was a shortfall of 86 workers to address current and twelve-month anticipated demand. The largest staffing shortfall was identified in the peer workforce space, where 20 potential positions were identified across six organisations. Administrators (10 positions across six organisations), AOD Workers (10 positions across six organisations), and Counsellors (eight positions across four organisations) were also identified as roles that needed to be filled.



2.2 Retention

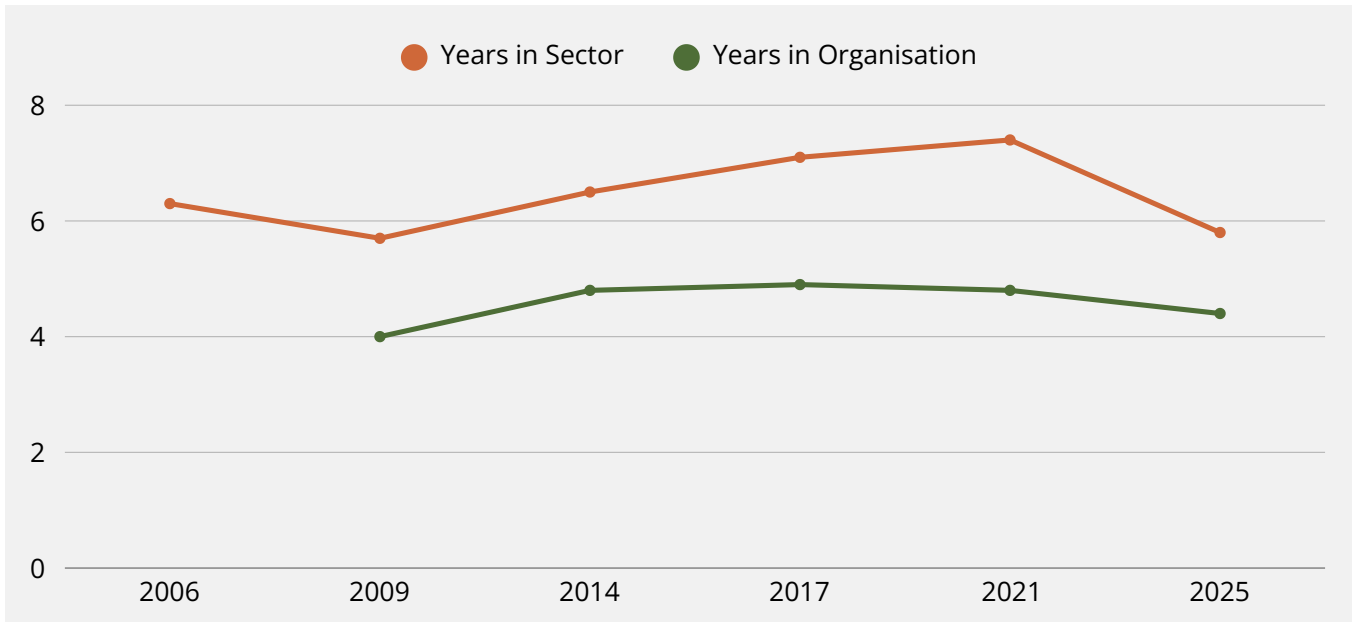


Diagram 2.2 Average length of time in organisation and sector, 2006 - 2025

The average length of time working in the ATOD sector is approximately six years and eight months, while the median length of time that workers have been in the sector is four years. Almost a quarter of respondents (21 percent) have been employed in the ATOD sector for 10 years or more.

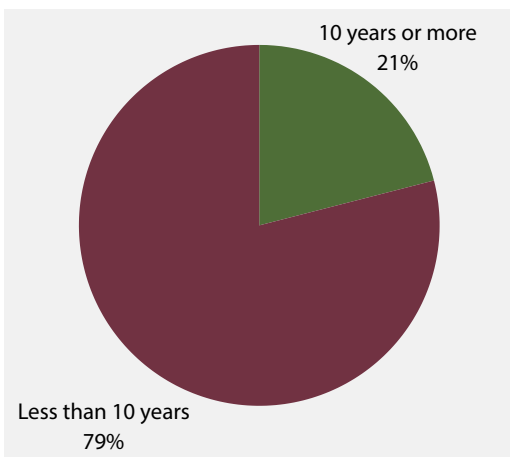


Diagram 2.3 Proportion of workforce more or less than 10 years in sector (n=167)

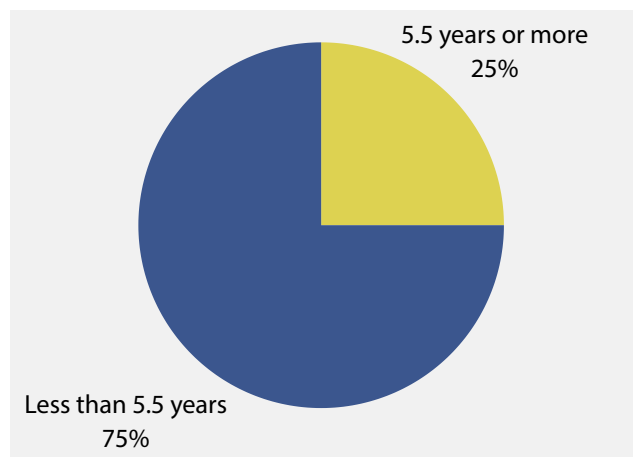


Diagram 2.4 Proportion of workforce more or less than 5.5 years in organisation (n=188)

The average length of time working in current organisation is four years and five months, while the median length of time a worker has remained in their current organisation is two and a half years.

A quarter of respondents have been employed in their organisation for five and a half years or longer.

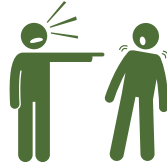
Factors **organisations** most often identify as likely to negatively impact retention:



High stress/burnout




Lack of career progression



Difficult clients



Intention to leave organisation and intention to leave sector

 **we asked**

Please indicate to what extent you agree:

- I frequently think about leaving my current job / the ATOD sector
- I am exploring career opportunities outside my current job / the ATOD sector
- It is likely that I will leave my current job / the ATOD sector in the next year

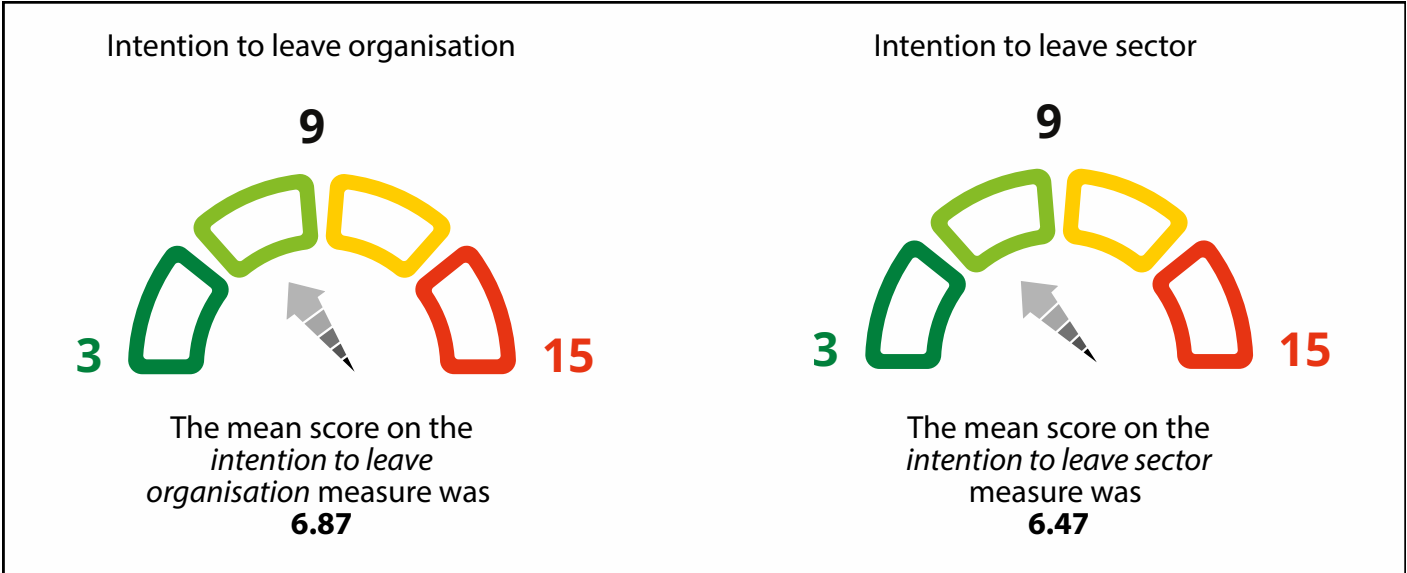


Diagram 2.5 Intention to leave scores

A score below the midpoint of 9 indicates a lower intention to leave; while a score above the midpoint indicates a higher intention to leave.

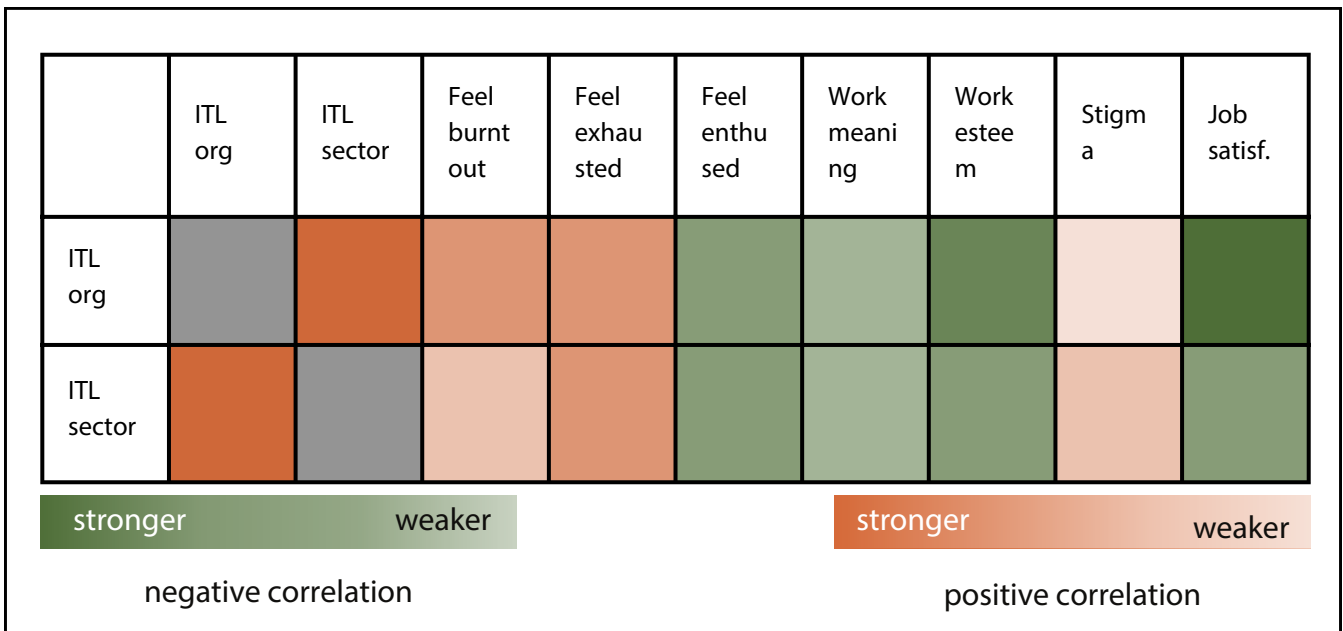


Diagram 2.6 Correlation of intention to leave (ITL) with feeling burnt out, feeling exhausted, feeling enthused, work meaning, work esteem, stigma by association and job satisfaction

Intention to leave organisation (ITL org) is *negatively* correlated with feeling enthusiastic about the job (feeling enthused), finding the work meaningful (work meaning), work esteem (i.e. feeling respected at work), and job satisfaction. Intention to leave organisation is *positively* correlated with feeling burnt out, feeling exhausted in the morning at the thought of another day at work (feeling exhausted), and stigma by association.

