Handbook for the Work Practice Questionnaire (WPQ):

A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field

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National Centre for Education and Training on Addiction

Flinders University 2004

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Foreword

In 2001 the National Centre for Education and Training on Addiction was commissioned by the Australian Government Department of Health and Ageing to undertake a project titled Evaluating the Impact of Alcohol and Other Drug Education and Training: Development of a Measurement Tool and Training Evaluation Guidelines. Additional support for the Evaluation Project was provided by the South Australian Department of Health. This document is one of the key products stemming from that project.

The Evaluation Project involved the development of an evaluation tool called the Work Practice Questionnaire (WPQ), and a set of related resources. The WPQ is a purpose-built measurement tool designed to assess a wide range of factors that influence work practices in relation to alcohol and other drugs.

Three key products were developed as part of the Evaluation Project. They are:

1. A monograph examining factors influencing training transfer and work practice change in relation to alcohol and other drugs: *From Training to Work Practice Change: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field.*

   The monograph examines a wide range of factors that influence work practices in relation to alcohol and other drugs. It provides a review of evidence related to the influence of the factors assessed in the Work Practice Questionnaire on training transfer and work practice. Strategies to address each of the factors in order to facilitate training transfer and work practice change are also discussed.

2. Guidelines for evaluating AOD-related training: *Guidelines for Evaluating Alcohol and Other Drugs Education and Training Programs.*

   The guidelines provide user-friendly information for evaluating alcohol and other drug education and training programs. The guidelines have been designed to support both novice and experienced trainers to develop, implement and analyse their training evaluation. The document includes a discussion of the aims and context of various types of evaluation, useful tools, tips and readings.

3. A handbook for the Work Practice Questionnaire: *Handbook for the Work Practice Questionnaire (WPQ): A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field*.

   The handbook provides a detailed description of the WPQ and its psychometric properties. The WPQ is a purpose-built measurement tool designed to assess a wide range of factors that influence work practices in relation to alcohol and other drugs. It includes 17 scales covering four domains:

   1. Individual
   2. Team
   3. Workplace
   4. Organisational.

   A post-training section includes two scales. The Handbook describes how the tool can be used, provides results of the reliability and validity studies undertaken, and includes a copy of the full questionnaire.

Although these products are stand-alone documents, they have been designed to complement each other and form a comprehensive set of resources to improve training evaluation. Copies of all these documents, and other materials related to workforce development, are available from the NCETA website at www.nceta.flinders.edu.au. For further information about this project or assistance with your evaluation projects contact NCETA on 8201 7549.

Project Team

A large team worked on this project. The project team comprised:

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Thanks are extended to the original team of investigators who developed the tender. Original investigators included Associate Professor Steve Allsop, Ms Simone Cormack, Dr Sharyn Watts, Dr Paul Williamson, Professor John Keeves, Dr Kyle Dyer and Ms Carol Kennedy. The groundwork undertaken by this group provided the basis for this innovative project.

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The assistance of staff from the Drug and Alcohol Services Council (DASC) Library, the Flinders University Library, and University of South Australia Library is also acknowledged.

The project team would also like to express gratitude to the health, welfare, education and law enforcement organisations across Australia that participated in the study and those that helped to distribute information, materials, and provided input and feedback into the project.

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OVERVIEW OF THE HANDBOOK

This handbook includes:

- a description of the factors assessed in the Work Practice Questionnaire (WPQ) and their relevance to work practice change. Readers interested in more detail regarding each factor are referred to the monograph, *From Training to Work Practice Change: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field* (Pidd et al., 2004)
- a copy of the measurement scale assessing each factor
- internal consistency and test-retest reliability results for each scale
- an overview of key findings from construct and criterion-related validation studies
- a full copy of the WPQ
- useful personal and organisational demographics to use with the tool
- a questionnaire that can be used to assess the frequency and perceived difficulty of a range of AOD-related work practices.

INTRODUCTION

Background

In 1998 a study was undertaken by the National Centre for Education and Training on Addiction (NCETA) on behalf of the Australian Government to inform the development of a national strategic approach to education and training programs for frontline workers who respond to alcohol and other drug (AOD) related issues. One of the 12 recommendations for priority action in a national strategic approach to AOD education and training was for the development of guidelines, methodologies and instruments to evaluate the impact of education and training initiatives. This recommendation was driven by the recognition that significant improvements were required in the assessment and measurement of the impact of AOD-related education and training on professionals' work practice. In 2001, NCETA was commissioned to undertake the development and evaluation of such an instrument, referred to herein as the Work Practice Questionnaire (WPQ).

What is the Work Practice Questionnaire?

The Work Practice Questionnaire is a purpose-built measurement tool designed to assess a wide range of factors that influence work practices in relation to alcohol and other drugs. The WPQ is mainly focused on the factors that impact work practices related to alcohol and other drug (AOD) issues.

To this end, the WPQ was developed to assess key individual, team, workplace, and organisational factors that impact on training transfer and work practice change, including but not limited to, education and training. The WPQ was designed to be a standardised measurement tool, generic in nature, to allow for applicability across a range of training settings and various frontline worker groups.

Why is the Work Practice Questionnaire Needed?

It is increasingly recognised by trainers, educators, and organisations investing in education and training that training outcomes must be measured not only in terms of changes in knowledge, skills and abilities, but also by measuring long-term sustainable outcomes, such as changes to work practice and maintenance of changes.

Measuring changes in work-related behaviours attributed to education and training programs can be difficult. Education and training programs do not occur in isolation. A wide range of factors influence trainees' capacity to benefit from education and training, including motivation to learn, expectations, needs, attitudes, existing knowledge and learning styles. In addition,

factors in the work environment, such as the availability of support and encouragement from co-workers and supervisors, and organisational systems and structures, also impact on the uptake of learning and the transfer of training to work practice.

The challenges associated with applying newly gained knowledge, skills and abilities to the workplace is widely recognised within the training literature as the "transfer of training problem" (Salas & Cannon-Bowers, 2001). Research on the influence of work environment factors on the transfer of training has been limited (Holton et al., 2000). However, a consistent recommendation within the training transfer literature is that organisations wishing to enhance the return from learning investments must understand the key factors that affect transfer of training to work practice, and then implement strategies to facilitate transfer. This is a particularly important point. Baldwin and Ford (1988) estimate that as little as 10% of training expenditures in the USA pay off in on-the-job performance.

The WPQ is designed to assess a selection of key individual, team, workplace and organisational factors that enhance or impede changes to work practices related to alcohol and other drug issues.

How Was the Work Practice Questionnaire Developed?

The WPQ scales were constructed on the basis of extensive review of the medical, nursing, education, social science, health promotion and organisational psychology literatures relevant to training transfer and work practice change. The structure and content of the WPQ scales underwent considerable refinement on the basis of a large-scale pilot study with participants from a wide range of occupations across the specialist AOD, general health, human services, education and law enforcement sectors. The scale development process also included an evaluation of the psychometric properties of the WPQ via test-retest, construct validity and criterion-related validity studies.

The WPQ was designed to be a practical and user-friendly measurement tool. Particular consideration was given to ensuring the tool is:

- relevant to a wide range of frontline workers
- relevant to a wide range of work practices related to alcohol and other drug related issues
- appropriate to use with most training types and content.

USING THE WORK PRACTICE QUESTIONNAIRE

How Can the Work Practice Questionnaire Be Used?

The Work Practice Questionnaire can be used to obtain information on a range of factors that enhance or impede AOD-related work practices. The WPQ is intended to be used as a training evaluation tool administered pre-training, shortly after training and, where possible, for longer-term follow-up after training is complete. Training evaluation is discussed in further detail in a companion document, *Guidelines for Evaluating Alcohol and Other Drug Education and Training Programs* (O'Neill, Addy, & Roche, 2004).

The WPQ can also be used to assess trainees' perception of education and training programs. The post-training scales included in the WPQ address the perceived relevance, usefulness and effectiveness of training in regard to workers' AOD-related work practice.

Used in combination, the measures of factors impacting work practice and trainees' perceptions of training programs can be used to guide the development of strategies to maximise the return on investment in staff education and training. Strategies to address each of the factors assessed in the WPQ are discussed in further detail in the monograph, *From Training to Work Practice Change: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field* (Pidd, Freeman, Skinner, Addy, Shoobridge, & Roche, 2004).

The WPQ can be used to identify facilitators and barriers to change in AOD-related work practices, regardless of whether a training program or other intervention has been put into place. Used in this way, the WPQ can provide valuable information regarding the types of interventions that may be useful in facilitating work practice change in regard to AOD-related issues (e.g., enhancing opportunities for supervision, increasing rewards and recognition for AOD-related work, enhancing professional development opportunities). Furthermore, the WPQ can provide useful information on the factors that indirectly influence organisational capacity and effectiveness (e.g., changes in team cohesion and team capacity post-training, changes in levels of perceived organisational role legitimacy post-training).

Who Can Use the Work Practice Questionnaire?

The WPQ is designed for educators and trainers to use pre- and post-training. It can also be used by organisations to identify facilitators and barriers to practice change in regard to AOD-related work practices.

Other Considerations for Using the Work Practice Questionnaire

In some circumstances it may be appropriate to use a sub-set of the WPQ domains that are most relevant or appropriate to a particular training program, organisation or occupational group. However, where scales are considered relevant to use, it is recommended that **ALL** items within that scale are used. This will ensure results are stable and reliable.

The WPQ can be adapted to be used in a variety of ways. Filter questions can be included at the start of scales to ensure respondents do not answer questions which are irrelevant or inappropriate. For example, a filter question can be inserted before the team cohesion and team capacity scales indicating that the scale is only to be completed by respondents who regularly work in groups or teams.

The WPQ can also be used as a tool to facilitate a qualitative discussion group with frontline workers. This approach may be particularly useful where time, resources or literacy pose a challenge to written completion of the WPQ.

In order to obtain more detailed information on factors that impact on work practice not measured by the WPQ, open-ended questions can be included at the end of the questionnaire. This will provide qualitative information that may help to interpret responses to the scales, or provide further information for a comprehensive training evaluation.

FACTORS AFFECTING WORK PRACTICE: THE FOUR DOMAINS

The Work Practice Questionnaire (WPQ) was developed in order to assist trainers, educators, managers and other key personnel to address the challenges of ensuring effective training transfer and work practice change. The WPQ addresses a range of individual, team and organisational factors that are likely to influence training transfer and work practice change. The WPQ does not address every possible factor that may influence work practice change – such a tool would be unwieldy and impractical to use. Rather, guided by a comprehensive review of the relevant research literature and extensive field-testing, the WPQ was designed to assess the key factors likely to influence AOD-related work practices.

The WPQ contains four domains (see Figure 1 next page):

- **Individual**
- **Team**
- **Workplace**
- **Organisational.**

The WPQ also contains two **post-training scales** which address participant's perceptions of the impact and relevance of training in regard to their work practice.

The **Individual** domain relates to the personal characteristics, beliefs and views of individual workers. Historically, it is mostly factors within this domain that AOD training evaluation has been limited to.

The **Team** domain addresses factors that relate to a team environment within the work situation such as team capacity, formal and informal support, and team cohesion.

The **Workplace** domain addresses factors in the working environment that are likely to impact on work practice such as availability of feedback, workload and other pressures, availability of support and general working conditions (e.g., job security, remuneration).

The **Organisational** domain addresses factors that impact on the functioning of the organisation as a whole, and hence may also impact on individual workers' capacity to perform effectively.

The **Post-training scales** address the perceived relevance, usefulness, and effectiveness of training in regard to workers' AOD-related work practice.

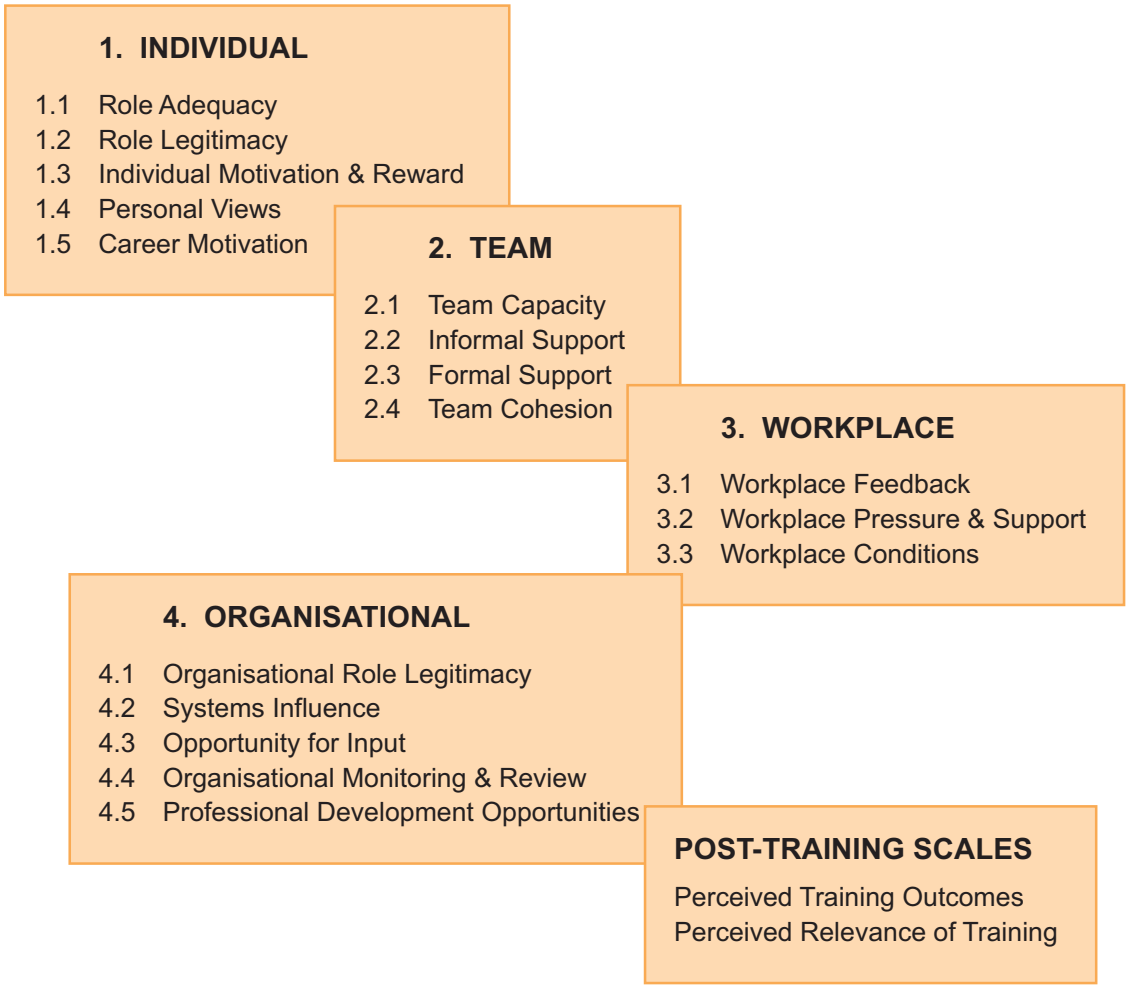

Figure 1
Structure of the Work Practice Questionnaire.

