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Lived Experience: Characteristics of Workers in Alcohol and Other Drug Nongovernment Organizations

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Abstract

Background: Workers with lived experience of problematic alcohol and other drug (AOD) use are increasingly recognized as integral to the AOD field. However, little is known about the prevalence or characteristics of AOD workers with lived experience across the general AOD workforce, in Australia or internationally. This study aimed to (1) investigate the prevalence of lived experience in AOD workers, (2) build an initial profile of workers with lived experience, (3) identify areas where appropriate support mechanisms may be warranted, and (4) generate recommendations for future work. **Method:** Nongovernment organization AOD workers from New South Wales, Australia, were invited to participate in a purpose-designed, online survey. Measures included demographic and workforce characteristics, work-related psychosocial factors, and health, quality of life, and AOD use. Descriptive analyses compared responses from workers with and without lived experience on key variables. **Results:** Two hundred and sixty-eight workers responded. Workers with lived experience comprised 43% of the sample; were more likely to be older; male; identify as lesbian, gay, homosexual, or queer; have lower salary; report discrimination in the workplace; abstain from alcohol; report opioid use; and experience less support outside work. **Conclusion:** This is the first Australian study to examine the profile of AOD workers with lived experience. Workers with lived experience constituted a substantial proportion of the AOD workforce. Analogous to other countries, comprehensive, appropriately tailored workforce development and support policies are required. Future research should build on these findings by extending to a broader population base, including government workers.

Keywords

alcohol and other drugs, online survey, lived experience, workforce development, Australia

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Globally, alcohol and other drug (AOD)-related harm places a high social and economic burden on society (Peacock et al., 2018). To effectively prevent and minimize this harm, it is crucial to gain a clear understanding of the diversity of the AOD workforce to ensure appropriate support and development strategies are in place (Roche, 2001; Roche & Nicholas, 2017) and to optimise effective clinical care and outcomes (van de Ven, Ritter, & Roche, 2019).

Workers with lived experience of problematic AOD use and recovery from AOD problems form a central part of the AOD workforce. Historically, workers with lived experience were pivotal in early recovery-focused initiatives (e.g., therapeutic communities), harm reduction (e.g., needle exchanges), and support groups and are recognized for their valuable contribution to the AOD workforce in Australia (Gethin, 2008) and internationally (Marshall, Dechman, Minichiello, Alcock, & Harris, 2015; Nelson, 2017). Workers with lived experience offer experiential knowledge and mutuality from the unique "perspective of someone who has been there" (Nelson, 2017, p. 464; Swanson, Caldwell, & Shearer, 2014) and have played a prominent role in the rise of modern treatment approaches (White & Evans, 2013). The benefits of consumer participation in service provision more generally are well-documented and include improved health outcomes, enhanced clinical decision-making, and improved service development (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Brener, Resnick, Ellard, Treloar, & Bryant, 2009; Consumer Focus Collaboration, 2001; Rance & Treloar, 2015; Reif et al., 2014).

Today, there is widespread support and commitment to growing and developing the lived experience workforce in the AOD sector. This is reflected in the emerging focus on engaging and building the capacity of peer workforce roles, including participation of designated peer support, peer advocate, and consumer workers in Australasia (Swanson et al., 2014), North America (Reif et al., 2014), and Europe (Public Health England, 2015).

However, the extant literature regarding lived experience in the AOD sector has almost exclusively focused on peer and consumer roles, with very little attention given to the lived experience of the AOD workforce more broadly. It is important to make this distinction, as the personal experience of AOD workers (who may or may not choose to disclose) does not define their role in the same way as peer workers. Although it is suggested that workers with lived experience are employed in a variety of "nonpeer" positions across the AOD sector (Gethin, 2008; Rothrauff, Abraham, Bride, & Roman, 2011; White & Evans, 2013), supporting evidence is sparse and potentially unreliable. White (2009), for example, highlighted and questioned the prevailing assumption that the majority of U.S. AOD counselors are in recovery and that they differ from nonlived experience colleagues in several key respects including knowledge, skills, and effectiveness (see also Anderson & Wiemer, 1992). To date, however, there is no specific data available to compare the experience of people with lived experience to those without lived experience across the AOD workforce. Workers with lived experience may face unique challenges and risks to well-being such as stress or threats to their own recovery (Butler et al., 2018; Gethin, 2008; Marshall et al., 2015) but may be reluctant to share their experience due to stereotypes and stigma in the field and wider community (Hyde, 2013; White, 2009). It is currently unknown whether such issues impact workers with lived experience across the general AOD workforce as well as those occupying specific peer-based roles.

In summary, there is a dearth of research regarding the prevalence of lived experience in AOD workers across the Australian AOD sector and international research is sparse. A preliminary assessment is essential to identify key areas for support and estimate future workforce needs. To address this gap, this article reports data from a survey of workers employed in AOD nongovernment organizations (NGOs) in New South Wales (NSW), Australia. It should be noted that while the term "lived experience" can be conceptualized in a number of ways, the present study focuses on lived experience of problematic AOD use, rather than experience with AOD use more generally.

The aims were to: (1) investigate the prevalence of lived experience in AOD workers; (2) build an initial profile of workers with lived experience; (3) identify areas where appropriate support

mechanisms and professional development needs may be warranted, and (4) generate recommendations for future work.