Intention to leave sector (ITL sector) is *negatively* correlated with finding the work meaningful, work esteem and job satisfaction and *positively* correlated with feeling burnt out, feeling burnt out, feeling exhausted, and stigma by association.

In other words, where workers have higher job satisfaction and feel that their job is meaningful and that they are respected in their workplace and where they experience less stigma by association, they are less likely to leave their organisation or the sector.



- While the sector may struggle to recruit new staff there is generally high satisfaction and low intention to leave, amongst the workforce.
- High job satisfaction, in roles where people feel that their work is meaningful and they are respected, is associated with lower intention to leave an organisation, while higher burnout and experiences of stigma by association are associated with higher intention to leave.

SECTION 3: THE QUALIFICATIONS STRATEGY

The ACT Alcohol and Other Drug Qualifications Strategy (previously the Minimum Qualification Strategy) was introduced in 2006 and aims to ensure the development and maintenance of a competent and professional alcohol, tobacco and other drug (ATOD) workforce in the ACT.¹⁷ It also aims to ensure that all ATOD workers in the ACT have a shared minimum knowledge and skill base.

While it is acknowledged that there is an extensive depth of expertise and skills within the ACT ATOD workforce, the Qualifications Strategy supports workers to have accredited credentials specific to their field. The Qualifications Strategy is based on nationally recognised standards through the provision of industry endorsed and delivered training.

ACT Health and Community Services Directorate provides funding to support the development and implementation of the Qualifications Strategy through the Alcohol Tobacco and Other Drug Association ACT (ATODA) including the provision of subsidised training places to eligible workers.

Compliance with the ACT Alcohol and Other Drug Qualifications Strategy is a performance expectation in all funding agreements between ACT Health and Community Services Directorate and specialist alcohol and other drug treatment and support services.

In order to meet the Qualifications Strategy requirements all specialist ACT ATOD services (funded by ACT Health and Community Services Directorate) will require relevant staff to either have or embark on obtaining with 12 months of entry to the sector (and complete within 3 years):

1. A qualification in ATOD or addiction studies which is equivalent to, or above, the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs (CHC43215)

OR

2. A health, social, or behavioural science related tertiary (university) qualification + the 'Alcohol and Other Drug Skill Set':

CHCAOD001 Work in an alcohol and other drugs context

CHCAOD004 Assess needs of clients with AOD issues

CHCAOD006 Provide interventions for people with AOD issues

CHCAOD009 Develop and review individual AOD treatment plans

AND

3. A First Aid qualification equivalent to the following units:

HLTAID009 - Provide cardiopulmonary resuscitation

HLTAID010 - Provide basic emergency life support

HLTAID011 - Provide First Aid



3.1 Attitudes towards the Qualifications Strategy

According to the Organisation Survey, most executives agree that the **Certificate IV in Alcohol and Other Drugs is an appropriate minimum qualification** for workers providing direct client services in their organisation.

Three of the eleven survey respondents indicate that their organisation would **equally accept as a minimum qualification a Certificate IV in Community Services, Mental Health, Youth Work or other Certificate IV.**

One organisation references the lack of accredited **AOD-specific peer worker qualifications** and another organisation feels that the Certificate IV in AOD is only an appropriate minimum qualification if **combined with practical experience**, noting that there may be scope for continuous upskilling through accredited professional development.

Respondents to the Workers' Survey were asked whether they thought the Certificate IV is an appropriate minimum level of qualification for the alcohol, tobacco and other drugs (ATOD) workforce in the ACT and were encouraged to provide a written response explaining their reasoning.

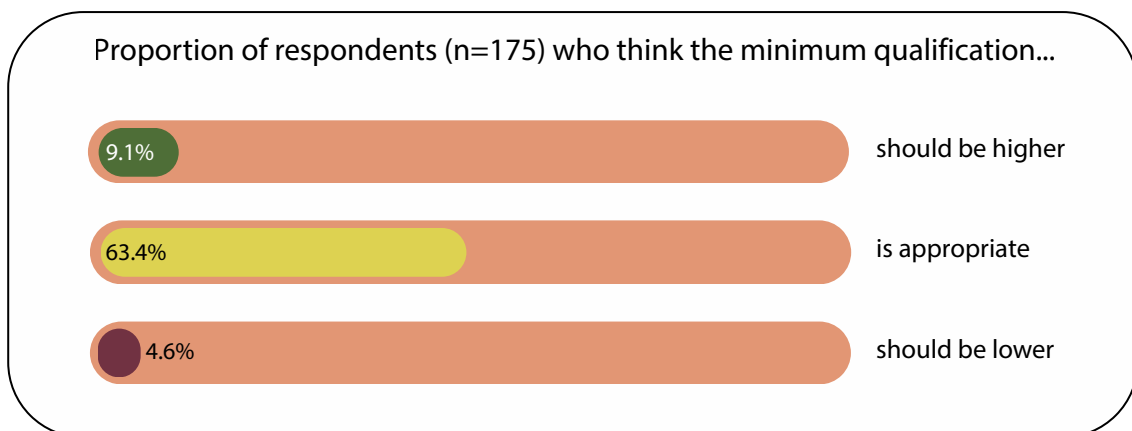


Diagram 3.1 Workforce perceptions of the Qualifications Strategy

Most respondents (63.4 percent) indicate that they believe the Certificate IV is an appropriate minimum qualification – although written responses provide important caveats to this. 9.1 percent think that the minimum qualification should be higher than a Certificate IV; 4.6 percent think it should be lower; and the remainder either don't know or provided another answer.

While some respondents view the Certificate IV in AOD as a good entry level qualification, a number advocated for what we call a Certificate IV +, with the plus referring to non-qualification factors such as lived experience, work experience, social skills / rapport, and on-the-job learning

Although I do feel consideration **NEEDS** to be given to account for lived experiences, and overall social skills. Some of the most wonderful workers I've met have the least qualifications - and can be more capable than others with higher qualifications.

This depends on the role being undertaken - Lived and living experience in some roles may be more integral to delivery of support than a Certificate IV or above in some contexts, and in other contexts a post-graduate degree may be required.

Some note that placements are a necessary part of ensuring that the Certificate IV adequately prepares people for the job.

A number of respondents note that the minimum qualification is role dependent – in many roles a higher (and in some roles, a lower) qualification is appropriate.

Finally, several respondents raise the possibility of a separate peer work pathway.

Peer workers should be clearly defined, but not necessarily have a cert IV

...could cause barriers to entering the workforce - especially so for peer workers.

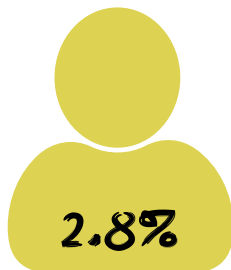
Peers have valuable experience not covered by AQF framework



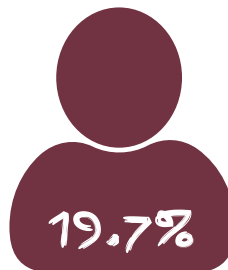
3.2 Attainment of the Qualifications Strategy



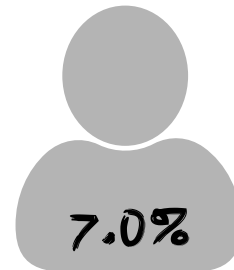
Required to meet and met (or on pathway to meet)



Required to meet and met except for first aid



Required to meet and not met (and not on pathway to meet)



Required to meet and unclear if met

Of those meeting or on track to meet the requirements of the Qualifications Strategy (n=100), three-quarters (75.0 percent) hold (or are working towards) a “qualification in ATOD or addiction studies which is equivalent to, or above, the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs”, while 25.0 percent have (or will shortly have) a “health, social, or behavioural science related tertiary (university) qualification plus the Alcohol and Other Drug Skillset”.