The WPQ consists of 132 items within the four domains:

- **Individual** (26 items)
- **Team** (27 items)
- **Workplace** (17 items)
- **Organisational** (27 items).

The **Post-Training** section contains 12 items. The **Demographic** section contains 23 items.

Table 1 below provides an overview of WPQ scales and component items including internal consistency and test-retest reliability scores.

Table 1
Overview of WPQ Domains and Component Factors (including internal consistency and test-retest reliability coefficients)

Domain	Scale	Items	Internal Consistency[1]	Test-retest Reliability[1]
1. Individual	1.1 Role Adequacy	i1–i6	.91	.86
	1.2 Role Legitimacy	i7–i13	.82	.81
	1.3 Individual Motivation and Reward	i14–i20	.89	.83
	1.4 Personal Views	i21–i23	.68	.75
	1.5 Career Motivation	i24–i26	.73	.69
2. Team	2.1 Team Capacity	t1–t9	.93	.88
	2.2 Informal Support	t10–t14	.90	.86
	2.3 Formal Support	t15–t19	.85	.87
	2.4 Team Cohesion	t20–t27	.94	.82
3. Workplace	3.1 Workplace Feedback	w1–w4	.79	.68
	3.2 Workplace Pressure and Support	w5–w10	.83	.78
	3.3 Workplace Conditions	w11–w17	.63	.72
4. Organisational	4.1 Organisational Role Legitimacy	o1–o7	.91	.81
	4.2 Systems Influence	o8–o12	.78	.83
	4.3 Opportunity for Input	o13–o16	.86	.74
	4.4 Organisational Monitoring and Review	o17–o20	.76	.71
	4.5 Professional Development Opportunities	o21–o27	.91	.83
Post-training	Perceived Training Outcomes	p1–p6	.92	.77
	Perceived Relevance of Training	p7–p12	.85	.72

Note. [1] Internal consistency (Cronbach's α) and test-retest reliability coefficients (Pearson *r*) are from the reliability study conducted in Phase Two.

The following sections describe in detail the four WPQ domains (Individual, Team, Workplace, and Organisational), the Post-Training scales, and the component scales. An overview of the test-retest, construct validation and criterion-related validity testing is also provided. Details about the origins of the individual questionnaire items used in the four domains and the post-training section can be found in Appendix A. A full version of the WPQ is provided in Appendix B.

INDIVIDUAL DOMAIN

The **Individual** domain relates to the personal characteristics, beliefs, and views of individual workers. AOD training evaluation has traditionally focused on factors with this domain. Individual factors address issues such as workers' perceptions of role legitimacy and role adequacy, and their attitudes towards responding to AOD issues.

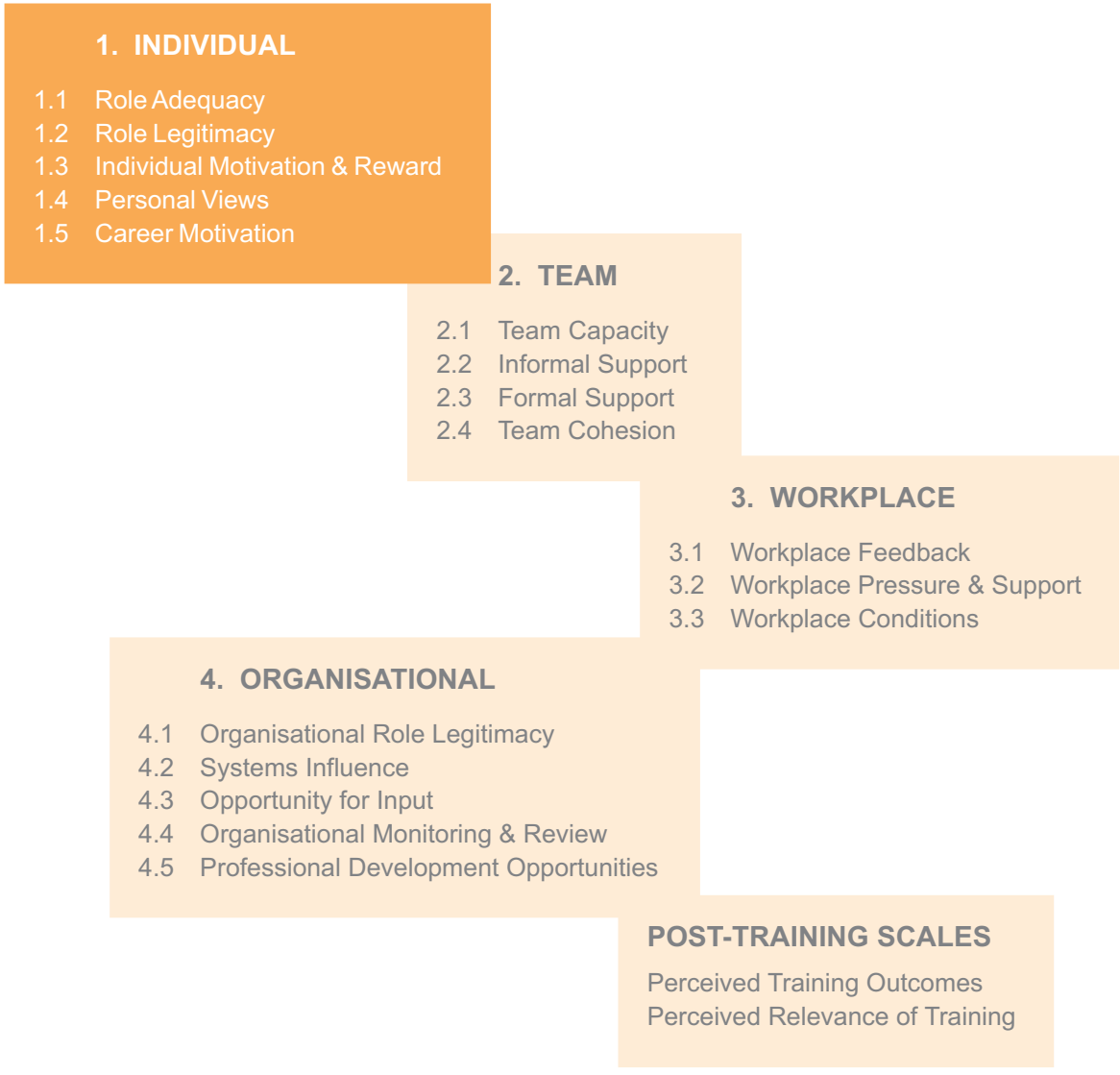

Figure 2
Components of the Individual domain.

1.1 Role Adequacy

Role Adequacy refers to workers' confidence in their capacity to effectively respond to AOD issues (Clement, 1986; Shaw et al., 1978). Judgements of role adequacy reflect perceived knowledge of, and level of skill in responding to, AOD issues (Clement, 1986; Shaw et al., 1978).

Table 2
Components of the Role Adequacy Scale (Individual 1.1)

Component		Disagree	Tend to disagree	Tend to agree	Agree
i.1.	I have the necessary experience to respond to alcohol and other drug related issues.	1	2	3	4
i.2.	In my work I have responded to a wide range of alcohol and other drug related issues.	1	2	3	4
i.3.	I am confident in my ability to respond to alcohol and other drug related issues.	1	2	3	4
i.4.	I have the necessary knowledge to help people with alcohol and other drug related issues.	1	2	3	4
i.5.	I do not have many of the skills necessary to respond to alcohol and other drug related issues.	1	2	3	4
i.6.	I am able to respond to people who have alcohol and other drug related issues as competently as I respond to people with other problems.	1	2	3	4

Note that item i.5 in this scale is negatively worded, and needs to be reverse coded when calculating scores for the scale. A higher score on Role Adequacy indicates greater confidence in responding to AOD issues.

Reliability

The Role Adequacy Scale has an internal consistency of .91 and a test-retest reliability of .86 when retested after a 2-3 week interval.

1.2 Role Legitimacy

Role Legitimacy concerns the extent to which an individual perceives their profession has a right to intervene in AOD issues, and clients would be likely to support such intervention. Whereas role adequacy concerns a "can I respond effectively?" judgement, role legitimacy concerns a "should I respond?" judgement. Perceptions of low role legitimacy are indicated by beliefs that treatment of clients with AOD-related problems is another profession's responsibility (Abed & Neira-Munoz, 1990), or that one lacks the support of the clients or the authority to intervene in AOD issues (Cartwright, 1980).

Table 3
Components of the Role Legitimacy Scale (Individual 1.2)

Component		Disagree	Tend to disagree	Tend to agree	Agree
i.7.	I have a legitimate role to play in responding to alcohol and other drug related issues.	1	2	3	4
i.8.	I am reluctant to take responsibility for alcohol and other drug related issues in my work.	1	2	3	4
i.9.	It is more appropriate for other colleagues to respond to alcohol and other drug related issues, than myself.	1	2	3	4
i.10.	I am uncertain of my role in responding to alcohol and other drug related issues.	1	2	3	4
i.11.	I am clear about my responsibilities in responding to alcohol and other drug related issues.	1	2	3	4
i.12.	I have a responsibility to ask clients questions about alcohol and other drug related issues.	1	2	3	4
i.13.	My clients believe I have a responsibility to ask them questions about alcohol and other drug related issues.	1	2	3	4

Note that items i.8, i.9 and i.10 are negatively worded, and need to be reverse coded when calculating scores for the scale. A higher score on Role Legitimacy indicates a stronger perception of the legitimacy of responding to AOD issues.

Reliability

The Role Legitimacy Scale has an internal consistency of .82 and a test-retest reliability of .81 when retested after a 2-3 week interval.

1.3 Individual Motivation and Reward

Individual motivation and reward addresses the extent to which workers are willing to respond to AOD issues (motivation), and the satisfaction and rewards obtained from this type of response. Work satisfaction and motivation has been the subject of extensive research within organisational psychology for the last 40 years (cf. Herzberg, Mausner, & Snyderman, 1959). Within organisational psychology, work satisfaction is defined as a positive response to one's work, and involves affective (feeling happy and fulfilled) and cognitive (judging the favourability of one's work conditions) components (Brief & Weiss, 2002). Motivation refers to an individual's desire to achieve a certain standard of performance and apply effort to reach this outcome. In the WPQ, motivation is considered in relation to workers' desire or willingness to responding to AOD issues in the course of their work.

Table 4
Components of the Individual Motivation and Reward Scale (Individual 1.3)

Component	Disagree	Tend to disagree	Tend to agree	Agree
i.14. I prefer not to respond to alcohol and other drug related problems as I find it too frustrating.	1	2	3	4
i.15. I refer people with alcohol and other drug related issues onto others to prevent me from wasting my time.	1	2	3	4
i.16. I believe that responding to alcohol and other drug related issues is important.	1	2	3	4
i.17. I get personal satisfaction responding to people affected by experiencing alcohol and other drug related issues.	1	2	3	4
i.18. My experience of responding to alcohol and other drug related issues has been rewarding.	1	2	3	4
i.19. On the whole I am satisfied with the way I work with people who have alcohol and other drug related issues.	1	2	3	4
i.20. I like to respond to alcohol and other drug related issues in my work.	1	2	3	4

Items i.14 and i.15 in this scale are negatively worded, and need to be reverse coded when calculating scores for the scale. A higher score on Individual Motivation and Reward indicates stronger motivation to respond to AOD issues, and greater satisfaction experienced in responding to AOD issues.

Individual motivation and reward may be examined by assessing Motivation (items i.14-i.16) and Reward (items i.17-i.20) separately. Measuring the two constructs independently may provide more precise information on workers' levels of motivation and job satisfaction, respectively.

Reliability

The Individual Motivation and Reward Scale has an internal consistency of .89 and a test-retest reliability of .83 when retested after a 2-3 week interval.

1.4 Personal Views

Personal Views address the extent to which workers hold negative and stereotypical views of individuals who use drugs.

Table 5
Components of the Personal Views Scale (Individual 1.4)

Component	Disagree	Tend to disagree	Tend to agree	Agree
i.21. Most people with alcohol and other drug related problems are not interested in addressing them.	1	2	3	4
i.22. I generally think people with alcohol and other drug related problems bring their difficulties on themselves.	1	2	3	4
i.23. I try to avoid responding to people with alcohol and other drug related problems as they are unreliable.	1	2	3	4

No items in this scale need to be reverse coded. A higher score on the Personal Views Scale indicates more negative attitudes towards individuals with AOD-related issues.

Reliability

The Personal Views Scale has an internal consistency of .68 and a test-retest reliability of .75 when retested after a 2-3 week interval.

1.5 Career Motivation

Career Motivation concerns workers' motivation to pursue a career in AOD-related work and the perceived rewards and advantages of doing so.

Table 6
Components of the Career Motivation Scale (Individual 1.5)

Component	Disagree	Tend to disagree	Tend to agree	Agree
i.24. There are professional advantages for me to respond to alcohol and other drug related issues.	1	2	3	4
i.25. Expertise in responding to alcohol and other drug related issues is highly regarded by my colleagues.	1	2	3	4
i.26. In career terms, there are definite advantages in improving my expertise in alcohol and other drug related areas.	1	2	3	4

No items need to be reverse coded for this scale. A higher score indicates a higher level of motivation to pursue a career in the AOD field.

Reliability

The Career Motivation Scale has an internal consistency of .73 and a test-retest reliability of .69 when retested after a 2-3 week interval.

TEAM DOMAIN

The **Team** domain addresses factors that relate to work team dynamics such as team culture, workload pressure, team communication, and morale. It is important to recognise that work groups and teams are becoming increasingly common, particularly in the health and human service sectors. Therefore, team factors are likely to exert a significant influence on individual work practice. Although there are some semantic differences between terms such as 'team', 'group', and 'work group', this project used such terms interchangeably to refer to the collection of individuals who interact regularly, exhibit task interdependence, possess one or more shared goals, and are embedded in a larger organisational setting (Kozlowski, Gully, McHugh, Salas, & Cannon-Bowers, 1996; Salas, Dickinson, Converse, & Tannenbaum, 1992).

Figure 3
Components of the Team Domain.

2.1 Team Capacity

Team Capacity to respond effectively to AOD issues is measured in relation to two key dimensions of team performance: (1) team confidence and collective efficacy (similar to Individual Role Adequacy), and (2) team norms and culture regarding AOD issues (similar to Individual Role Legitimacy).