Method

The findings presented in this article are part of a larger, custom-designed survey of NGO AOD workers in NSW, designed to map demographic profiles and gauge the level of health and well-being in the AOD workforce. The survey was co-designed by the National Centre for Education and Training on Addiction, the Network of Alcohol and other Drugs Agencies (NADA), and Matua Raki, New Zealand. Details of the full instrument and report can be found elsewhere (Roche et al., 2018).[1]

Data were collected between September and November 2017, hosted by the online survey platform SurveyMonkey®. AOD workers in NGO sector organizations in NSW were invited to participate in the survey via e-mail invitations sent through NADA member and stakeholder communication networks. The survey was also promoted on AOD sector online forums (websites and social media), at AOD training events, and by respondents who were encouraged to distribute the survey to colleagues. Ethical approval was obtained from Flinders University Social and Behavioural Research Ethics Committee (No. 7647).

Measures

Lived experience. Lived experience was assessed by asking respondents to indicate whether they had experienced problematic AOD use, for which they may or may not have sought treatment or support (Y/N). Respondents with lived experience were asked to indicate whether they had disclosed their lived experience in the workplace (Y/N) and whether their current role was an identified lived experience position (Y/N), defined as being employed for their specific skill set including experience of AOD use, which they drew upon purposefully in their work.

Demographic characteristics. In the current study, personal demographic measures of interest included age, gender, sexual orientation, and whether respondents identify as Aboriginal or Torres Strait Islander. Financial measures included annual gross salary range, as well as a single-item assessment of financial well-being: *Can you live comfortably on your pay?* (four response options from *never* to *always*; Van Veldhoven & Meijman, 1994). Education level was assessed by highest non-AOD qualification and AOD-related qualification.

Workplace characteristics. Measures relating to workplace characteristics included years of service in current position, current NGO, and the AOD sector in total; work roles (direct client services, management, administration); work location (urban, regional, rural/remote); contract type (participants were asked to select between permanent, fixed term, or casual contracts); full- or part-time work; and contracted weekly working hours.

Work-related psychosocial factors and experiences. Work-related satisfaction was measured using four items. Satisfaction with current position was measured by the item: *You are satisfied with your present job* (five options from *strongly agree* to *strongly disagree*; Lehman, Greener, & Simpson, 2002). Two single items measured level of satisfaction with working in the NGO sector and satisfaction with work–life balance (five options from *very dissatisfied* to *very satisfied*). In relation to supervision, level of satisfaction with line management received was measured by four options from *quite dissatisfied* to *very satisfied*.

Perception of job insecurity was measured by the single item: *In the next 12 months, what is the chance that you could lose your job for a reason that is beyond your control?* (five options from *almost certain* to *almost no chance*; Pacheco, Morrison, Cochrane, Blumenfeld, & Rosenberg, 2016). Two

items based on previous work (O'Driscoll & Beehr, 1994) and adapted for the AOD sector measured turnover intention in relation to seeking a new job: (1) within the AOD sector but outside current NGO and (2) outside the AOD sector (five options from *strongly agree* to *strongly disagree*). Occupational self-efficacy was assessed by the level of agreement with the statement: *I am confident that I have the necessary skills and knowledge to do my job effectively* (five options from *strongly agree* to *strongly disagree*).

Respondents were asked to indicate whether they had experienced workplace discrimination, bullying, and harassment (Y/N). The degree to which workers felt that they could express their identity at work was assessed by the item: *People in Australia have different lifestyles, cultures, and beliefs that express their identity. How easy or hard is it for you to be yourself at work?* (five options from *very easy* to *very hard*; Stats NZ Tatauranga Aotearoa, 2018).

Perceptions of social support were assessed using the Brief Job Stress Questionnaire (Shimomitsu et al., 2000), a 9-item measure with three 3-item subscales relating to the degree of support received from (1) supervisors, managers, and teamleaders; (2) co-workers; and (3) spouse, family, and friends. Example items are: *How freely can you talk with the following people? How reliable are the following people when you are troubled?* (five options from *not at all* to *extremely*). Good reliability was achieved for all subscales ($\alpha s \geq .83$). A further measure of support was: *In general, do you feel supported to undertake your role?* (Y/N).

Health, quality of life, AOD use, and concern from significant others. Respondents were asked to rate their general health (five options from *poor* to *excellent*; Ware & Sherbourne, 1992) and quality of life (five options from *very poor* to *very good*; Power, 2003). AOD use over the past 3 months was assessed by items based on the Alcohol, Smoking and Substance Involvement Screening Test—Frequency & Concern (McRee, Babor, Lynch, & Vendetti, 2018). Frequency of alcohol use categories applied in the current study were never/once or twice a week, 1–4 times per week, daily/almost daily, and alcohol use at risky levels: (Y/N). Respondents reported whether they had used the following substances over the past 3 months: tobacco, cannabis, cocaine, amphetamine-type substances, sedatives or sleeping pills, prescription pain medication, heroin, or opioids (Y/N). The final items asked whether a friend or relative had expressed concern about their alcohol, tobacco, or other drug use, either (1) within the past 3 months or (2) yes, but not in the past 3 months (Y/N).