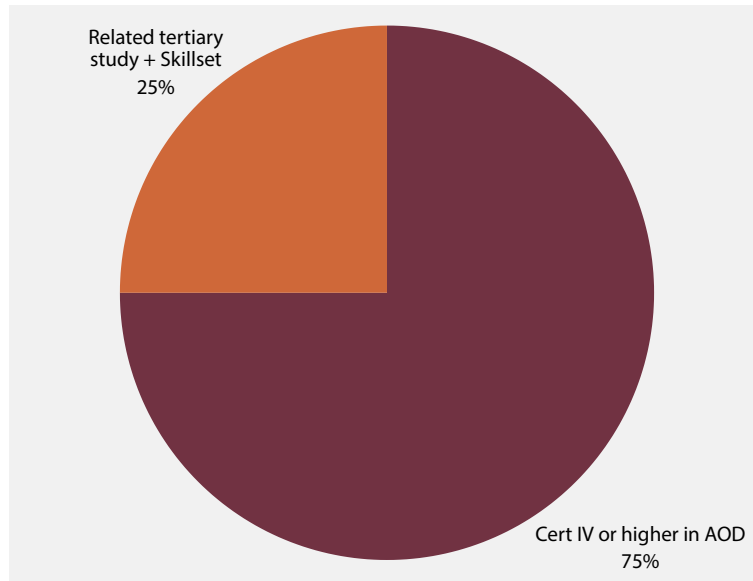
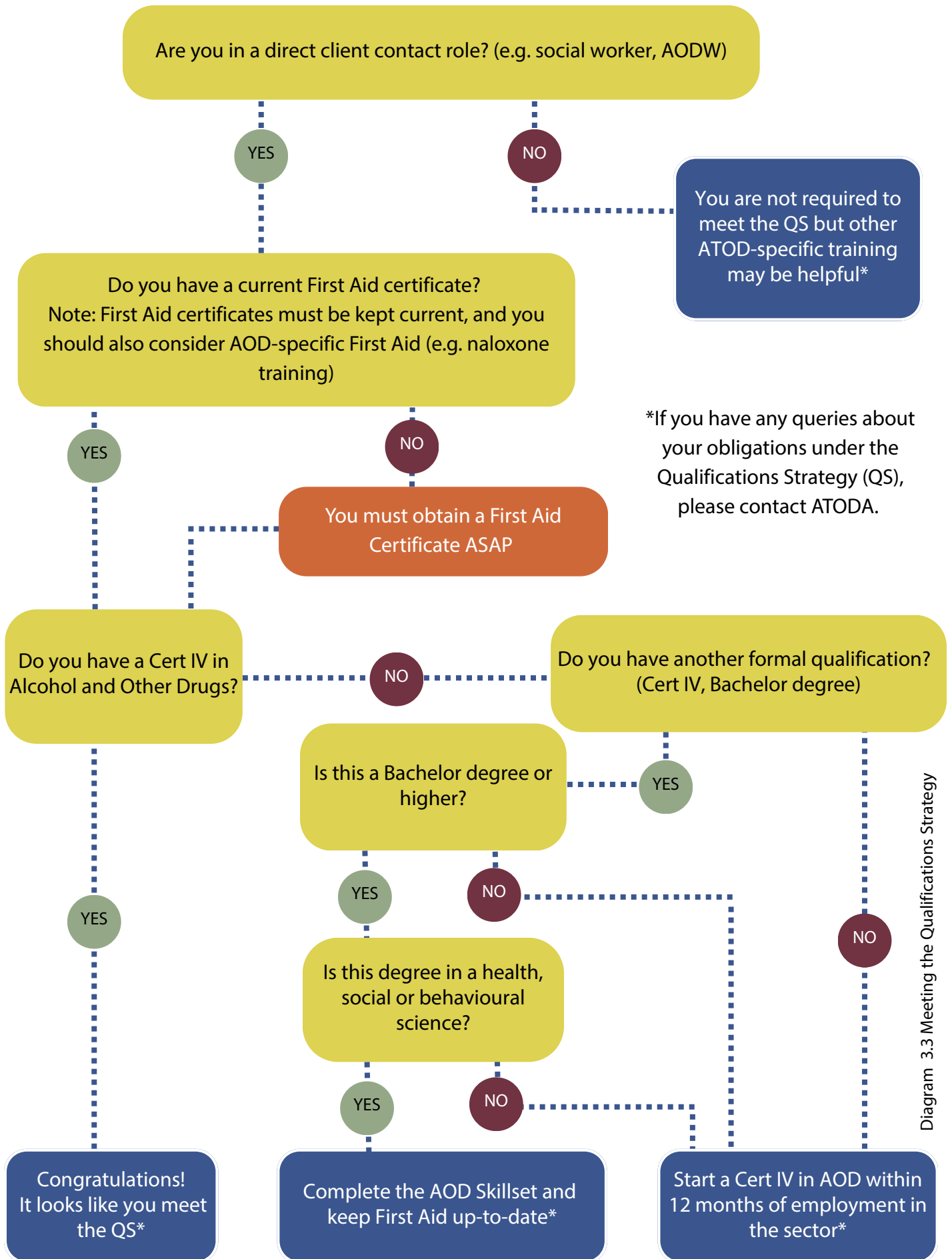


Diagram 3.2 How the workforce meets the Qualifications Strategy (n=100)

Individuals are assessed as meeting the Qualifications Strategy where they have completed a relevant qualification. They are assessed as on track to meet the qualifications strategy where they are currently undertaking a relevant qualification or have indicated that they intend to embark on a relevant qualification within the next 12 months. Of those meeting or on track to meet the Qualifications Strategy, 85 percent have already fulfilled the requirements, while the remaining 15 percent are working towards.

Of those *not* meeting the Qualifications Strategy (n=42), 35.7 percent have completed all or part of the AOD Skillset but do not hold any other accepted qualification under the Strategy (almost half of these have completed a Certificate IV in Mental Health, Community Services, or Youth Work); 31.0 percent have a “health, social, or behavioural science related tertiary (university) qualification” but have not completed or are not on a pathway to complete the AOD Skillset; 9.5 percent have met the requirements of the Qualifications Strategy with the exception of a First Aid Certificate; 7.1 percent are not on any pathway to completing requirements of the Qualifications Strategy; and 16.7 percent have an unknown status in relation to the Qualifications Strategy due to incomplete or unclear survey responses.

The diagram on the following page allows workers to assess whether they are meeting the Qualifications Strategy.



*If you have any queries about your obligations under the Qualifications Strategy (QS), please contact ATODA.

Diagram 3.3 Meeting the Qualifications Strategy



3.3 Where to next for the Qualifications Strategy?

The Workforce Profile uncovered several areas that may need to be addressed to ensure that the Qualifications Strategy remains fit for purpose, including:

1. A gap in qualifications that are appropriate to the specific job description of peer workers and that don't impose unnecessary barriers to expansion of the peer workforce
2. The possibility of an alternative pathway to meeting the Qualifications Strategy through a Certificate IV in a related non-AOD discipline
3. The need for role-specific minimum qualifications
4. Whether there is scope for ongoing professional development under the Qualifications Strategy



88.2%

of **peer workers** who are required to, meet the Qualifications Strategy (n=17) do so



16.7%

of all respondents who are required to meet the Qualifications Strategy and don't currently do so (n=42), hold a Certificate IV in either Mental Health, Community Services, or Youth Work.



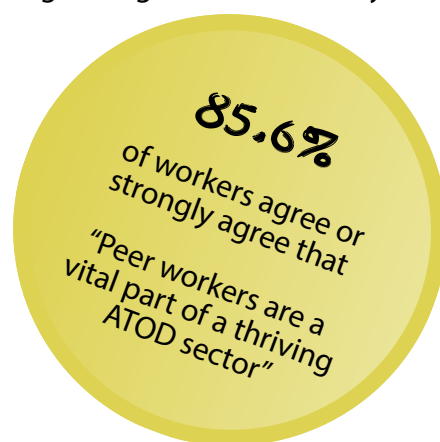
- The sector is in broad agreement that the minimum qualification, as established through the Qualifications Strategy, is set at an appropriate level, with some key issues that may be addressed in the future.
- 60.0 percent of the workforce have completed the requirements of the Qualifications Strategy and a further 10.4 percent are on track do so in accordance with the requirements of the strategy.

SECTION 4: LIVED AND LIVING EXPERIENCE AND THE PEER WORKFORCE

Lived experience refers to direct, personal knowledge and expertise gained from having a current or historical experience with 1) alcohol, tobacco and other drug use; or 2) alcohol, tobacco and other drug treatment; or 3) supporting someone who falls into one of the previous two categories.¹⁸ Individuals with lived experience may or may not choose (and may or may not be permitted) to disclose their lived experience in their workplace and may or may not choose (and may or may not be permitted) to explicitly utilise their lived experience as part of their work practice.

A **peer worker** is someone who identifies and is identified as sharing an experience of alcohol, tobacco and other drug use and who uses their lived experience and their individual and group identity to inform their work by 1) building trust with service users within the context of an equitable relationship; 2) shaping therapeutic interventions and care provision; 3) giving support and understanding; 4) providing information and education; and 5) progressing individual and systemic advocacy.¹⁹

“Valuing peer support workers and people with lived experience,” was written into the ACT Drug Strategy Action Plan 2022–2026.⁸ ATODA has welcomed the Government’s focus on a key segment of the alcohol, tobacco and other drugs workforce and notes the value of a sustainably funded and resourced peer workforce in the Territory.



Across the sector, peer work is clearly valued. A total of 20 potential peer roles were identified that could be filled immediately if there was resourcing to do so (almost doubling the current peer workforce). While there is enthusiasm across the sector to employ more peers, a combination of constraints relating to funding, organisational structures and lack of formalised pathways into peer work has, to date, limited further development of a sector-wide peer workforce.





4.1 Lived experience

People with lived experience of the impacts of alcohol, tobacco and other drugs make up a significant proportion of the sector.

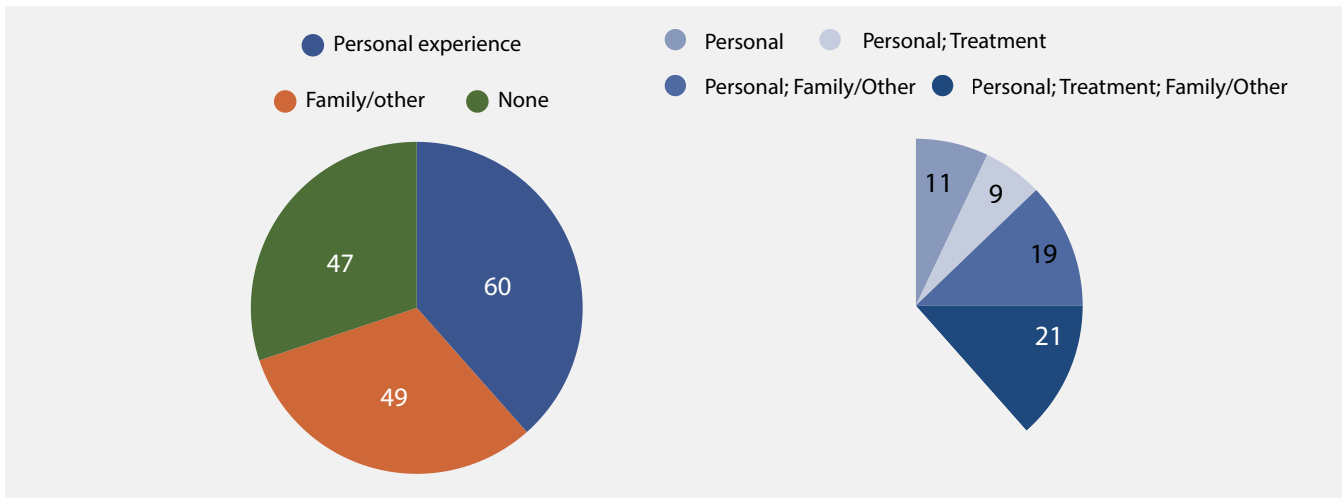


Diagram 4.1 Lived experience in the ACT ATOD sector by number of workers (n=156)

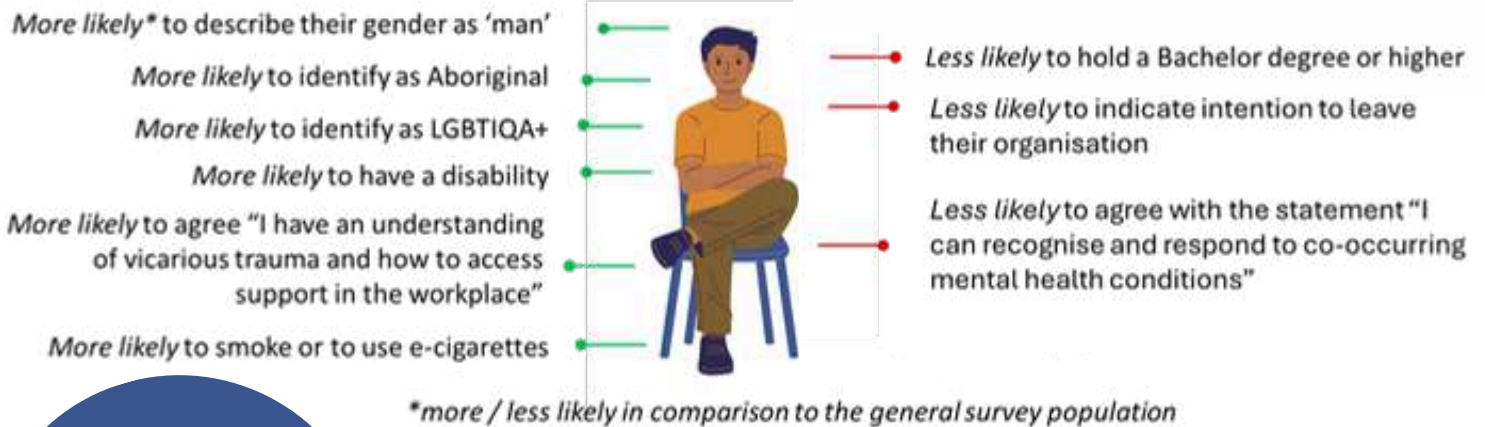
In the Workers' Survey, respondents were asked if they identify as having lived/living experience in relation to alcohol and/or drug use and were provided with the following responses (multiple responses possible):

- * I have personal experience of impacts from my own alcohol and/or drug use
- * I have personal experience of engaging with a treatment or harm reduction service for my own alcohol and/or drug use
- * I am a family member or close friend of someone who has experienced impacts from alcohol and/or drug use
- * I have other past or present lived experience of alcohol and/or drug use not listed above (please specify)
- * I do not identify as having lived experience of alcohol and/or drug use
- * I prefer not to say

The proportion of workers with any lived experience (i.e. responding in the affirmative to any one or more of the first four response options) is 69.9 percent.

