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Australia's National Research Centre on AOD Workforce Development

Satisfaction, Stress & Retention

Among Alcohol & Other Drug Workers in Australia

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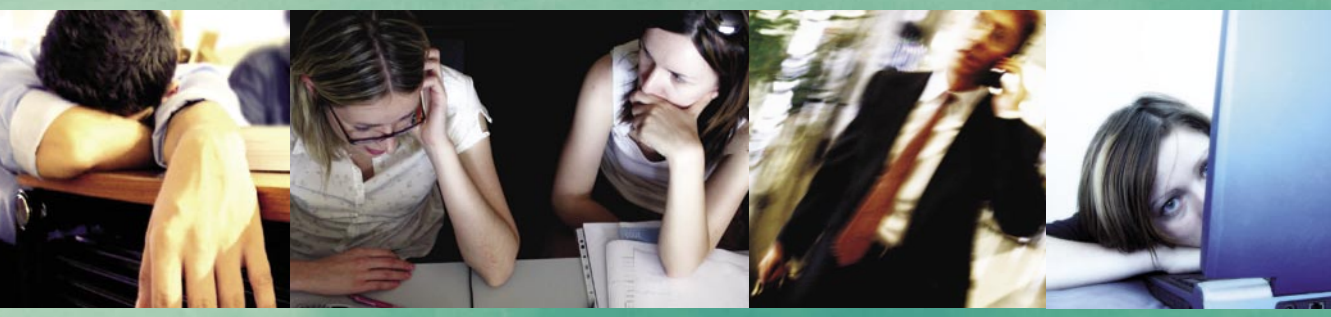

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This publication is part of a suite of resources addressing work stress and retention issues in the AOD field. Other publications in this series include:

Skinner, N. & Roche, A.M. (2005) Stress and Burnout: A Prevention Handbook for the Alcohol and Other Drugs Workforce. A workforce development resource. Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

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About NCETA

The National Centre for Education and Training on Addiction (NCETA) is an internationally recognised research centre that works as a catalyst for change in the alcohol and other drugs (AOD) field. The promotion of Workforce Development (WFD) principles, research and evaluation of effective practices is NCETA's core business.

Established in 1992, NCETA is a collaborative venture between Flinders University and the South Australian Department of Health. Since 1999 NCETA has been funded by the Australian Government Department of Health and Ageing through the National Drug Strategy. NCETA is located within the School of Medicine at Flinders University in South Australia.

NCETA's mission is to advance the capacity of health and human services organisations and workers to respond to alcohol- and drug-related problems.

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EXECUTIVE SUMMARY

This report presents key findings from a national survey of frontline Alcohol and Other Drug (AOD) workers from treatment services across Australia. The study was undertaken by the National Centre for Education and Training on Addiction (NCETA) in 2005, and is the first study of its kind in Australia. Further results from this study are also reported elsewhere (see Duraisingam, Pidd, & Roche, in press).

The primary aim of the study was to examine crucial work factors that were likely to impact on the broader workforce development issue of retention within the AOD field. In particular, the focus was on factors associated with work stress, job satisfaction, and turnover intention. In addition, specific attention was also directed to workers with predominantly alcohol-related workloads, and treatment agencies that provided services for Indigenous clients.

Data collection

- The 2001 Clients of Treatment Service Agencies (COTSA) database was used as the sampling frame for the study.
- A total of 3,524 surveys (estimated to be the total number of AOD workers employed at participating agencies) were sent out to 369 eligible agencies and 1,412 surveys were returned.
- The overall response rate was 38%, constituting 1,345 valid surveys that were used in the final analyses.

Respondent characteristics

The following table lists the main demographics of the AOD workers who participated in the study. The majority of workers in the study were:

- generalist AOD workers (40%) and nurses (31%)
- permanent (76%) and full-time (70%)
- tertiary-qualified (89%)
- trained in AOD-specific non-accredited and accredited short courses.

Table 1: Demographics of AOD workers in the study

Demographics	
Gender	
Female	66%
Male	34%
Age	
Mean	43 years
Range	20-73 years
≥ 45 years	48%
Length of service in current workplace	
Median	3.5 years
Range	<1-40 years
Length of service in AOD field	
Median	5 years
Range	<1-40 years
Organisational sector	
Government	50%
Non-government	42%
Private	7%
Location	
Urban	62%
Regional	17%
Rural & remote	18%

Key work factors

Role overload:

- Nearly a third of workers reported excessive workloads.
- Female workers reported more role overload than male workers. More female workers (24%) reported unfair workloads, compared to male workers (13%).
- Staff shortages were a major problem causing work-related pressure.

Client-related pressure:

- Half the workers reported high levels of pressure when dealing with violent and aggressive clients.
- Medical staff indicated higher levels of client-related pressure, compared to other workers.

Job autonomy:

- 70% of workers indicated that they had freedom to make decisions about their job roles and responsibilities.
- Casual workers reported less decision-making latitude than contract workers.
- A larger proportion of rural workers reported higher job autonomy compared to urban workers.

Workplace social support:

- Overall, 71% of workers reported high levels of supervisor support.
- On average, 80% of workers reported that co-workers were supportive, helpful and competent in their work.
- Supervisors from non-government agencies were reported to be more supportive, compared to those from government agencies.

Professional development opportunities:

- Over half (57%) the workers reported that their organisation provided and / or allowed access to professional development opportunities.
- 54% of workers indicated that there was no provision for back-up staff to enable workers to attend training. Nearly 70% of workers in rural areas, compared to 51% of urban workers, reported that back-up staff were not provided by their organisation.
- Generalist AOD workers reported more opportunities for professional development than doctors.

Pay satisfaction / equity:

- Nearly half (49%) the workers expressed dissatisfaction with pay.
- More than a third of workers considered their pay unfair compared to their co-workers' pay.
- 31% of workers agreed their pay was unfair compared to what other AOD organisations paid.
- Non-government workers were less satisfied with their pay compared to government workers.

Work stress

- Nearly one in five workers reported above average levels of stress.
- Predictors of high work stress were role overload (21%), low job autonomy (6%), high client-related pressure (4%), low workplace social support (3%), and low professional development opportunities (1%).
- High work stress was strongly associated with low levels of job satisfaction.

Job satisfaction

- 78% of workers reported high levels of job satisfaction.
- The most satisfying aspects of AOD work were derived from altruistic factors such as client outcomes, one-to-one client interactions and doing work that was of value to society.
- Predictors of high job satisfaction were high job autonomy (13%), high workplace social support (6%), more opportunities for professional development (2%), and low levels of client-related pressure (2%).
- Older workers, and non-government agency workers reported higher job satisfaction.
- Workers with TAFE qualifications reported higher satisfaction compared to those with university qualifications.

Retention and turnover intention

- 54% of workers have thought about leaving their job.
- 31% of workers planned to look for a new job over the next 12 months.
- 19% of workers intended to look for a new job outside the AOD field.
- Younger workers and those with fewer years of service in their current workplace had higher intentions to quit.
- TAFE-qualified workers had lower turnover intentions compared to those with university qualifications.
- Predictors of high turnover intention were low job satisfaction (27%), high stress (4%), low workplace social support (1%), and dissatisfaction / inequity with pay (1%).

- The top retention strategies endorsed by workers were better pay, more recognition or appreciation of effort, more career and training opportunities, and more support in the workplace.
- The barriers to working in the AOD field most frequently identified by workers were low salary and / or poor benefits, perceptions of difficult clients, and the stigma and lack of respect associated with the field.

Alcohol-related workloads

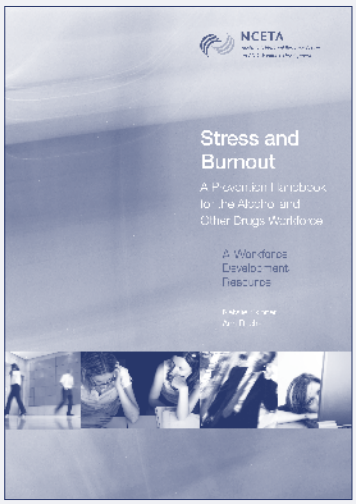
- Overall, 35% of workers mainly dealt with clients whose predominant issue was alcohol-related.
- In remote areas, 76% of workers reported having primarily alcohol-related workloads.
- A larger proportion of non-government agency workers reported high alcohol-related workloads, compared to government agency workers.
- Only 5% of workers reported high levels of pressure when dealing with clients with alcohol-related problems.
- High alcohol-related workload was significantly correlated with high levels of job satisfaction and low levels of turnover intention.

Provision of AOD services for Indigenous clients

- The majority of workers (n=1,230) who completed this section stated that their agency provided services to Indigenous clients.
- 53% of workers reported a strong need for services for Indigenous people in their area and 64% stated that this need was only partially met while 13% stated that this need was fully met.
- 51% of workers indicated that they were “somewhat” culturally competent and a further 33% felt that they were culturally competent to deal with Indigenous issues.
- A lack of access to appropriate Indigenous-specific resources was reported by 62% of workers.
- Those that did not feel culturally competent and those who did not have access to Indigenous-specific resources reported significantly lower levels of job satisfaction compared to those who felt culturally competent and who had access to relevant resources.

Workforce development recommendations

- Individual and organisational strategies to reduce or alleviate work stress are needed for a substantial proportion of the AOD workforce. Such strategies need to focus on building the capacity of workers to cope with stress, manage heavy workloads, and deal with violent / aggressive clients and complex client presentations.
- Most workers are intrinsically motivated to stay in the AOD field and derived satisfaction from contributing to successful individual (client) and societal outcomes. However, to maintain these levels of job satisfaction workers need to have substantial decision-making latitude in their work role and responsibilities.
- Factors associated with high levels of work stress, low levels of job satisfaction, and strong turnover intentions were role overload, lack of workplace social support, high levels of client-related pressure, lack of professional development opportunities, and pay dissatisfaction and inequity. Strategies designed to reduce levels of work stress and increase retention need to focus on these factors.



For more information on effective strategies to reduce work stress and improve the well-being of AOD workers, please refer to:

Skinner, N. & Roche, A.M. (2005) ***Stress and Burnout: A prevention handbook for the alcohol and other drugs workforce. A workforce development resource.*** Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Available at: www.nceta.flinders.edu.au or e-mail nceta@flinders.edu.au for a free copy.

INTRODUCTION

In 2005, the National Centre for Education and Training on Addiction (NCETA) conducted a survey of frontline workers employed in specialist drug and alcohol treatment service agencies across Australia. The aim of the study was to examine crucial organisational and job factors that are most likely to impact upon outcomes relating to the broader workforce development issues of well-being and retention within the Alcohol and Other Drug (AOD) field. The background, rationale, methodology, results and implications of the project are presented here.

Background

Current context

Alcohol is the principal drug of concern for which treatment is sought in Australia (Commonwealth of Australia, 2004). There is also evidence that the complexity and scope of alcohol-related problems are increasing and patterns of use are undergoing significant change. However, the capacity of many treatment services may not be sufficient to manage the increasingly complex changes of alcohol- and other drug-related issues (Alcohol and Other Drugs Council of Australia (ADCA), 2003; Roche, O'Neill, & Wolinksi, 2004; Stockwell, Heale, Dietze, Chikritzhs, & Catalano, 2001).