Statistical Analyses

Workers with and without lived experience were compared on the demographic and workplace characteristics, work-related psychosocial factors, and health, quality of life, and AOD use measures. Analyses of frequencies were conducted to determine patterns of response, and χ^2 tests of independence and independent samples *t* tests were performed to examine between-group differences by lived experience status. Where data were missing due to nonapplicability or respondents opting not to answer the question, percent and means are presented for complete cases only. Statistical significance was inferred from a threshold of $p \leq .05$, reported with effect sizes to indicate the magnitude of effect. Cohen's (1988) *d* is presented for *t* tests and can be interpreted by conventional standard of 0.2 = small, 0.5 = medium, and 0.8 = large, and Cramér's *V* (donated as ϕ_c) is presented for χ^2 whereby 0.1 = small, 0.3 = medium, and 0.5 = large.

Results

Demographic and Workplace Characteristics of Sample

Two hundred and ninety-four respondents completed the larger survey of AOD NGO workers in NSW (Roche et al., 2018). Of these, 20 respondents did not answer the lived experience question and 6

Table 1. Demographic Characteristics, by Lived Experience Status.[a]

Variable	No Lived Experience ($n = 154$)	Lived Experience ($n = 114$)	Total ($N = 268$)
Age, mean (*SD*)*	42.22 (12.72)	45.26 (10.28)	43.51 (11.86)
Gender[b, **]			
Female	76.0 (117)	54.4 (62)	66.8 (179)
Male	24.0 (37)	44.7 (51)	32.8 (88)
Transgender female	0	0.9 (1)	0.4 (1)
Sexual orientation**			
Straight or heterosexual	91.2 (135)	74.8 (80)	84.3 (215)
Lesbian, gay, homosexual, queer[c]	8.8 (13)	25.2 (27)	15.7 (40)
Aboriginal/Torres Strait Islander	5.8 (9)	12.3 (14)	8.6 (23)
Annual gross salary range[d,e, *]			
≤AUD$30k	3.0 (4)	6.9 (7)	4.7 (11)
AUD$30,001–AUD$50k	19.4 (26)	16.7 (17)	18.2 (43)
AUD$50,001–AUD$70k	41.8 (56)	55.9 (57)	47.9 (113)
≥AUD$70,001k	35.8 (48)	20.6 (21)	29.2 (69)
Can live comfortably on pay[f]	45.9 (67)	36.1 (39)	41.7 (106)
Highest non-AOD qualification			
School	10.5 (13)	15.2 (14)	12.5 (27)
Certificate/diploma	30.6 (38)	41.3 (38)	35.2 (76)
Bachelor's degree	29.0 (36)	21.7 (20)	25.9 (56)
Postgraduate qualification	29.9 (37)	21.7 (20)	26.4 (57)
Highest AOD-related qualification			
None	18.8 (24)	17.4 (16)	18.2 (40)
Short course[g]/certificate/diploma	39.8 (51)	53.3 (49)	45.5 (100)
Bachelor's degree	13.3 (17)	15.2 (14)	14.1 (31)
Postgraduate qualification	28.1 (36)	14.1 (13)	22.3 (49)

Note. AOD = alcohol and other drug.

[a]Data are expressed as % (no.) unless otherwise indicated. [b]Transgender female category not included in analysis due to low cell count ($n = < 5$). [c]Bisexual category removed due to nonselection. [d]Analysis adjusted for PT/FT status. [e]Result should be interpreted with caution due to low cell count ($n = < 5$). [f]% of respondents selecting: can often or always live comfortably. [g]Accredited.

Difference between groups significant at $^{*}p \leq .05$. $^{**}p \leq .01$.

selected the option "prefer not to say," leaving $N = 268$ for analysis in the current study. It is estimated that the NGO AOD workforce in NSW comprises approximately 1,000 workers (NADA, 2014); therefore, the responses from this survey represent the views of around one third of the workforce.

Demographic and workplace characteristics are shown in Tables 1 and 2, respectively. The mean age of the sample was 44 (range = 21–67 years), with 67% female workers. Eighty-four percent of workers identified as straight or heterosexual and 9% Aboriginal and/or Torres Strait Islander. Almost 50% of the sample reported an annual gross household income between AUD$50 and AUD$100,000 (49% of part-time workers and 46% of full-time workers).[2] Likewise, 48% of the sample reported an annual gross salary range between AUD$50 and AUD$70,000 (35% of part-time workers and 56% of full-time workers). Forty-two percent indicated that they can often or always live comfortably on their pay. Approximately half (52%) of the sample held a non-AOD-related university level (bachelor's degree or postgraduate) qualification, and the majority (46%) held a certificate or diploma-level AOD-related qualification (Table 1).

On average, workers reported 4 years of service in their current position, 5 years in their current NGO, and 8 years of service in the AOD field in total (Table 2). In relation to work roles performed, 76% reported working directly with clients, 30% had management roles, and 41% undertook

Table 2. Workplace Characteristics, by Lived Experience Status.[a]

Variable	No Lived Experience ($n = 154$)	Lived Experience ($n = 114$)	Total ($N = 268$)
Years in current position, mean (*SD*)	3.44 (3.46)	4.08 (4.31)	3.70 (3.83)
Years in current NGO, mean (*SD*)	4.92 (4.87)	5.44 (4.75)	5.13 (4.82)
Years in AOD sector, mean (*SD*)	7.92 (8.48)	8.45 (7.30)	8.14 (7.99)
Work roles[b]			
Direct client services	76.0 (117)	75.4 (86)	75.5 (203)
Management	30.5 (47)	29.8 (34)	30.2 (81)
Administration	37.7 (58)	46.5 (53)	41.4 (111)
Work location			
Urban	47.6 (70)	59.1 (65)	52.5 (135)
Regional	38.1 (56)	25.5 (28)	32.7 (84)
Rural/remote	14.3 (21)	15.4 (17)	14.8 (38)
Contract type			
Permanent	80.8 (118)	83.5 (91)	82.0 (209)
Fixed term	12.3 (18)	10.1 (11)	11.4 (29)
Casual	6.8 (10)	6.4 (7)	6.7 (17)
Works full time (≥35 hr per week)	70.2 (99)	66.3 (67)	68.6 (166)
Work hours per week, mean (*SD*)	35.60 (10.62)	33.88 (10.10)	34.88 (10.42)