Table 7
Components of the Team Capacity Scale (Team 2.1)

Component		Disagree	Tend to disagree	Tend to agree	Agree
t.1.	There is a comprehensive knowledge base among the people I work closely with concerning alcohol and other drug issues.	1	2	3	4
t.2.	Generally, responses to alcohol and other drug related issues provided by the people I work closely with are of good quality.	1	2	3	4
t.3.	Collectively, the skill base of the people I work closely with means we are well equipped to respond to alcohol and other drug related issues.	1	2	3	4
t.4.	I work closely with people who are not confident in their ability to respond to alcohol and other drug related issues.	1	2	3	4
t.5.	People I work closely with are willing to respond to alcohol and other drug related issues.	1	2	3	4
t.6.	The people I work closely with consider responding to alcohol and other drug related issues a legitimate part of their work.	1	2	3	4
t.7.	In general, people I work closely with give cases concerning alcohol and other drug related problems low priority.	1	2	3	4
t.8.	People I work closely with consider education and training for alcohol and other drug related issues an essential aspect of staff development.	1	2	3	4
t.9.	I work closely with people who are good role models in terms of responding to alcohol and other drug related issues.	1	2	3	4

Items t.4 and t.7 are negatively worded, and need to be reverse coded when calculating scores for the scale. A higher score on Team Capacity indicates greater confidence in a team's ability to respond effectively to AOD issues, and more supportive team norms and culture regarding AOD-related work practices. Team confidence and norms may be examined by assessing Team Confidence (items t.1-t.4) and Team Norms (items t.5-t.9) separately. Measuring the two constructs independently may provide more precise information on these two dimensions of Team Capacity.

Reliability

The Team Capacity scale has an internal consistency of .93 and a test-retest reliability of .88 when retested after a 2-3 week interval.

2.2 Informal Support

Informal Support refers to workers' access to sources of support other than those provided directly by the organisation. Informal support is usually regarded in terms of support and advice or information from colleagues within the organisation or from other organisations. Informal support is distinct from formal and organisational support.

Table 8
Components of the Informal Support Scale (Team 2.2)

Component		Disagree	Tend to disagree	Tend to agree	Agree
t.10.	Informal supervision (e.g., encouragement, peer support, guidance, mentoring) is provided amongst staff on alcohol and other drug related issues.	1	2	3	4
t.11.	I receive support from the people I work closely with about the work I do concerning alcohol and other drug related issues.	1	2	3	4
t.12.	There is good communication among the people I work closely with about alcohol and other drug related issues.	1	2	3	4
t.13.	My colleagues encourage me to intervene in alcohol and other drug related issues.	1	2	3	4
t.14.	If I needed to, it would be easy to find someone to give me advice on responses to alcohol and other drug related issues relevant to my workplace.	1	2	3	4

No items in the scale require reverse coding. A higher score on Informal Support reflects a stronger perception of informal support.

Reliability

The Informal Support Scale has an internal consistency of .90 and a test-retest reliability of .86 when retested after a 2-3 week interval.

2.3 Formal Support

Formal Support refers to the provision of advice, guidance and resources by supervisors, managers or other representatives of an organisation. In contrast to informal support, which is offered in a spontaneous and unstructured manner between colleagues, formal support is provided within the context of established hierarchies of seniority and supervision within an organisation. Three sources of formal support are assessed in the WPQ: (1) access to a supervisor experienced with AOD-related issues, (2) organisational policies and procedures, and (3) the provision of quality resources to support AOD-related responses.

Table 9
Components of the Formal Support Scale (Team 2.3)

Component		Disagree	Tend to disagree	Tend to agree	Agree
t.15.	Staff have access to a supervisor with expertise in alcohol and other drug related issues.	1	2	3	4
t.16.	Formal supervision (e.g., guidance, preceptorship) is provided amongst staff on alcohol and other drug related issues.	1	2	3	4
t.17.	The organisation I work for supports staff efforts to respond to alcohol and other drug related issues.	1	2	3	4
t.18.	This organisation has policies and procedures that support alcohol and drug related work.	1	2	3	4
t.19.	Staff have access to the tools/resources needed to respond to alcohol and other drug related issues (e.g., standard questionnaires, quit kits, referral information).	1	2	3	4

No items in the Formal Support Scale require reverse coding. Higher scores on this scale indicate stronger perceptions of formal support.

Reliability

The Formal Support Scale has an internal consistency of .85 and a test-retest reliability of .87 when retested after a 2-3 week interval.

2.4 Team Cohesion

Team Cohesion refers to feelings of solidarity, community, and attraction to the group and its members (Levine & Moreland, 1990; Spector, 2000).

Table 10
Components of the Team Cohesion Scale (Team 2.4)

Component		Disagree	Tend to disagree	Tend to agree	Agree
t.20.	There is good team spirit amongst the people I work closely with.	1	2	3	4
t.21.	Morale is high among the people I work closely with.	1	2	3	4
t.22.	Generally, communication amongst the people I work closely with is good.	1	2	3	4
t.23.	Encouragement and support is commonly provided amongst the people I work closely with.	1	2	3	4
t.24.	In my workplace staff engage in good teamwork.	1	2	3	4
t.25.	In general I have a good relationship with staff at my workplace.	1	2	3	4
t.26.	I feel comfortable to ask for help or support from my colleagues or peers.	1	2	3	4
t.27.	In my workplace, the majority of staff do their share of work.	1	2	3	4

No items in this scale require reverse coding. A higher score reflects stronger perceived team cohesion.

Reliability

The Team Cohesion Scale has an internal consistency of .94 and a test-retest reliability of .82 when retested after a 2-3 week interval.

WORKPLACE DOMAIN

The **Workplace** domain addresses factors in the working environment that are likely to impact on work practice such as availability of feedback, workload and other pressures, availability of support and general working conditions (e.g., job security, remuneration). It is important to make a distinction between factors at this level, and those at the organisational level. Factors in the Workplace domain relate to the individual's perceptions of their everyday working environment, whereas the factors in the Organisational domain address broader issues related to organisational functioning and effectiveness, which may in turn impact on individual work practice.

Figure 4
Components of the Workplace Domain.

3.1 Workplace Feedback

Workplace Feedback refers to the perceived availability and quality of performance feedback from supervisors and other staff. In organisational psychology, feedback has been defined as the degree to which direct and clear information is available on the effectiveness of workers' job performance (Hackman & Oldham, 1976).

Table 11
Components of the Workplace Feedback Scale (Workplace 3.1)

Component		Disagree	Tend to disagree	Tend to agree	Agree
w.1.	I receive feedback from other people in my workplace on how I am performing my role.	1	2	3	4
w.2.	I have the opportunity (informally or formally) to discuss and receive feedback about my work performance with other staff.	1	2	3	4
w.3.	I am unhappy with the quality of feedback I receive about my work performance from other staff.	1	2	3	4
w.4.	Supervisors engage in constructive feedback with staff.	1	2	3	4

Item w.3 is negatively worded and needs to be reverse coded when calculating scores for this scale. Higher scores on Workplace Feedback indicate more positive perceptions of the frequency and quality of feedback.

Reliability

The Workplace Feedback Scale has an internal consistency of .79 and a test-retest reliability of .68 when retested after a 2-3 week interval.

3.2 Workplace Pressure and Support

Workplace Pressure and Support addresses the extent to which workers perceive performance expectations and workloads to be manageable, and are provided with adequate support when faced with work-related difficulties or problems.

Table 12
Components of the Workplace Pressure and Support Scale (Workplace 3.2)

Component		Disagree	Tend to disagree	Tend to agree	Agree
w.5.	Too much is expected of all staff in my workplace.	1	2	3	4
w.6.	Staff members experience constant pressure in my workplace.	1	2	3	4
w.7.	Supervisors expect too much from staff in my workplace.	1	2	3	4
w.8.	There are enough staff in my workplace to provide quality services.	1	2	3	4
w.9.	Most of the time, supervisors provide adequate support when problems arise.	1	2	3	4
w.10.	In general, supervisors encourage staff to find positive solutions when problems arise.	1	2	3	4

Items w.5, w.6 and w.7 are negatively worded and need to be reverse coded when calculating scores for this scale. Higher scores on Workplace Pressure and Support indicate lower levels of pressure and higher levels of support.

Reliability

The Workplace Pressure and Support Scale has an internal consistency of .83 and a test-retest reliability of .78 when retested after a 2-3 week interval.

3.3 Workplace Conditions

Workplace Conditions refers to the 'basics' of a healthy and efficient working environment, including considerations such as the physical work setting, adequacy of job security and pay, and efficient systems and procedures.

Table 13
Components of the Workplace Conditions Scale (Workplace 3.3)

Component		Disagree	Tend to disagree	Tend to agree	Agree
w.11.	In my workplace staff are encouraged to take their allocated breaks.	**1**	**2**	**3**	**4**
w.12.	In my workplace, things are quite disorganised.	**1**	**2**	**3**	**4**
w.13.	In my workplace, time is wasted because of inefficiencies.	**1**	**2**	**3**	**4**
w.14.	In my workplace, the physical working conditions are good.	**1**	**2**	**3**	**4**
w.15.	I have my own allocated 'space' in my work environment.	**1**	**2**	**3**	**4**
w.16.	I am satisfied with my level of job security.	**1**	**2**	**3**	**4**
w.17.	I am satisfied with my level of pay.	**1**	**2**	**3**	**4**

Items w.12 and w.13 are negatively worded and need to be reverse coded when calculating scores for this scale. Higher scores on Workplace Conditions indicate more favourable perceptions of working conditions.

Reliability

The Workplace Conditions Scale has an internal consistency of .63 and a test-retest reliability of .72 when retested after a 2-3 week interval.

ORGANISATIONAL DOMAIN

The **Organisational** domain addresses factors that impact on the functioning of the organisation as a whole, and hence may also impact on workers' capacity to perform effectively. This domain includes factors that reflect workers' perceptions of the culture and climate within their organisation, for example Organisational Role Legitimacy, Professional Development Opportunities, and Opportunity for Staff Input. It also includes systems factors that may influence the functioning of an entire organisation, and perceptions of their organisation's openness to change and review.

Figure 5
Components of the Organisational Domain.

4.1 Organisational Role Legitimacy

Organisational Role Legitimacy addresses the extent to which an organisation's culture, policies, practices, and behavioural expectations support, guide and encourage workers to respond to AOD issues. Organisational Role Legitimacy is conceptualised in the WPQ as a dimension of an organisation's culture or climate regarding AOD work practice.

Table 14
Components of the Organisational Role Legitimacy Scale (Organisational 4.1)

Component		Disagree	Tend to disagree	Tend to agree	Agree
o.1.	There is a philosophy that guides this organisation's responses to alcohol and other drug related issues.	1	2	3	4
o.2.	Responses to alcohol and other drug related issues are consistent with this organisation's responses to other health and/or social problems.	1	2	3	4
o.3.	This organisation has clearly stated goals/objectives about its involvement in alcohol and drug related issues.	1	2	3	4
o.4.	Staff roles and responsibilities in responding to alcohol and other drug related issues are clearly laid out in their job descriptions.	1	2	3	4
o.5.	This organisation consistently strives to improve the alcohol and other drug related services it provides.	1	2	3	4
o.6.	This organisation has a legitimate role to play in responding to alcohol and other drug related issues.	1	2	3	4
o.7.	This organisation promotes itself as an organisation that responds to alcohol and other drug related issues.	1	2	3	4

No items in this scale require reverse coding. Higher scores on Organisational Role Legitimacy indicate a higher level of perceived organisational role legitimacy.

Reliability

The Organisational Role Legitimacy Scale has an internal consistency of .91 and a test-retest reliability of .81 when retested after a 2-3 week interval.

4.2 Systems Influence

Systems influence refers to factors in the broader systemic environment that impact on organisational functioning. A systems perspective is based on the recognition that individual workers and the organisations in which they work are influenced by the larger external political, legal, and economic systems and structures in which they operate.

Table 15
Components of the Systems Influence Scale (Organisational 4.2)

Component		Disagree	Tend to disagree	Tend to agree	Agree
o.8.	Responding to alcohol and other drug related issues is a part of this organisation's service requirements and conditions of funding.	1	2	3	4
o.9.	This organisation receives funding specifically for responding to alcohol and other drug related issues.	1	2	3	4
o.10	This organisation undergoes external evaluation of its alcohol and other drug related responses.	1	2	3	4
o.11	Organisations in similar fields act as leaders or champions to this organisation.	1	2	3	4
o.12	This organisation sees itself as competing with other organisations providing similar responses to alcohol and other drug related issues.	1	2	3	4

No items in this scale require reverse coding. Higher scores on the Systems Influence Scale indicate stronger perceived impact of external systems on the organisation.

Reliability

The Systems Influence Scale has an internal consistency of .78 and a test-retest reliability of .83 when retested after a 2-3 week interval.

4.3 Opportunity for Input

Opportunity for Input addresses the degree to which workers are provided with opportunities to express their views and opinions regarding work practice, and to participate in planning and decision-making within the organisation.

Table 16
Components of the Opportunity for Input Scale (Organisational 4.3)

Component		Disagree	Tend to disagree	Tend to agree	Agree
o.13	This organisation is receptive to staff ideas and suggestions.	1	2	3	4
o.14	Forums are available in this organisation where I can express my views and opinions.	1	2	3	4
o.15	In this organisation disagreements are worked through.	1	2	3	4
o.16	As a staff member I can participate in the internal governance of the organisation (e.g., practice and policy committees, working committees).	1	2	3	4

There are no items in this scale requiring reverse coding. Higher scores on Opportunity for Input reflect greater perceived opportunity to provide input into the organisation's decision-making.

Reliability

The Opportunity for Input Scale has an internal consistency of .86 and a test-retest reliability of .74 when retested after a 2-3 week interval.

4.4 Organisational Monitoring and Review

The changing nature of AOD work and the necessity for work practice to keep pace with this change requires organisations to monitor and review work practices and client services. Organisational Monitoring and Review addresses the extent to which organisations regularly assess and re-examine internal processes related to policies and procedures, staff job descriptions, and the quality of service provision.

Table 17
Components of the Organisational Monitoring and Review Scale (Organisational 4.4)

Component		Disagree	Tend to disagree	Tend to agree	Agree
o.17	Policies and procedures in this organisation tend to change only when there are external (legislation, media, change of government) pressures to do so.	1	2	3	4
o.18	In this organisation, policies and procedures are regularly reviewed.	1	2	3	4
o.19	This organisation reviews job descriptions regularly.	1	2	3	4
o.20	This organisation monitors the quality of the services it provides.	1	2	3	4

Item o.17 is negatively worded, and needs to be reverse coded when calculating scores for this scale. Higher scores on Organisational Monitoring and Review indicate a stronger perception that the organisation regularly monitors and reviews its policies, procedures, and service provision.

Reliability

The Organisational Monitoring and Review Scale has an internal consistency of .76 and a test-retest reliability of .71 when retested after a 2-3 week interval.

4.5 Professional Development Opportunities

The Professional Development Opportunities Scale addresses the extent to which individuals are encouraged and supported to pursue opportunities for further development of their skills, knowledge, and abilities.

Table 18
Components of the Professional Development Opportunities Scale (Organisational 4.5)

Component		Disagree	Tend to disagree	Tend to agree	Agree
o.21	Staff members are encouraged to undertake training courses.	1	2	3	4
o.22	Professional development planning in this organisation takes into account individual needs and interests.	1	2	3	4
o.23	Staff members are supported in pursing qualifications or professional development related to their job.	1	2	3	4
o.24	This organisation provides back-up staff to allow people to attend training.	1	2	3	4
o.25	This organisation provides staff with access to a wide variety of education and training opportunities.	1	2	3	4
o.26	All staff members have equal access to training.	1	2	3	4
o.27	Opportunities exist in this organisation for developing new skills.	1	2	3	4

There are no items requiring reverse coding in this scale. Higher scores on Professional Development Opportunities indicate greater perceived opportunities for professional development activities.