Continuous improvement in service quality, efficiency and effectiveness, and the capacity of services to respond to change, depends on the ability to attract, support and retain a diverse and skilled workforce (Libretto, Weil, Nemes, Linder, & Johansson, 2004). However, the national and international perspective is that the AOD field faces significant difficulties in recruiting and retaining qualified staff to keep pace with the increasing demand for treatment services (Ask et al., 1998; Commonwealth of Australia, 2004; Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003; McLellan, Carise, & Kleber, 2003; Ogborne & Graves, 2005; Pitts, 2001; Roche, O'Neill, & Wolinksi, 2004; Schubert, Pond, Kraft, & Aguirre-Molina, 2004; Victorian Alcohol & Drug Association (VAADA), 2003; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003).

Continuous improvement in service quality & capacity to respond to change depends on the ability to attract, support & retain a diverse & skilled workforce

Impetus

NCETA previously undertook a study of 234 managers of AOD specialist treatment agencies to examine the provision of specialist alcohol services and associated workforce development issues faced by the AOD sector (Roche, O'Neill, & Wolinksi, 2004; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003). In addition to reporting a predominance of clients with alcohol-related problems, managers also indicated difficulties in recruiting and retaining workers. The lack of qualified staff, poor remuneration, inadequate funding and heavy workloads were identified as key issues facing the field. These findings raised important questions regarding the availability of trained AOD frontline workers and the ability of services to effectively manage alcohol problems, as well as other drug problems, in the future.

Key factors

While adequate remuneration and funding levels are important issues for recruitment and retention, two other factors consistently linked with staff turnover in the wider organisational research literature are lack of job satisfaction and work stress (Barak, Nissly, & Levin, 2001; Cotton & Tuttle, 1986; Griffeth, Hom, & Gaertner, 2000; Hom & Griffeth, 1995; Landau & Abelson, 1994; Tett & Meyer, 1993).

Job satisfaction is a particularly salient issue for the AOD field. Maintaining levels of job satisfaction has been shown to relate to higher standards of performance and worker retention (Judge, Thoresen, Bono, & Patton, 2001; Tett & Meyer, 1993). Research from the U.K., Canada, and the U.S. has found that AOD specialists report relatively high levels of job satisfaction (Evans & Hohenshil, 1997; Farmer, Clancy, Oyefeso, & Rassool, 2002; Ogborne & Graves, 2005). The most common sources of job satisfaction identified by AOD treatment staff are personal growth, interactions with clients, collegial co-worker relationships and a commitment to treatment (Gallon, Gabriel, & Knudsen, 2003). In contrast, factors such as workload, paperwork and other "bureaucratic issues" have been identified by AOD workers as a significant source of dissatisfaction (Ogborne & Graves, 2005).

Work stress & job dissatisfaction have been consistently linked to staff turnover

Health and human services workers often experience high levels of work-related demands and are therefore particularly at risk of stress and burnout (Dollard, Winefield, & Winefield, 2003; Dollard, Winefield, & Winefield, 2001; Dollard, Winefield, Winefield, & De Jonge, 2000). Stress is experienced when individuals perceive they are unable to cope with the demands placed upon them (Farmer, Clancy, Oyefeso, & Rassool, 2002). A related

concept is burnout which is essentially the experience of chronic stress over a long-term period (Maslach, Schaufeli, & Leiter, 2001).

The difficulties and challenges of AOD-related work that contribute to stress are also likely to result in low job satisfaction. The relationship between work stress and job satisfaction is interconnected (Cordes & Dougherty, 1993; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998) and many of the same organisational factors influence both work-related stress and job satisfaction.

Rationale

A national workplace study was undertaken to address the lack of Australian research concerning factors that impact on retention of the AOD workforce. The aim of this survey was to examine the relationship between workplace factors and outcomes such as job satisfaction, stress and turnover. It was envisaged that the key findings from this study would identify relationships between key work factors and outcomes associated with retention. Such findings would allow strategies to be developed that could facilitate retention, minimise turnover and stress, and increase job satisfaction among AOD frontline workers. These strategies could be further used to develop new and / or improve current workforce development policies and processes in the AOD field.

Therefore, the current study was designed to investigate key questions regarding retention of AOD workers that have been neglected in previous research, including:

- What factors contribute to turnover intention in the AOD field?
- What factors contribute to AOD workers' job satisfaction in their work?
- What factors contribute to AOD workers' stress in the workplace?
- What role does job satisfaction and stress play in AOD workers' retention and turnover?
- Are there significant demographic differences (e.g., gender, age, occupation, qualifications, sector, geographical location, and work patterns) in relation to key workforce development issues?

Given the increasing complexity and scope of alcohol-related problems, care was taken to incorporate a particular focus on frontline workers who respond to problematic alcohol use within specialist treatment services. In the formative stages of this project, the funders requested that the survey also assess issues relevant to working with Indigenous clients.

Design

This project involved two distinct components:

i. A comprehensive literature review, and

ii. A national survey of frontline workers in specialist alcohol and drug treatment agencies.

LITERATURE REVIEW

Overview

The purpose of this review is to examine the existing literature related to job satisfaction, stress and the retention of alcohol and other drug (AOD) workers, and to identify directions for future research. Literature was sourced from Australian and international research databases including CINAHL, MEDLINE, Health Source, ERIC, PsycInfo, PsycArticles, Social Sciences Citation Index, APAIS, Current Contents, and Drugs. In addition, 'grey' literature such as reports and conference proceedings were actively sought. Bibliographies of relevant documents were also searched for additional literature. The search was restricted to English language texts and to the last decade, although earlier published research was included when consistently cited in later work.

The review is presented in two parts:

i. an overview of workforce development issues relevant to the AOD workforce and alcohol treatment services in particular, and
ii. existing research evidence regarding the factors that contribute to job satisfaction, stress, retention and turnover of AOD workers.

Workforce development issues in the AOD sector

There is a pressing need to address the issue of workforce development in the AOD sector. Changing patterns of alcohol and other drug use, co-morbidity issues, increasing levels of service demand, an increasing AOD knowledge base, and changes in intervention and treatment protocols have led to growing concern about the capacity of treatment services to respond effectively to AOD issues.

The adequacy of service provision for alcohol-related problems in particular, is also a matter of increasing concern. Alcohol is the most common drug of concern for which treatment is sought (Commonwealth of Australia, 2004). There is also evidence that the complexity and scope of alcohol-related problems are increasing and patterns of use are undergoing significant change. However, the capacity of many treatment services may not be sufficient to manage these changes (Alcohol and Other Drugs Council of Australia (ADCA), 2003; Roche, O'Neill, & Wolinksi, 2004; Stockwell, Heale, Dietze, Chikritzhs, & Catalano, 2001).

A key factor for continuous improvement in service quality, efficiency and effectiveness, and the capacity of services to respond to change, is the ability to attract, support and retain a diverse workforce that has the required knowledge, skills, and abilities (Libretto, Weil, Nemes, Linder, & Johansson, 2004). However, there is widespread concern (both nationally and internationally), that the AOD field faces significant difficulties in recruiting and retaining qualified staff to keep pace with the increasing demand for treatment services (Ask et al., 1998; Commonwealth of Australia, 2004; Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003; Malcolm, 2001; McLellan, Carise, & Kleber, 2003; Ogborne & Graves, 2005; Pitts, 2001; Schubert, Pond, Kraft, & Aguirre-Molina, 2004; Victorian Alcohol & Drug Association (VAADA), 2003; Wolinski, O'Neill, Roche, Freeman, & Donald, 2003).

A number of issues can contribute to difficulties in recruiting and retaining workers in AOD organisations including (Australian and Other Drugs Council of Australia (ADCA), 2003; Ogborne & Graves, 2005; Pitts, 2001; Roche, 2001, 2002a; Wolinksi, O'Neill, Roche, Freeman, & Donald, 2003):

i. inadequate salary packages
ii. lack of resources (including funds)
iii. lack of professional development opportunities
iv. limited scope for advancement and promotion
v. lack of job security
vi. remoteness of services
vii. stigma attached to working in the AOD field.

Despite the widespread experience of recruitment and retention challenges in the AOD sector, existing research on workforce development issues has tended to have a narrow focus. Broader workforce development issues have been largely neglected (Gallon, Gabriel, & Knudsen, 2003).

This study was designed to address key questions regarding turnover and retention of AOD workers that have been neglected in previous research, including:

- What factors contribute to turnover in the AOD field?
- What role do rewards play in staff retention and turnover?
- What factors contribute to AOD workers' job satisfaction in their work?
- What factors contribute to AOD workers' stress in the workplace?
- What roles do job satisfaction and stress play in AOD workers' retention and turnover?

There is widespread concern that the AOD field faces significant recruitment & retention difficulties which could affect its capacity to manage increasing service demand & complexity of AOD-related problems

WHO CONSTITUTES THE AOD WORKFORCE?

A variety of professions are involved in responding to AOD issues and in general the AOD workforce can be classified as either generalist or specialist workers (Ask et al., 1998). A generalist worker may be required to respond to alcohol-related problems on occasion, but does not usually work in a specific AOD setting (e.g., GPs and pharmacists). In contrast, specialist frontline workers are those whose primary role is to prevent or treat AOD-related problems, which may include problematic alcohol issues (Alcohol and Other Drugs Council of Australia (ADCA), 2003).

The current study is focused on specialist workers. These workers are likely to be more effective in providing treatment to individuals dependent on alcohol or other drugs. One advantage of specialist treatment over generalist treatment is the greater period of time available to the specialist workers to engage, counsel, and treat, the client's alcohol- or drug-related problems (Ask et al., 1998). Further, recent treatment interventions such as the new pharmacotherapies, require specialised, technical knowledge and are thus more suited to specialist intervention (Freeman, Wolinski, O'Neill, & Roche, 2002).

Retention and turnover in the AOD field

Turnover rates in the AOD field

While anecdotal evidence suggests that high rates of staff turnover is a significant problem for many AOD organisations in Australia (Pierce & Long, 2002; Victorian Alcohol and Drug Association (VAADA), 2003) there is no concrete data which indicates the actual extent of this problem. In contrast, a number of studies conducted in the U.S. and Canada have reported a range of turnover estimates for the AOD workforce. For example, a study of AOD treatment agencies in the U.S. Pacific Northwest estimated that, on average, agencies experience a 25% turnover rate per year, with resignations being the most common reason for staff turnover (Gallon, Gabriel, & Knudsen, 2003). Similarly, a national study of U.S. drug treatment counsellors reported a turnover rate of 49% over six months (McLellan, Carise, & Kleber, 2003) while a study of Canadian AOD workers found that 30% of respondents under the age of 40 intended to leave the AOD field within the next five years (Ogborne & Graves, 2005).

Turnover can be costly. Indirect costs include loss of productivity, increase in work stress, & decrease in morale of remaining workers

Workforce development implications of high turnover

Turnover can be costly, particularly when it involves the unplanned loss of workers who leave voluntarily and whom employers would prefer to keep (Frank, Finnegan, & Taylor, 2004). In addition to the direct costs of recruiting a replacement, indirect costs of turnover include lost productivity, decreased worker morale, and increased stress (Barak, Nissly, & Levin, 2001; Frank, Finnegan, & Taylor, 2004). High turnover rates may also impact on the quality and availability of treatment services (Abrams, 2004; Barak, Nissly, & Levin, 2001; Kupperschmidt, 2002) by contributing to long waiting lists and adding to the workload of remaining workers and thereby increasing the risk of stress and burnout. It may further reinforce clients' mistrust of the system and dissuade workers from staying in or entering the field (Guerts, Schaufeli, & De Jonge, 1998).