Note. AOD = alcohol and other drug; NGO = nongovernment organization.
[a]Data are expressed as % (no.) unless otherwise indicated. [b]Respondents could nominate more than one option.

administrative duties. Just over half of respondents worked in urban locations in NSW. The majority (82%) were employed in permanent positions and most were employed full time (69%), averaging a mean of 35 working hours per week.

Although little recent data are available on the characteristics of the Australian AOD workforce, national indications suggest that workers are predominantly female (66%), aged approximately 45 or over, with an average duration of working in the AOD field for approximately 5 years (Duraisingam, Pidd, Roche, & O'Conner, 2006). Previous workforce surveys in NSW have reported similar demographics and also indicate that around half of workers hold university qualifications and specific AOD-related qualifications, with less than 10% of workers from Aboriginal or Torres Strait Islander backgrounds (Gethin, 2008; NADA, 2014). Thus, although available comparison data are somewhat sparse and caution is warranted, the current findings appear broadly representative of national NGO AOD workforces overall.

Prevalence of Lived Experience

In all, 42.5% ($n = 114$) of the sample identified as having lived experience. Of those with lived experience, 68.4% ($n = 78$) reported that they had disclosed their lived experience in the workplace and 18.4% ($n = 21$)[3] reported that they were employed in an identified lived experience position (i.e., employed for their experience of AOD use, which they draw upon purposely in their work).

Differences Between Those With and Without Lived Experience

Demographic and workplace characteristics. When comparing demographic and workplace characteristics, workers with lived experience were slightly but significantly older, $t(243) = -2.0$, $p = .047$, $d = .26$; more likely to be male, $\chi^2(1,267) = 13.14$, $p < .001$, $\phi_c = .22$; and more likely to identify as lesbian, gay, homosexual, or queer, $\chi^2(1,255) = 12.71$, $p < .001$, $\phi_c = .22$ (Table 1). Identification as

Table 3. Work-Related Psychosocial Factors and Experiences, by Lived Experience Status.[a]

Variable	No Lived Experience ($n = 154$)	Lived Experience ($n = 114$)	Total ($N = 268$)
Satisfaction with:			
Present job[b]	72.0 (85)	73.4 (58)	72.6 (143)
NGO AOD sector[c]	62.6 (72)	70.9 (56)	66.0 (128)
Work–life balance[c]	59.2 (72)	56.3 (45)	58.2 (117)
Supervision: line management[c]	63.9 (53)	55.9 (33)	60.6 (86)
Perception of job insecurity[d]	32.0 (33)	27.3 (18)	30.2 (51)
Turnover intention[b]			
To leave current NGO	21.5 (26)	12.7 (10)	18.0 (36)
To leave AOD sector	21.7 (26)	16.7 (13)	19.7 (39)
Confidence in skills and knowledge[b]	93.1 (121)	92.1 (82)	92.7 (203)
Negative workplace experiences			
Discrimination*	17.6 (22)	29.1 (25)	22.3 (47)
Bullying	42.4 (53)	48.3 (42)	44.8 (95)
Harassment	20.0 (25)	31.0 (27)	24.5 (52)
Find it easy to "be yourself" at work[e, *]	77.2 (105)	63.1 (65)	71.1 (170)
Feel supported to undertake role	86.8 (105)	81.5 (66)	84.7 (171)
Social support, mean (*SD*)[f]			
Supervisor/manager/teamleader	2.14 (0.58)	2.15 (0.59)	2.14 (0.58)
Co-workers	2.35 (0.53)	2.30 (0.52)	2.33 (0.52)
Spouse/family/friends*	2.71 (0.39)	2.56 (0.48)	2.65 (0.43)

Note. AOD = alcohol and other drug; NGO = nongovernment organization.
[a]Data are expressed as % (no.) unless otherwise indicated. [b]% of respondents selecting: agree or strongly agree. [c]% of respondents selecting: mostly satisfied or very satisfied. [d]% of respondents selecting: medium, high, or almost certain chance of losing job. [e]% of respondents selecting: easy or very easy. [f]Min–max scale range = 1–4.
Difference between groups significant at $^*p \leq .05$.

Aboriginal and/or Torres Strait Islander was reported by a higher percentage of lived experience workers (12% vs. 6%, *ns*). Adjusting for part/full-time work, those with lived experience reported significantly lower annual gross salary ranges, $\chi^2(3,223) = 8.79$, $p = .032$, $\phi_c = .20$, and were less likely to report that they could often or always live comfortably on their pay, although this difference was nonsignificant (36% vs. 46%). There were no significant between-group differences for qualification level, although workers with lived experience tended to report more certificate/diploma-level AOD-related qualifications and fewer postgraduate qualifications (Table 1).

No differences were found by lived experience status for years of service in current position, current NGO, or AOD sector in total. The type of work roles performed, work locations, contract type, and weekly working hours were also similar between groups (Table 2).