Reliability

The Professional Development Opportunities Scale has an internal consistency of .91 and a test-retest reliability of .83 when retested after a 2-3 week interval.

POST-TRAINING SCALES

The WPQ **Post-Training Scales** address participants' perceptions of the impact of training on their knowledge, skills and abilities (Perceived Training Outcomes) and the relevance of training to their work practice (Perceived Training Relevance) (see Figure 6). The focus of these scales is on the perceived utility of training in regards to knowledge and skill development and improvement of work practice. Research evidence indicates that utility-type reaction measures (training considered job-relevant) are more strongly related to learning, performance and training transfer than affective-type reaction measures (whether the trainee liked the training) (Alliger, Tannenbaum, Bennett, Traver, & Shotland, 1997; Warr & Bunce, 1995).

Figure 6
Components of the Post-Training Scales.

5.1 Perceived Training Outcomes

Perceived Training Outcomes addresses the extent to which training is perceived to result in improvements to AOD-related work practice, including outcomes such as improved confidence, skill and knowledge, and capacity to address barriers to providing effective responses.

Table 19
Components of the Perceived Training Outcomes Scale (Post-Training Scales 5.1)

Component		Disagree	Tend to disagree	Unsure	Tend to agree	Agree
p.1.	This training program has enabled me to respond to alcohol and other drug related issues with greater confidence.	1	2	3	4	5
p.2.	I gained skills or knowledge from this training program that enabled me to work more effectively with alcohol and other drug related issues.	1	2	3	4	5
p.3.	This training program effectively illustrated links between the theory of responding to alcohol and other drug related issues and the practical aspects of responding.	1	2	3	4	5
p.4.	The information/materials provided in the training program improved the quality of alcohol and other drug related responses in my workplace.	1	2	3	4	5
p.5.	All in all, this training program improved my responses to alcohol and other drug related issues in my workplace.	1	2	3	4	5
p.6.	This training program addressed practical constraints of responding to alcohol and other drug related issues.	1	2	3	4	5

No items in this scale require reverse coding. A higher score on Perceived Training Outcomes indicates greater perceived usefulness of the training.

Reliability

The Perceived Training Outcomes Scale has an internal consistency of .92 and a test-retest reliability of .77 when retested after a 2-3 week interval.

5.2 Perceived Relevance of Training

Perceived Relevance of Training addresses the extent to which a training program is appropriate, relevant, and consistent with trainees' work-related roles, demands, and performance expectations.

Table 20
Components of the Perceived Relevance of Training Scale (Post-Training Scales 5.2)

Component		Disagree	Tend to disagree	Unsure	Tend to agree	Agree
p.7.	This training program effectively incorporated relevant workplace issues.	1	2	3	4	5
p.8.	The content of this training program was appropriate for my current work needs.	1	2	3	4	5
p.9.	This training program encouraged me to pursue further learning 'on-the-job'.	1	2	3	4	5
p.10.	This training program was consistent with my job requirements.	1	2	3	4	5
p.11.	This training program was too removed from my experiences at my workplace to be useful.	1	2	3	4	5
p.12.	I have used some of the things I learnt at this training program in my work.	1	2	3	4	5

Item p.11 is negatively worded and needs to be reverse coded when calculating scores for this scale. A higher score on this scale reflects stronger perceived relevance of the training for work practice.

Reliability

The Perceived Relevance of Training Scale has an internal consistency of .85 and a test-retest reliability of .72 when retested after a 2-3 week interval.

PSYCHOMETRIC TESTING

A series of studies were conducted to evaluate the psychometric properties of the WPQ. The following section provides an overview of the reliability, construct validity and criterion-related validity studies.

Overview of the Reliability Study

A test-retest reliability study was conducted on all WPQ scales. Participants were drawn from a range of organisations including AOD specialist services, community health centres, hospitals, mental health services, and youth agencies. Internal consistency coefficients were calculated from the Time 1 sample data. Frontline workers completed the WPQ on two separate occasions, approximately 2 to 3 weeks apart. Time 1 questionnaires (*N* = 1582) were disseminated to frontline workers predominantly from South Australia. A total of 215 (14%) questionnaires were returned. Ten days after receiving the first WPQ, individuals were sent a second copy (Time 2 measure). Of the 215 individuals who completed the WPQ at Time 1, 182 (85%) returned their second questionnaire.

The final (test-retest) sample included 52 males and 129 females (4 cases missing). The age of the participants ranged from 23 to 75 (*M* = 43.2, *SD* = 10.6). Participants were drawn from South Australia (*N* = 100), Western Australia (*N* = 1), the Northern Territory (*N* = 2), Queensland (*N* = 10), New South Wales (*N* = 12), Victoria (*N* = 18) and Tasmania (*N* = 2) (37 cases missing).

Overview of the Construct Validation Study

Construct validity assesses whether a scale measures a particular construct (e.g., process, type of knowledge) it was designed to measure (Gregory, 1996). The two main methods of construct validation involve tests of convergent and divergent validity. Convergent validity assesses the scale's concordance with existing measures of the same or similar constructs (Gregory, 1996). A positive correlation between the new scale and an existing scale provides evidence that the scale measures the desired construct. Divergent validity assesses the independence of the construct from other theoretically unrelated constructs (Gregory, 1996). A low or negligible correlation between the scale and existing measures of similar constructs indicates that the scale measures a construct that does not overlap with existing constructs.

A construct validation study was undertaken on various scales within the WPQ using a range of previously developed measurement tools. Where possible, measurement tools were chosen that have been rigorously validated or widely used in the research literature. Most scales chosen were previously cited in peer reviewed journals, and most reported

acceptable internal reliabilities. In a few cases scales were chosen based on a theoretical considerations regarding similarity to the constructs measured in the WPQ.

Six scales were not included in the construct validity study, because well-established scales measuring similar constructs could not be located. The 5 scales excluded from the analysis were Workplace Conditions, Organisational Role Legitimacy, Organisational Monitoring and Review, Systems Influence, Perceived Training Outcomes, and Perceived Relevance of Training.

The 13 WPQ scales included in the construct validation study were separated into two sets to ensure the length of the questionnaire was reasonable. An equal number of questionnaires were distributed to frontline workers (*N* =1888 for each set) across Australia. For both sets, 250 responses were received. Participants were drawn from a wide range of organisations including AOD specialists services, community health centres, youth agencies, and mental health organisations.

The sample for Set One included 92 males and 157 females (1 case missing). The age of the participants ranged from 20 to 70 (*M* = 41.0, *SD* = 10.5). The participants for Set One were drawn from South Australia (*n* = 4), Western Australia (*n* = 13), the Northern Territory (*n* = 18), Queensland (*n* = 41), New South Wales (*n* = 72), the Australian Capital Territory (*n* = 2), Victoria (*n* = 73), and Tasmania (*n* = 12) (15 cases missing).

The sample for Set Two included 104 males and 146 females. Participants were from South Australia (*n* = 6), Western Australia (*n* = 12), the Northern Territory (*n* = 9), Queensland (*n* = 38), New South Wales (*n* = 76), the Australian Capital Territory (*n* = 6), Victoria (*n* = 81), and Tasmania (*n* = 6) (16 cases missing).

Scales used for construct validation

Emotional exhaustion and depersonalisation

The *Maslach Burnout Inventory* (Maslach, Jackson, & Leiter, 1996) is a widely used measure of burnout. The inventory contains three subscales: *Emotional Exhaustion* (feeling emotionally drained by work), *Depersonalisation* (impersonal responses and feelings towards clients), and *Personal Accomplishment* (a sense of competence and achievement at work). The first two scales were used in the construct validation.

Performance expectations, feedback/performance coaching, transfer design, and perceived content validity

The *Learning Transfer System Inventory* (LTSI) is designed to measure characteristics of the workplace that improve the application of training to the work environment (Holton & Bates, 1998). The LTSI scales used in the construct validation were *Performance Expectations* (beliefs concerning the expectation that effort in transferring the training will result in improved job performance) and *Feedback/Performance Coaching* (perceived level of feedback and constructive input received in the workplace).

Cohesion, stress, and communication

The *Organizational Readiness for Change* (ORC) questionnaire assesses the characteristics of an organisation that may impact on organisational readiness for change (Lehman et al., 2002). Three scales from the ORC were used for construct validation: *Cohesion* (perceptions of teamwork and the quality of relationships among colleagues), *Stress* (perceptions of one's own and others' workload and levels of frustration and strain), and *Communication* (perceptions of the quality of communication among staff members and the ability to express opinions and provide input).

Co-worker and supervisor support

House's (1981) measures of co-worker support and supervisor support are 3-item scales tapping worker's perceptions of support in the workplace. Support is operationalised as the perception that one can rely on co-workers or the supervisor when work becomes difficult, and the perceived willingness of co-workers and supervisors to listen to employees' work-related problems.

Role conflict and role ambiguity

It has been estimated that approximately 85% of studies on role conflict and role ambiguity have used Rizzo, House, and Lirtzman's (1970) *Role Conflict* and *Role Ambiguity* scales (Gonzalez-Roma & Lloret, 1998). The Role Conflict Scale addresses the extent to which job requirements and demands conflict are incompatible. The Role Ambiguity Scale addresses perceptions of the clarity of job requirements, roles, and responsibilities.

General job satisfaction and internal work motivation

Hackman and Oldham's (1975) *Job Diagnostic Survey* contains one of the most widely used measures of job satisfaction and motivation. The *General Job Satisfaction Scale* assesses satisfaction and positive affect concerning one's job in general. The *Internal Work Motivation Scale* assesses the extent to which a worker strives to achieve high standards of work performance and experiences satisfaction in achieving this goal.

Role overload

Two well-established scales measuring role overload were used in the construct validation: Beehr, Walsh, and Taber's (1976) *Role Overload Scale* and the *Role Overload Scale* (Cammann, Fichman, Jenkins, & Klesh, 1983) from the Michigan Organizational Assessment Questionnaire (MOAQ) . Both scales address the extent to which individuals perceive their work load to be too heavy to manage in the time available.

Transfer climate

Burke and Baldwin's (1999) *Transfer Climate Scale* measures trainee's perceptions of workplace support for the transfer of training to work practice, including supervisor support and subordinate receptiveness. Six items were taken from this scale to measure perceived supervisor support for the transfer of training.

Therapist Attitude Scale

The *Therapist Attitude Scale* is an adaptation of Kavanagh, Spence, Strong, Wilson, Sturk, and Crow's (2003) *Supervision Attitude Scale*, which in turn was adapted from the *Family Attitude Scale* (Kavanagh et al., 1997). The Therapist Attitude Scale measures workers'

positive and negative affect towards their clients, including feelings of frustration, enjoyment, perceptions of coping capacity, and clients' demeanour (e.g., appreciative, cooperative).

Team potency

Guzzo, Yost, Campbell, and Shea's (1993) *Team Potency Scale* addresses team members' perceptions of their work group's effectiveness, and capacity to overcome difficulties and achieve a high standard of performance.

Overview of construct validation findings

Overall, sound support was obtained for the construct validity of the Work Practice Questionnaire. Most of the WPQ scales demonstrated moderate correlations with well-established measures of similar constructs. These findings provide support for the construct validity of the WPQ scales. In other words, the study findings indicate that the scales accurately measure the constructs for which they were designed.

The results of the convergent and divergent validity analyses are shown in Tables 21 and 22. With the exception of Rizzo et al.'s (1970) Role Ambiguity Scale, higher scores on a measure indicate higher levels of a construct (e.g., higher scores on Hackman and Oldham's (1975) General Job Satisfaction measure indicate greater job satisfaction). Higher scores on Rizzo et al.'s (1970) Role Ambiguity Scale indicate less role ambiguity. Higher scores on Workplace Pressure and Support indicate higher levels of support and lower levels of pressure.

Table 21
Convergent Validity of the Work Practice Questionnaire (WPQ) Scales

WPQ Scale	Validation Scale	*r*
INDIVIDUAL DOMAIN		
Role Adequacy	Personal Accomplishment (Maslach et al., 1996)	.36***
Individual Motivation and Reward	General Job Satisfaction (Hackman & Oldham, 1975)	.34***
	Internal Work Motivation (Hackman & Oldham, 1975)	.09
Personal Views	Depersonalisation (Maslach et al., 1996)	.50***
	Therapist Attitude Scale (Kavanagh et al., 2003)	–.61***
Career Motivation	Performance Expectations (LTSI) (Holton et al., 2000)	.39***
TEAM DOMAIN		
Team Capacity	Team Potency (Guzzo et al., 1993)	.38***
Informal Support	Co-Worker Support (House, 1981)	.50***
Formal Support	Supervisor Support (House, 1981)	.49***
Team Cohesion	Cohesion (ORC) (Lehman et al., 2002)	.76***
WORKPLACE DOMAIN		
Workplace Feedback	Feedback/Performance Coaching (LTSI) (Holton et al., 2000)	.63***
Workplace Pressure and Support	Stress (ORC) (Lehman et al., 2002)	–.64***
	Role Overload (Beehr, Walsh, & Taber, 1976)	–.58***
	Role Overload (MOAQ) (Cammann et al., 1983)	–.54***
ORGANISATIONAL DOMAIN		
Opportunity for Input	Communication (ORC) (Lehman et al., 2002)	.59***
Professional Development Opportunities	Transfer Climate (Burke & Baldwin, 1999)	.71***

Note. ORC = *O*rganisational *R*eadiness for *C*hange Scale; LTSI = *L*earning *T*ransfer *S*ystem *I*nventory; MOAQ = *M*ichigan *O*rganizational *A*ssessment *Q*uestionnaire.
***$p < .001$.

Table 22
Divergent Validity of the Work Practice Questionnaire (WPQ) Scales

WPQ Scale	Validation Scale	*r*
Role Legitimacy	Role Conflict (Rizzo et al., 1970)	–.23***
	Role Ambiguity (Rizzo et al., 1970)	.33***[a]

Note. [a] High scores on Role Ambiguity indicate a lack of role ambiguity, hence a positive correlation indicates that higher levels of role legitimacy are associated with a decrease in role ambiguity.
***$p < .001$.

Overview of the Criterion-Related Validity Study

Criterion-related validity measures the extent to which a scale predicts an outcome (i.e., criterion) that is expected to be associated with the construct measured in the scale (Carmines & Zeller, 1979). For example, a measure of students' motivation to learn would be expected to predict scores on an exam.

The criterion-related validation study for the Work Practice Questionnaire assessed the extent to which the WPQ scales predicted the frequency and perceived difficulty of six common AOD-related work practices: *screening*, *referral*, *assessment*, *education,* and/or *information provision*, *early/brief interventions*, *counselling/therapy*. Concurrent validity analysis (using current behaviours) was used to assess the criterion-related validity of the WPQ scales.