Retention of effective workers serves a range of important purposes including ensuring (Skinner, Freeman, Shoobridge, & Roche, 2003):

- a highly skilled and effective workforce
- a return-on-investment to the organisation from formal and informal training of workers
- the development of cohesive work groups and teams
- an available pool of mentors and supervisors.

Retention is therefore necessary to reduce turnover costs and increase productivity within the organisation (Frank, Finnegan, & Taylor, 2004). In order to effectively retain workers, the factors that motivate AOD workers to remain or leave the workplace need to be identified (Barak, Nissly, & Levin, 2001).

Factors influencing retention and turnover

A range of factors may impact on a worker's decision to stay or leave an organisation, including circumstances unrelated to work (e.g., illness, spouse's new job). Surveys of AOD workers have identified a number of factors that contribute to high turnover in non-government organisations (NGOs) and other sectors including (Pierce & Long, 2002; Pitts, 2001):

- inadequate salary and remuneration
- lack of career opportunities
- poor people skills of the manager / coordinator
- difficulties of working in rural areas (e.g., isolation)

- lack of adequate funding
- difficult working environment (e.g., inadequate premises, lack of resources for infrastructure, lack of training, stigma associated with AOD issues)
- conflicting roles and responsibilities (e.g., administration and clinical).

There is also some evidence that low salary is a key factor that affects the recruitment and retention of workers in the AOD field (Gallon, Gabriel, & Knudsen, 2003; Wolinksi, O'Neill, Roche, Freeman, & Donald, 2003).

With regard to workers in the human service sector in general, a recent meta-analysis indicated that workers in this sector were likely to think about leaving their jobs if they (Barak, Nissly, & Levin, 2001):

- lacked organisational and professional commitment
- felt dissatisfied with their jobs
- experienced chronic stress but insufficient social support.

Further, workers who had alternative employment options, who were unhappy with management practices and were experiencing chronic stress, actually left their organisation (Barak, Nissly, & Levin, 2001).

A large research literature has also examined the factors that impact on retention and turnover of workers from a variety of professions. Two factors consistently linked with turnover are *job (dis)satisfaction and work stress* (Barak, Nissly, & Levin, 2001; Cotton & Tuttle, 1986; Griffeth, Hom, & Gaertner, 2000; Hom & Griffeth, 1995; Landau & Abelson, 1994; Tett & Meyer, 1993).

The following section identifies:

i. the concepts of work stress and job satisfaction
ii. relevant research from the AOD and related fields
iii. common antecedents of stress and job satisfaction.

It draws upon research with related professions in the health and human services sector, as there is very little research on AOD workers per se. There is evidence that work stress and job satisfaction are closely related. The difficulties and challenges of AOD-related work that contribute to stress are also likely to result in low job satisfaction. Indeed, research indicates that the relationship between these two job outcomes is interconnected (Cordes & Dougherty, 1993; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998). In other words, many of the same organisational factors influence both outcomes.

Job satisfaction, stress, burnout and turnover may also influence each other. According to Lonne (2003), the stress / burnout-job satisfaction-turnover issue is circular in nature (Lonne, 2003). For instance, work demands such as heavy workloads increase stress, which leads to burnout over the long term. This increases staff turnover, which subsequently causes an increase in the workloads of remaining workers. These workers become more stressed and dissatisfied, thus making them more likely to think about leaving their jobs and so on.

Job satisfaction

Job satisfaction reflects the degree of pleasure or fulfilment a person derives from their work (Spector, 2000). It is based on the perceived match between an individual's expectations or standards and the degree to which these are met in the job (McCormick & Ilgen, 1980). Maintaining good levels of job satisfaction have been shown to relate to higher standards of performance and worker retention (Judge, Thoresen, Bono, & Patton, 2001; Tett & Meyer, 1993).

Job satisfaction of AOD workers

Job satisfaction is a particularly salient issue for the AOD field. Research from the U.K., Canada and the U.S. has found that although most AOD specialists reported relatively high levels of job satisfaction (Evans & Hohenshil, 1997; Farmer, Clancy, Oyefeso, & Rassool, 2002; Ogborne & Graves, 2005), a substantial proportion reported dissatisfaction with their job (Farmer, Clancy, Oyefeso, & Rassool, 2002; Ogborne & Graves, 2005). Important sources of job satisfaction identified by AOD specialists in the U.S. include the opportunity to help people, belief in the moral worth of their work, and the ability to use their own methods of working. Lack of opportunities for career advancement has also been identified as a significant source of job dissatisfaction (Evans & Hohenshil, 1997). This includes the availability of clinical supervision (Evans & Hohenshil, 1997) and opportunities for promotion and advancement (Knudsen, Johnson, & Roman, 2003).

Maintaining good levels of job satisfaction relate to higher performance standards & worker retention

In a study of workforce development issues for AOD specialist staff in the Pacific Northwest of the U.S., Gallon et al. found that the four most common sources of job satisfaction identified by treatment staff were personal growth, interactions with clients, collegiate co-worker relationships and a commitment to treatment (Gallon, Gabriel, & Knudsen, 2003). Issues related to workload, paperwork and other "bureaucratic issues" have also been identified by AOD workers as a significant source of dissatisfaction (Ogborne & Graves, 2005).

Workforce development implications of low job satisfaction

Maintaining good levels of job satisfaction should be a high priority for the AOD field for two key reasons. Satisfied workers are more likely to:

- deliver a higher standard of performance (Judge, Thoresen, Bono, & Patton, 2001)
- stay with the organisation (i.e. less turnover) (Tett & Meyer, 1993).

Stress

Stress is experienced when individuals feel unable to cope with the demands placed upon them (Farmer, Clancy, Oyefeso, & Rassool, 2002). More specifically, work stress refers to psychological, physical and behavioural responses to work-related demands over a discrete or short-term period (Dollard, Winefield, & Winefield, 2003). A related concept is burnout which is essentially the experience of chronic stress over a long-term period, due to not being able to cope with work psychologically and emotionally (Maslach, Schaufeli, & Leiter, 2001). One of the main components of burnout is emotional exhaustion, which is essentially an indicator of work stress (Koeske & Koeske, 1989, 1993).

Stress in AOD workers

It is increasingly acknowledged that workers in the health and human services field often experience high levels of work-related demands and stressors, and are therefore particularly at risk of stress and burnout (Dollard, Winefield, & Winefield, 2003; Dollard, Winefield, & Winefield, 2001; Dollard, Winefield, Winefield, & De Jonge, 2000). Similarly, AOD workers face many significant challenges related to (Knudsen, Johnson, & Roman, 2003; Pierce & Long, 2002; Pitts, 2001; Roche, 2002b; Schubert, Pond, Kraft, & Aguirre-Molina, 2004; Skinner, Freeman, Shoobridge, & Roche, 2003):

Work stress refers to psychological, physical & behavioural responses to work demands over a discrete or short-term period

- the client population (complex circumstances, stigmatisation of drug use, reluctance to engage in treatment)
- community attitudes towards drug users (and the people who work with them)
- the need to continually develop and refresh knowledge and skills to manage changing treatments and complex client presentations (e.g., poly drug use)
- working conditions (e.g., remuneration, availability of professional development, job security, access to clinical supervision, heavy client workloads).

Anecdotal evidence suggests that stress is a significant issue for the AOD workforce and therefore identification of factors that can prevent stress is a high priority. No studies were identified that could provide an estimate of stress levels in frontline workers of AOD organisations. However, a small number of studies have examined the antecedents of stress in AOD workers.

For instance, a study conducted in New South Wales found that high levels of emotional exhaustion were associated with excessive workloads, role ambiguity (lack of clarity in daily routines, rules and policies) and daily hassles (with work, friends, family and environment) (Price & Spence, 1994). A study of Queensland AOD workers found that lower levels of emotional exhaustion were reported by workers who also reported high levels of support from co-workers, supervisors and senior management, manageable workloads, some degree of decision-making authority / control, rewards for work and fair treatment from supervisors (Pirie, 2003).

More evidence is provided by international research. For example, a study of U.S. AOD workers found that higher levels of emotional exhaustion were linked with less workplace support and lower levels of self confidence concerning work-related skills (Shoptow, Stein, & Rawson, 2000). In another study, Farmer (1995) found that the major stressors for workers in drug treatment clinics were organisational and client-related factors. High workloads, staff shortages, unsupportive work relations, poor physical work conditions and difficult patients featured as the main sources of stress for workers and more than half the workers also experienced high levels of emotional exhaustion (Farmer, 1995).

Workforce development implications of stress

There is evidence that stress has negative implications for organisations, individual workers and clients. Stress has well established links with three key job-related outcomes (Lee & Ashforth, 1996):

i. Reduced job satisfaction

ii. Lower organisational commitment

iii. Increased turnover.

A range of negative outcomes are also likely for individual workers affected by stress including (Maslach, Schaufeli, & Leiter, 2001):

- mental health problems (e.g., anxiety and depression)
- psychosomatic complaints (e.g., insomnia, gastrointestinal disturbances)
- physical health problems (e.g., cardiovascular diseases, immune suppression).

In addition, there is evidence of a link between emotional exhaustion and client outcomes (Garman, Corrigan, & Morris, 2002; Leiter, Harvie, & Frizzell, 1998). A study of mental health treatment teams in the U.S. found that teams characterised by higher levels of emotional exhaustion were associated with lower levels of client satisfaction in regard to their treatment and therapist (Garman, Corrigan, & Morris, 2002).

Predictors of job satisfaction and stress

Heavy workloads & work-related pressure are key factors in the development of work stress

Workload

Demanding workloads are common in the health and human services sector. Indeed, working long hours in high pressure environments is considered appropriate and acceptable in many areas of the workforce. However, it has been well established that a heavy workload and work-related pressures are key factors in the development of work-related stress (Dollard, Winefield, Winefield, & De Jonge, 2000; Karasek, 1979; Lee & Ashforth, 1993a, 1993b, 1996; Vagg & Spielberger, 1998). High workloads have also been linked with lower job satisfaction (Brown & Mitchell, 1993; Ellickson & Logsdon, 2002; Muchinsky, 1993), increased anxiety and frustration, and to a lesser extent, depression and intention to quit (Beehr, Jex, Stacy, & Murray, 2000; Spector & Jex, 1998).

Job autonomy

The opportunity to exert some degree of control over one's work has been identified as a key factor in the prevention of stress and burnout (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Dollard, Winefield, Winefield, & De Jonge, 2000; Lee & Ashforth, 1996; Warr, 1994), as well as the enhancement of job satisfaction (Hackman & Oldham, 1976; Jackson & Schuler, 1985). There is some evidence that AOD workers place a high degree of value on autonomy and control over their work, particularly in regard to input into treatment approaches and decisions (Gallon, Gabriel, & Knudsen, 2003; Knudsen, Johnson, & Roman, 2003). In addition, there is evidence that increased autonomy is also associated with effective job performance, decreased anxiety and depression and other health complaints (Sparks, Faragher, & Cooper, 2001).