The proportion of workers with personal lived experience (i.e. responding in the affirmative to any one or more of the first two response options) is 38.5 percent.

Worker with personal lived experience



Over 50% of workers with lived experience use it in their role frequently (once or twice a week) or all the time (every day)

76.2 percent of respondents to the Workers' Survey agree or strongly agree that "Lived experience is a form of expertise in the alcohol, tobacco and other drug (ATOD) sector."

Disclosing lived experience

I find my lived experience a powerful factor in my ability to build rapport and provide effective support to my clients.

Being seen and not judged for addiction but celebrated for overcoming addiction.

Very open and honest team, it is a safe space to share information with colleagues and everyone is caring and non-judgemental.

Being transparent in my workplace is a feeling of ease and enables me to work more effectively and be my true self.

Written responses about disclosing lived experience fell into one of the following categories: it supported interpersonal, workplace relations; it provided a greater sense of self and wellbeing; it enhanced client-worker relationships; it was, or became, integral to the role; it allowed for greater workplace support.

For those who have disclosed their lived experience in the workplace, the most frequently cited reason for doing so is: "I want to support the visibility of lived experience workers", closely followed by "I felt like it was the right thing to do" and "I want to challenge stigma and discrimination."

Just 17 percent of workers with lived experience had **not** disclosed their lived experience in the workplace. The most frequent reason given for non-disclosure is "I don't think it is relevant to do so" followed by "I have not had the opportunity to do so". Other responses were fairly evenly split between "My workplace discourages or disallows me from doing so"; "I expect to be judged"; "My experiences of stigma and discrimination have made me cautious of disclosing"; and "I am uncomfortable doing so".

When asked to provide further feedback on the experience of disclosing lived experience in the workplace, responses showed concern about 'professionalism':

"A person's lived experience of ATOD use should not be disclosed in a professional workplace"

61.1%

disagree or strongly disagree

I did not disclose my lived experience at my interview. I knew I had all the right quals for the job. I disclosed my lived experience casually in a conversation appropriate to the disclosure. I personally wanted to know I was being employed for my professionalism

It's my personal life (that was) and does not belong in the workplace as a supervisor of staff"

I think staff disclosing their lived experience to use as a tool for connecting to clients isn't that useful in the long term. Often staff rely upon 'relating' to clients by disclosing their AOD history assuming this is all that's needed to be qualified to work in the industry. This is unprofessional at best, dangerous at worst.

These comments may suggest a need to more clearly articulate the utility of lived experience to the work that is undertaken in the ATOD sector and delineate the distinction between lived experience and the professional peer role. Increasingly, there is a trend towards the professionalisation of lived experience in the sector, with training available to support workers, specifically those in non-peer roles, to better know how and when to disclose or not disclose lived experience.

Organisational support of the lived experience workforce



My workplace is supportive of me as a person with lived experience of alcohol, tobacco and other drug (ATOD) harms (n=108)



I am encouraged to use my lived experience in my work practice (n=108)



My lived experience has negatively impacted my career progression in the ATOD sector (n=105)



If my lived experience is impacting my work, I can comfortably discuss this at work and/or get the support of my workplace (n=105)



I feel that I have sufficient training to use my lived experience safely and appropriately in the workplace (n=105)



My lived experience makes it harder for me to achieve a good work–life balance (n=105)



I have more restrictions in my work role compared to other workers without lived experience who are doing a similar job (n=103)



Disagree/Strongly disagree

Neither agree nor disagree

Agree/Strongly agree

Lived experience and stigma in the workplace

Survey participants were asked how strongly they agree with the statement “People who regularly and/or consistently use drugs are not reliable employees in the ATOD sector” (n=167)

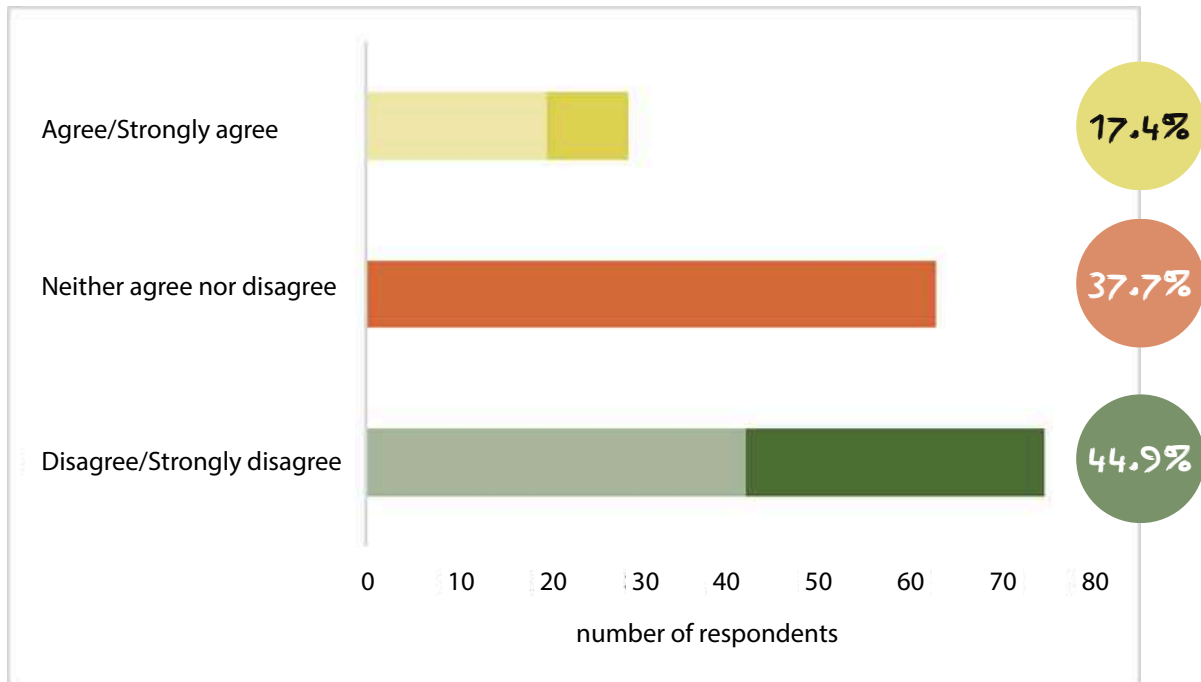


Diagram 4.2 Agreement with statement: “People who regularly and/or consistently use drugs are not reliable employees in the ATOD sector” (n=167)

Workers with lived experience (n=87) were asked how strongly they agree with the statement “Over the past year I have observed stigmatisation or discrimination towards service users at the service where I work”. 78.6 percent disagree or strongly disagree with this statement.



4.2 Peer work

At the time of the surveys being conducted, there was a total of 22 workers in identified ATOD peer or lived experience roles (peer workers, peer treatment support workers and lived experience mentors) in the ACT. Other than the ACT's peer-led organisation (CAHMA), two organisations in the ACT had engaged workers in peer or lived experience roles (this has since expanded to at least three organisations).

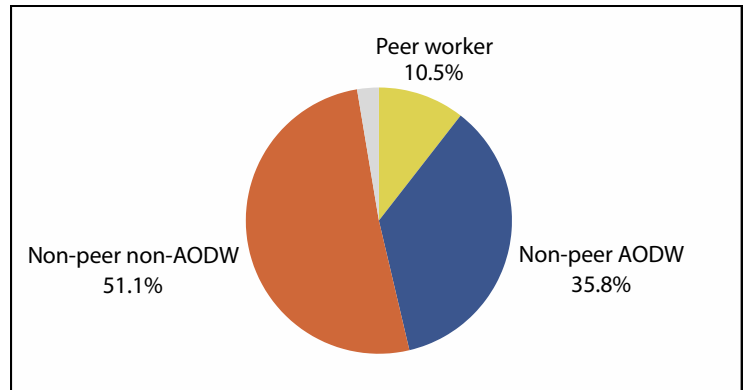


Diagram 4.3 Workforce (n=190) in peer worker, non-peer AODW and non-peer non-AODW categories

A total of 20 peer workers completed the Workers' Survey—representing 10.5 percent of total survey respondents (n=190) and approximately 90 percent of peer workers from across the sector who were in scope (n=22). Almost all peer workers are in direct client contact roles. Of peer workers who completed the survey, 15 percent hold management roles. Ensuring that peer workers have legitimate career pathways into and within ATOD services is vital to ensure the sustainability of the peer workforce and, importantly, the availability of peer supervision.

About peers

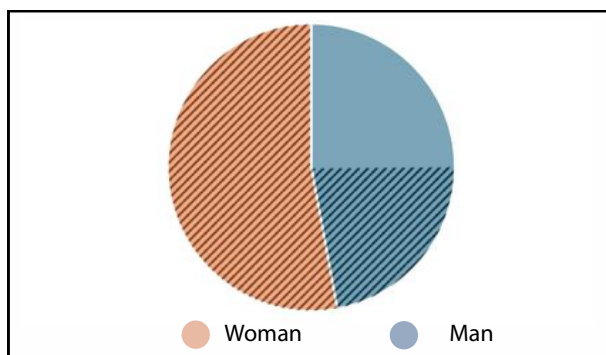


Diagram 4.4 Gender divide of peer workers (woman=orange) compared to gender divide of all workforce (woman=striped)

Peer workers (n=20) were compared to non-peer AOD workers (n=68).

Peer workers have a similar demographic profile to non-peer AOD workers. Although not statistically significant, there appears to be a weak positive correlation between being a peer worker and having carer responsibilities - meaning peer workers may be slightly more likely than non-peer AOD workers to be caring for a child, older person or a person with a disability outside of work.

The data shows that, 64.7 percent of peer workers have caring responsibilities outside of work. There is also a non-significant weak negative correlation between being a peer worker and identifying gender as 'woman', meaning that peer workers are more likely to identify their gender as 'man' than non-peer AOD workers.