Distribution of criterion-related validity questionnaires

A total of 215 criterion-related validity questions were sent out to the reliability sample.

Results of criterion-related validation study

Six representative work practices were chosen for the criterion-related validity analysis. As shown in Tables 23 through 28, various sub-sets of the WPQ scales were found to predict the frequency and perceived difficulty of the six AOD-related work practices. Overall, 10 WPQ scales were found to consistently predict the frequency of AOD-related work practices. Overall, the frequency of AOD-related work practices increased with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- less negative and stereotypical views of drug users
- an interest in pursuing a career in the AOD field
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal and informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues.

The perceived difficulty of performing the six AOD-related work practices was predicted by a variety of WPQ scales, with little consistency in predictors across the six work practices.

The key findings from the criterion-related validity study are presented in Tables 23 through 28. Only significant correlations between the WPQ scales and the measure of AOD-related work practices are presented. Correlations of moderate or high strength (r >= .25) are highlighted.

In the measure of AOD-related work practices, frequency was coded from 1 (*never*) to 7 (*every day*). Difficulty was coded from 1 (*very easy*) to 5 (*very difficult*).

Frequency and perceived difficulty of referral

As Table 23 shows, 10 WPQ scales demonstrated moderate associations with frequency of referral. Referral behaviours increased in frequency with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- less negative and stereotypical views of drug users
- an interest in pursuing a career in the AOD field
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal and informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues.

Nine WPQ scales demonstrated moderate associations with the perceived difficulty of referral. Perceived difficulty of referral decreased with:

- stronger role adequacy
- less negative and stereotypical views of drug users
- stronger perceptions of team efficacy and support for AOD-related work
- higher levels of formal and informal support
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that staff are provided with opportunities to communicate their views and opinions on organisational policies, procedures and work practices
- the perception that an organisation engages in regular review and assessment of policies, procedures and work practices
- higher levels of organisational support for staff education, training and professional development.

Table 23
Predictors of the Frequency and Perceived Difficulty of Referral (N = 146)

Frequency	*r*	Perceived difficulty	*r*
Role Adequacy	.41***	Role Adequacy	–.24**
Role Legitimacy	.42***	Role Legitimacy	–.18**
Individual Motivation and Reward	.42***	Individual Motivation and Reward	–.22*
Personal Views	–.30***	Personal Views	.26**
Career Motivation	.36***	Career Motivation	–.22*
Team Capacity	.44***	Team capacity	–.35***
Informal Support	.39***	Informal support	–.38***
Formal Support	.36***	Formal support	–.37***
Team Cohesion	.22***	Team cohesion	–.21*
Workplace Pressure and Support	.21*	Workplace Feedback	–.20*
Organisational Role Legitimacy	.42***	Organisational Role Legitimacy	–.27**
Systems Influence	.34***	Opportunity for Input	–.25**
Organisation Monitoring and Review	.18*	Organisation Monitoring and Review	–.26**
		Professional Development Opportunities	–.28**

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Frequency and perceived difficulty of screening

As Table 24 shows, six WPQ scales demonstrated moderate associations with frequency of screening practices. Screening practices increased in frequency with:

- stronger role adequacy and role legitimacy
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues
- the perception that an organisation engages in regular review and assessment of policies, procedures and work practices.

Two WPQ scales demonstrated moderate associations with the perceived difficulty of screening. Perceived difficulty of screening decreased with:

- stronger role adequacy and role legitimacy.

Table 24
Predictors of the Frequency and Perceived Difficulty of Screening (N = 87)

Frequency	*r*	Perceived difficulty	*r*
Role Adequacy	.28**	Role Adequacy	–.34**
Role Legitimacy	.28**	Role Legitimacy	–.34**
Career Motivation	.21*		
Team Capacity	.31**		
Informal Support	.22*		
Formal Support	.31**		
Organisational Role Legitimacy	.37***		
Systems Influence	.33**		
Organisation Monitoring and Review	.26*		

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Frequency and perceived difficulty of assessment for AOD related issues

As Table 25 shows, 10 WPQ scales demonstrated moderate associations with frequency of assessment for AOD-related issues. Assessment practices increased in frequency with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- less negative and stereotypical views of drug users
- an interest in pursuing a career in the AOD field
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal and informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues.

Five WPQ scales demonstrated moderate associations with the perceived difficulty of assessment. Perceived difficulty of assessment decreased with:

- stronger role adequacy and role legitimacy
- higher levels of formal and informal support
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business).

Table 25
Predictors of the Frequency and Perceived Difficulty of Assessment (N = 124)

Frequency	*r*	Perceived difficulty	r
Role Adequacy	.41***	Role Adequacy	–.32**
Role Legitimacy	.45***	Role Legitimacy	–.32**
Individual Motivation and Reward	.40***	Individual Motivation and Reward	–.24*
Personal Views	–.26**	Career Motivation	–.23*
Career Motivation	.25**	Informal Support	–.29**
Team Capacity	.35***	Formal Support	–.25*
Informal Support	.30***	Organisational Role Legitimacy	–.32**
Formal Support	.34***		
Organisational Role Legitimacy	.42***		
Systems Influence	.38***		

Frequency and perceived difficulty of education and/or information provision

As Table 26 shows, eight WPQ scales demonstrated moderate associations with frequency of education and/or information provision. These practices were more frequent with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal and informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues.

Two WPQ scales demonstrated moderate associations with the perceived difficulty of education and/or information provision. Perceived difficulty of these practices decreased with:

- stronger role adequacy
- higher levels of motivation and satisfaction associated with AOD-related work.

Table 26
Predictors of the Frequency and Perceived Difficulty of Education and/or Information Provision (N = 161)

Frequency	*r*	Perceived difficulty	*r*
Role Adequacy	.43***	Role Adequacy	–.27**
Role Legitimacy	.47***	Role Legitimacy	–.20*
Individual Motivation and Reward	.41***	Individual Motivation and Reward	–.31***
Personal Views	–.21**	Informal Support	–.24**
Career Motivation	.23**	Organisational Role Legitimacy	–.22**
Team Capacity	.33***	Opportunity for Input	–.17*
Informal Support	.32***		
Formal Support	.32***		
Organisational Role Legitimacy	.44***		
Systems Influence	.39***		

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Frequency and perceived difficulty of early/brief interventions

As Table 27 shows, nine WPQ scales demonstrated moderate associations with frequency of early/brief interventions. Early/brief intervention increased in frequency with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- less negative and stereotypical views of drug users
- an interest in pursuing a career in the AOD field
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisations' response to AOD issues.

Two WPQ scales demonstrated weak associations with the perceived difficulty of early/brief interventions. Perceived difficulty of intervention decreased with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work.

Table 27
Predictors of the Frequency and Perceived Difficulty of Early/Brief Interventions (N = 139)

Frequency	*r*	Perceived difficulty	*r*
Role Adequacy	.40***	Role Adequacy	–.23*
Role Legitimacy	.45***	Role Legitimacy	–.19*
Individual Motivation and Reward	.44***	Individual Motivation and Reward	–.24**
Personal Views	–.27**	Career Motivation	–.21*
Career Motivation	.28**	Informal Support	–.21*
Team Capacity	.31***		
Informal Support	.26**		
Organisational Role Legitimacy	.38***		
Systems Influence	.41***		

Note. $*p < .05$. $**p < .01$. $***p < .001$.

Frequency and perceived difficulty of counselling/therapy

As Table 28 shows, 10 WPQ scales demonstrated moderate associations with frequency of counselling/therapy. These work practices increased in frequency with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- less negative and stereotypical views of drug users
- an interest in pursuing a career in the AOD field
- stronger perceptions of team efficacy and supportive norms/culture regarding AOD-related work
- higher levels of formal and informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business)
- stronger perceptions that systems factors (e.g., funding, external evaluation) influence the organisation's response to AOD issues.

Five WPQ scales demonstrated moderate associations with the perceived difficulty of counselling/therapy. Perceived difficulty of these work practices decreased with:

- stronger role adequacy and role legitimacy
- higher levels of motivation and satisfaction associated with AOD-related work
- higher levels of informal support for AOD-related work practices
- stronger perceptions of organisational role legitimacy (i.e., that responding to AOD issues is part of the organisation's core business).

Table 28
Predictors of the Frequency and Perceived Difficulty of Counselling/Therapy (N = 138)

Frequency	*r*	Perceived difficulty	*r*
Role Adequacy	.52***	Role Adequacy	–.33***
Role Legitimacy	.55***	Role Legitimacy	–.28**
Individual Motivation and Reward	.50***	Individual Motivation and Reward	–.33***
Personal Views	–.27**	Informal Support	–.26**
Career Motivation	.30***	Formal Support	–.20*
Team Capacity	.40***	Workplace Pressure and Support	–.19*
Informal Support	.36***	Organisational Role Legitimacy	–.26**
Formal Support	.33***		
Team Cohesion	.17*		
Organisational Role Legitimacy	.48***		
Systems Influence	.44***		

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

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APPENDIX A

ORIGINAL SOURCES OF ITEMS IN THE WORK PRACTICE QUESTIONNAIRE

Item	Source	Details
	INDIVIDUAL DOMAIN	
i.1.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 2 ("Does not have the necessary experience in quit-smoking counselling").
i.2.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 1 ("In my work I come into contact with a wide range of different types of alcohol-related problems").
i.3.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 3 ("Lack of confidence in my ability to counsel smokers").
i.4.	Shaw, S., Cartwright, A. K. J., Spratley, T., & Harwin, J. (1978). *Responding to drinking problems*. London: Croom Helm.	Adapted from p. 164, Role Adequacy item ("I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers").
	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 1 ("Does not have the necessary knowledge").
i.5.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 3 ("Has low levels of skill in smoking counselling").
i.6.	Shaw, S., Cartwright, A. K. J., Spratley, T., & Harwin, J. (1978*). Responding to drinking problems.* London: Croom Helm.	Adapted from p. 164, Role Support item ("In general, I feel I have less skill in working with drinkers than with other types of client").
i.7.	Anderson, P. (1985). Managing alcohol problems in general practice. *British Medical Journal*, *290*, 1873-1875.	Adapted from p. 1874, Table 1, item 1 ("I have a legitimate role to work with drinkers").
i.8.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 9 ("Is reluctant to take responsibility for smoking counselling").
i.9.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 755, 1. Overall therapeutic attitude: (a) Motivation to work with drinkers, item 2 ("I feel that the best I personally can offer drinkers is referral to somebody else").
i.10.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 10 ("Being unfamiliar with the health promotion role expected of me").

(continued)

Item	Source	Details
	INDIVIDUAL DOMAIN — *continued*	
i.11.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted p. 429, items used in Overall Attitude, Support and Self-esteem Scales: (a) Overall Therapeutic Attitudes, 4. The Extent to which they felt they had the right to work with drinkers, item 2 ("I feel I have a clear idea of my responsibilities in helping drinkers").
i.12.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted from p. 429, Items Used in Overall Attitude, Support and Self-esteem Scales: (a) Overall Therapeutic Attitudes, 4. The Extent to which they felt they had the right to work with drinkers, item 4 ("I feel I have the right to ask clients questions about their drinking when necessary").
i.13.	Shaw, S., Cartwright, A. K. J., Spratley, T., & Harwin, J. (1978). *Responding to drinking problems*. London: Croom Helm.	Adapted from p. 164, Role legitimacy item ("I feel that my clients believe I have the right to ask questions about drinking when necessary").
i.14.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 7 ("Resists involvement in smoking counselling").
	Karam-Hage, M., Nerenberg, L., & Brower, K. J. (2001). Modifying residents' professional attitudes about substance abuse treatment and training. *American Journal on Addictions, 10*, 40-47.	Adapted from p.46, Addiction Psychiatry Questionnaire, Part B, item 11 ("I came to this conference because it is frustrating to work with addicted patients").
i.15.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 6 ("Referring problem drinkers onto others saves me much wasted time").
i.16.	Steckler, A., Goodman, R., McLeroy, K., Davis, S., & Koch, G. (1992). Measuring the diffusion of innovative health promotion programs. *American Journal of Health Promotion, 6*, 214-225.	Adapted from p. 222, Awareness and concern questions, Factor 2: Concern about tobacco use prevention, item 1 ("I don't believe preventing tobacco use among youth is so important").
i.17.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted from p. 428, Items Used in Overall Attitude, Support and Self-esteem Scales: (a) Overall Therapeutic Attitudes ("In general, one can get satisfaction from working with drinkers").
i.18.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted from p. 428, Items Used in Overall Attitude, Support and Self-esteem Scales: (a) Overall Therapeutic Attitudes, 2. Their expectations of work satisfaction with these clients, item 2 ("In general, it is rewarding to work with drinkers").

(continued)

Item	Source	Details
	INDIVIDUAL DOMAIN — *continued*	
i.19.	Cartwright, A. K. J. (1980). The attitudes of helping agents toward the alcoholic client: The influence of experience, support, training, and self-esteem. *British Journal of Addiction, 75*, 413-431.	Adapted from p. 429, Items Used in Overall Attitude, Support and Self-esteem Scales: (a) Overall Therapeutic Attitudes, scale 5: Their self-esteem in this specific field, item 2 ("On the whole I am satisfied with the way I work with drinkers").
i.20.	Karam-Hage, M., Nerenberg, L., & Brower, K. J. (2001). Modifying residents' professional attitudes about substance abuse treatment and training. *American Journal on Addictions, 10*, 40-47.	Adapted from p.46, Addiction Psychiatry Questionnaire, Part B, item 16 ("I like working with patients who have an addiction problem").
i.21.	Karam-Hage, M., Nerenberg, L., & Brower, K. J. (2001). Modifying residents' professional attitudes about substance abuse treatment and training. *American Journal on Addictions, 10*, 40-47.	Adapted from p.46, Addiction Psychiatry Questionnaire, Part B, item 14 ("Most addicted patients resist treatment and do not get better").
i.22.	Karam-Hage, M., Nerenberg, L., & Brower, K. J. (2001). Modifying residents' professional attitudes about substance abuse treatment and training. *American Journal on Addictions, 10*, 40-47.	Adapted from p. 46, Addiction Psychiatry Questionnaire, Part B, item 15 ("Addiction is more of a character problem than a disease").
i.23.	Karam-Hage, M., Nerenberg, L., & Brower, K. J. (2001). Modifying residents' professional attitudes about substance abuse treatment and training. *American Journal on Addictions, 10*, 40-47.	Adapted from p. 46, Addiction Psychiatry Questionnaire, Part B, item 17 ("I try to avoid patients with addiction problems and transfer their care to someone else").
i.24.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy*. Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 18 ("There is no professional advantage for me in offering this type of service").
i.25.	Constructed by the project team and project reference group.	
i.26.	Cross, D. (1973). The Worker Opinion Survey: A measure of shop-floor satisfaction. *Occupational Psychology, 47*, 193-208. Cited in C. Wilson (1991*). The influence of police specialisation on job satisfaction: A comparison of general duties officers and detectives*. National Police Research Unit (or Australasian Centre for Policing Research).	Adapted from p. 21, item 3.6 ("My experience increases my prospects").