Adequacy and fairness of rewards and remuneration

Perceived inadequate remuneration or rewards has been identified as a contributor to burnout, job dissatisfaction (Brown & Mitchell, 1993; Ellickson & Logsdon, 2002), poor performance, turnover and absenteeism (Brewer & Skinner, 2003). However, it is often difficult for AOD organisations to provide tangible, material rewards to workers due to limited funding. Non-financial rewards such as positive feedback and recognition, opportunities to work in preferred roles (e.g., "temporary promotions") and opportunities to attend conferences / workshops have also been shown to be highly valued by many workers. For instance, Gallon et al. found that the most satisfying / rewarding aspects

of work identified by clinical staff employed in substance abuse treatment agencies were of a more personal and human nature (i.e. personal growth, relationship with co-workers, and interactions with clients) (Gallon, Gabriel, & Knudsen, 2003). Similarly, Knudsen and colleagues found that AOD treatment counsellors who perceived their organisation to be rewarding and supportive were more likely to be committed to the organisation and less likely to consider leaving (Knudsen, Johnson, & Roman, 2003).

Consistent with these findings, there is evidence that burnout is linked with workers' perception of an unfair exchange of resources and investments between themselves and their employing organisation (Buunk & Schaufeli, 1993; De Jonge & Schaufeli, 1998; Schaufeli, Van Dierendonck, & Van Gorp, 1996). This relationship has been observed in a range of health professionals including medical specialists (Smets, Visser, Oort, Schaufeli, & De Haes, 2004), GPs (Bakker, Schaufeli, Sixma, Bosveld, & Van Dierendonck, 2000), and nurses (Schaufeli, Van Dierendonck, & Van Gorp, 1996).

Availability of social support

Social support from supervisors and co-workers has been identified as a key factor in the prevention or alleviation of stress and burnout (Demerouti, Bakker, De Jonge, Janssen, & Schaufeli, 2001; Kalliath & Beck, 2001; Lee & Ashforth, 1996; Schaufeli & Bakker, 2004). Providing support is suggested to enhance coping capacity, reduce the severity of stress and buffer the impact of work demands on well-being (Cohen & Wills, 1985; Viswesvaran, Sanchez, & Fisher, 1999). Research has indicated that a lack of support, particularly from supervisors, reduces workers' ability to cope with challenging jobs and increases the risk of workers leaving (Barak, Nissly, & Levin, 2001).

A consistent finding across a wide range of occupations is that job satisfaction is positively associated with perceived support from supervisors and co-workers (Baruch-Feldman, Brondolo, Ben-Dayan, & Schwartz, 2002; Dollard & Winefield, 1998; Dollard, Winefield, Winefield, & De Jonge, 2000). There is some evidence that support from direct supervisors, rather than people further removed in the organisational hierarchy, is more strongly related to job satisfaction (Baruch-Feldman, Brondolo, Ben-Dayan, & Schwartz, 2002).

Clinical supervision

Clinical supervision can be described as a "working alliance" between practitioners that focuses on enhancing the clinical effectiveness of the "supervisee" (Ask & Roche, 2004; Hart, 1982; Kavanagh, Spence, Wilson, & Crow, 2002; Shanley, 1992). The need for support and encouragement from a more experienced worker can be particularly important for workers in the AOD field given the challenging nature

of some of the ethical and clinical issues that can be experienced on a day-to-day basis. Clinical supervision can address a number of recognised contributors to stress and burnout. Kadushin (2002) argues that supportive supervision can provide psychological and interpersonal resources that equip workers to cope with work-related stresses while at the same time channelling the emotional energy required for effective job performance (Kadushin, 2002). Research suggests that the quality of clinical supervision is also related to levels of stress and burnout as well as job satisfaction (Hyrkas, 2005).

Adequacy and availability of professional development

Lack of career opportunities is an important issue for the AOD field and have been identified as a significant source of job dissatisfaction for AOD workers (Evans & Hohenshil, 1997; Knudsen, Johnson, & Roman, 2003). Opportunities for professional development is also suggested to aid in the prevention of burnout (Bakker, Demerouti, & Verbeke, 2004) and increase organisational commitment (Benson, 2003; Lee & Bruvold, 2003).

It is important to note that these factors are essentially organisational and job characteristics, and not worker characteristics. This means that employers and policy-makers have the power to improve these conditions and thereby reduce stress and turnover in the AOD field.

Employers & policy-makers have the power to improve organisational & job characteristics that affect worker well-being & turnover

Conclusion

Working in the alcohol and other drugs field is not without substantial challenges. It involves dealing with a host of issues beyond the complexity of addiction. It includes managing the systemic obstacles that surround the industry and the diverse nature of the professions involved, whilst not always having the optimum resources to deliver comprehensive treatment services. Given this context, research into elements of the broader framework of workforce development, such as recruitment and retention of AOD workers, is essential.

METHODOLOGY

Project reference group

A reference group comprising 12 members[1] with varied professional expertise was established at the beginning of the project. Their role was to provide input into the development of the conceptual framework for the study, the logistics of study execution, and to inform the development of the survey instrument.

Survey instrument

A purpose-designed survey instrument[2] was developed to examine issues pertinent to job satisfaction, stress, and the retention of AOD frontline workers. Specifically, it identified:

- attitudes towards clients with various presentations,
- perceptions of barriers to entering the AOD field,
- perceptions of strategies to promote retention,
- current levels of job satisfaction and stress,
- perceptions of intentions to leave the job and / or AOD field,
- perceptions of work factors that may inhibit or promote job satisfaction, stress and turnover intention,
- perceptions of demand and adequacy of AOD services, resources and training for Indigenous clients, and
- demographic information including age, gender, location, occupation, work patterns, sector, highest qualifications, length of service in current organisation and AOD field.

These measures were obtained from well-established and validated scales that have been widely used in previous research.[3]

Figure 1 below outlines the proposed relationships between the work factors and outcomes which were measured in the survey. These work factors and outcomes were identified in previous research as key influences on job satisfaction, stress and turnover intention.

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[1] A list of reference group members is provided in the Acknowledgements section of this report.

[2] The survey instrument is included in the Appendix.

[3] Most scales used in this research proved to have high reliability and coherent factor structures. Detailed descriptions and explanations of the instrument's properties are available on request.

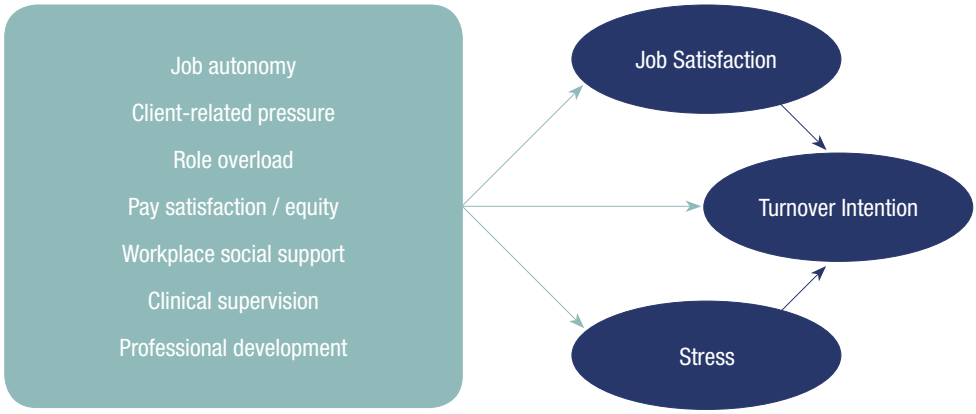


Figure 1: The relationships between work factors and job satisfaction, stress and turnover intention

A draft of the survey was produced and trialled with a focus group of local frontline AOD workers. Participants in the focus group were asked to comment on aspects of the survey including content, format, language and clarity of instructions. This feedback was utilised to refine the survey.

Sampling frame

The contact details of specialist alcohol and other drug treatment services included in the study were sourced from the 2001 version of the Clients of Treatment Service Agencies (COTSA) database (Shand & Mattick, 2001). A drug and alcohol treatment service is defined as an agency that provides one or more face-to-face specialist treatment services to people with alcohol and / or other drug problems (Torres, Mattick, Chen, & Baillie, 1995). It includes a variety of outpatient treatment services, inpatient rehabilitation programs, detoxification, therapeutic communities, methadone maintenance plus an additional service, and smoking cessation programs. However, this definition excludes self-help groups, sobering-up centres, and services that only provide information, education, accommodation, brief counselling and crisis interventions (Shand & Mattick, 2001). The sample consisted of government, non-government, and private specialist AOD treatment services from various locations throughout the country.

Ethics approval

Ethics approval for the project was obtained in March 2005 from Flinders University's Social and Behavioural Research Ethics Committee.

Pilot study

Before commencing the main study, a pilot study was undertaken to test the appropriateness of the survey and to trial the proposed methodology. The survey was distributed to a sample of 90 frontline workers employed at 10 agencies listed on the COTSA database. Participants were asked to complete the survey and to comment on the content and format. A total of 31 pilot surveys were returned (i.e. 34% response rate) and feedback from the pilot study was used to further refine the questionnaire.

Survey implementation

For the main study, managers of agencies listed on the COTSA database were contacted via telephone, or by e-mail if they could not be reached by telephone. Managers were informed of the study and its importance. Their assistance was sought in distributing the surveys to frontline workers in their agency. Managers were assured of confidentiality and anonymity of the survey. Once managers agreed to assist, they were asked to confirm their name, contact details, and the number of frontline workers they managed, so that the appropriate number of surveys could be mailed out to their agency. If managers declined to participate, they were asked the reason(s) for declining and basic agency demographics (i.e. location, sector, and number of workers) were recorded.

Two waves of data collection were conducted. The first wave of surveys was sent out to managers with a cover letter reiterating the importance and details of the study, along with a note of appreciation for their help in the distribution of surveys to staff. A reply-paid envelope was attached to each survey.

In the second wave of data collection, reminder letters and additional copies of the survey were sent out to managers of participating agencies two weeks after the initial wave. Other recruitment strategies to increase response rates, such as advertising the study on the Alcohol and Drug Council of Australia (ADCA) e-mail update list-server and the NCETA website, were also adopted.

Data analyses

Data obtained by the survey were analysed using the Statistical Package for Social Sciences (SPSS) software. Descriptive statistics were used to summarise key responses and demographic characteristics of the sample. Multivariate statistics (stepwise regressions) were used to examine the relationship between the work factors and outcomes (i.e. job satisfaction, stress and turnover intention).

RESULTS

Sample characteristics

Attempts were made to contact all agencies listed on the COTSA database by telephone, surface mail or e-mail. Of the 532 agencies listed in the COTSA database, 30% (n=163) could not be contacted or did not participate due to the reasons listed in Table 2. A total of 46 agencies that had either closed down, were listed more than once on the COTSA database, no longer provided treatment services, or did not fit the definition of a specialist AOD treatment service, were excluded from the sample. Thus, the total number of agencies eligible to be included in the final sample was 486. Of these, a further 117 agencies that did not return calls or respond to notifications, needed further approval or ethics clearance, or were too busy to participate, accounted for 24% of the total eligible agency sample. This resulted in 76% (n=369) of eligible agencies being included in the final sampling frame.

A total of 3,524 surveys (representing the total number of AOD workers employed at participating agencies) were sent out to these 369 agencies and 1,412 surveys were returned. The final number of valid surveys used in subsequent analyses was 1,345. This represented a 38% response rate. Actual numbers of respondents reported in the results section vary due to non-responses for some survey items.