When compared to the general survey population, there is a statistically significant weak negative correlation between being a peer worker and identifying gender as 'woman'. This means that peer workers are slightly more likely than other workers in the sector to identify their gender as 'man'.

Peers at work

- Peer workers are significantly less likely to be employed in permanent positions and are more likely to be in their first ATOD role.

Being a Peer of lived experience it has made me help and want to help and support others in the same way that I was supported.

- There is no significant difference between peer workers and non-peer AOD workers in terms of income, propensity to work overtime, fulltime vs part time work status, and the length of time they have worked in their role, their organisation or the sector.

- Peer workers are no more likely than non-peer AOD workers to consider their workplace supportive of them “as a person with lived experience of ATOD harms”.
- Peer workers are not significantly more or less likely to consider their lived experience as having “negatively impacted career progression in the ATOD sector”; to believe that if their lived experience is impacting their work, they can “comfortably discuss this at work and/or get the support of my workplace”; to feel that they had sufficient training to use their “lived experience safely and appropriately in the workplace”; “that they had more restrictions in their work role “compared to other workers without lived experience who are doing a similar job”; or to find that lived experience made it harder to “achieve a good work–life balance.”
- Peer workers are significantly more likely to feel that they are “encouraged to use my lived experience in my work practice.”

As a peer worker I offer my past and present living experience to help identify with the client and explain what it was that i did in my life to face challenging situations.

Peer qualifications

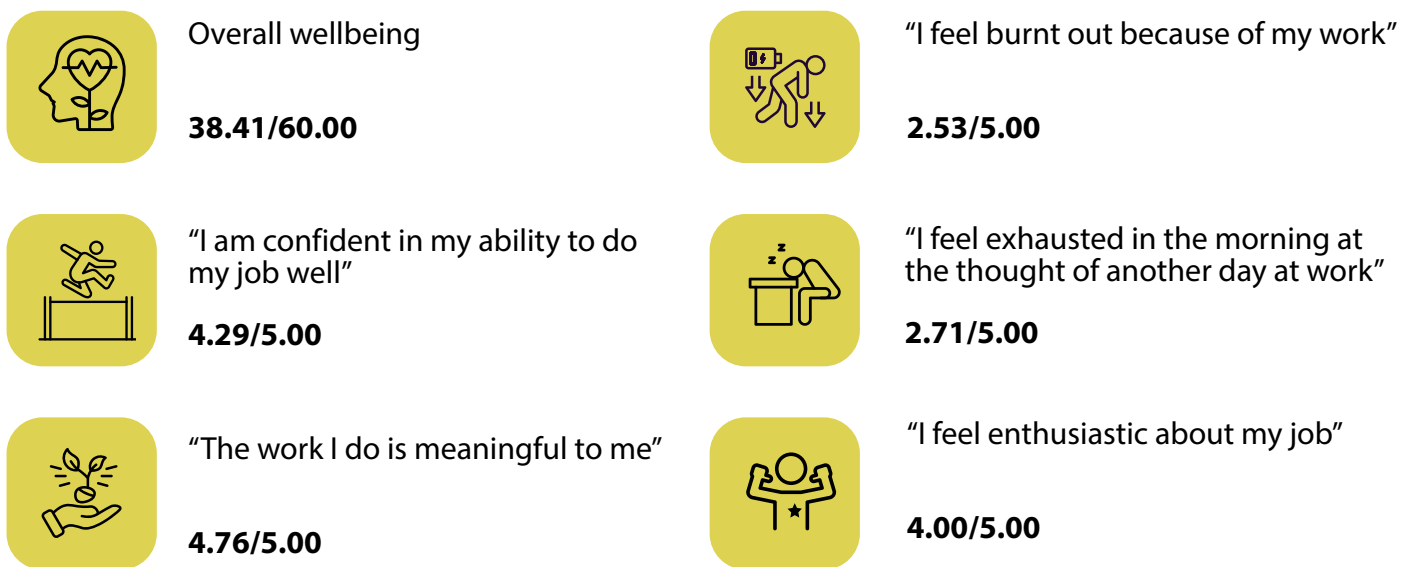
When looking at whether individuals hold a Bachelor degree or higher, there is no significant difference between peer workers and non-peer AOD workers. Approximately a quarter of peer workers have a Bachelor degree or higher.

When asked about the Qualifications Strategy, peers are mentioned as a specific population that may require a different approach to prevent barriers to entering the workforce. However, peer workers are not significantly more or less likely to meet the Qualifications Strategy requirements than non-peer AOD workers.

For peer workers, expertise gained through lived experience is appropriately prioritised above formal qualifications. Regardless of a peer worker's prior education, ongoing professional development and learning within the workplace context is important to ensure that peer workers are continually developing the skills and capabilities to provide consistently high-quality treatment and harm reduction services and to open up career progression opportunities for peer workers within and beyond the sector.

Peer wellbeing

Average scores on selected wellbeing and satisfaction measures for peer workers.



Peer workers in direct client contact roles who answered the wellbeing questions (n=17), report similar wellbeing outcomes to non-peer AOD workers, with the exception of stigma by association, where being a peer worker was correlated with experiencing significantly *more* stigma by association.[^] There are a number of possible reasons that peers may experience greater stigma by association, the most obvious being that a shared experience of stigma is a key qualifying characteristic of a peer worker.¹⁹ However, it is also possible that peer training sensitises peer workers to stigma in order to counter persistent stigmatising narratives.

On the stigma by association measure, peer workers (n=16) were most likely to agree or strongly agree that "The ATOD sector is seen as less important than other medical fields or social services" and to agree that "I feel stigmatised by the general public because I work in the ATOD sector," and "I feel stigmatised by other health professionals because I work in the ATOD sector."



- A significant proportion of the sector (69.9 percent) has lived experience of the impacts of alcohol or other drug use on themselves or someone close to them.
- While there is scope for a greatly expanded peer workforce, barriers to establishing this remain.

SECTION 5: WORKPLACE COMPETENCIES

Understanding the strengths (competencies) of the workforce can help ATODA to develop and better target appropriate training and resources to support the sector. Questions around workplace competencies have appeared in surveys conducted by other AOD Peak Organisations. ATODA drew on the range of questions asked by the Alcohol, Tobacco and other Drugs Council (ATDC) Tasmania in their 2023 Workforce Survey and adapted them for the ACT context.

We found that most workers feel confident in their ability to do their job and those in direct client contact roles (n=122) report high confidence in their ability across most work practices.

For those in management roles (n=48) an additional series of questions was asked around leadership competencies.



91.8% of workers agree or strongly agree that they are confident in their ability to do their job well

Workers who have direct client contact (n=122) were asked how strongly they agree with the following statements. The proportion indicates those who agree or strongly agree.



5.1 Clinical knowledge

While workers with direct client contact are expected to have sound clinical knowledge, as reflected in the requirements of the Qualifications Strategy, what that looks like may vary slightly by role. As such, knowing classification systems and diagnostic criteria may not be an indicator of relevant clinical knowledge for all workers.

85.6%

I have a strong understanding of the properties and effects of commonly used drugs and their interactions

89.3%

I know how to recognise and respond to overdose

91.6%

I know how to provide a brief intervention, when appropriate to do so

58.5%

I know the different classification systems and diagnostic criteria for ATOD-related health conditions (e.g. DSM-5 criteria for SUD, AUDIT, DUDIT)



5.2 Recognising and responding to service user needs

Person-centred approaches are inherently responsive to individual service user needs. In the context of complexity, including the presence of co-occurring conditions, this responsiveness is a critical skill.²⁰

93.1%

I can recognise and respond appropriately to service users who are under the influence, ensuring their immediate risks and safety needs are met

89.3%

I can recognise and respond to co-occurring mental health conditions

87.8%

I know how to support service users to develop strategies to support and manage relapse

92.3%

I know how to support a service user to identify and develop strategies to reduce ATOD-related harm



5.3 Strategies and skills

The ACT ATOD workforce is guided by best practice approaches and remains adaptive to emerging research on alcohol, tobacco and other drugs and on treatment and harm reduction approaches.

85.3%

I have the skills to sensitively explore issues and needs relating to trauma (trauma informed practice)

71.6%

I use a range of evidence-based tools and strategies in my practice (e.g. MI, CBT etc)

61.3%

I have strong knowledge of medications used to treat ATOD-related health conditions

82.3%

I incorporate strategies to enable behaviour change as part of my practice



5.4 Screening and assessment

While some services utilise highly formal screening and assessment tools, others take a less structured approach. Regardless of the method, having tools to identify a range of service user needs is important.

83.9%

I am confident using standardised screening and assessment tools to gather relevant service user information

90.1%

I am familiar with the range of possible concerns and needs that people with co-occurring ATOD and mental health concerns are likely to experience

83.9%

I am confident that I can identify issues of family violence and respond appropriately

45.8%

I know how to screen for gambling harms



5.5 Access and equity

Promoting and maintaining equitable access to treatment and support is a priority objective of the ACT Drug Strategy Action Plan 2022-2026.⁸

93.2%

I am confident using culturally appropriate communication to create a welcoming, safe and supportive environment for service users

69.4%

I know how to access interpreters to facilitate accessible, timely and effective communication

70.2%

I consult with lived and living experience workers to inform and strengthen my practice

90.8%

I am confident in my ability to call out discriminatory or stigmatising behaviour when I see it within my service



5.6 Cultural Safety

Culturally safe workplaces are important to ensure that all workers are able to fully contribute to their organisation. Such workplaces reduce stigma, leading to better treatment and harm reduction outcomes.²¹

93.2%

I feel confident that I can work effectively with service users from Aboriginal and Torres Strait Islander communities

93.1%

I feel confident that I can work effectively with service users from culturally and linguistically diverse communities

96.3%

I feel confident that I can work effectively with LGBTIQ+ service users

94.7%

I feel confident that I can work effectively with service users living with disabilities



5.7 Managing complexity and risk

Services are increasingly called on to manage complex and co-occurring needs.²² Ensuring the sector is adequately resourced to do so is a key priority for ATODA.

89.4%

I know how to apply strategies to work effectively with service users with complex behaviours

88.7%

I am confident in my ability to de-escalate conflict that arises with an aggressive or violent service user

87.9%

I can manage the risks associated with co-occurring substance use and mental health problems

84.1%

I know how to perform appropriate risk assessments with service users and develop safety plans



5.8 System navigation

Where workers are confident in navigating the treatment and harm reduction landscape, collaborative approaches and partnerships can be established towards better treatment and harm reduction outcomes.

91.6%

I am confident working cooperatively and collaboratively with other service providers to support service users

84.0%

I know the appropriate referral pathways I can use with a service user if they have other treatment needs or co-occurring issues

73.7%

I understand how to engage family members or carers as part of an assessment and/or care plan

74.1%

I have a good grasp of ATOD policies, strategies and legislative frameworks that guide my work



5.9 Leadership and management

Workers who are in leadership and management roles (n=32) were asked how strongly they agree with a series of questions about their skills and capabilities.

Research has shown that better leadership is linked to better outcomes in healthcare, including greater service user satisfaction, improved organisational performance, elevated scores on employee wellbeing, better staff retention, and higher quality of care.