Item	Source	Details
	TEAM DOMAIN	
t.1.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 151, item 56 ("Working with experienced nurses who 'know' the hosptial").
t.2.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 14 ("Only few, if any, of my colleagues have success in dealing with alcohol-related problems").
t.3.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 150, item 33 ("Working with nurses who are clinically competent").
t.4.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 3 ("Lack of confidence in my ability to counsel smokers").
t.5.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Centre for Leadership Studies (1993), in Cooke M. (1998), p. 340, 2.7: Readiness Scale, item 9 ("Is reluctant to take responsibility for smoking counselling").
t.6.	Anderson, P. (1985). Managing alcohol problems in general practice. *British Medical Journal*, *290*, 1873-1875.	Adapted from p. 1874, Table 1: Attitudes of General Practitioners Working with Drinkers, item 1 ("I have a legitimate role to work with drinkers").
t.7.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 12 ("Within my department, cases involving alcohol-related problems are likely to be given equal priority as other cases").
	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 5 ("Smoking is a low priority").
t.8.	Constructed by the project team and project reference group.	
t.9.	Constructed by the project team and project reference group.	
t.10.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 8 ("I feel that I receive little or no encouragement from my seniors to get involved in alcohol-related problems").
t.11.	Constructed by the project team and project reference group.	
t.12.	Constructed by the project team and project reference group.	

(continued)

Item	Source	Details
	TEAM DOMAIN — *continued*	
t.13.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 8 ("I feel that I receive little or no encouragement from my seniors to get involved in alcohol-related problems").
t.14.	Shaw, S., Cartwright, A. K. J., Spratley, T., & Harwin, J. (1978). *Responding to drinking problems*. London: Croom Helm.	Adapted from p. 164, Role support item ("If I felt the need when working with drinkers, I could easily find a member of another profession who would be able to give me expert advice about any problem relevant to their area").
t.15.	Constructed by the project team and project reference group.	
t.16.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 150, item 40 ("A preceptor program for newly hired RNs") or item 3 ("A good orientation program for newly employed nurses").
t.17.	Constructed by the project team and project reference group.	
t.18.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 17 ("There are no policies requiring this sort of intervention").
t.19.	Constructed by the project team and project reference group.	
t.20.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 342, 2.9: Work Environment Scale, item 11 ("There is not much group spirit").
t.21.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational* Psychology, *70*, 211-228.	Adapted from p. 226, School Organisational Health Questionnaire: Morale Subscale, item 2 ("The morale in this school is high").
t.22.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Professional Interaction Subscale, item 1 ("There is good communication between staff members in this school").
t.23.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Professional Interaction Subscale, item 2 ("I receive support from my colleagues").

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Item	Source	Details
	TEAM DOMAIN — *continued*	
t.24.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 3 (“Lack of staff teamwork on smoking interventions”).
t.25.	Eisenberger, R., Cummings, J., Armeli, S., & Lynch, P. (1997). Perceived organizational support, discretionary treatment and job satisfaction. *Journal of Applied Psychology*, *82*, 812–820.	Adapted from p. 816, Table 1, item 8 (“Relationship with coworkers”).
t.26.	Constructed by the project team and project reference group.	
t.27.	Cross, D. (1973). The Worker Opinion Survey: A measure of shop-floor satisfaction. *Occupational Psychology, 47*, 193-208. Cited in C. Wilson (1991*). The influence of police specialisation on job satisfaction: A comparison of general duties officers and detectives*. National Police Research Unit (or Australasian Centre for Policing Research).	Adapted from p. 21, item 6.8 (“Do their share of work”).

Item	Source	Details
	WORKPLACE DOMAIN	
w.1.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 226, School Organisational Health Questionnaire: Appraisal and Recognition subscale, item 1 ("I am regularly given feedback on how I am performing my role").
w.2.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 226, School Organisational Health Questionnaire: Appraisal and Recognition subscale, item 4 ("I have the opportunity to discuss and receive feedback on my work performance").
w.3.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 226, School Organisational Health Questionnaire: Appraisal and Recognition subscale, item 2 ("I am happy with the quality of feedback I receive on my work performance").
w.4.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 8 ("I feel that I receive little or no encouragement from my seniors to get involved in alcohol-related problems").
w.5.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Excessive Work Demands subscale, item 2 ("There is too much expected of teachers in this school").
w.6.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished dissertation), p. 342, 2.9: Work Environment Scale, item 6 ("There is constant pressure to keep working").
w.7.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished dissertation), p. 343, 2.9: Work Environment Scale, item 63 ("Supervisors expect far too much from employees").
w.8.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 150, item 12 ("Enough registered nurses on staff to provide quality patient care").

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Item	Source	Details
	WORKPLACE DOMAIN — *continued*	
w.9.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 343 (Appendix 2, 2.9: Work Environment Scale, item 44 "Supervisors encourage employees to rely on themselves when a problem arises")
w.10.	Lightfoot, P., & Orford, J. (1986). Helping agents' attitudes towards alcohol-related problems: Situations vacant? A test and elaboration of a model. *British Journal of Addiction, 81*, 749-756.	Adapted from p. 756, Situational Constraint Scale Items, item 8 ("I feel that I receive little or no encouragement from my seniors to get involved in alcohol-related problems").
w.11.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Excessive Work Demands subscale, item 4 ("There is no time for teachers to relax in this school").
w.12.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 342, 2.9: Work Environment Scale, item 7 "Things are sometimes pretty disorganised").
w.13.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 343, 2.9: Work Environment Scale, item 15 ("There's a lot of time wasted because of inefficiencies").
w.14.	Eisenberger, R., Cummings, J., Armeli, S., & Lynch, P. (1997). Perceived organizational support, discretionary treatment and job satisfaction. *Journal of Applied Psychology*, *82*, 812–820.	Adapted from p. 816, Table 1, item 4 ("Physical working conditions").
w.15.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 336, 2.3: Barriers to smoking intervention, item 1 ("Lack of office space").
w.16.	Eisenberger, R., Cummings, J., Armeli, S., & Lynch, P. (1997). Perceived organizational support, discretionary treatment and job satisfaction. *Journal of Applied Psychology*, *82*, 812–820.	Adapted from p. 816, Table 1, item 6 ("Job security").
w.17.	Steckler, A., Goodman, R., McLeroy, K., Davis, S., & Koch, G. (1992). Measuring the diffusion of innovative health promotion programs. *American Journal of Health Promotion, 6*, 214-225.	Adapted from p. 221, Exhibit 1: Organisational Climate, item 25d ("All in all, how satisfied are you with the following things…Pay").

Item	Source	Details
	ORGANISATION DOMAIN	
o.1.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 150, item 31 ("A clear philosophy of nursing pervades the patient care environment").
o.2.	Constructed by the project team and project reference group.	
o.3.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Goal Congruence Subscale, item 3 ("The school has a clearly stated set of objectives and goals").
o.4.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 338, 2.5: Formalisation of rules, item 9 ("There is a complete written job description for my job").
o.5.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p.150, item 37 ("An active quality-assurance program").
o.6.	Anderson, P. (1985). Managing alcohol problems in general practice. *British Medical Journal*, *290*, 1873-1875.	Adapted from p. 1874, Table 1: Attitudes of General Practitioners Working with Drinkers, item 1 ("I have a legitimate role to work with drinkers").
o.7.	Constructed by the project team and project reference group.	
o.8.	Constructed by the project team and project reference group.	
o.9.	Constructed by the project team and project reference group.	
o.10.	Constructed by the project team and project reference group.	
o.11.	Constructed by the project team and project reference group.	
o.12.	Constructed by the project team and project reference group.	
o.13.	Steckler, A., Goodman, R., McLeroy, K., Davis, S., & Koch, G. (1992). Measuring the diffusion of innovative health promotion programs. *American Journal of Health Promotion, 6*, 214-225.	Adapted from p. 221, Exhibit 1: Organisational Climate, item 23 ("How receptive are those above you to our ideas and suggestions?").
o.14.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted p. 227, School Organisational Health Questionnaire: Participative Decision-making Subscale, item 3 ("There are forums in this school where I can express my views and opinions").

(continued)

Item	Source	Details
	ORGANISATIONAL DOMAIN _ *continued*	
o.15.	Steckler, A., Goodman, R., McLeroy, K., Davis, S., & Koch, G. (1992). Measuring the diffusion of innovative health promotion programs. *American Journal of Health Promotion, 6*, 214-225.	Adapted from p. 221, Exhibit 1: Organisational Climate, item 26 ("How are differences and disagreements handled in this school system?").
o.16.	Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research, 49*, 146-153.	Adapted from p. 150, item 36 ("Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees) and item 42 ("Staff nurses have the opportunity to serve on hospital and nursing committees").
o.17.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 343, 2.9: Work Environment Scale, item 77 ("Rules and policies are constantly changing").
o.18.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from Moos (1994), in Cooke (1998) (unpublished thesis), p. 343, 2.9: Work Environment Scale, item 77 ("Rules and policies are constantly changing")
o.19.	Constructed by the project team and project reference group.	
o.20.	Constructed by the project team and project reference group.	
o.21.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Professional Growth Subscale, item 2 ("I am encouraged to pursue further personal development").
o.22.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228.	Adapted from p. 227, School Organisational Health Questionnaire: Professional Growth Subscale, item 3 ("The professional development planning in the school takes into account my individual needs and interests").
o.23.	Steckler, A., Goodman, R., McLeroy, K., Davis, S., & Koch, G. (1992). Measuring the diffusion of innovative health promotion programs. *American Journal of Health Promotion, 6*, 214-225.	Adapted from p. 221, Exhibit 1: Organisational Climate, item 14 ("Our administration makes an effort to talk with us about our career aspirations within the school system").
o.24.	Constructed by the project team and project reference group.	
o.25.	Constructed by the project team and project reference group.	
o.26.	Constructed by the project team and project reference group.	

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Item	Source	Details
	ORGANISATIONAL DOMAIN — *continued*	
o.27.	Hart, P., Wearing, A., Conn, M., Carter, N., & Dingle, R. (2000). Development of the school organisational health questionnaire: A measure for assessing teacher morale and school organisational climate. *British Journal of Educational Psychology, 70*, 211-228	Adapted from p. 227, School Organisational Health Questionnaire: Professional Growth Subscale, item 4 ("There are opportunities in this school for developing new skills").

Item	Source	Details
	POST-TRAINING SCALES	
	Perceived Training Outcomes	
p.1.	Constructed by the project team and project reference group.	
p.2.	Constructed by the project team and project reference group.	
p.3.	Constructed by the project team and project reference group.	
p.4.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 334, 2.2: Attribute Scale, item 7 ("Using the Fresh Start Program improves the quality of the work the clinic does").
p.5.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 334, 2.2: Attribute Scale, item 7 ("Using the Fresh Start Program improves the quality of the work the clinic does").
p.6.	Constructed by the project team and project reference group.	
	Perceived Relevance of Training	
p.7.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from p. 334, 2.2: Attribute Scale, item 3 ("Using the *Fresh Start* Program is compatible with all aspects of clinic work") and item 8 ("I think using the *Fresh Start* Program does not fit in well with clinic routine").
p.8.	Holton, E. F., III., Bates, R. A., & Ruona, W. E. A. (2000). Development of a generalized learning transfer system inventory. *Human Resource Development Quarterly, 11*, 333-360.	Adapted from p. 345, Learning Transfer System Inventory (LTSI), sample item from the Perceived content validity subscale ("What is taught at training closely resembles my job requirements").
p.9.	Constructed by the project team and project reference group.	
p.10.	Holton, E. F., III., Bates, R. A., & Ruona, W. E. A. (2000). Development of a generalized learning transfer system inventory. *Human Resource Development Quarterly, 11*, 333-360.	Adapted from p.345, Learning Transfer System Inventory (LTSI), sample item from the Perceived content validity subscale ("What is taught at training closely resembles my job requirements").
p.11.	Holton, E. F., III., Bates, R. A., & Ruona, W. E. A. (2000). Development of a generalized learning transfer system inventory. *Human Resource Development Quarterly, 11*, 333-360.	Adapted from p. 345, Learning Transfer System Inventory (LTSI), sample item from the Perceived content validity subscale ("What is taught at training closely resembles my job requirements").
p.12.	Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy.* Unpublished doctoral dissertation, University of New South Wales, Sydney.	Adapted from 2.2: Attribute Scale, item 22 ("I have had plenty of opportunity to see the Fresh *Start* program being used"), p. 334.

Appendix A References

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Cooke, M. (1998). *Barriers to the systematic provision of smoking cessation education during pregnancy*. Unpublished doctoral thesis, University of New South Wales, Sydney. Abstract available at: http://notes.med.unsw.edu.au/ndarc.nsf/website/Publications.thesis.cooke

Eisenberger, R., Cummings, J., Armeli, S., & Lynch, P. (1997). Perceived organizational support, discretionary treatment and job satisfaction. *Journal of Applied Psychology*, *82*, 812–820.

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Holton, E. F., III., Bates, R. A., & Ruona, W. E. A. (2000). Development of a generalized learning transfer system inventory. *Human Resource Development Quarterly*, *11*, 333-360.

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Wilson, C. (1991). *The influence of police specialisation on job satisfaction: A comparison of general duties officers and detectives*. National Police Research Unit (or Australasian Centre for Policing Research).

APPENDIX B

WORK PRACTICE QUESTIONNAIRE

(FULL VERSION)

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The Work Practice Questionnaire:

A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field

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Administration Instructions

The Work Practice Questionnaire (WPQ) is intended to be used as an AOD training evaluation tool. It addresses a range of individual, team and organisational factors that are likely to influence training transfer and work practice change. The WPQ also contains scales that address trainees' perception of education and training programs.

The WPQ can be administered prior to training and post-training as a short and/or long-term evaluation tool.

There are three companion documents that support the WPQ:

1. A monograph examining factors influencing training transfer and work practice change in relation to alcohol and other drugs: *From Training to Work Practice Change: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field.*[1]

   The monograph examines a wide range of factors that influence work practices in relation to alcohol and other drugs. It provides a review of evidence related to the influence of the factors assessed in the Work Practice Questionnaire on training transfer and work practice. Strategies to address each of the factors in order to facilitate training transfer and work practice change are also discussed.

2. Guidelines for evaluating AOD-related training: *Guidelines for Evaluating Alcohol and Other Drugs Education and Training Programs.*[1]

   The guidelines provide user-friendly information for evaluating alcohol and other drug education and training programs. The guidelines have been designed to support both novice and experienced trainers to develop, implement and analyse their training evaluation. The document includes a discussion of the aims and context of various types of evaluation, useful tools, tips and readings.

3. A handbook for the Work Practice Questionnaire: *Handbook for the Work Practice Questionnaire (WPQ): A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field*.[1]

   The handbook provides a detailed description of the WPQ and its psychometric properties.