Table 2: Agency non-participation categories

Reasons for non-participation		Frequency	(%)
1.	No response*	78	48
2.	Local ethics approval required	27	16
3.	Service not appropriate**	19	12
4.	Agency rationalised / closed	12	7
5.	Staff too busy	11	7
6.	Service no longer provided	7	4
7.	Same service repeated twice on list	5	3
8.	Service temporarily not provided***	3	2
9.	Manager perceived service as not relevant	1	1
	Total	**163**	**100**

Note:

** No response to phone calls, e-mails, left messages*

*** Service did not fit COTSA criteria of a specialist AOD treatment service*

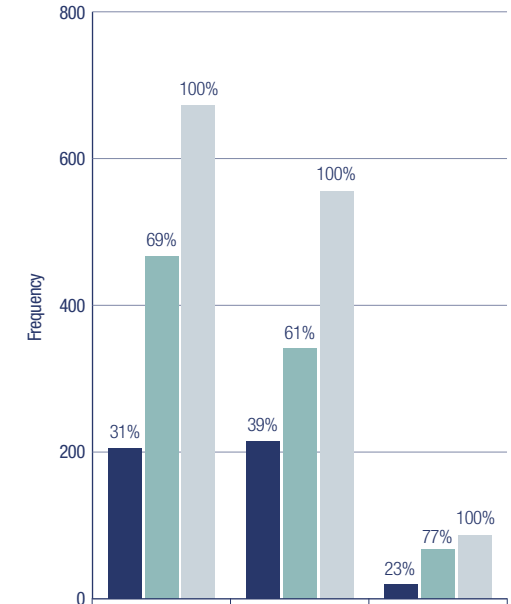
**** Service temporarily not provided due to short-term staff shortages / vacancies*

Workers' age, gender and work locations

Overall, the majority of respondents were female (66%), however, proportions of male and female workers in government, non-government, and private AOD organisations varied (see Figure 2). Similar proportions of male and female workers were employed in metropolitan and non-metropolitan agencies. In metropolitan agencies, 33% of workers were male and 67% were female. In agencies located in non-metropolitan areas, 34% of workers were male and 66% were female.

The mean age of respondents was 43 years (range 20 - 73 yrs) and the mean age of males (44 yrs) and females (42 yrs), was similar. While similar, the mean age of males was significantly higher than the mean age of females ($p < .01$).

Nearly half the respondents (48%) were aged 45 years and over. Figure 3 shows the age breakdown of respondents in the sample. There were no significant age differences for organisational type (government, non-government, private) or employment location (metropolitan vs rural).



	Government	Non-government	Private
Male	205	215	20
Female	467	341	67
Total	672	556	87

Figure 2: Proportion of male and female AOD workers across sectors (n=1,332)

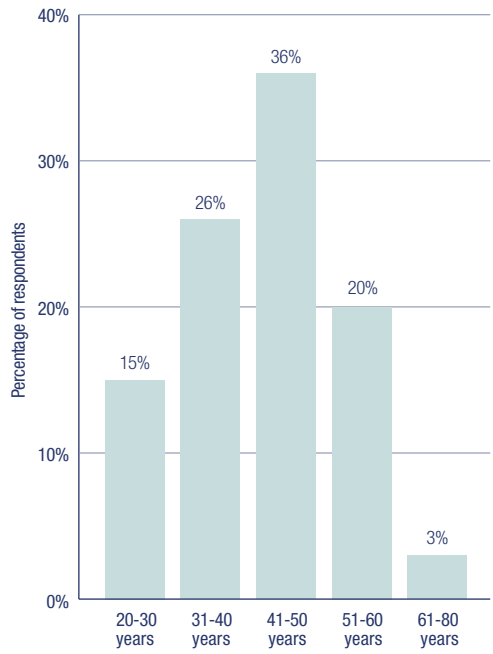


Figure 3: Proportion of AOD workers by age group (n=1,313)

Length of service

The median[4] length of service in the AOD field was 5 years (range <1-40 yrs). The median length of service in respondents' current work organisation was 3.5 years (range <1-40 yrs). More than half the respondents (56%) had been working in the AOD field for 5 years or less, and nearly three quarters (73%) had been working in their current organisation for the same amount of time that they had been in the AOD field (Figure 4).

Mean length of service in current work organisation was significantly longer for government employees (M = 5.6 yrs, SD = 5.7 yrs) and private agency employees (M = 5.8 yrs, SD = 4.8 yrs), compared to non-government employees (M = 4.0 yrs, SD 4.1 yrs; $p < .001$). Males had worked significantly longer in the AOD field (M = 7.6 yrs, SD = 6.9 yrs), compared to females (M = 6.8 yrs, SD = 6.2 yrs; $p < .05$).

Significant occupational differences were also observed for length of service

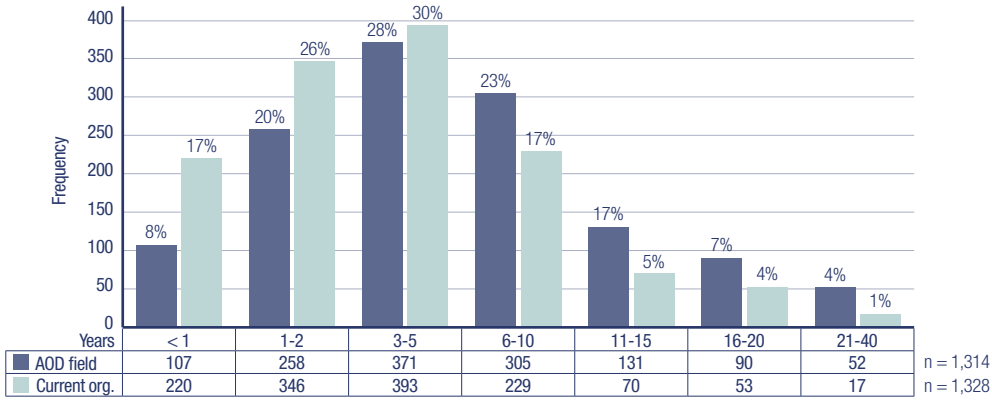


Figure 4: Proportion of respondents by length of service in the AOD field and current work organisation

Table 3: Mean length of service and standard deviations across professions

Length of service / Profession	AOD field (years)			Current organisation (years)		
	M	SD	n	M	SD	n
AOD worker	6.4*	5.9	513	4.3*	4.2	513
Nurse	8.2*	7.0	408	5.8*	6.0	414
Psychologist	6.2*	5.7	137	4.1*	4.4	140
Social worker	6.9	7.0	111	4.6	5.1	112
Counsellor / therapist	6.7	6.2	72	4.6	4.8	71
Doctor	9.6	7.4	42	6.6	5.4	43

*Note: n = number of respondents; * p < .001*

[4] Due to wide variability in scores, the median was used as the most appropriate measure of central tendency for length of service.

in the AOD field and length of service in current work organisation (see Table 3). Nurses had worked significantly longer in the AOD field and in their current work organisation, compared to AOD generalist workers and psychologists. Age was positively correlated with length of service in the AOD field, and length of service in current work organisation ($r = .37$, $p < .01$). No other significant differences in length of service were observed.

Occupation and qualifications

The majority of respondents (71%) were either AOD generalist workers (n=517) or nurses (n=419) (Figure 5). Most generalist AOD workers (e.g., welfare workers, support workers, and youth workers) did not have any specific professional qualifications. Nearly 80% of nurses were female. The majority of psychologists (74%), social workers (71%), and counsellors (68%) were female. In contrast, the majority of doctors (64%) were male.

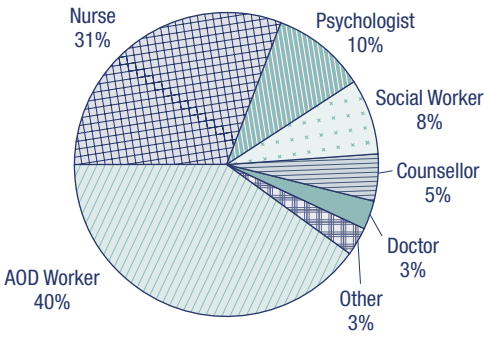


Figure 5: Proportion of respondents by occupation (n=1,339)

The proportion of workers in each occupational category varied greatly across organisational sectors, particularly between government and non-government agencies (see Figure 6). For non-government agencies, the majority of workers were generalist AOD workers (62%). Compared to government and private agencies, a much smaller proportion of nurses worked in non-government agencies. Similarly, less than 1% of doctors (n=2) who responded to the survey worked in non-government agencies. The proportion of social workers and counsellors / therapists working in non-government agencies was slightly larger than the proportion working in government and private agencies.

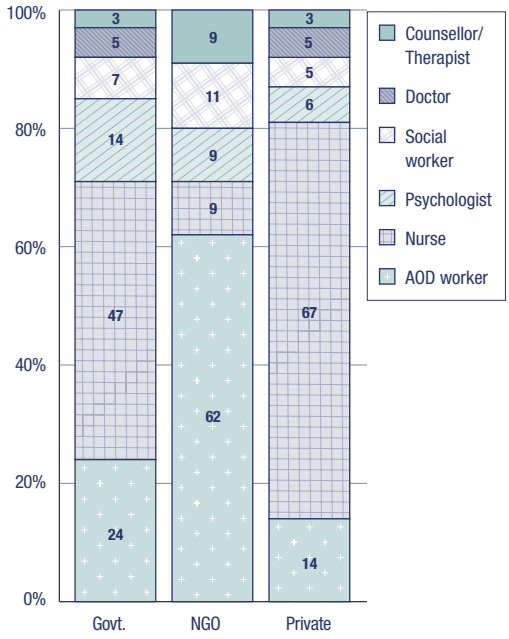


Figure 6: Proportion of respondents by occupation and organisational sector

Three quarters of the sample considered themselves to be in permanent employment with their current employers. Seventy percent of respondents were in full-time work (Table 4).

The majority of respondents (89%) possessed some form of tertiary qualifications with only 8% (n=104) having no post-secondary school qualifications (Table 5). Most doctors (55%) and psychologists (63%) had postgraduate qualifications (Figure 7). The largest proportion of TAFE-qualified respondents (41%) were AOD workers.