Work-related psychosocial factors and experiences. Work-related psychosocial factors and experiences by lived experience status are displayed in Table 3. In the total sample, 73% reported satisfaction with present job, 66% were satisfied with working in the NGO AOD sector more broadly, work–life balance satisfaction stood at 58%, and satisfaction with line management was 61%. No significant differences were found by lived experience status for these variables. Similarly, no differences were found for perceived chance of job loss in the next 12 months, which stood at 30% across the workforce, or for confidence in skills and knowledge to do the job, which was high at 93% across the sample. Turnover intentions, to leave both current NGO and the AOD sector, were slightly lower in those with lived experience than those without (13% vs. 22% and 17% vs. 22%, respectively, *ns*).

Table 4. Health, Quality of Life, AOD Use in Past 3 Months, and Concern From Significant Other, by Lived Experience Status.[a]

Variable	No Lived Experience ($n = 154$)	Lived Experience ($n = 114$)	Total ($N = 268$)
General health rating[b]	82.6 (95)	78.5 (62)	80.9 (157)
Quality of life rating[c]	89.8 (106)	84.0 (68)	87.4 (174)
Alcohol frequency[d,e, **]			
Never/once or twice	39.2 (47)	67.9 (55)	50.7 (102)
1–4× per week	54.2 (65)	27.2 (22)	43.3 (87)
Daily/almost daily	6.7 (8)	4.9 (4)	6.0 (12)
Alcohol at risky levels[e,f, **]	52.5 (63)	32.1 (26)	44.3 (89)
Tobacco[e]	23.5 (28)	34.6 (28)	28.0 (56)
Cannabis[e]	7.5 (9)	9.9 (8)	8.5 (17)
Cocaine[e,g]	4.2 (5)	2.5 (2)	3.5 (7)
Amphetamine-type substances[e,g]	0.8 (1)	4.9 (4)	2.5 (5)
Sedatives or sleeping pills[e]	7.6 (9)	13.6 (11)	10.0 (20)
Opioids[e,h, *]	10.0 (12)	22.5 (18)	15.0 (30)
Friend/relative expressed concern			
Alcohol use—Ever**	7.5 (9)	21.3 (17)	13.0 (26)
Alcohol use—Past 3 months[g]	1.7 (2)	2.5 (2)	2.0 (4)
Tobacco use—Ever**	15.8 (19)	40.0 (32)	25.5 (51)
Tobacco use—Past 3 months*	10.8 (13)	22.5 (18)	15.5 (31)
Other drug use—Ever[g]	2.5 (3)	23.5 (19)	10.9 (22)
Other drug use—Past 3 months[f]	1.7 (2)	3.7 (3)	2.9 (5)

Note. AOD = alcohol and other drug.

[a]Data are expressed as % (no.). [b]% of respondents selecting: good, very good, or excellent. [c]% of respondents selecting: good or very good. [d]Result should be interpreted with caution due to one cell with low count ($n = < 5$). [e]Used in the past 3 months.[f]Consumption of five (male) or four (female) drinks on one occasion.[g]Analysis not performed due to low cell count ($n = <5$). [h]Descriptor included prescription pain medication, heroin, or opioids.

Difference between groups significant at $^{*}p \leq .05$. $^{**}p \leq .01$.

However, workers with lived experience were significantly more likely to report having experienced discrimination in the workplace, $\chi^2(1,211) = 3.87$, $p = .049$, $\phi_c = .14$ (Table 3). Experiences of workplace harassment was also reported more frequently by those with lived experience (31% vs. 20%, *ns*). There was a significant difference in the degree to which workers felt able to express their identity at work: 77% of workers without lived experience found it easy or very easy to "be themselves" at work compared to 63% of lived experience workers, $\chi^2(1,239) = 5.67$, $p = .017$, $\phi_c = .15$. No differences were found for experiences of bullying, which was reported by 45% of workers across the sample.

Workers felt highly and equally supported to undertake their role in general (85% across the sample), and no between-group differences were found for perceptions of social support from supervisors, managers, teamleaders, or coworkers. However, those with lived experience reported receiving significantly less social support from their spouse, family, or friends, $t(209) = 2.52$, $p = .012$, $d = .34$, suggesting a lower level of support outside of work than their nonlived experience colleagues (Table 3).

Health, quality of life, AOD use, and concern from significant others. Eighty-one percent of workers reported their general health to be good to excellent, and 87% rated their quality of life to be good or very good, with no differences between groups (Table 4). In relation to AOD use, workers with lived experience were significantly more likely to have never, or once or twice, used alcohol in the past 3 months,

$\chi^2(1,201) = 16.26, p < .001, \phi_c = .28$ (68% vs. 39%), and significantly less likely to report drinking at risky levels, $\chi^2(1,201) = 8.16, p = .004, \phi_c = .20$ (32% vs. 53%). No differences were found for tobacco or any other drug use with the exception of opioids, $\chi^2(1,200) = 5.88, p = .015, \phi_c = .17$, used by 23% of workers with lived experience in the past 3 months compared to 10% of nonlived experience workers (Table 4). Friends, relatives, and others of those with lived experience were significantly more likely to have expressed concern in the past 3 months for tobacco use, $\chi^2(1,200) = 4.99, p = .026, \phi_c = .16$, and at some time in the past for both alcohol, $\chi^2(1,200) = 8.02, p = .005, \phi_c = .20$, and tobacco, $\chi^2(1,200) = 14.76, p < .001, \phi_c = .27$. This trend was also evident for other drug use but could not be tested statistically due to low sample sizes (Table 4).

