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OCCUPATIONAL THERAPY CLINICIANS' ATTITUDES TOWARD COLLECTIVE BARGAINING IN NEW SOUTH WALES, AUSTRALIA*

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ABSTRACT

This article presents the results of an investigation of the attitudes of New South Wales occupational therapy clinicians toward collective bargaining for themselves and occupational therapy academics. Data were collected using a mailed survey instrument that included scales measuring attitudes toward collective bargaining and collecting demographic data. New South Wales clinicians are supportive of collective bargaining in general for both themselves and academic occupational therapists. They are, however, not supportive of strike action for themselves even over serious professional issues. Level of education was found to correlate with scores on the clinical collective bargaining subscale.

The decrease in health care dollars in the Australian public health sector is having, and will continue to have, a marked impact on the delivery of occupational therapy (OT) services [1]. Occupational therapy authors have called on the profession to become more politically active within the health care sector to maximize their influence over decision makers and secure the position of the profession within the public sector [2, 3].

The restructuring of the public health care system in the state of New South Wales has resulted in various levels of representation across sections of the system. The level of representation achieved has depended on the extent to which occupational therapists, in conjunction with other allied health professionals, have been able to push for management structures within their areas to ensure they are

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represented in decision-making forums [4]. In areas where they have been politically aware and active good representation structures have been established. In areas where therapists have been less active and aware, limited access to decision making has resulted.

This may result in increased job dissatisfaction in relation to salaries, staffing levels, and working conditions, including poor facilities and equipment, which have been shown previously to concern occupational therapists [3, 5].

One organization able to actively fight for good representation structures and working conditions for therapists is an industrial union. The attitudes of occupational therapy clinicians toward unions and their activities have not been investigated and reported in Australia. It has been postulated in the Canadian literature, however, that therapists may experience a conflict between unionism and professionalism [6, 7]. Union membership has been found to be influenced by income, age, gender [8], knowledge of unions [9], socialization during undergraduate education [6], and the influence of supervisors and mentors.

Australian occupational therapy academics have been found to be supportive of collective bargaining in principle for both themselves and clinical therapists but not supportive of strike action by clinical therapists, except over serious professional issues. However, in practice, less than fifty percent were members of a union and less than 25 percent had ever been involved in the union beyond basic membership [10].

The question addressed in this study was: What are the attitudes of New South Wales occupational therapy clinicians toward industrial unions.

METHOD

The sample consisted of forty-two New South Wales occupational therapists employed in clinical settings. A clinical setting was defined as any facility where direct client services were provided.

Instrument

The data collection instrument for this investigation was a questionnaire based on the Nursing Faculty Collective Bargaining Attitudinal Survey Instrument developed by Crisci, Fisher, Blixt, and Brewer [11]. The survey instrument was modified to relate to occupational therapists in clinical and academic settings. The instrument determines attitudes toward collective bargaining, including strike action and unionism/professionalism conflict. The content validity of the questionnaire was determined by having faculty and clinical occupational therapists review the items to ensure their appropriateness for occupational therapists in Australian clinical and academic settings.

Demographic data collected to determine factors that may influence attitudes toward collective bargaining included information concerning age, sex, whether

the position held was one designated as an occupational therapy position, the clinical grade of the position held (seniority), years of experience as an occupational therapist in both full-time and part-time positions, years of experience in any other field, union and professional association membership, most influential source of information about unions, level of education, family attitude toward unions, level of involvement in a union, and level of knowledge about unions.

Procedures

The questionnaire was distributed to the sample via the mailing lists of both the professional association (The New South Wales Association of Occupational Therapists) and the union (The Occupational Therapists Vocational Branch of the Public Service Association). Seventy-five occupational therapists who were on the mailing list of the professional association and working in clinical settings were randomly selected. Forty-five occupational therapists were randomly sampled from the membership of the union. Questionnaires were mailed to therapists' work addresses.