Table 4: Number and percentage of workers by work arrangements

Work arrangements	Frequency	(%)
Permanent	1,021	76
Contract	237	18
Casual	66	5
Other	12	1
Total	**1,336**	**100**
Full-time	925	70
Part time	404	30
Total	**1,329**	**100**

Table 5: Number and proportion of workers by highest qualification completed

Highest qualifications completed	Frequency	(%)
Secondary school – less than Year 12	55	4
Secondary school – completed Year 12	49	4
TAFE	262	20
Undergraduate / Honours degree	528	40
Postgraduate (Cert. / Dip. / Master / PhD)	323	24
Other: Diploma / Advanced Diploma / Graduate Diploma / Graduate Cert.	73	5
Other	47	3
Total	**1,337**	**100**

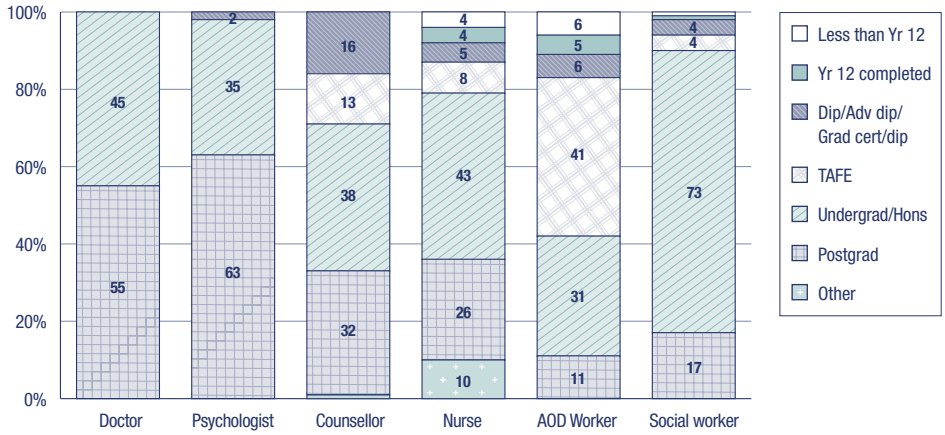


Figure 7: Proportion of respondents by highest qualification completed and occupation

AOD-related qualifications / training

As outlined in Table 6, the type of AOD-related training courses that were most frequently undertaken by respondents were non-accredited and accredited short courses.

Table 6: Numbers of respondents who had completed AOD-related training courses or qualifications

AOD training / qualifications	Frequency*
Non-accredited training	796
Accredited short courses	705
TAFE training	372
Undergraduate degree / Honours	187
Postgraduate	144
Diploma / Advanced diploma / Grad. diploma / Grad. cert.	48
Other	57

*Note: * Respondents could select more than one category*

The proportions of workers who had attended non-accredited AOD courses were evenly spread across most occupations (Table 7)[5]. In most cases more than half of each occupational group had attended non-accredited courses (including in-service training), with the exception of doctors (39%). However, significant differences were observed between occupational groups that had attended accredited training ($p < .001$). Overall, AOD workers were the group most likely to have completed accredited AOD training, followed by counsellors, social workers and nurses (see Table 7).

Significant differences were also found by occupation for AOD tertiary qualifications ($p < .001$). Over half the generalist AOD workers (63%) had completed tertiary training (mainly TAFE), while only about a third of nurses and psychologists had done so. Most of the tertiary training completed by nurses and psychologists was at university level. Similarly, a larger proportion of AOD workers, nurses and counsellors had completed accredited AOD short courses compared to doctors and psychologists (see Table 7). No other significant differences in training or qualifications were observed.

Table 8 details the proportion of respondents who had undertaken non-accredited, accredited, and tertiary-level AOD specific courses across organisational sectors. Significant differences were only observed across organisational type ($p < .001$). In general, a larger proportion of non-government workers had completed AOD-specific training compared to respondents employed in government or private sectors.

[5] Pharmacists were not included in this analysis due to low numbers, and the 'other' category was excluded as it represented small numbers of different professions.

Table 7: Proportion of respondents who had completed AOD-specific training by occupation

Course \ Occupation	AOD worker (%)	Nurse (%)	Psych. (%)	Social worker (%)	Dr. (%)	Counsellor/ Therapist (%)	n
Non-accredited short courses	61	59	59	65	39	59	1,303
Accredited short courses	60*	54*	39*	45	25*	59*	1,303
Tertiary training	63*	37*	34*	49	46	54	1,304

*Note: * p = .000. Psych. = psychologist; Dr. = doctor*

Table 8: Proportion of respondents who had completed AOD-specific training by organisational sector

Course \ Organisation	Govt. (%)	Non-govt. (%)	Private (%)	n
Non-accredited short courses	54*	66*	57	1,317†
Accredited short courses	48*	60*	39*	1,317†
Tertiary training	43*	55*	34*	1,317†

*Note: * p = .000.*
† n does not include 17 respondents who worked for multiple employers, or whose work was funded from multiple sources.

Work factors

Client-related pressure

Most client-related pressures concerned clients' behavioural characteristics rather than clients' AOD issues (Table 9). In particular, around half of the sample reported high levels of pressure in relation to violent and aggressive clients, while about one third of respondents reported high levels of pressure in relation to manipulative and demanding clients. A quarter also experienced high levels of pressure in relation to uncooperative clients and those with co-morbidity issues. The majority of workers felt little or no pressure in relation to clients with alcohol-related or poly drug use presentations, or younger clients.

A client pressure scale was developed that comprised nine items concerning client presentations as outlined in Table 9. Scores for each item ranged from 0 (not applicable) and 1 (no pressure) to 6 (extreme pressure). Each client presentation item score was added to give a total client pressure score. The maximum client-related pressure score that could be reported was 54.

Mean pressure scores for client presentations (M = 24.3, SD = 7.1, range 0-45) were normally distributed, indicating the majority of respondents experienced at least some pressure when dealing with clients. Significant differences in client-related pressure were observed between occupational groups. Nurses and doctors experienced significantly more pressure than counsellors, psychologists, and general AOD workers ($p < .001$) (see Figure 8).

Respondents were also asked to rank, in order of importance, the main workplace factors that created pressure for them at work (see Table 10). The most frequently selected factors were work conditions (staff shortages and workload) and client characteristics (difficult clients and clients with complex presentations) (Table 10).

Table 9: Responses to degree of pressure in relation to client presentations

Issue \ Pressure	None (%)	A little (%)	Some (%)	A lot (%)	Extreme (%)	n
Co-morbidity	8	24	38	24	4	1,334
Poly drug use	27	27	33	10	1	1,329
Alcohol-related problems	41	32	20	4	1	1,326
Younger clients	27	32	23	9	2	1,329
Manipulative clients	9	23	34	25	8	1,328
Demanding clients	8	23	34	27	8	1,331
Violent clients	7	15	23	28	24	1,333
Aggressive clients	6	19	26	31	17	1,335
Uncooperative clients	13	28	34	18	5	1,337

Note: Percentage of respondents who selected 'not applicable' is not included

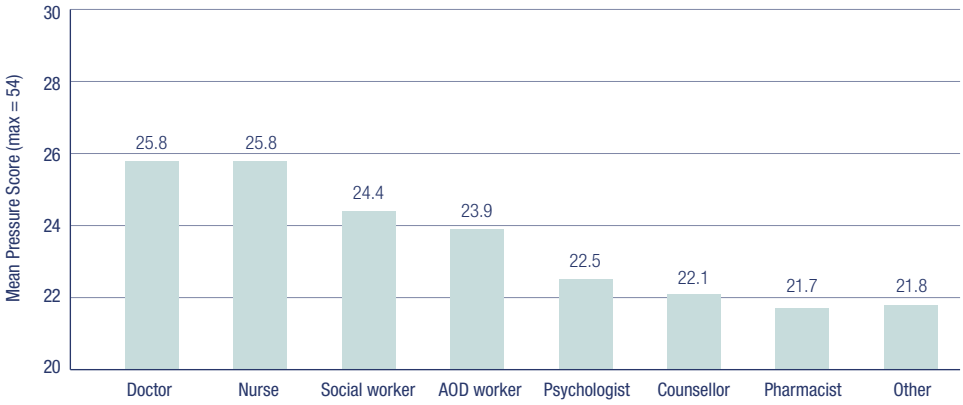


Figure 8: Average client pressure scores by occupation

Table 10: Top-ranked workplace pressure factors

Pressure	n	(%)
Staff shortages	154	14
Workload	148	13
Difficult clients	142	13
Complex client presentations	115	10
Lack of workplace support	99	9
Conflict between clinical and admin roles	83	8
Uncertainty about future funding	81	7
Inadequate rewards	79	7
Shortage of infrastructure	69	6
Conflicting models of care between agencies	66	6
Lack of professional development	36	3
Unsuitable / limited contractual agreements	14	1
Clients with alcohol-related problems	5	<1
Other (staff conflict, poor management, poor govt. policies & support, etc.)	36	3
Total	**1,127**	**100**

Workplace factors that created pressure for respondents varied according to occupation. Psychologists, general AOD workers, nurses, and doctors reported significantly more pressure when dealing with poly drug presentations compared to counsellors ($p < .001$). Similarly, compared to counsellors, nurses and doctors reported significantly more pressure when dealing with manipulative clients ($p < .001$). Nurses also reported significantly more pressure when dealing with violent and aggressive clients compared to psychologists and general AOD workers ($p < .001$). Nurses and general AOD workers reported significantly more pressure when dealing with younger clients compared to psychologists ($p < .001$).

Workplace social support

The workplace social support scale comprised eight statements regarding the supportiveness of supervisors and colleagues (see Table 11). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree). Supervisor item scores were added to give a total score for supervisor support and co-worker item scores were added to give a total score for co-worker support. Scores for supervisor and co-worker support were then added to give a total score for workplace social support. The maximum possible workplace social support score was 40.

The majority of respondents agreed that their supervisor was generally supportive and helpful. There was also strong agreement that co-workers were friendly, helpful, and competent in their work (see Table 11). Overall, most respondents perceived there to be strong support in their workplaces ($M = 31$, $SD = 5.4$, range 8-40). However, supervisors from non-government agencies were reported to be slightly more supportive than supervisors in government agencies ($p = .01$). For example, a larger proportion of workers from government agencies (15%) disagreed that their supervisor was concerned about staff welfare, compared to workers from non-government agencies (9%). There were no other significant demographic differences for workplace social support.

Table 11: Responses to workplace support (WS) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
Supervisor Support						
Concerned about the welfare of those under him / her	4	8	13	44	31	1,335
Pays attention to what I am saying	3	9	12	47	30	1,337
Helpful in getting the job done	3	10	17	45	26	1,334
Successful in getting people to work together	4	13	23	40	20	1,327
Co-worker support						
Competent in doing their job	1	7	13	48	31	1,336
Take a personal interest in me	2	7	22	49	21	1,334
Are friendly	1	2	9	54	36	1,339
Helpful in getting the job done	1	4	13	50	31	1,335

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

Professional development

The professional development scale comprised six statements concerning the provision of, and access to, professional development opportunities (Table 12). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total professional development score. The maximum possible professional development score was 30. Respondents' professional development scores ranged from 6 to 30 with a mean of 20.4 (SD = 5.2).

More than half (57%) agreed that professional development opportunities, and access to these opportunities, were provided by their organisations (see Table 12). However, a substantial proportion (18%) disagreed or strongly disagreed that they were provided with professional development opportunities or encouraged to undertake training courses. In addition, just over half (54%) the respondents indicated that their organisation did not provide back-up to enable staff to attend professional development.

Respondents employed in non-government agencies reported higher levels of professional development opportunities than those employed in government agencies ($p < .001$). In addition, there were significant differences between rural and urban workers concerning the provision of back-up staff in order to attend training ($p < .001$). Nearly 70% of respondents employed in rural areas, compared to 51% of those employed in urban areas, disagreed or strongly disagreed that back-up staff was provided. A larger proportion of respondents employed on a casual basis (46%) reported that their organisation provided them with back-up staff, compared to those employed on a permanent (28%) or contract (23%)

Table 12: Responses to professional development (PD) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
Staff members are encouraged to undertake training courses	3	12	16	49	20	1,335
PD planning in this organisation takes into account individual needs and interests	7	18	23	40	12	1,340
Staff members are supported in pursuing qualifications or PD in relation to their job	5	12	20	46	17	1,335
This organisation provides back-up to staff to allow people to attend training	20	34	18	21	7	1,335
This organisation provides staff with access to training	4	11	20	52	13	1,334
Opportunities exist in this organisation for developing new skills	5	11	21	48	15	1,334

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

basis ($p < .001$). Proportionally more TAFE-qualified respondents (36%), compared to postgraduate-qualified respondents (22%), reported that back-up staff was provided ($p < .001$).