Discussion

This is the first Australian study to be undertaken to examine the profile of AOD workers with lived experience of problematic AOD use. First, a substantial proportion (43%) of AOD workers in the current sample reported lived experience. Despite the dearth of comparison data, previous analysis of the New Zealand addiction (including gambling) workforce reported that 32% considered themselves to be in recovery from a substance use problem (Adamson, Deering, Schroder, Townshend, & Ditchburn, 2009). This is consistent with estimates that the representation of lived experience in the U.S. addiction treatment workforce stands at approximately 30% (White, 2009; White & Evans, 2013). Thus, the proportion of those with lived experience in the current sample could be considered higher than expected. Notably, only 18% were employed in a lived experience position. It is encouraging that nearly 70% of those with lived experience had disclosed their experience to their employer, which may indicate a supportive workplace (Butler et al., 2018). It would be useful for future studies to examine differences between workers who choose to disclose and those who do not, in addition to identifying factors that may be linked to this decision. Time elapsed since problematic use or current abstinence status may be contributing factors in this regard.

When comparing worker groups, those with lived experience differed to their nonlived experience colleagues in several important respects. In terms of personal characteristics, workers with lived experience in the NGO sector were more likely to be slightly but significantly older, male, and identify as lesbian, gay, homosexual, or queer, all with small–medium effect sizes. Identification as Aboriginal and/or Torres Strait Islander was also trending in the data. These sociodemographic factors are predictive of higher levels of AOD use and problems in the community at large. As such, workers with these characteristics may be well placed to offer empathic mutual support to treatment recipients and service clients.

In terms of AOD use, lived experience workers were more likely to abstain from alcohol and less likely to drink at risky levels. However, significantly higher levels of past concern by friends/family was reported, suggesting that these workers have undergone positive change. Evidence suggests that smoking rates in the AOD sector workforce are high generally (Cookson et al., 2014), and targeted smoking cessation programs or initiatives to support workers to reduce or cease consumption may be warranted across the workforce to help improve overall health. Workers with lived experience were also more likely to have used prescription pain medication, heroin, or opioids in the past 3 months, although it should be noted that these drugs were assessed using a combined measure. We are therefore unable to speculate on the reasons underlying this finding, and future studies are advised to separate measures of pain medication, heroin, and opioids to gain a clearer understanding. However, additional support from supervisors and employers may be warranted.

Workers with lived experience also reported significantly higher levels of discrimination in the workplace and were less likely to feel as though they could "be themselves" at work. Reports of workplace harassment were also slightly higher in this group, consistent with international reports suggesting that prejudice around AOD use may lead to discrimination for clinicians with a personal

history of substance use disorders (White, 2009). AOD dependence is more stigmatized than any other health or social condition and continues to pose a barrier in workplaces, health systems, and wider community around the world (Brener, Von Hippel, Von Hippel, Resnick, & Treloar, 2010; FitzGerald & Hurst, 2017; Gilchrist et al., 2011; Room, Rehm, Trotter, Paglia, & Ustun, 2001). Furthermore, research from the U.S. suggests that stigma attached to the sector is one of the reasons for lower pay in this field in comparison to other areas of behavioral health care (Addiction Technology Transfer Centre [ATTC] Network, 2017). The findings around negative workplace experiences are therefore important with regard to the pervasive nature of stigma, and speak to the value and importance of addressing stigma in the workplace as part of an integrated workplace well-being approach (Harvey et al., 2017). Organizations should seek to ensure fairness of treatment; provide guidance toward and reinforce the use of appropriate and nonstigmatizing language, and facilitate help-seeking and open reporting around problematic workplace behaviors and cultures.

Workers with lived experience also reported less social support from family and friends, which raises the potential for additional risks to general health and well-being. Social isolation and lack of social support are associated with higher morbidity (Viswesvaran, Sanchez, & Fisher, 1999) and lower life expectancy (House, 2001). Furthermore, previous work has demonstrated that strong social support networks are important for the well-being of lived experience workers (Best, Savic, & Daley, 2016; Butler et al., 2018). To improve work–life outcomes, steps to provide additional measures of social support and connection within organizations may include the provision of structured opportunities for positive interaction (e.g., praise, encouragement, and respect) between co-workers, managers, and supervisors and routinely assessing for signs of burnout or withdrawal (Roche & Nicholas, 2017).

Finally, the findings relating to remuneration are of interest. The average salary range across the whole sample was lower than the average annual Australian salary of approximately AUD$81,600 (Australian Bureau of Statistics, 2017), which was reflected by only 42% of workers stating that they could live comfortably on their pay. However, workers with lived experience reported lower pay than those without lived experience despite working similar hours and with comparable years of service. Although this disparity may reflect trends toward lower education levels in the lived experience group, this pattern echoes international reports that workers in recovery are paid less for comparable work (White, 2009), and also suggests that workers with lived experience may have less access to senior roles than their nonlived experience counterparts. It is crucial to recognize where and why such discrepancies occur throughout the AOD sector and ensure appropriate pay recognition. Increasing educational opportunities and access to certification processes in countries where this applies may go some way to address this (ATTC, 2017). It is also noteworthy that workers with lived experience reported slightly lower turnover intentions than those without lived experience. Although this difference was not statistically significant, it is important to flag as a potentially useful avenue for future investigation, as preventing turnover is important to ensure a stable workforce that can provide continuity in client care.