The questionnaire was accompanied by a cover letter explaining the purpose of the research, stressing the voluntary nature of participation, the fact that all information collected was confidential, and that consent to participate was implied upon return of a completed questionnaire.

A follow-up letter was sent to the total sample thanking those who had returned the questionnaire and reminding those who had not to do so if they wished to respond.

Analyses

Descriptive statistics were calculated on all variables. Chi square analysis using a significance level of .01 was used to determine the statements where more respondents agreed than disagreed with an item. A *t*-test was performed on the total collective bargaining scores for each of the subscales to determine whether there was a difference in the attitudes of clinicians toward collective bargaining for themselves and for occupational therapists in academic positions. A simple regression equation was calculated using the totals for the clinical subscale and each of the following demographic variables: sex, age, grade, full-time and part-time experience, educational level, union membership, professional association membership, family attitude toward unions, major source of influence about unions, and knowledge of unions.

RESULTS

The small sample size in this study should be borne in mind when considering results presented. The low return rate (35%) may be a result of three factors. First, it was possible (for confidentiality reasons) to mail questionnaires only to the

work addresses of those sampled, using the professional association's mailing list. These addresses may not have been current at the time of mailing due to the failure of members to notify the association if they had changed jobs. Four questionnaires were returned to the researcher for this reason. However, others not returned may not have reached the occupational therapists to whom they were addressed. A delayed mailing from the union's list resulted in a shorter response time before the suggested return date than was intended. This may have discouraged some therapists from returning the questionnaire, although a follow-up letter was sent. A lack of interest on the part of occupational therapists in this topic may be a third reason for the low response rate.

Table 1 summarizes the demographic data obtained about the sample.

The *t*-test revealed no significant difference between the clinicians' attitudes toward collective bargaining for themselves and for academic occupational therapists ($t = -.15$, $DF = 72$, $p = .88$).

Chi square results (Table 2) indicate that for only two of the eleven items on the clinical subscale was there no difference between the number of respondents agreeing or disagreeing at the .01 level. These were: Item 4: "There are circumstances in which a strike would be a legitimate means of collective action by OTs"; and Item 11: "In order to preserve professional freedom, OTs should have the right to strike over serious issues." The other statements were significantly different from what would be expected by chance (Appendix A).

On all but one item on the faculty subscale a significant difference (at the .01 level) existed between those agreeing and disagreeing from what would be expected by chance. This was Item 19: "There are circumstances in which a strike would be a legitimate means of collective action by faculty."

For the regression equations only two of the predictor variables were significantly related to the score on the clinical subscale. These were union membership ($F = 4.77$, $p = .035$), which accounted for 10.6 percent of the variance; and level of education ($F = 5.42$, $p = .025$), which accounted for 11.9 percent of the variance.

DISCUSSION

Occupational therapy clinicians in New South Wales believe there is a place for collective bargaining in both the Australian health care sector and in higher education. They support collective bargaining in principle for themselves and academics. In practice 62.49 percent are members. This membership rate is higher than for occupational therapy academics, less than 50 percent of whom were members [10]. This would seem to indicate slightly greater support for the union, the body able to bargain collectively for therapists.

Clinicians are not significantly supportive of the strike action for themselves, even over serious issues related to professional freedom. For academic occupational therapists however, they are supportive of strike action over threats to