On average, respondents from South Australia and Victoria reported statistically significant higher overall levels of professional development opportunities compared to respondents from both Queensland and New South Wales ($p < .001$; see Table 13).[6] In terms of occupational differences, generalist AOD workers reported higher levels of professional development opportunities than doctors ($p < .01$). For instance, a greater proportion of AOD workers (72%) agreed or strongly agreed that staff were encouraged to undertake training, compared to 44% of doctors. No other significant demographic differences were observed.

Table 13: Mean scores for professional development across State / Territory

State / Territory	Mean Score	SD	n
ACT	21.7	3.44	33
NT	21.6	4.56	59
SA	21.6*	4.83	84
VIC	21.3#	4.47	284
WA	20.2	5.38	172
NSW	19.7	5.30	420
QLD	19.4	5.76	196
TAS	18.6	5.18	36

*Note: *SA mean scores significantly higher than NSW & QLD mean scores ($p<.001$);*

#VIC mean scores significantly higher than NSW & QLD mean scores ($p<.001$);

Max score for scale = 30; SD = Standard Deviation

[6] Analysis for statistical differences does not depend on mean scores alone but on the relationship between mean scores, standard deviations and sample sizes.

Clinical supervision

The clinical supervision scale comprised five questions concerning the provision of, and access to, clinical supervision (Table 14). Response options were scored as 0 (not applicable), 1 (no), and 2 (yes) and the score for each item was added to give a total clinical supervision score. The maximum possible score for client supervision was 10.

Respondents' scores for clinical supervision ranged from 0 to 5 with a mean of 3.5 (SD = 1.7). The majority of respondents (64%) felt their organisation offered effective clinical supervision. However, a substantial minority reported that these needs were not being met (see Table 14). A larger proportion of those employed on a permanent basis (42%) reported levels of clinical supervision did not meet their needs compared to those employed on a contract basis (31%).

Occupational and workplace differences were also observed for individual items in the clinical supervision scale ($p < .001$). A smaller proportion of doctors (22%) reported receiving supervision on a regular basis compared to other professions (range 51% - 75%) reporting regular supervision. Proportionally more counsellors (75%) and AOD workers (64%) reported regular supervision than nurses (51%). There were also significant differences between government and non-government workers concerning the perceived regularity of supervision ($p = .001$). A larger proportion of respondents employed in non-government agencies (65%) received clinical supervision on a regular basis compared to respondents employed in government agencies (55%). Nearly 70% of respondents employed on a contract basis reported supervision on a regular basis compared to 57% of those employed on permanent basis ($p < .01$).

Table 14: Responses to clinical supervision (CS) items

Questions	Not applicable (%)	No (%)	Yes (%)	n
Does your organisation offer staff effective clinical supervision?	5	31	64	1,327
When necessary, do you have access to a clinical supervisor?	5	21	74	1,327
Is the level of clinical supervision adequate to your needs	8	37	55	1,322
Does your supervisor have the skills to deliver effective supervision?	9	23	68	1,317
Do you receive supervision on a regular basis?	4	39	56	1,328

Table 15: Responses to role overload (RO) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
I have too much work to do everything well	4	35	26	27	8	1,329
The amount of work I am asked to do is fair	2	18	23	50	7	1,330
I never seem to have enough time to get everything done	3	31	25	34	7	1,329

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

Role overload

The role overload scale comprised three statements concerning respondents' workload (Table 15). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total role overload score. The maximum possible role overload score was 15.

Respondents' scores ranged from 3 to 15 with a mean of 8.7 (SD = 2.6). Just over half felt that their workload was "fair", however, one in three workers reported they had "too much work to do everything well" and nearly half believed that they did not have "enough time to get everything done" (Table 15).

Female respondents had significantly higher role overload scores (M = 9, SD = 2.7) compared to males (M = 8, SD = 2.4; $p < .01$). Overall, a larger proportion of females (24%), compared to males (13%), thought their workload was unfair. In addition, 44% of females, compared to 35% of males, felt they never had enough time to get everything done. No other significant differences across demographic variables were observed.

Alcohol-related workload

More than a third of respondents (35%) reported that their current workload mainly comprised clients with predominantly alcohol-related problems. A larger proportion of non-government employees (39%) compared to government employees (31%) reported primarily working with clients with alcohol-related problems ($p < .001$). A substantially larger proportion of those working in remote areas (76%) reported their workload was largely alcohol-related, compared to those employed in urban (32%) and regional (33%) areas.

Job autonomy

The job autonomy scale comprised three statements concerning the degree of decision-making latitude respondents had at their workplace (Table 16). Scores for each item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total job autonomy score. The maximum possible job autonomy score was 15. Respondents' scores ranged from 3 to 15 with a mean of 11.1 (SD = 2.3). The majority of respondents (70%) felt they had freedom to make decisions about their work responsibilities and how to perform their job (Table 16).

Table 16: Responses to job autonomy (JA) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
My job allows me to make a lot of decisions on my own	2	9	11	57	20	1,328
In my job I have very little freedom to decide how I do my work	16	59	15	8	3	1,327
I have a lot to say about what happens in my job	3	15	24	47	11	1,327

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

Casual workers had significantly lower autonomy scores (M = 10, SD = 2.4) than contract workers (M = 11, SD = 2.3; p = .002). Differences were also observed for individual autonomy scale items. A larger proportion of rural respondents (85%) reported greater latitude to make decisions on their own compared to those in urban areas (76%; p < .01). Compared to nearly 60% of respondents employed on a contract or permanent basis, only 37% of those employed on a casual basis agreed that they had a lot of say about what happens in their job (p = .001). No other significant demographic differences in job autonomy scores were indicated.

Pay satisfaction and equity

The pay satisfaction / equity scale comprised three statements concerning pay satisfaction and pay equity (Table 17). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total remuneration satisfaction / equity score. The maximum possible pay satisfaction / equity score was 15. Respondents' scores ranged from 3 to 15 with a mean of 8.5 (SD = 2.8). Approximately half the respondents (49%) reported dissatisfaction with their pay, while around a third considered their pay to be inequitable compared to that of their colleagues, or compared to what other AOD organisations paid (Table 17). The only significant differences observed occurred across organisational types. Those employed in non-government agencies were significantly less satisfied with their pay than were government workers (p < .001). A greater proportion of non-government workers (41%) disagreed that their pay scale was fair, particularly when compared to what their counterparts in other AOD agencies were being paid (p < .001).

Compared to other occupational groups, the largest proportion of respondents to report satisfaction with their pay was doctors (55%; p < .001). Counsellors and generalist AOD workers (who were over-represented in non-government agencies) were less satisfied with their pay compared to nurses (p < .001). Nearly three quarters of counsellors (72%) and over half

Table 17: Responses to pay satisfaction / equity (P) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
I am very satisfied with my pay	20	29	26	22	3	1,327
My pay is fair considering what other people in this organisation are paid	12	23	27	33	5	1,323
My pay is fair considering what other AOD organisations in this field pay	12	19	37	28	4	1,326

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

Table 18: Responses to job satisfaction (JS) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
I feel real enjoyment in my job	1	5	13	52	29	1,330
Most days I am enthusiastic about my job	1	5	12	59	23	1,329
I feel well satisfied with my job	1	9	19	53	18	1,329

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

(55%) the AOD workers disagreed or strongly disagreed that they were very satisfied with their pay ($p < .001$).

A larger proportion of postgraduate-qualified respondents (40%), compared to TAFE-qualified respondents (24%), agreed or strongly agreed that their pay was fair considering what their counterparts were getting paid in other AOD agencies ($p < .01$). No other significant differences across demographic variables were found.

Satisfaction with contractual arrangements

Slightly under half of the respondents (42%) reported satisfaction with their current contractual conditions, 24% were not satisfied, while 34% were ambivalent. There were no significant demographic differences observed for this work factor.

Work outcomes

Job satisfaction

The job satisfaction scale comprised three statements concerning the degree of satisfaction, enthusiasm, and enjoyment associated with work (Table 18). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total job satisfaction score. The maximum possible job satisfaction score was 15. Respondents' scores ranged from 3 to 15 with a mean of 11.8 (SD = 2.3). The majority of respondents (more than three quarters) were satisfied with their jobs (Table 18).

Job satisfaction was positively associated with age ($r = .08$, $p < .01$), with older workers reporting higher job

satisfaction. Significant differences were observed across occupations and organisation type. Counsellors reported more satisfaction in their work than nurses ($p = .01$). A greater proportion of non-government workers (87%) agreed or strongly agreed that they found "real enjoyment" in their work compared to 77% of government workers ($p < .001$).

In addition, respondents with TAFE qualifications were more satisfied with their job compared to those with undergraduate and postgraduate qualifications ($p=.002$). The majority of TAFE-qualified workers (91%) agreed or strongly agreed that they were enthusiastic about their job

Table 19: Top-ranked job satisfaction-related aspects of AOD work

Satisfaction-related aspect	(%)
Successful outcomes for clients	41
One-to-one client interaction	20
Doing work of value to society	12
Opportunities for personal learning / growth	6
Relationship with co-workers	4
Salary / benefits	2
Career growth	1

on most days compared to 78% of undergraduate-qualified and 79% of postgraduate-qualified workers ($p < .001$). There were no other significant demographic differences indicated.

Almost all respondents (99%) found at least some part of their work satisfying. Successful client outcomes, one-to-one client interactions, and the opportunity to make a worthwhile contribution to society were the predominant factors contributing to satisfaction (Table 19).

Work-related stress (exhaustion)

The work stress scale comprised eight statements concerning stresses and strains associated with work (Table 20). Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the scores for each item were added to give a total stress score. The maximum possible work stress score was 40. Respondents' scores ranged from 8 to 40 with a mean of 20.0 (SD = 5.8). While the majority of respondents reported low stress scores, a substantial

Table 20: Responses to work stress (S) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
Working with people all day is really a strain for me	12	50	23	14	1	1,327
I feel I'm working too hard on my job	5	45	30	18	2	1,328
I feel frustrated by my job	8	41	25	23	3	1,326
I feel like I am at the end of my tether	23	52	17	7	1	1,327
I feel emotionally drained from my work	11	40	26	21	2	1,329
I feel burned out from my work	16	49	20	13	2	1,328
I feel fatigued when I get up in the morning and have to face another day on the job	15	49	20	14	2	1,331
I feel used up at the end of the workday	11	40	21	24	4	1,330

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

proportion (approximately 19%) reported scores indicative of high stress levels.

The proportion of respondents agreeing or strongly agreeing with the stress-related statements presented in Table 20 ranged from 9% reporting "I feel like I am at the end of my tether" to 28% reporting "I feel used up at the end of the workday". Nearly a quarter (23%) agreed that they felt emotionally drained from their work, and 15% felt burnt out.

Permanent workers reported significantly higher stress scores than those employed as contract or casual workers ($p < .01$). There were no other significant demographic differences observed for work stress.