The WPQ does not address every possible factor that may influence training transfer and work practice change – such a tool would be unwieldy and impractical to use. Rather, guided by a comprehensive review of the relevant research literature and extensive field-testing, the WPQ was designed to assess the key factors likely to influence AOD-related work practices.

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[1] Available from the NCETA website www.nceta.flinders.edu.au.

Structure of the WPQ

The WPQ contains four domains:

1. Individual (5 scales)
2. Team (4 scales)
3. Workplace (3 scales)
4. Organisational (5 scales).

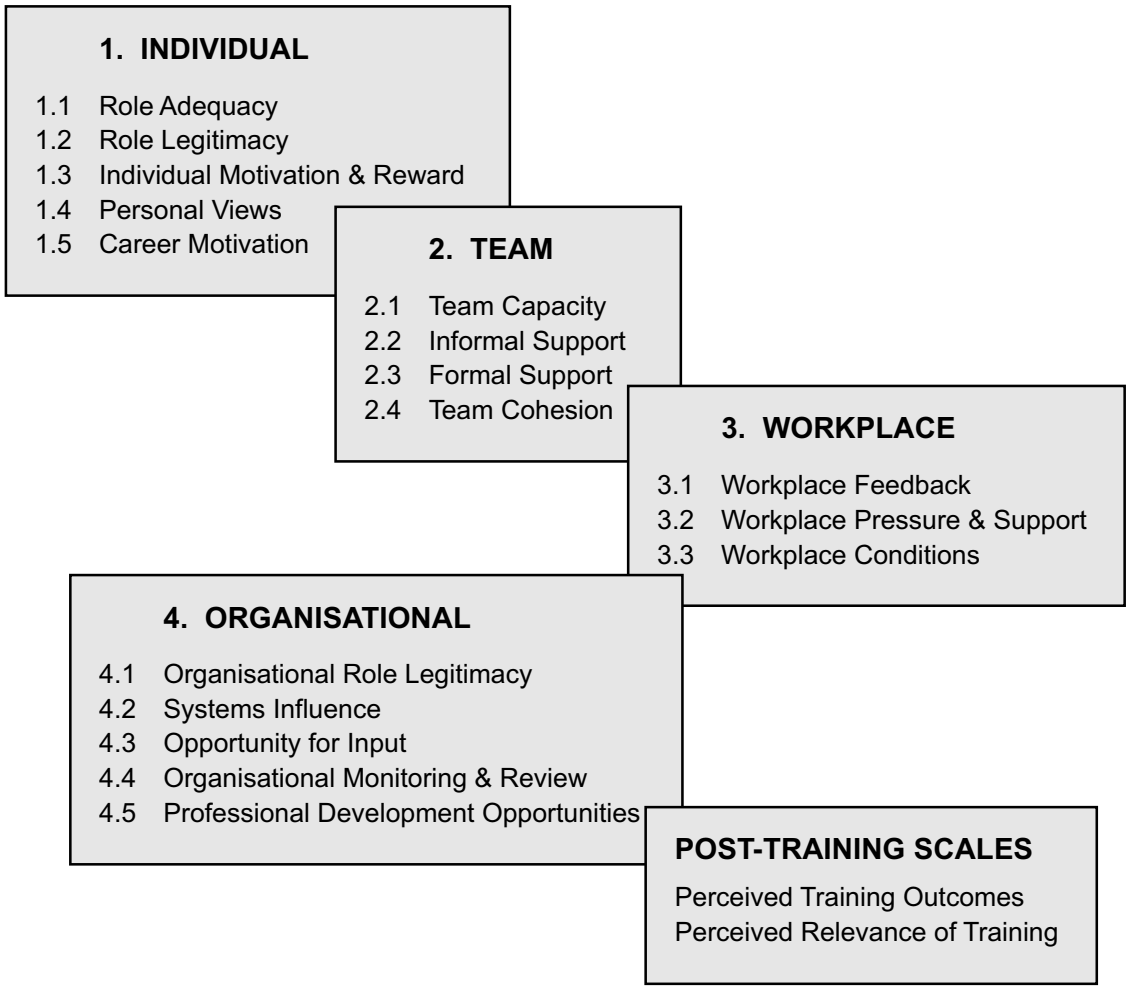

Figure 1
Structure of the Work Practice Questionnaire.

The **Individual** domain relates to the personal characteristics, beliefs and views of individual workers. Historically, it is mostly factors within this domain that AOD training evaluation has been limited to.

The **Team** domain addresses factors that relate to a team environment within the work situation such as team capacity, formal and informal support, and team cohesion.

The **Workplace** domain addresses factors in the working environment that are likely to impact on work practice such as availability of feedback, workload and other pressures, availability of support and general working conditions (e.g., job security, remuneration).

The **Organisational** domain addresses factors that impact on the functioning of the organisation as a whole, and hence may also impact on the capacity of individual workers to perform effectively.

The WPQ also contains two **post-training scales** which address participant's perceptions of the impact and relevance of training in regard to their work practice.

In some circumstances it may be appropriate to use a sub-set of the WPQ scales that are most relevant or appropriate to a particular training program, organisation or occupational group. However, where scales are considered relevant to use, it is recommended that ALL items within a scale are used. This will ensure scale scores are stable and reliable.

The WPQ usually takes approximately 9 minutes to complete.

Scoring

The score on each scale is obtained by calculating the average score across scale items. Some items in the WPQ are negatively worded and need to be reverse-coded prior to calculating the scale score. Table 1 indicates items that need to be reverse-coded.

Table 1
WPQ Scale Items Requiring Reverse-Coding

WPQ scale	Item(s) to be reverse-coded
Role Adequacy	i.5
Role Legitimacy	i.8, i.9, i.10
Individual Motivation and Reward	i.14, i.15
Team Capacity	t.4, t.7
Workplace Feedback	w.3
Workplace Pressure and Support	w.5, w.6, w.7
Workplace Conditions	w.12, w.13
Organisational Monitoring and Review	o.17
Perceived Relevance of Training	p.11

Application of the WPQ to AOD Work Practice

The WPQ can be used to guide the development of strategies to maximise the 'return on investment' in staff education and training. Strategies to address each of the factors assessed in the WPQ are discussed in further detail in the monograph *From Training to Work Practice: An Examination of Factors Influencing Training Transfer in the Alcohol and Other Drugs Field* (Pidd, Freeman, Skinner, Addy, Shoobridge, & Roche, 2004)[2].

The WPQ can also be used to identify facilitators and barriers to change in AOD-related work practices, regardless of whether a training program or other intervention has been put into place. Used in this way, the WPQ can provide information about the types of interventions that may be useful in facilitating appropriate AOD work practice change (e.g., enhancing supervision, increasing rewards and recognition for AOD-related work, enhancing professional development opportunities). Furthermore, the WPQ can provide useful information on the factors that indirectly influence organisational capacity and effectiveness (e.g., changes in team cohesion and team capacity post-training, changes in levels of perceived organisational role legitimacy post-training).

[2] Available from the NCETA website www.nceta.flinders.edu.au.

The Work Practice Questionnaire

This questionnaire contains a range of items concerning your views on responding to alcohol and other drug (AOD) related issues in your work practice, and your views regarding various aspects of your working environment.

Please complete BOTH SIDES of each page and read instructions carefully. Please try to answer ALL questions.

Please circle the number which best describes your level of agreement with each statement in the questionnaire. For example, if you really like jazz music - you would circle number 4.

	Disagree	Tend to disagree	Tend to agree	Agree
I really like jazz music.	1	2	3	(4)

INDIVIDUAL

INDIVIDUAL 1.1 ROLE ADEQUACY

		Disagree	Tend to disagree	Tend to agree	Agree
i.1.	I have the necessary experience to respond to alcohol and other drug related issues.	1	2	3	4
i.2.	In my work I have responded to a wide range of alcohol and other drug related issues.	1	2	3	4
i.3.	I am confident in my ability to respond to alcohol and other drug related issues.	1	2	3	4
i.4.	I have the necessary knowledge to help people with alcohol and other drug related issues.	1	2	3	4
i.5.	I do not have many of the skills necessary to respond to alcohol and other drug related issues.	1	2	3	4
i.6.	I am able to respond to people who have alcohol and other drug related issues as competently as I respond to people with other problems.	1	2	3	4

INDIVIDUAL 1.2 ROLE LEGITIMACY

		Disagree	Tend to disagree	Tend to agree	Agree
i.7.	I have a legitimate role to play in responding to alcohol and other drug related issues.	1	2	3	4
i.8.	I am reluctant to take responsibility for alcohol and other drug related issues in my work.	1	2	3	4
i.9.	It is more appropriate for other colleagues to respond to alcohol and other drug related issues, than myself.	1	2	3	4
i.10.	I am uncertain of my role in responding to alcohol and other drug related issues.	1	2	3	4
i.11.	I am clear about my responsibilities in responding to alcohol and other drug related issues.	1	2	3	4
i.12.	I have a responsibility to ask clients questions about alcohol and other drug related issues.	1	2	3	4
i.13.	My clients believe I have a responsibility to ask them questions about alcohol and other drug related issues.	1	2	3	4

INDIVIDUAL 1.3 INDIVIDUAL MOTIVATION AND REWARD

		Disagree	Tend to disagree	Tend to agree	Agree
i.14.	I prefer not to respond to alcohol and other drug related problems as I find it too frustrating.	1	2	3	4
i.15.	I refer people with alcohol and other drug related issues onto others to prevent me from wasting my time.	1	2	3	4
i.16.	I believe that responding to alcohol and other drug related issues is important.	1	2	3	4
i.17.	I get personal satisfaction responding to people affected by experiencing alcohol and other drug related issues.	1	2	3	4
i.18.	My experience of responding to alcohol and other drug related issues has been rewarding.	1	2	3	4
i.19.	On the whole I am satisfied with the way I work with people who have alcohol and other drug related issues.	1	2	3	4
i.20.	I like to respond to alcohol and other drug related issues in my work.	1	2	3	4

INDIVIDUAL 1.4 PERSONAL VIEWS

		Disagree	Tend to disagree	Tend to agree	Agree
i.21.	Most people with alcohol and other drug related problems are not interested in addressing them.	1	2	3	4
i.22.	I generally think people with alcohol and other drug related problems bring their difficulties on themselves.	1	2	3	4
i.23.	I try to avoid responding to people with alcohol and other drug related problems as they are unreliable.	1	2	3	4

INDIVIDUAL – *continued*

INDIVIDUAL 1.5 CAREER MOTIVATION

	Disagree	Tend to disagree	Tend to agree	Agree
i.24. There are professional advantages for me to respond to alcohol and other drug related issues.	1	2	3	4
i.25. Expertise in responding to alcohol and other drug related issues is highly regarded by my colleagues.	1	2	3	4
i.26. In career terms, there are definite advantages in improving my expertise in alcohol and other drug related areas.	1	2	3	4

TEAM

TEAM 2.1 TEAM CAPACITY

		Disagree	Tend to disagree	Tend to agree	Agree
t.1.	There is a comprehensive knowledge base among the people I work closely with concerning alcohol and other drug issues.	1	2	3	4
t.2.	Generally, responses to alcohol and other drug related issues provided by the people I work closely with are of good quality.	1	2	3	4
t.3.	Collectively, the skill base of the people I work closely with means we are well equipped to respond to alcohol and other drug related issues.	1	2	3	4
t.4.	I work closely with people who are not confident in their ability to respond to alcohol and other drug related issues.	1	2	3	4
t.5.	People I work closely with are willing to respond to alcohol and other drug related issues.	1	2	3	4
t.6.	The people I work closely with consider responding to alcohol and other drug related issues a legitimate part of their work.	1	2	3	4
t.7.	In general, people I work closely with give cases concerning alcohol and other drug related problems low priority.	1	2	3	4
t.8.	People I work closely with consider education and training for alcohol and other drug related issues an essential aspect of staff development.	1	2	3	4
t.9.	I work closely with people who are good role models in terms of responding to alcohol and other drug related issues.	1	2	3	4

TEAM 2.2 INFORMAL SUPPORT

		Disagree	Tend to disagree	Tend to agree	Agree
t.10.	Informal supervision (e.g., encouragement, peer support, guidance, mentoring) is provided amongst staff on alcohol and other drug related issues.	1	2	3	4
t.11.	I receive support from the people I work closely with about the work I do concerning alcohol and other drug related issues.	1	2	3	4
t.12.	There is good communication among the people I work closely with about alcohol and other drug related issues.	1	2	3	4
t.13.	My colleagues encourage me to intervene in alcohol and other drug related issues.	1	2	3	4
t.14.	If I needed to, it would be easy to find someone to give me advice on responses to alcohol and other drug related issues relevant to my workplace.	1	2	3	4

TEAM 2.3 FORMAL SUPPORT

		Disagree	Tend to disagree	Tend to agree	Agree
t.15.	Staff have access to a supervisor with expertise in alcohol and other drug related issues.	1	2	3	4
t.16.	Formal supervision (e.g., guidance, preceptorship) is provided amongst staff on alcohol and other drug related issues.	1	2	3	4
t.17.	The organisation I work for supports staff efforts to respond to alcohol and other drug related issues.	1	2	3	4
t.18.	This organisation has policies and procedures that support alcohol and drug related work.	1	2	3	4
t.19.	Staff have access to the tools/resources needed to respond to alcohol and other drug related issues (e.g., standard questionnaires, quit kits, referral information).	1	2	3	4

TEAM 2.4 TEAM COHESION

		Disagree	Tend to disagree	Tend to agree	Agree
t.20.	There is good team spirit amongst the people I work closely with.	1	2	3	4
t.21.	Morale is high among the people I work closely with.	1	2	3	4
t.22.	Generally, communication amongst the people I work closely with is good.	1	2	3	4
t.23.	Encouragement and support is commonly provided amongst the people I work closely with.	1	2	3	4
t.24.	In my workplace staff engage in good teamwork.	1	2	3	4
t.25.	In general I have a good relationship with staff at my workplace.	1	2	3	4
t.26.	I feel comfortable to ask for help or support from my colleagues or peers.	1	2	3	4
t.27.	In my workplace, the majority of staff do their share of work.	1	2	3	4

WORKPLACE

WORKPLACE 3.1 WORKPLACE FEEDBACK

		Disagree	Tend to disagree	Tend to agree	Agree
w.1.	I receive feedback from other people in my workplace on how I am performing my role.	1	2	3	4
w.2.	I have the opportunity (informally or formally) to discuss and receive feedback about my work performance with other staff.	1	2	3	4
w.3.	I am unhappy with the quality of feedback I receive about my work performance from other staff.	1	2	3	4
w.4.	Supervisors engage in constructive feedback with staff.	1	2	3	4

WORKPLACE 3.2 WORKPLACE PRESSURE AND SUPPORT

		Disagree	Tend to disagree	Tend to agree	Agree
w.5.	Too much is expected of all staff in my workplace.	1	2	3	4
w.6.	Staff members experience constant pressure in my workplace.	1	2	3	4
w.7.	Supervisors expect too much from staff in my workplace.	1	2	3	4
w.8.	There are enough staff in my workplace to provide quality services.	1	2	3	4
w.9.	Most of the time, supervisors provide adequate support when problems arise.	1	2	3	4
w.10.	In general, supervisors encourage staff to find positive solutions when problems arise.	1	2	3	4