Table 1. Demographic Profile of Sample

	Percent		Percent
Sex:		Family Attitude:	
Male = 2	4.76	Pro-union = 10	23.81
Female = 40	95.24	Anti-union = 21	50.00
Age:		Neither = 11	26.19
20-25 = 3	7.14	Most Influential Information	
26-30 = 12	28.57	Source:	
31-35 = 11	26.19	Family = 4	9.52
36-40 = 5	11.90	Undergrad. educ. = 1	2.38
41-45 = 2	4.76	Colleagues in first job = 4	9.52
46-50 = 3	7.14	Colleagues gen. = 14	33.33
51-55 = 3	7.14	Mentor = 3	7.14
56+ = 3	7.14	Senior work coll. = 0	0.00
Position:		Union info. source = 5	11.90
OT designated = 37	92.50	Postgrad. educ. = 1	2.38
Not-OT designated = 3	7.50	Other = 10	23.81
Missing = 2		Knowledge of Unions:	
Grade:		Uninformed = 6	14.63
One = 15	36.59	Somewhat uninf. = 4	9.76
Two = 9	21.95	Somewhat inform. = 26	63.41
Three = 6	14.63	Informed = 5	12.20
Four = 5	12.20	Well-informed = 0	0.00
Five = 2	4.88	Missing = 1	
Other = 4	9.76	Union Involvement:	
Missing = 1		Voc. branch exec. = 2	4.76
Percent Appointment:		Union rep. = 5	11.90
Full-time = 35	83.33	Workplace del. = 7	16.67
Part-time = 7	16.67	Member only = 31	73.81
Highest Education		Never member = 8	19.05
Level:		(should not total 100%)	
Undergrad. dip. = 6	14.29		
Bachelor's		Years F/T Experience	
degree = 19	45.24	Mean = 10.05	
Postgrad. dip. = 9	21.43	Min. = 2	
Coursework Mas. = 6	14.29	Max. = 30	
Research MA = 2	4.76	Years P/T Experience	
Ph.D. = 0	0.00	Mean = 1.92	
Union Membership:		Min. = 0	
Member = 27	64.29	Max. = 18	
Nonmember		Years Exp. Other Field	
Past-member = 7	16.67	Mean = 0.86	
Not past member = 8	19.05	Min. = 0	
		Max. = 10	

Table 2. Percentages of Agreement and Chi Square Tests

Items in Questionnaire	Clinical Subscale		Academic Subscale	
	Percent	Chi	Percent	Chi
Coll. barg. has a place (1 & 13)	95.2	30.3810	91.4	24.0286
Coll. barg. is a threat to prof. image (2 & 16)	16.7	18.6667	8.5	24.0286
I support coll. barg. (3 & 14)	88.1	24.3810	85.7	17.8571
Strike is legitimate (4 & 19)	47.6	0.000	71.4	6.4285
Coll. barg. increases voice in decision making (5 & 17)	90.5	27.5238	91.2	23.0588
Most effective way to influence decisions is to negotiate (6 & 12)	83.3	18.6667	82.9	15.1142
Unified action to achieve professionalism (7 & 22)	77.0	11.5238	77.1	10.3143
Coll. barg. safeguards rights and prof. freedom (8 & 15)	85.7	21.4286	91.4	24.0286
Coll. barg. results in more equitable decisions in prof. and economic issues (9 & 20)	92.7	29.8780	91.2	23.0588
Coll. barg. brings higher salaries and benefits (10 & 18)	80.5	15.2439	88.2	19.8824
Right to strike over serious issues, prof. freedom (11 & 21)	64.3	3.4285	82.9	15.1142

academic freedom. This may reflect the unionism/professionalism conflict described by Brocket [7] and McColl and Miles-Tapping [6]. It is presumably the strike action itself therapists do not support, rather than other forms of collective bargaining, since a significantly greater number of clinicians disagreed than agreed that collective bargaining was a serious threat to professional image for either themselves or academics. They were also supportive of unified action as the only way for themselves and academics to achieve professionalism if they were not treated professionally.

Clinicians agreed more often than disagreed that collective bargaining increased the voice an average OT had in decisions related to professional practice and academic governance. They also agreed the most effective ways to have meaningful influence over decisions was to negotiate via collective bargaining. In practice, only one third of those sampled had been involved beyond basic membership either currently or in the past, and for just over half of that group their level

of involvement was limited to workplace delegate. This level of involvement is again slightly higher than for academics. However, this should be considered carefully in light of the sampling difficulties experienced.