Taken together, the current findings highlight a need for further investigation into comprehensive and appropriately tailored policies to better support workers with lived experience of AOD use, including tackling stigma and discrimination, improving access to social supports, and closer attention to pay equity. What is striking from this study is that: (1) most workers with lived experience in the AOD sector are not employed in consumer and peer workforce roles, and (2) the proportion of those who identify as lived experience workers is approaching almost half of the workforce. Clearly, this is an important and understudied area, as little is known about the implications of personal histories for the workers themselves or the impact this may have on work with clients. Lived experience of problematic AOD use is widespread but not aligned to specific roles/positions in clinical services. Although workforce development is often discussed with reference to targeting certain roles and

positions, the current findings suggest that a more system-wide approach to the AOD workforce around issues of discrimination, stress, salary, and training is required.

These findings also suggest that the distinction between the peer and professional workforce may be less clearly delineated than previously indicated, and the perspectives of lived experiences workers are applicable across the workforce more generally. The way in which "AOD lived experience" is conceptualized is multifaceted and may relate to problematic (or non-problematic) personal use; witnessing use by a family member, or other significant experiences at neighborhood or community levels (Rothrauff et al., 2011; White, 2009). Therefore, a broader conceptualization of lived experience is required across the sector to better inform future work and workforce development.

In summary, clarity and distinction around "AOD lived experiences" in relation to both worker role and definition is currently lacking. It is important to engage with all workers with lived experience to seek feedback about sector policy, workforce development, and research priorities that could lead to strengthening supports in the workplace. A collaborative co-design approach is required for beneficial change. Lessons may be learned from existing frameworks in comparable sectors such as mental health, for example, the recently launched Lived Experience Framework for NSW (Mental Health Commission of NSW, 2018) and the mental health international charter, providing guiding principles, values, and practices from a global perspective (Stratford et al., 2019).

Limitations

As an initial study in this area, the findings offer useful insights. However, this is tempered by a number of caveats. The study size and sample were relatively small, with statistical tests yielding small to medium effects. Several potentially useful analyses could not be undertaken due to small cell sizes. Limitations in the survey items were evident; for example, quantity of AOD use alongside frequency of use measures would be preferable. The study focused on nongovernment workers and may therefore have particular relevance to the NGO sector. It is not known to what extent the findings can be generalized to government service workers, who may be systematically different in a variety of respects. Future studies would benefit from a larger sample and broader population base. However, given the comparable demographic profile of available national workforce data (Duraisingam et al., 2006), cautious optimism regarding generalizability may be assumed.

Conclusion

Given the dearth of national and international literature, this article makes an important contribution to the broader extant literature in relation to lived experience, highlighting support mechanisms and key points for future consideration. Workers reporting lived experience in the AOD sector come from varied backgrounds, and a more comprehensive conceptualization and understanding of lived experience is required to address AOD workforce development needs, both nationally and overseas. This article highlights this gap and calls for more to be done in the area.

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Notes

1. The sample in this article is based on the number of respondents who answered the single item relating to lived experience of problematic alcohol and other drug use and may vary from total participant numbers presented in the report. To enable interpretation of analyses, variable coding applied here may differ from the report.
2. Part-time and full-time status was categorized using the Australian Bureau of Statistics (2018) definition of part-time working hours $\leq$34 hr per week and full-time working hours $\geq$35 hr per week.
3. Six respondents who selected "no" to lived experience but "yes" to being employed in a lived experience position were removed due to unreliability of data.

References

Adamson, S., Deering, D., Schroder, R., Townshend, P., & Ditchburn, M. (2009). *National telephone survey of the addiction treatment workforce*. National Addiction Centre, University of Otago.

Addiction Technology Transfer Centre Network. (2017). *National Workforce Report 2017: Strategies for recruitment, retention and development of the substance use disorder treatment and recovery services workforce*. Author.

Anderson, S. C., & Wiemer, L. E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596–603.

Australian Bureau of Statistics. (2017). *Average weekly earnings, Australia* (cat. 6302.0). Author.

Australian Bureau of Statistics. (2018). *Labour statistics: Concepts, sources and methods* (cat. 6102.0.55.001). Author.

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, *63*, 1–9.

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

Brener, L., Resnick, I., Ellard, J., Treloar, C., & Bryant, J. (2009). Exploring the role of consumer participation in drug treatment. *Drug and Alcohol Dependence*, *105*, 172–175.

Brener, L., Von Hippel, W., Von Hippel, C., Resnick, I., & Treloar, C. (2010). Perceptions of discriminatory treatment by staff as predictors of drug treatment completion: Utility of a mixed methods approach. *Drug and Alcohol Review*, *29*, 491–497.

Butler, M., Savic, M., Best, D. W., Manning, V., Mills, K. L., & Lubman, D. I. (2018). Wellbeing and coping strategies of alcohol and other drug therapeutic community workers: A qualitative study. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *39*, 118–128.

Cohen, J. (1988). *Statistical power and analysis for the behavioral sciences* (2nd ed.). Lawrence Erlbraum.

Consumer Focus Collaboration. (2001). *The evidence supporting consumer participation in health*. Author.

Cookson, C., Strang, J., Ratschen, E., Sutherland, G., Finch, E., & McNeill, A. (2014). Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudeds. *BMC Health Services Research*, *14*, 1–8.