WORKPLACE 3.3 WORKPLACE CONDITIONS

		Disagree	Tend to disagree	Tend to agree	Agree
w.11.	In my workplace staff are encouraged to take their allocated breaks.	1	2	3	4
w.12.	In my workplace, things are quite disorganised.	1	2	3	4
w.13.	In my workplace, time is wasted because of inefficiencies.	1	2	3	4
w.14.	In my workplace, the physical working conditions are good.	1	2	3	4
w.15.	I have my own allocated ‘space’ in my work environment.	1	2	3	4
w.16.	I am satisfied with my level of job security.	1	2	3	4
w.17.	I am satisfied with my level of pay.	1	2	3	4

ORGANISATIONAL

ORGANISATIONAL 4.1 ORGANISATIONAL ROLE LEGITIMACY

		Disagree	Tend to disagree	Tend to agree	Agree
o.1.	There is a philosophy that guides this organisation's responses to alcohol and other drug related issues.	1	2	3	4
o.2.	Responses to alcohol and other drug related issues are consistent with this organisation's responses to other health and/or social problems.	1	2	3	4
o.3.	This organisation has clearly stated goals/objectives about its involvement in alcohol and other drug related issues.	1	2	3	4
o.4.	Staff roles and responsibilities in responding to alcohol and other drug related issues are clearly laid out in their job descriptions.	1	2	3	4
o.5.	This organisation consistently strives to improve the alcohol and other drug related services it provides.	1	2	3	4
o.6.	This organisation has a legitimate role to play in responding to alcohol and other drug related issues.	1	2	3	4
o.7.	This organisation promotes itself as an organisation that responds to alcohol and other drug related issues.	1	2	3	4

ORGANISATIONAL 4.2 SYSTEMS INFLUENCE

		Disagree	Tend to disagree	Tend to agree	Agree
o.8.	Responding to alcohol and other drug related issues is a part of this organisation's service requirements and conditions of funding.	1	2	3	4
o.9.	This organisation receives funding specifically for responding to alcohol and other drug related issues.	1	2	3	4
o.10.	This organisation undergoes external evaluation of its alcohol and other drug related responses.	1	2	3	4
o.11.	Organisations in similar fields act as leaders or champions to this organisation.	1	2	3	4
o.12.	This organisation sees itself as competing with other organisations providing similar responses to alcohol and drug related issues.	1	2	3	4

ORGANISATIONAL 4.3 OPPORTUNITY FOR INPUT

		Disagree	Tend to disagree	Tend to agree	Agree
o.13.	This organisation is receptive to staff ideas and suggestions.	1	2	3	4
o.14.	Forums are available in this organisation where I can express my views and opinions.	1	2	3	4
o.15.	In this organisation disagreements are worked through.	1	2	3	4
o.16.	As a staff member, I can participate in the internal governance of the organisation (e.g., practice and policy committees, working committees).	1	2	3	4

ORGANISATIONAL 4.4 ORGANISATIONAL MONITORING AND REVIEW

		Disagree	Tend to disagree	Tend to agree	Agree
o.17.	Policies and procedures in this organisation tend to change only when there are external (legislation, media, change of government) pressures to do so.	1	2	3	4
o.18.	In this organisation, policies and procedures are regularly reviewed.	1	2	3	4
o.19.	This organisation reviews job descriptions regularly.	1	2	3	4
o.20.	This organisation monitors the quality of the services it provides.	1	2	3	4

ORGANISATIONAL – *continued*

ORGANISATIONAL 4.5 PROFESSIONAL DEVELOPMENT OPPORTUNITIES

		Disagree	Tend to disagree	Tend to agree	Agree
o.21.	Staff members are encouraged to undertake training courses.	1	2	3	4
o.22.	Professional development planning in this organisation takes into account individual needs and interests.	1	2	3	4
o.23.	Staff members are supported in pursing qualifications or professional development related to their job.	1	2	3	4
o.24.	This organisation provides back-up staff to allow people to attend training.	1	2	3	4
o.25.	This organisation provides staff with access to a wide variety of education and training opportunities.	1	2	3	4
o.26.	All staff members have equal access to training.	1	2	3	4
o.27.	Opportunities exist in this organisation for developing new skills.	1	2	3	4

POST-TRAINING SECTION: PERCEPTIONS OF TRAINING

PERCEIVED TRAINING OUTCOMES	Disagree	Tend to disagree	Unsure	Tend to agree	Agree
p.1. This training program has enabled me to respond to alcohol and other drug related issues with greater confidence.	1	2	3	4	5
p.2. I gained skills or knowledge from this training program that enabled me to work more effectively with alcohol and other drug related issues.	1	2	3	4	5
p.3. This training program effectively illustrated links between the theory of responding to alcohol and other drug related issues and the practical aspects of responding.	1	2	3	4	5
p.4. The information/materials provided in the training program improved the quality of alcohol and other drug related responses in my workplace.	1	2	3	4	5
p.5. All in all, this training program improved my responses to alcohol and other drug related issues in my workplace.	1	2	3	4	5
p.6. This training program addressed practical constraints of responding to alcohol and other drug related issues.	1	2	3	4	5

PERCEIVED RELEVANCE OF TRAINING	Disagree	Tend to disagree	Unsure	Tend to agree	Agree
p.7. This training program effectively incorporated relevant workplace issues.	1	2	3	4	5
p.8. The content of this training program was appropriate for my current work needs.	1	2	3	4	5
p.9. This training program encouraged me to pursue further learning ‘on-the-job’.	1	2	3	4	5
p.10. This training program was consistent with my job requirements.	1	2	3	4	5
p.11. This training program was too removed from my experiences at my workplace to be useful.	1	2	3	4	5
p.12. I have used some of the things I learnt at this training program in my work.	1	2	3	4	5

Personal and Organisational Demographics

Please circle the number in the right hand side that corresponds to the alternative that best describes your situation. For example, in the following question if you like summer better than winter, you would circle number one in the right hand side. Some questions ask you to write in the space provided.

Which do you like better summer or winter?	1	Summer	01
	2	Winter	02

TYPE OF ORGANISATION

1. What type of organisation do you work for? Please choose only ONE option.

1	AOD specialist service (including needle exchange)	01
2	Community health centre	02
3	Hospital	03
4	Pharmacy - community or hospital?	04
5	Accident and emergency service	05
6	Mental health - community or hospital?	06
7	Youth agency	07
8	Other health agency	08
9	Private practice	09
10	Social or welfare agency	10
11	Aboriginal Community Controlled Organisation	11
12	Juvenile justice	12
13	Corrections	13
14	Policing agency	14
15	Primary or secondary school	15
16	University	16
17	Other *(please specify)*.....	17

2. In which state or territory do you currently work?.....

3. Is the organisation you work for:

1	Government	01
2	Non-government	02
3	Private	03
4	Other *(please specify)*.....	04

4. Please indicate in which of the following geographic locations your workplace is situated. Please circle more than one option if your workplace has multiple sites in different geographic locations.

1	Major urban area (population between 100 000 – 1 million or more)	01
2	Other urban or country area (population between 1000 – 99 999)	02
3	Small country or rural area (population between 200 – 999)	03
4	Rural/remote area (population less than 200)	04

YOUR CURRENT POSITION AND OTHER DETAILS

5. What is your age in years?

   Years .....

6. What is your gender?

1	Male	01
2	Female	02

7. Which of the following best describes your current position in the workplace?

1	Director of organisation	01
2	Manager of department or unit	02
3	Team leader	03
4	Team member	04
5	Staff member (work in organisation, but not as part of a team)	05
6	Independent staff (work solo, e.g., rural worker, GP practice)	06
7	Self-employed	07
8	Other *(please specify)*.....	08

8. How long have you been working for this organisation? Please be as accurate as possible.

   Years ..... Months .....

9. In the context of your entire professional working life, how much experience do you have responding to alcohol and other drug related issues?

   Years ..... Months .....

10. Approximately what percentage of your time do you currently spend responding to alcohol and other drug related issues?

1	1-20%	01
2	21-40%	02
3	41-60%	03
4	61-80%	04
5	81-100%	05

11. What is your occupation? (e.g., youth worker, nurse, police officer, GP, drug counsellor, care worker, psychologist)

    My occupation is:

    .....

12. Please circle your PRINCIPAL AREAS OF PRACTICE.
    You can circle up to TWO areas of practice.

1	Administration	01
2	Service management and/or program and service development	02
3	Workforce development (e.g., staff development, training, policy)	03
4	Direct health treatment & intervention in primary health care settings (e.g., medicine, general practice, emergency response)	04
5	Direct health treatment & intervention in allied health services (e.g., AOD treatment agencies, pharmacy, psychology, mental health)	05
6	Social/welfare related work (e.g., community development/work, social work, advocacy, housing, child protection)	06
7	Health promotion/prevention work	07

TYPE OF ORGANISATION *(continued)*

12. *(continued)*

8	Education	08
9	Law enforcement, Policing or Correctional work	09
10	Other *(please specify)*	10

13. From the list of activities, what are your THREE main roles when responding to alcohol and other drug related issues in your workplace? Circle up to three activities:

1	Referral	01
2	Screening	02
3	Assessment	03
4	Education and/or information provision	04
5	Early/brief intervention	05
6	Crisis management	06
7	Emergency aid/services	07
8	Primary or allied health care service delivery	08
9	Medicine/general practice	09
10	Client care/support activities	10
11	Counselling/therapy	11
12	Case management	12
13	Health promotion/prevention	13
14	Community development and/or welfare activities	14
15	Medication prescribing	15
16	Medication dispensing	16
17	Withdrawal management	17
18	Administration	18
19	Service/program management	19
20	Workforce development (including staff support, training, policy)	20
21	Safety	21
22	Law enforcement/Policing (including diversion activities)	22
23	Other *(please specify)*	23

PREVIOUS AND CURRENT EDUCATION AND TRAINING

14. In the first column, please indicate THE HIGHEST formal qualifications you have COMPLETED in full.

    In the second column, please indicate if you are CURRENTLY ENROLLED in any formal education.

		COMPLETED	CURRENTLY ENROLLED
	SECONDARY EDUCATION		
1	Some secondary school – completed years 8 or 9	01	01
2	Secondary school – completed 10	02	02
3	Secondary school – completed 11	03	03
4	Secondary school – completed 12	04	04
	CERTIFICATE LEVEL		
5	Certificate I or II	05	05
6	Certificate III or IV	06	06
	ADVANCED DIPLOMA & DIPLOMA LEVEL		
7	Diploma Level	07	07
8	Advanced Diploma & Associate Degree Level	08	08
	BACHELOR DEGREE LEVEL		
9	Undergraduate degree (e.g., B.A, B.Sc)	09	09
10	Honours degree	10	10
	GRADUATE DIPLOMA & GRADUATE CERTIFICATE LEVEL		
11	Graduate Certificate	11	11
12	Graduate Diploma	12	12
	POSTGRADUATE DEGREE LEVEL		
13	Master Degree	13	13
14	Doctoral Degree	14	14
	OTHER EDUCATION		
15	Non-award courses *(please specify)*	15	15

QUALIFICATIONS IN RELATION TO ALCOHOL AND OTHER DRUGS

15. Have you undertaken or enrolled in any education or training where **alcohol and other drugs** are a PRIMARY FOCUS or a SUBSTANTIAL COMPONENT of the course?

YES → Go to Q.16

NO → Go to Q.17

16. In the first column, please indicate ALL qualifications you have COMPLETED where **alcohol and other drugs** were the primary focus or a substantial component of the course.

In the second column, please indicate if you are CURRENTLY ENROLLED in any education or training where **alcohol and other drugs** is a primary focus or a substantial component of the course.

		COMPLETED	CURRENTLY ENROLLED
1	Non-accredited training courses (including in-service)	01	01
2	Accredited short courses	02	02
3	Certificate II in Community Services (AOD work)	03	03
4	Certificate III in Community Services (AOD work)	04	04
5	Certificate IV in Community Services (AOD work)	05	05
6	Aboriginal Primary Health Care Certificate	06	06
7	Diploma of Community Services (AOD work)	07	07
8	Advanced Diploma of Community Services (AOD work)	08	08
9	Undergraduate degree	09	09
10	Honours degree	10	10
11	Diploma	11	11
12	Advanced Diploma	12	12
13	Graduate Certificate	13	13
14	Graduate Diploma	14	14
15	Masters	15	15
16	PhD/Doctorate	16	16
17	Other *(please specify)*	17	17

17. HAVE you received **ANY** form of **education and training covering alcohol and other drug related issues?** This can include all options listed in question 16, as well as an alcohol and other drug related subject/coursework within a more general course, in-service training, etc.

YES → Go to Q.18

NO → Go to end of questionnaire

18. Has the education and training you have received been useful in assisting you respond to alcohol and other drug related issues in your work?

YES → Go to Q.19

NO → Go to question 20 below

19. Of the education and training you have received, please RANK UP TO THREE of the MOST useful in terms of assisting you to respond to alcohol and other drug related issues in your current work.
(*please put a 1 next to the education or training that was most useful, a 2 next to that which was next useful and so on*).

		Rank 1st, 2nd & 3rd most useful
1	Alcohol and other drug related content or subject in a general course	_____
2	Non-accredited training courses (including in-service)	_____
3	Professionally endorsed qualification (eg., Hospital-based nursing, police training)	_____
4	Accredited short courses or accredited in-service	_____
5	Certificate II in Community Services (AOD work)	_____
6	Certificate III in Community Services (AOD work)	_____
7	Certificate IV in Community Services (AOD work)	_____
8	Diploma of Community Services (TAFE)	_____
9	Advanced diploma of Community Services (TAFE)	_____
10	Aboriginal Primary Health Care Certificate (TAFE)	_____
11	Undergraduate degree	_____
12	Honours degree	_____
13	Diploma (University)	_____
14	Advanced diploma (University)	_____
15	Graduate certificate	_____
16	Graduate diploma	_____
17	Masters	_____
18	PhD/Doctorate	_____
19	Other (please specify).....	_____

PREVIOUS EXPERIENCES WITH AOD EDUCATION & TRAINING: IMPACT ON WORK PRACTICES

Please circle the number which best describes your level of agreement with the following statements:

		Disagree	Tend to disagree	Tend to Agree	Agree
20.	Overall, the alcohol and other drug related education and training I have received helped me to improve my responses to alcohol and other drug related issues in my work.	**1**	**2**	**3**	**4**
21.	The alcohol and other drug education and training related directly to my work.	**1**	**2**	**3**	**4**
22.	The education and training provided me with the necessary knowledge and skills to respond to people with alcohol and other drug related issues.	**1**	**2**	**3**	**4**
23.	I need more education and training to increase my ability to respond appropriately to alcohol and other drug related issues.	**1**	**2**	**3**	**4**

Thank you for completing this questionnaire

Australian Government

Department of Health and Ageing