Clinicians felt that collective bargaining helped to safeguard therapists' rights and professional or academic freedom. There was also significant agreement that collective bargaining may result in higher salaries, improved benefits, and more equitable economic and professional decisions. These are areas about which occupational therapists have been shown to be concerned [3, 5].

Union members were more favorable toward collective bargaining than nonmembers, which may be expected. However, as discussed above, they were not significantly supportive of strike action. The level of education was also significantly related to the clinical collective bargaining subscale. Previous research has shown that socialization during undergraduate education influences attitudes toward unions. However, respondents have not indicated undergraduate or postgraduate education as a primary source of influence over their attitudes toward unions when asked directly about this. It would be interesting to conduct further research into the extent to which occupational therapists have been influenced by their different undergraduate experiences (diploma versus degree) and their postgraduate experiences.

CONCLUSIONS

The aim of this study, to determine the attitudes of occupational therapy clinicians toward collective bargaining, was met via the administration of an attitudinal survey. The study, however, should be viewed as exploratory and preliminary due to the sampling difficulties experienced.

Results indicate support for collective bargaining in principle by occupational therapy clinicians for themselves and academic OTs. It is seen as a means to improve salaries, ensure equitable decision making, and to maintain professional freedom and rights. Strike action as a form of collective bargaining, however, is not supported for themselves even over serious professional issues. It is supported for academics in relation to threats to academic freedom. The extent to which this attitude reflects a professionalism/unionism conflict for therapists should be investigated further.

Similarly, the role of both undergraduate and graduate education in shaping attitudes toward collective bargaining should be investigated in more detail to determine the most appropriate role of faculty and curricula in preparing students to be politically involved and aware.

Further research on a national level is required to determine attitudes of clinicians toward unions and their activities as well as their attitudes toward and involvement in "political arenas" more broadly. Such information would assist unions and professional associations in recruiting and involving members in

collective bargaining, negotiation, and lobbying processes, which have been highlighted as essential for the future of the profession.

APPENDIX
Occupational Therapy Collective Bargaining Attitudinal Survey Instrument

The purpose of this section is to assess your attitudes toward collective bargaining for occupational therapists (OT's) in **CLINICAL SETTINGS**.* Please answer the following questions using this scale:

SCALE: CA = completely agree; MA = mostly agree; SA = slightly agree; SD = slightly disagree; MD = mostly disagree; CD = completely disagree

1. Collective bargaining by OT's has a place in Australian health care.	CA	MA	SA	SD	MD	CD
2. Collective bargaining is a serious threat to the professional image of OT's.	CA	MA	SA	SD	MD	CD
3. I would (do) support collective bargaining for OT's.	CA	MA	SA	SD	MD	CD
4. There are circumstances in which a strike would be a legitimate means of collective action by OT's.	CA	MA	SA	SD	MD	CD
5. Collective bargaining increases the voice an average OT has in decisions relating to professional practice.	CA	MA	SA	SD	MD	CD
6. The most effective way for OT's to have meaningful influence over decisions is to negotiate via collective bargaining.	CA	MA	SA	SD	MD	CD
7. When OT's are not treated as professionals, unified action is the only way to achieve professionalism.	CA	MA	SA	SD	MD	CD

*Clinical setting is defined as any facility where direct client services are provided.

8. Collective bargaining helps safeguard OT's rights and professional freedom.	CA	MA	SA	SD	MD	CD
9. Collective bargaining results in more equitable decision making regarding professional and economic issues.	CA	MA	SA	SD	MD	CD
10. Collective bargaining by OT's is likely to bring higher salaries and improved benefits.	CA	MA	SA	SD	MD	CD
11. In order to preserve professional freedom, OT's should have the right to strike over serious issues.	CA	MA	SA	SD	MD	CD

The purpose of this section is to assess your attitudes toward collective bargaining for OCCUPATIONAL THERAPY faculty in **ACADEMIC SETTINGS**.* Please answer using the same scale as before.