91.6%

I have the capabilities to provide supportive and effective professional supervision

100%

I know how to respond effectively to critical incidents in the workplace

94.4%

I have the skills to manage conflict in the workplace and have difficult conversations

97.1%

I am confident in my capabilities to lead and manage staff



The ACT ATOD sector is highly competent. Amongst direct client contact workers areas of particular strength (over 90% agree or strongly agree) include:

- providing a brief intervention, when appropriate to do so;
- recognising and responding to service users who are under the influence;
- supporting a service user to identify and develop strategies to reduce ATOD-related harm;
- familiarity with the range of possible concerns and needs that people with co-occurring ATOD and mental health concerns are likely to experience;
- using culturally appropriate communication to create a welcoming, safe and supportive environment for service users;
- ability to call out discriminatory or stigmatising behaviour in a service;
- working effectively with diversity including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities and with LGBTIQ+ service users and service users living with disability;
- working cooperatively and collaboratively with other service providers to support service users ; and
- understanding of vicarious trauma and how to access support in the workplace.

Amongst direct client contact workers, there are areas that may require additional support or training (less than 70 percent agree or strongly agree). Noting that some of these may have scored lower as they are not relevant to every role, they include:

- accessing interpreters to facilitate accessible, timely and effective communication;
- screening for gambling harms; and
- knowledge of medications used to treat ATOD-related health conditions.

SECTION 6: SMOKING AND VAPING



6.1 Smoking and vaping status

We asked workers about their use of tobacco products (including tobacco cigarettes, 'roll-your-own' tobacco, cigars, pipes, and other tobacco products that are smoked) and about their use of electronic cigarettes or vapes. Although these rates are much lower than for people using ATOD services, they are about three times higher than the rates in the general ACT population, aged 14 years and over.



22.2 percent of workers indicate they use tobacco products on a daily or occasional basis



81.8%

of ACT ATOD service users were smokers when they first started to use the service⁵

7.4%

of the general ACT population (aged 14 years and over) use tobacco products on a daily or occasional basis²³



17.8 percent of workers indicate they use electronic cigarettes/ vapes daily or occasionally*



51.0%

of ACT ATOD service users had used e-cigarettes in the past year⁵

5.7%

of the general ACT population (aged 14 years and over) use electronic cigarettes/ vapes daily or occasionally²³



6.2 Providing smoking and vaping cessation support



There is strong evidence that providing best practice nicotine dependence treatment and support alongside alcohol and other drug treatment and support improves outcomes for both.²⁴

Best practice includes providing brief interventions (such as the 'Ask, Advise, Help' model), and providing combination nicotine replacement therapy (NRT) complemented by behavioural support.²⁵



* (includes 'at least weekly', 'at least monthly', or 'less than monthly')



We asked workers with direct client contact to self-assess how consistently they provide smoking and vaping brief interventions and support

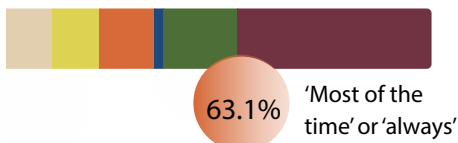
In the context of high rates of tobacco and e-cigarette use among people using ATOD services, the ATOD workforce should be prepared and competent to ask service users about nicotine dependence, and to provide appropriate advice and support



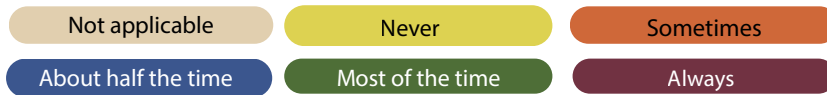
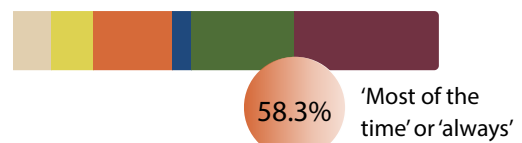
Tobacco products and smoking



I ask service users if they use a tobacco product (n=92)



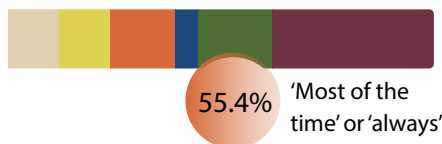
If a service user says they use tobacco products, I offer them some kind of smoking cessation advice (n=91)



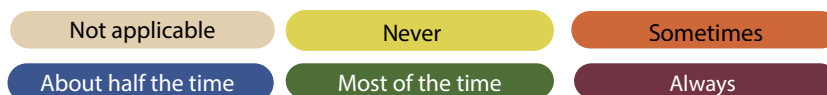
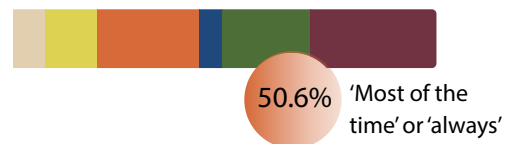
E-cigarettes and vaping



I ask service users if they use vapes (e-cigarettes) (n=92)



If a service user says they use vapes, I offer information about vaping and, if appropriate, cessation support (n=91)



Workers who report using tobacco products and/or e-cigarettes are no more or less likely to report providing - or having competency to provide - smoking or vaping brief interventions and support to service users



We asked workers with direct client contact to self-assess their level of competency to provide smoking and vaping brief interventions and support



Proportion responding 'agree' / 'strongly agree' to the following competencies

	 98.5%	 81.6%
Knowledge and understanding of harms and risks	98.5%	81.6%
Confident talking to service users about smoking/vaping and effects	89.8%	69.6%
Confident providing information on cessation treatments and their outcomes	80.8%	65.0%
Providing a brief intervention	81.9%	67.7%
Where to refer for additional support	84.1%	68.3%
Feel confident providing information about vaping as an alternative to smoking and understand where it is appropriate to do so	68.3%	
Feel confident that understand current vaping legislation and how it impacts users at my service	56.0%	



The workforce data reinforces the need to:

- Provide accessible and affordable smoking and vaping cessation and harm reduction support to workers in the ATOD sector, including access to subsidised NRT
- Offer tailored training to all workers in the ATOD sector that:
 - Encourages workers to offer nicotine dependence treatment and support alongside alcohol and other drug treatment and harm reduction
 - Supports workers to apply a harm reduction approach appropriate to the treatment goals of individual service users
 - Focuses on upskilling and building capabilities to provide effective vaping cessation and harm reduction support
 - Builds capabilities - for both smoking and vaping - to move beyond 'asking', to 'advising' and 'helping'

The sector's **Reducing Nicotine Harms Project** is using this information to improve the provision of smoking and vaping support to ATOD service users.



The data shows that for workers in the ACT's ATOD sector:

- smoking and vaping rates are about three times higher than in the general ACT population;
- high proportions are confident that they understand the harms and risks of using tobacco and e-cigarettes;
- while high proportions (between half and two-thirds) ask all or most service users about their use of tobacco and/or e-cigarettes, this is not necessarily translating into providing 'advice' or 'help';
- fewer are providing - and lower proportions report competencies to provide - brief interventions for e-cigarette use, compared to tobacco use; and
- clinically significant proportions are 'never' or 'sometimes' providing smoking and/or vaping brief interventions, or possibly believe it is outside their scope of practice (i.e., responded 'not applicable').

SECTION 7: WORKPLACE WELLBEING AND SATISFACTION



7.1 Wellbeing

Workplace wellbeing can be defined as “how we feel *at work* and *about our work*”.²⁶ It encompasses physical and psychological health, quality of life and burnout. Wellbeing in the ACT ATOD sector has been measured through the Workforce Profile since 2017. The inclusion of wellbeing measures reflects a broader shift towards recognising the importance of wellbeing in the ACT community. The ACT Government’s Wellbeing Framework reflects a commitment to promoting wellbeing and to valuing wellbeing as a policy goal.²⁷ The ACT ATOD sector workforce has tended to track relatively well across different workplace wellbeing measures. Notably there was no significant impact to workplace wellbeing as a result of consecutive localised natural disasters and COVID-19 lockdowns over the 2019 - 2021 period.

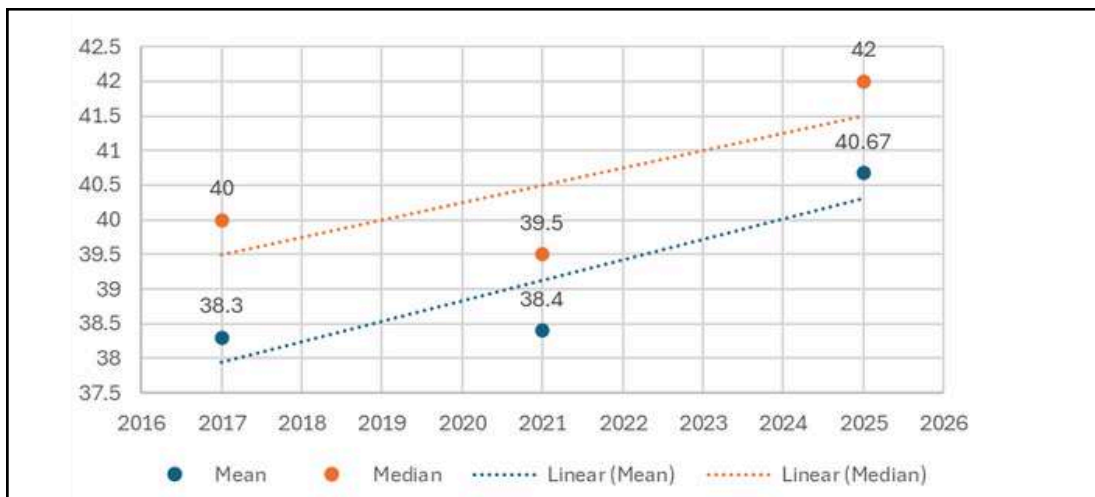


Diagram 7.1 Changes in overall wellbeing scores 2017 - 2025

Organisational perspectives on wellbeing

Services promote wellbeing by creating positive, inclusive, and supportive work environments.

Key actions that services take include:

- Providing sufficient, high quality supervision to meet the needs of the workforce
- Enabling workplace flexibility
- Supporting inclusion and diversity and ensuring that barriers to full workplace participation are removed wherever possible
- Valuing the lived and living experience workforce
- Promoting cultural and psychological safety
- Being aware and responsive to stigma by association



We asked*

What is one innovation that your organisation has implemented / offered in the past 12 months to support the wellbeing of the workforce?

*in the Organisation Survey



What do services identify as the top wellbeing concerns or priorities for their workforce in the next 12-months?

Managing workloads to prevent burnout - Supporting staff through change and uncertainty - Responding to service user needs including co-occurring issues, homelessness, social isolation and criminalisation - Dealing with racism - Recruitment to fill vacancies - Prioritisation of self-care - Community burden - Management of vicarious trauma - Maintaining a positive work environment and culture - Cost of living - Safety - Ongoing clinical supervision and external supervision - Work-life balance - Ongoing learning and training - Burn-out - Staff taking sufficient leave - Mental health - Community overload

Worker perspectives on wellbeing

Survey respondents were asked to think about their “life in the past four weeks” and rate their psychological health, physical health, and quality of life on a scale of 0 (the worst you have ever felt) to 20 (the best you have ever felt). Scores were added up to obtain an overall wellbeing score ranging from 0 to 60.