Duraisingam, V., Pidd, K., Roche, A., & O'Conner, J. (2006). *Stress satisfaction and retention among alcohol and other drug workers in Australia*. The National Centre for Education and Training on Addiction, Flinders University.

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics*, *18*, 19.

Gethin, A. (2008). *NSW alcohol and other drug non-government sector: Workforce profile and issues*. Network of Alcohol and Other Drug Agencies.

Gilchrist, G., Moskalewicz, J., Slezakova, S., Okruhlica, L., Torrens, M., Vajd, R., & Baldacchino, A. (2011). Staff regard towards working with substance users: A European multi-centre study. *Addiction*, *106*, 1114–1125.

Harvey, S. B., Modini, M., Joyce, S., Milligan-Saville, J. S., Tan, L., Mykletun, A., & Mitchell, P. B. (2017). Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occupational Environmental Medicine*, *74*, 301–310.

House, J. S. (2001). Social isolation kills, but how and why? *Psychosomatic Medicine*, *63*, 273–274.

Hyde, P. S. (2013). *Report to congress on the nation's substance abuse and mental health workforce issues*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Lehman, W. E., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, *22*, 197–209.

Marshall, Z., Dechman, M. K., Minichiello, A., Alcock, L., & Harris, G. E. (2015). Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. *Drug and Alcohol Dependence*, *151*, 1–14.

McRee, B., Babor, T. F., Lynch, M. L., & Vendetti, J. A. (2018). Reliability and validity of a two-question version of the World Health Organization's alcohol, smoking and substance involvement screening test: The ASSIST-FC. *Journal of Studies on Alcohol and Drugs*, *79*, 649–657.

Mental Health Commission of New South Wales. (2018). *Lived experience framework for NSW*. Author.

Nelson, A. (2017). Addiction workforce development in Aotearoa New Zealand. *Drugs: Education, Prevention and Policy*, *24*, 461–468.

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

O'Driscoll, M. P., & Beehr, T. A. (1994). Supervisor behaviors, role stressors and uncertainty as predictors of personal outcomes for subordinates. *Journal of Organizational Behavior*, *15*, 141–155.

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

Peacock, A., Leung, J., Larney, S., Colledge, S., Hickman, M., Rehm, J., & Degenhardt, L. (2018). Global statistics on alcohol, tobacco and illicit drug use: 2017 status report. *Addiction*, *113*, 1905–1926.

Power, M. (2003). Development of a common instrument for quality of life. In A. Nosikov & C. Gudex (Eds.), *EUROHIS: Developing common instruments for health surveys* (pp. 145–164). IOS Press.

Public Health England. (2015). *Service user involvement: A guide for drug and alcohol commissioners, providers and service users*. Author.

Rance, J., & Treloar, C. (2015). "We are people too": Consumer participation and the potential transformation of therapeutic relations within drug treatment. *International Journal of Drug Policy*, *26*, 30–36.

Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*, 853–861.

Roche, A. (2001). What is this thing called workforce development?. In A. Roche & J. McDonald (Eds.), *Systems, settings, people: Workforce development challenges for the alcohol and drugs field* (pp. 5–22). National Centre for Education and Training on Addiction, Flinders University.

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

Roche, A., & Nicholas, R. (2017). Workforce development: An important paradigm shift for the alcohol and other drugs sector. *Drugs: Education, Prevention and Policy*, *24*, 443–454.

Room, R., Rehm, J., Trotter, R. T., Paglia, A., & Ustun, T. B. (2001). Cross-cultural views on stigma, valuation, parity and societal values towards disability. In T. B. Ustun, S. Chatterji, J. E. Bickenbach, R. T. Trotter, R. Room, J. Rehm, & S. Saxena (Eds.), *Disability and culture: Universalism and diversity* (pp. 247–291). Hogrefe & Huber.

Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. *Journal of Substance Abuse Treatment*, *40*, 67–76.

Shimomitsu, T., Haratani, T., Nakamura, K., Kawakami, N., Hayashi, T., & Odagiri, Y. (2000). The final development of the Brief Job Stress Questionnaire mainly used for assessment of the individuals. In M. Kato (Ed.), *The Ministry of Labour sponsored grant for the prevention of work-related illness, FY 1999 report* (pp. 126–164). Tokyo Medical University.

Stats NZ Tatauranga Aotearoa. (2018). *New Zealand general social survey*. Author.

Stratford, A. C., Halpin, M., Phillips, K., Skerritt, F., Beales, A., Cheng, V., … Davidson, L. (2019). The growth of peer support: An international charter. *Journal of Mental Health*, *28*, 627–632.

Swanson, C., Caldwell, V., & Shearer, R. (2014). *Competencies for the mental health and addiction service user, consumer and peer workforce*. Te Pou o to Whakaaro Nui.

van de Ven, K., Ritter, A., & Roche, A. (2019). Alcohol and other drug (AOD) staffing and their workplace: Examining the relationship between clinician and organisational workforce characteristics and treatment outcomes in the AOD field. *Drugs: Education, Prevention and Policy*. Advance online publication. doi:10.1080/09687637.2019.1622649

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

Viswesvaran, C., Sanchez, J. I., & Fisher, J. (1999). The role of social support in the process of work stress: A meta-analysis. *Journal of Vocational Behavior*, *54*, 314–334.

Ware, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care*, *30*, 473–483.

White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioural Health and Intellectual Disability Services.

White, W., & Evans, A. (2013). The recovery agenda: The shared role of peers and professionals. *Public Health Reviews*, *35*, 4.

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