12. The most effective way for faculty to have meaningful influence over decisions at university is to negotiate via collective bargaining.	CA	MA	SA	SD	MD	CD
13. Collective bargaining for faculty has a place in Australian higher education.	CA	MA	SA	SD	MD	CD
14. I would (do) support collective bargaining for OT academics.	CA	MA	SA	SD	MD	CD
15. Collective bargaining helps safeguard faculty rights and academic freedom.	CA	MA	SA	SD	MD	CD
16. Collective bargaining is a serious threat to the professional image of university faculty.	CA	MA	SA	SD	MD	CD
17. Collective bargaining increases the voice of the average faculty member in academic governance matters.	CA	MA	SA	SD	MD	CD

*Academic setting refers to a university that includes an undergraduate program in occupational therapy.

18. Collective bargaining by faculty is likely to bring higher salaries and improved benefits.	CA	MA	SA	SD	MD	CD
19. There are circumstances in which a strike would be a legitimate means of collective action by faculty.	CA	MA	SA	SD	MD	CD
20. Collective bargaining results in more equitable decision making regarding tenure, promotion and conditions of employment.	CA	MA	SA	SD	MD	CD
21. In order to ensure the preservation of academic freedom, faculty should have the right to strike over serious issues.	CA	MA	SA	SD	MD	CD
22. When faculty are not treated as professionals, unified action is the only way to achieve professionalism.	CA	MA	SA	SD	MD	CD

Demographic Information

Please indicate your responses to these questions by placing a tick in the space to the left of the appropriate answer.

1. Are you: ___ Female ___ Male?

2. Please indicate your age:
   ___ 20-25 ___ 26-30 ___ 31-35 ___ 36-40
   ___ 41-45 ___ 46-50 ___ 51-55 ___ 56+

3. Are you in a:
   ___ designed occupational therapy position
   ___ position not designated as an OT position?

4. Are you a:
   ___ grade one ___ grade four
   ___ grade two ___ grade five
   ___ grade three ___ other, please specify
   _____?

5. Is your appointment:
   ___ full time ___ part time (days _____)?

6. Please indicate your years of experience as a clinician:
   _____ years full time experience
   _____ years part time experience
   (You may use both of the above if appropriate)

7. Please indicate your years of experience in any other field during your working life:
   years experience field
   _____
   _____

8. Please indicate your highest level of education:
   ___ undergraduate diploma ___ bachelors degree
   ___ post graduate diploma ___ coursework MA
   ___ research MA ___ PhD

9. Are you:
   ___ currently a member of NSWAOT
   ___ not currently an NSWAOT member but have been in the past
   ___ not currently an NSWAOT member and have not been in the past?

10. When you were younger, would you describe your family attitude toward unions as having been:
    ___ pro union
    ___ anti union
    ___ neither pro nor anti union?

11. What would you describe as the most influential source of information about unions you have received?:
    ___ your family
    ___ your undergraduate education
    ___ work colleagues in your first job
    ___ work colleagues generally
    ___ someone you would describe as a mentor
    ___ more senior work colleagues
    ___ a union pamphlet or other union information source
    ___ post graduate education
    ___ other; please describe _____

12. Please indicate the level of your involvement in union activities, both past and present. Mark as many responses as are appropriate.
    ___ no involvement
    ___ member only
    ___ work place delegate
    ___ union representative for some purpose
    ___ PSA vocational Branch executive member
    ___ other; please describe _____

13. Would you describe your knowledge of unions and the industrial process as:
    ___ uninformed ___ somewhat uninformed
    ___ somewhat informed ___ informed
    ___ well informed

Thank you for your cooperation in completing this questionnaire. Please return it in the envelope provided by **Wednesday 3 February 1993**. Please return it to Susan Griffin, 32 Persic Street, Belfield 2191.

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