87.8%
of workers
“actively engage in self-
care strategies”

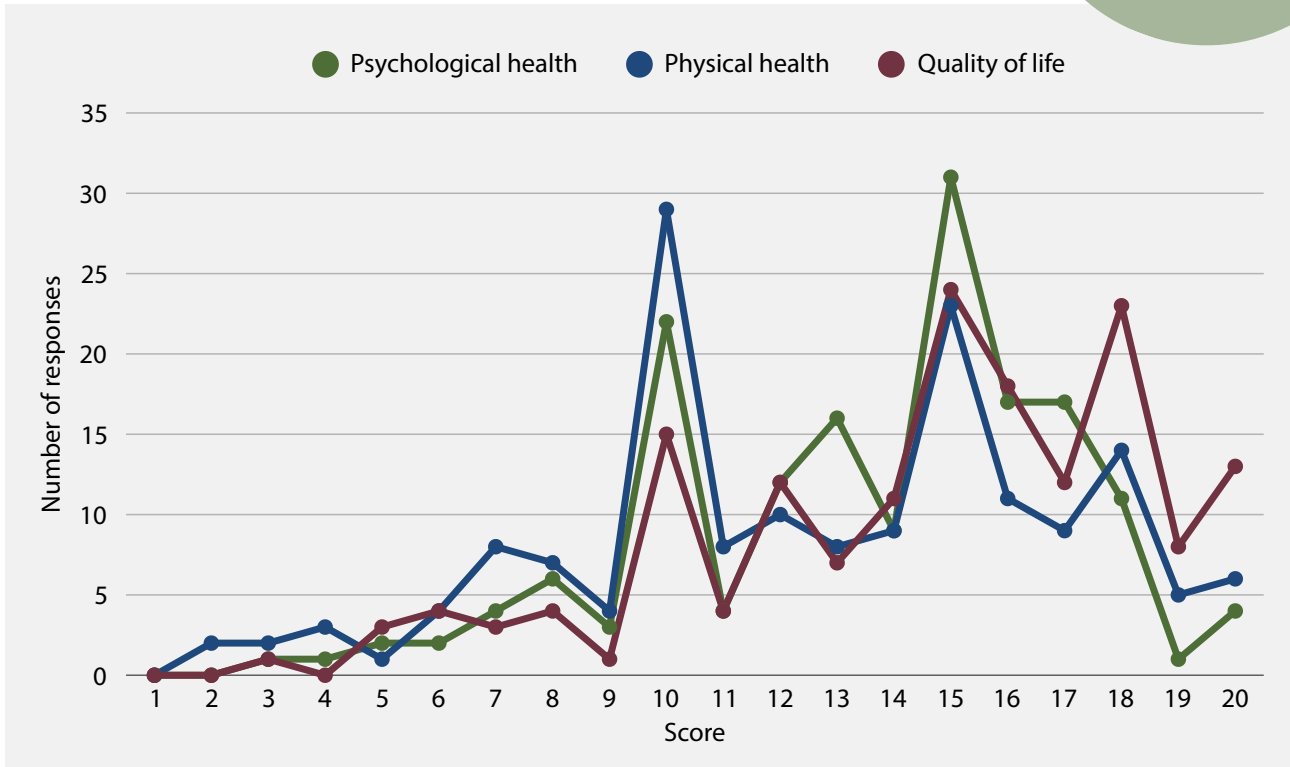


Diagram 7.2 Psychological health, physical health, quality of life (n=163)

There was a cluster of responses at the midpoint (10) and a similar cluster at the three-quarter point (15), after which psychological health dropped precipitously, while physical health and quality peaked again at 18.

	psychological health	physical health	quality of life	overall wellbeing
Mean	13.48	12.69	14.51	40.67
Median	14.00	13.00	15.00	42.00

The mean scores across all three elements of health and wellbeing were above the midpoint of 10, meaning that a majority of respondents score above the midpoint on psychological health, physical health and quality of life. Notably, physical health scored lowest, while quality of life had the highest average score.

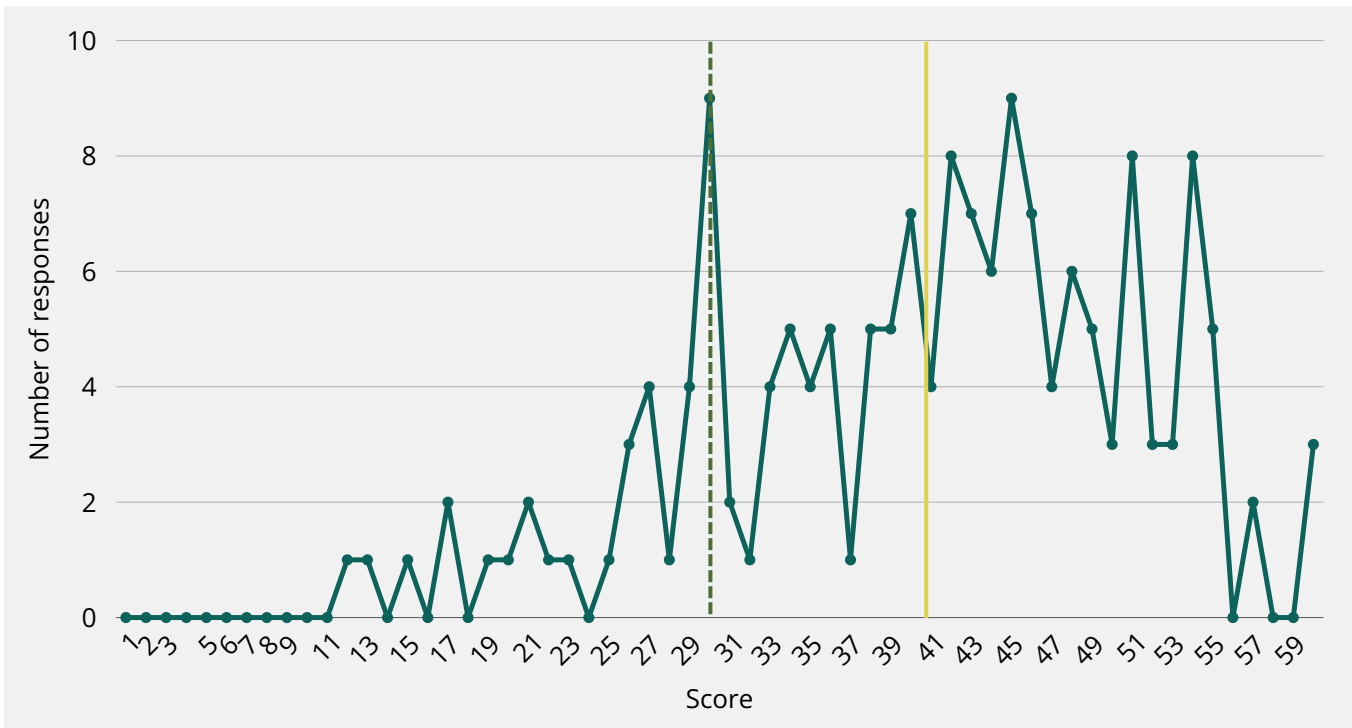





Diagram 7.3 Overall wellbeing (n=163)


The midpoint for overall wellbeing is 30, while the mean score is 40.67, meaning the majority of respondents score higher than the midpoint on overall wellbeing.

- Having a **Bachelor degree or higher** is associated with higher overall wellbeing (n=162)
- Where workers report higher **stigma by association** they experience lower overall wellbeing (n=157)
- Where workers feel **more respected in their job** they experience higher overall wellbeing (n=160)

Burnout

To build a picture of burnout in the ACT ATOD workforce we used three single-item measures. Two questions were derived from a seven-item measure of burnout, while a third question, also validated as a single-item measure, was derived from the vigor subscale of a multi-item engagement scale.



We asked

- 1) Thinking about your experience of work, to what degree do you feel burnt out because of your work?
- 2) Thinking about your experience of work, how often are you exhausted in the morning at the thought of another day at work?
- 3) How often at work do you feel enthusiastic about your job?

Although multi-item measures are preferred and have been used in previous years, validated single item measures are used in recognition of the length of the Workers Survey.

Feeling burnt out

2.49

mean score on scale of 1-5 where >3 indicates feeling more burnt out



Feeling exhausted

2.56

mean score on scale of 1-5 where >3 indicates feeling more exhausted



Feeling enthusiastic

3.83

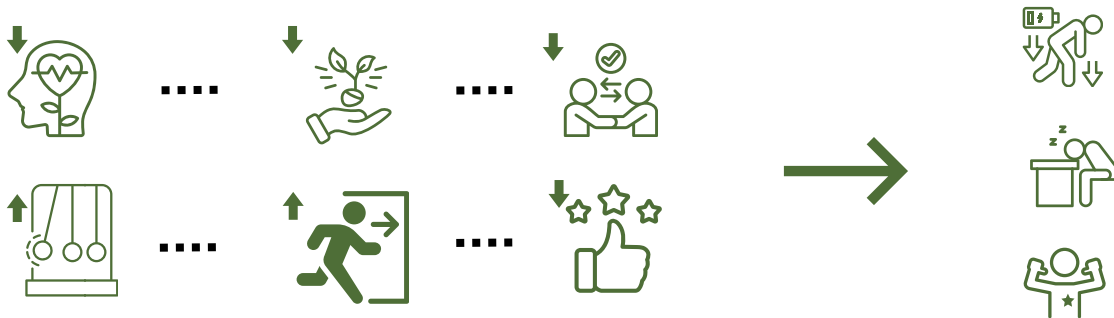
mean score on scale of 1-5 where >3 indicates feeling more enthused



Workers who are women, younger, working longer hours per fortnight, and earning more money, tend to experience higher rates of burnout, as assessed by the question: "To what degree do you feel burnt out because of your work?"



Being a woman and earning a higher income is also associated with being "exhausted in the morning at the thought of another day at work."



Burnout, as indicated in responses to the questions: "To what degree do you feel burnt out because of your work?"; "How often are you exhausted in the morning at the thought of another day at work?"; and "How often do you feel enthusiastic about your job?" is associated with lower overall wellbeing, lower assessment of work as 'meaningful', lower perception of respect and esteem in the workplace, higher experience of stigma by association, higher intention to leave organisation and sector, and lower job satisfaction.



Experiencing time pressures at work is associated with feeling more burnt out and more exhausted.



Lower confidence in ability to do the job well is associated with feeling more burnt out and less enthusiastic about work.

51.5%
of respondents say they feel burnt out because of their work somewhat, to a high degree or to a very high degree



7.2 Job satisfaction



We asked

Thinking about your current work, all in all, how satisfied are you with your job?

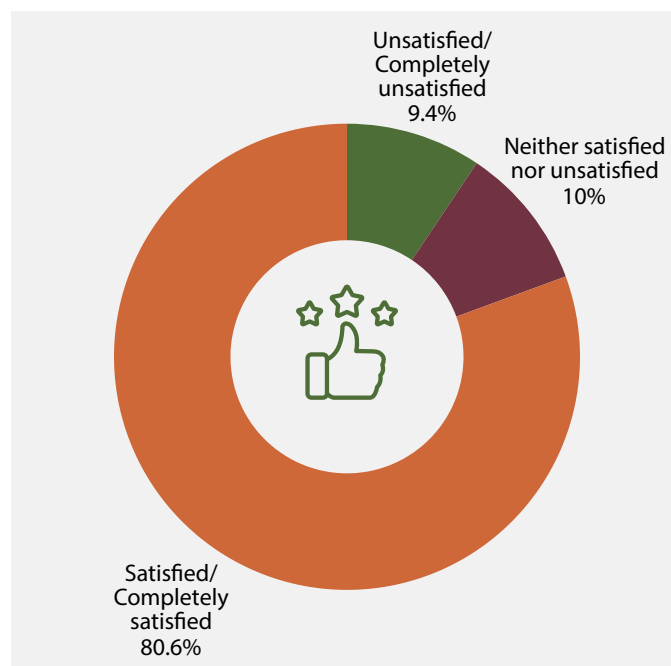


Diagram 7.4 Job satisfaction (n=160)

We further asked respondents how strongly they agree or disagree with the following statements:

- The work I do is meaningful to me (work meaning)
- I have constant time pressures due to a heavy workload (time pressure)
- I am confident in my ability to do my job well (confidence)
- I experience adequate support in difficult situations* (esteem #1)
- I receive the respect I deserve from my superior or a respective relevant person* (esteem #2)
- Considering all my efforts and achievements, I receive the respect and prestige I deserve at work* (esteem #3)
- I think I might lose my job in the near future* (esteem #4)
- In my organisation I am encouraged to try new and different ideas (innovation)

Higher job satisfaction is strongly predictive of lower intention to leave organisation and lower intention to leave sector.

*validated as multi-item measure with 3 other questions as indicated



7.3 Stigma by association

While the stigma that people who use ATOD experience is significant and should be addressed in its own right, it's worth noting that substance-related stigma can, to some extent, adhere to those who are connected to someone using ATOD. This may be a genuine connection (for example, a family member) or a perceived connection (for example, someone of a shared cultural background).²⁸ Sometimes referred to as "courtesy stigma"²⁹ or "secondary stigma",³⁰ stigma by association refers to "discrimination or prejudice experienced by individuals who are associated with people who are stigmatised, even though they do not possess the stigmatised attribute or identity themselves".³¹

There is growing recognition that healthcare professionals who work with a) people who live with stigmatised conditions, such as people with HIV or those experiencing certain mental health conditions, or b) people from stigmatised communities, such as sex workers, may experience a form of stigma by association. A 2024 study by Brener et al.³¹ explored stigma by association amongst the Australian ATOD workforce and found that those who experienced more stigma by association also reported poorer workplace wellbeing, higher burnout and greater intention to leave the sector. A key finding of the study was that lived experience did *not* act as a protective factor.³²



we asked

How strongly do you agree with the following statements:

- I feel stigmatised by other health professionals because I work in the ATOD sector
- I feel stigmatised by the general public because I work in the ATOD sector
- Other health professionals look down on me because I work in the ATOD sector
- The general public looks down on me because I work in the ATOD sector
- The ATOD sector is seen as less important than other medical fields or social services
- People think I should advance my career by moving out of the ATOD sector
- I have experienced discrimination from other health professionals because I work in the ATOD sector

The average stigma by association score across respondents (n=157) was 2.33 with a standard deviation (SD) of 0.86, and a possible range between 1 and 5. Scores above the midpoint of 3 indicate higher stigma by association, while scores below the midpoint indicate lower stigma by association. The result was lower than the stigma by association score of 2.95 (SD 0.94) identified by Brener et al. in their AOD service provider cohort.³¹



The highest number of agree or strongly agree responses (44.4%) was to the statement: "the ATOD sector is seen as less important than other medical fields or social services," followed by "I feel stigmatised by the general public because I work in the ATOD sector," (19.0%) and "people think I should advance my career by moving out of the ATOD sector" (17.5%)

Higher stigma by association correlated with lower overall wellbeing	$r = -.198^{**}$	$p = .014$
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Higher stigma by association is correlated with feeling burnt out , feeling exhausted and feeling less enthusiastic	$r = .251^{**}$	$p = .002$
	$r = .293^{**}$	$p = <.001$
	$r = -.242^{**}$	$p = .003$

Higher stigma by association is correlated with higher intention to leave organisation and intention to leave sector	$r = .262^{**}$	$p = .001$
	$r = .322^{**}$	$p = <.001$

Higher stigma by association is correlated with lower job satisfaction	$r = -.228^{**}$	$p = .005$
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Higher stigma by association is correlated with lower work esteem and work meaning	$r = -.317^{**}$	$p = <.001$
	$r = -.200^*$	$p = .013$

The findings (n=154) show that there is a correlation between stigma by association and burnout (across all three measures), intention to leave both organisation and sector, job satisfaction, work esteem and work meaning. Addressing stigma by association is likely to be particularly effective in improving these workplace outcomes, with a potential positive impact on retention.

It has been suggested that health and community sector services are ideal sites for addressing stigma, including self-stigmatisation, experienced by service users.³³ Recognising how stigma by association also impacts workers in the sector is an important adjunct to broader efforts to change the landscape of stigma and ensure that services are safe and accessible for everyone. Wellbeing strategies that take into account the way in which workers can be co-located with service users in processes of stigma and social marginalisation, are important.³⁴

Previous studies on stigma by association across diverse sectors have found mixed results around whether lived experience increases or decreases the risk of experiencing stigma by association.³⁵⁻
³⁷ We hypothesised that while lived experience may not function as a protective, as per the findings from Brener et al., having a peer identity and being in a specified peer role might reduce the experience of stigma by association.

	Stigma association	Lived experience	Peer work	Weekly income	Gender	Highest education
Stigma association						
Lived experience						
Peer work	.241**	.230**				
Weekly income			-.299**			
Gender			-.210**			
Highest education		-.272**	-.187*	.178*	.193*	

Note. $p < .05^*$, $p < .01^{**}$ Only statistically significant correlations are shown; white cells indicate non-significant relationship; orange indicates positive relationship; green indicates negative relationship

Diagram 7.6 Correlations showing relationship between stigma by association and key demographic and workplace items

The table above shows that being a peer worker is *positively* correlated with stigma by association. The experience of stigma is a qualifying characteristic of peer work and one that may distinguish peer work from lived experience. Being identified as a peer can expose individuals to increased visibility in relation to their drug or alcohol use and therefore, at increased risk of being at the receiving end of stigmatising attitudes. At the same time, engaging in peer work can be an important mechanism for addressing stigma and self-stigmatisation, as it “repositions a commonly stigmatised and discriminated attribute as one of core strength, and provides a meaningful pathway for people who have significant experiences in the area to reframe their entire life as something valuable, knowledgeable and positive”.¹⁹ Peer work training may sensitise peers to stigma, providing skills and knowledge to recognise its impact in their own lives and in the lives of service users, in order to be better equipped to engage in individual and systemic advocacy.



- In line with previous Workforce Profiles, it was found that workers in the sector experience mostly positive wellbeing outcomes.
- A workplace in which people feel respected is more protective of worker wellbeing and may reduce burnout.
- Experiences of stigma by association are correlated with poorer wellbeing outcomes and lower job satisfaction, as measured across a number of items.
- Being a peer worker may reduce the risk of experiencing stigma by association.



Key Findings



1

- The ACT ATOD sector employs approximately 400 people (equivalent to 287 FTE).
- 70.2 percent of respondents to the Workers' Survey indicated that they spend about half or more of their week on direct client contact activities.
- A randomly selected worker in the field is more likely to be...
 - aged between 40 and 54;
 - a woman;
 - working in a permanent, full-time role;
 - working overtime at least a few times a month;
 - earning over \$1500 per month;
 - qualified with a bachelor degree or higher and have ATOD-specific qualifications;
 - a person with some form of ATOD lived experience; and
 - a current or former smoker.

2

- While the sector may struggle to recruit new staff there is generally high satisfaction and low intention to leave, amongst the workforce .
- High job satisfaction, in roles where people feel that their work is meaningful and they are respected, is associated with lower intention to leave an organisation, while higher burnout and experiences of stigma by association are associated with higher intention to leave.

3

- The sector is in broad agreement that the minimum qualification, as established through the Qualifications Strategy, is set at an appropriate level, with some key issues that may be addressed in the future.
- 60.0 percent of the workforce have completed the requirements of the Qualifications Strategy and a further 10.4 percent are on track do so in accordance with the requirements of the strategy.

4

- A significant proportion of the sector (69.9 percent) has lived experience of the impacts of alcohol or other drug use on themselves or someone close to them.
- While there is scope for a greatly expanded peer workforce, barriers to establishing this remain.



5

The ACT ATOD sector is highly competent. Amongst direct client contact workers areas of particular strength (over 90% agree or strongly agree) include:

- providing a brief intervention, when appropriate to do so;
- recognising and responding to service users who are under the influence;
- supporting a service user to identify and develop strategies to reduce ATOD-related harm;
- familiarity with the range of possible concerns and needs that people with co-occurring ATOD and mental health concerns are likely to experience;
- using culturally appropriate communication to create a welcoming, safe and supportive environment for service users;
- ability to call out discriminatory or stigmatising behaviour in a service;
- working effectively with diversity including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities and with LGBTIQ+ service users and service users living with disability;
- working cooperatively and collaboratively with other service providers to support service users; and
- understanding of vicarious trauma and how to access support in the workplace

Amongst direct client contact workers, there are areas that may require additional support or training (less than 70 percent agree or strongly agree). Noting that some of these may have scored lower as they are not relevant to every role, they include:

- accessing interpreters to facilitate accessible, timely and effective communication;
- screening for gambling harms; and
- knowledge of medications used to treat ATOD-related health conditions.

6

Amongst workers in the ACT ATOD sector:

- smoking and vaping rates are about three times higher than in the general ACT population;
- high proportions are confident that they understand the harms and risks of using tobacco and e-cigarettes;
- while between half and two-thirds ask all or most service users about their use of tobacco and/or e-cigarettes, this is not necessarily translating into providing 'advice' or 'help';
- fewer are providing or feel competent to provide brief interventions for e-cigarette use, compared to tobacco use; and
- clinically significant proportions are 'never' or 'sometimes' providing smoking and/or vaping brief interventions, or possibly believe it is outside their scope of practice (i.e., responded 'not applicable').

7

- In line with previous Workforce Profiles, it was found that workers in the sector experience mostly positive wellbeing outcomes.
- A workplace in which people feel respected is more protective of worker wellbeing and may reduce burnout.
- Experiences of stigma by association are correlated with poorer wellbeing outcomes and lower job satisfaction, as measured across a number of items.
- Being a peer worker may reduce the risk of experiencing stigma by association.

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Appendices



Appendices are available on the ATODA website. To view, click on the QR code below.

Appendix A Organisation Survey

Appendix B Workers' Survey

Appendix C Methods

Appendix D Data tables





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