Turnover intention

The turnover intention scale comprised three statements concerning respondents' intention to quit their current job (Table 21)[7]. Scores for each statement item ranged from 1 (strongly disagree) to 5 (strongly agree) and the score for each item was added to give a total turnover intention score. The maximum possible turnover intention score was 15. Respondents' scores ranged from 3 to 15 with a mean of 8.7 (SD = 30).

Over half the respondents (54%) had thoughts about leaving their job and a smaller proportion (31%) intended to look for a new job in the next 12 months (Table 21). Almost one in five workers (19%) intended to search for a job outside the AOD field.

Turnover intention was negatively associated with age ($r = -.19$, $p < .001$) and length of service in current organisation ($r = -.08$, $p < .01$), indicating that younger respondents and those with shorter lengths of service in their current workplace had higher intentions to quit.

Respondents with TAFE qualifications had lower turnover intentions compared to those with undergraduate and postgraduate qualifications ($p < .001$). Only 9% of respondents with TAFE qualifications intended to look for a new job outside the AOD field, compared to 22% of those with university qualifications. No other significant differences were indicated across demographic variables.

Table 21: Responses to turnover intention (TI) items

Statements	SD (%)	D (%)	NA/ND (%)	A (%)	SA (%)	n
I have thought about leaving my job	9	21	16	42	12	1,330
I plan to look for a new job over the next 12 months	15	31	23	19	12	1,329
I intend to search for a new job outside the AOD field	19	32	30	14	5	1,326

Note: SD – strongly disagree, D – disagree, NA/ND – neither agree nor disagree, A – agree, SA – strongly agree

[7] An additional item, "I intend to search for a new job within the AOD field but outside this organisation", to which 16% of respondents agreed, was excluded from the analysis as it reduced the reliability of the scale. It is likely that some workers who are very comfortable with their AOD roles would nevertheless prefer, or be actively sought for, opportunities elsewhere.

Associations between variables

A correlation analysis was conducted to explore relationships between variables (Table 22). Overall, work outcome variables correlated with each other in the expected directions. Similarly, work factor variables mostly correlated with each other in the expected directions.

Two exceptions to this trend were alcohol-related workload, which did not correlate with any other work factor; and client pressure, which only correlated with role overload, job autonomy and satisfaction with pay. Work factor variables also correlated with work outcome variables in the expected direction. The only exception to this was for alcohol-related workload which was not associated with levels of work stress. High alcohol-related workload was associated with high levels of job satisfaction and low levels of turnover intention.

Table 22: Correlations between work factors and outcomes

	CP	RO	AW	JA	WS	P	C	PD	CS	JS	S	TI
Work Factors												
1. Client-related pressure (CP)	1.00											
2. Role overload (RO)	.155**	1.00										
3. Alcohol-related workload (AW)	.030	-.065	1.00									
4. Job autonomy (JA)	-.094**	-.129**	-.005	1.00								
5. Workplace social support (WS)	-.038	-.250**	.062	.400**	1.00							
6. Pay satisfaction / equity (P)	-.099**	-.137**	-.033	.153**	.125**	1.00						
7. Satisfaction with contractual arrangements (C)	-.067	-.235**	.030	.270**	.291**	.482**	1.00					
8. Professional development (PD)	-.034	-.235**	-.012	.366**	.496**	.211**	.393**	1.00				
9. Clinical supervision (CS)	-.044	-.237**	.017	.220**	.417**	.097**	.227**	.406**	1.00			
Work Outcomes												
10. Job satisfaction (JS)	-.163**	-.137**	.100**	.366**	.362**	.122**	.238**	.347**	.249**	1.00		
11. Stress (exhaustion) (S)	.292**	.459**	-.023	-.306**	-.346**	-.157**	-.249**	-.328**	-.310**	-.514**	1.00	
12. Turnover intention (TI)	.082**	.219**	-.092**	-.243**	-.334**	-.170**	-.317**	-.309**	-.232**	-.519**	.446**	1.00

*Note: ** Correlation is significant at the .01 level*

Predictors of work outcomes

A series of stepwise regressions were conducted to determine the influence of workplace factors on outcome variables (i.e. job satisfaction, stress, and turnover intention).

Job satisfaction

Job autonomy was the strongest predictor of job satisfaction, contributing 13% of the variance in job satisfaction scores. Specifically, higher levels of job autonomy were associated with higher levels of job satisfaction. Other factors that predicted high job satisfaction were high levels of workplace support, high levels of professional development opportunities, and low levels of client-related pressure. Together, these factors contributed to 23% of the variance in job satisfaction (see Table 23).

Stress

Role overload was the leading predictor of high stress, accounting for 21% of the variance in stress scores. Specifically high role overload predicted high stress. Other predictor variables in the model were low levels of job autonomy, high levels of client-related pressure, low levels of workplace support, and lack of professional development. Combined, these factors accounted for 35% of the variance in stress scores (Table 24).

Table 23: Predictor variables for job satisfaction

Predictor variables	Adj R^2	R^2 change	Beta	t	Sig.
Constant	–	–	6.48	15.19	.000
Job autonomy	.13	.13	.22	7.78	.000
Workplace social support	.19	.06	.08	6.30	.000
Professional development	.21	.02	.08	5.87	.000
Client-related pressure	.23	.02	-.04	-5.39	.000

Adjusted R^2 = .23

Table 24: Predictor variables for work-related stress

Predictor variables	Adj R^2	R^2 change	Beta	t	Sig.
Constant	–	–	20.52	17.36	.000
Role overload	.21	.21	.78	14.55	.000
Job autonomy	.27	.06	-.37	-5.58	.000
Client-related pressure	.31	.04	.17	9.11	.000
Workplace support	.34	.03	-.15	-4.93	.000
Professional development	.35	.01	-.14	-4.49	.000

Adjusted R^2 = .35

Turnover intention

As previous research has indicated that stress and job satisfaction are strong predictors of turnover intention, both these outcome variables were entered together with workplace variables into the regression model for turnover intention.

Job satisfaction was the strongest predictor of turnover intention, accounting for 27% of the variance in turnover intention scores. Specifically, low levels of job satisfaction predicted intention to quit. Other predictors included high stress, low levels of workplace support, pay dissatisfaction / inequity, and high levels of client-related pressure. Combined, these variables accounted for 34% of the variance in turnover intention (Table 25).

Perceptions of recruitment and retention issues

Respondents were asked what they thought were the most important strategies to retain workers and the main barriers to working in the AOD field.

Top strategies to retain workers

The top-ranked strategy to retain workers, endorsed by 22% of respondents, was to increase salaries (Table 26). Other retention strategies that were highly regarded by respondents included more recognition and appreciation of effort (16%), more career (12%) and training opportunities (11%), and more support in the workplace (11%).

Table 25: Predictor variables for turnover intention

Predictor variables	Adj R^2	R^2 change	Beta	t	Sig.
Constant	–	–	15.43	19.76	.000
Job satisfaction	.27	.27	-.48	-13.12	.000
Stress	.31	.04	.12	7.94	.000
Workplace social support	.33	.01	-.07	-4.61	.000
Pay satisfaction / equity	.33	.01	-.09	-3.44	.001
Client-related pressure	.34	.00	-.03	-2.48	.013

Adjusted R^2 = .34

Barriers to working in the AOD field

Mirroring the top-ranked retention strategies, the barriers to working in the AOD field most frequently identified by workers were low salary and / or poor benefits (29%) (Table 27). Perceptions of difficult clients (20%) and stigma and lack of respect associated with the field (18%) were the next most frequently reported barriers to working in the AOD field.

AOD services for Indigenous clients

A section was included in the survey to investigate the demand for AOD services and the adequacy of service responses for Indigenous clients. Approximately 89% (n =1,192) of survey respondents completed this section of

Table 26: Top-ranked retention strategies

Retention Strategies	Frequency	(%)
Salary increases	149	22
More recognition / appreciation of effort	108	16
More career opportunities	84	12
More training opportunities	77	11
More supportive workplaces	77	11
Reduced administrative workload	45	6
Clinical supervision	43	6
Flexible working hours	40	6
Improved physical work environment	33	5
Smaller caseloads	23	3
Better work benefits (e.g., superannuation, car allowance)	11	2
Total	**690**	**100**

Table 27: Top-ranked barriers to working in the AOD field

Barriers to Entry	Frequency	(%)
Low salary / poor benefits	294	29
Perceptions of difficult clients	207	20
Stigma / lack of respect	181	18
Lack of promotion of AOD related careers	118	11
Workload	93	9
Lack of encouragement to work in the AOD field	71	7
Limited availability of AOD education / training	38	4
Differences between industrial awards	19	2
Total	**1,021**	**100**

the questionnaire. As outlined in Table 28, the majority of these respondents indicated that their agency provided services to Indigenous clients, and that there was either a strong need (53%) or some need (38%) for such services in their area. However, almost two thirds felt Indigenous needs were only being partially met, while 9% believed that these needs were not met.

Half (51%) the respondents felt they were 'somewhat' culturally competent in dealing with Indigenous issues, and a third believed they were competent in this area. A lack of access to appropriate Indigenous-related resources was indicated by over half the sample.

Workers who did not feel culturally competent in dealing with Indigenous issues reported significantly lower job satisfaction scores (M = 11.4, SD = 2.2) compared to those who considered themselves culturally competent (M = 12.1, SD = 2.2; $p < .001$). In addition, those who did not have access to appropriate Indigenous-specific resources reported significantly lower job satisfaction scores (M = 12.3, SD = 2.1) compared to those who did have such access (M = 11.5, SD = 2.4; $p < .001$).

Table 28: Proportion of respondents describing the need and adequacy of AOD services to Indigenous peoples

Questions		No (%)	Not sure (%)	Yes (%)	n
Does your agency provide services to Indigenous clients?		3	3	94	1,230
	DK (%)	No need (%)	Some need (%)	Strong need (%)	n
How would you describe the need for Indigenous AOD services in your area?	7	2	38	53	1,206
	DK (%)	Not met (%)	Partially met (%)	Fully met (%)	n
To what extent is this need being met?	14	9	64	13	1,188
		No (%)	Somewhat (%)	Yes (%)	n
Do you feel culturally competent to deal with Indigenous issues?		16	51	33	1,199
		No (%)	Some but not enough (%)	Yes (%)	n
Do you have access to appropriate Indigenous-specific resources?		18	44	38	1,176

Note: DK – Don't know

DISCUSSION

The current study was designed to examine the workforce development needs of Australians employed in frontline AOD treatment agencies. A particular emphasis was placed on factors that impact on workers' turnover intentions, levels of work stress, and levels of job satisfaction.[8] On the surface, the findings of this study indicate that the majority of Australian AOD workers appear to be faring quite well, in terms of job satisfaction and levels of work stress. However, a more in-depth analysis indicates that the Australian AOD workforce faces substantial workforce development challenges in terms of staff retention and worker well-being.

The Australian AOD workforce faces substantial WFD challenges in terms of staff retention & worker well-being

Professional development and clinical supervision

While the majority of those who responded to the survey were generalist AOD workers with no specific professional qualifications, most had some form of tertiary qualifications at the TAFE, undergraduate, or postgraduate level. However, the most common AOD-specific training that respondents had undertaken was non-accredited or accredited short courses. Due to this reliance on short courses to provide the AOD specific skills and knowledge required by AOD workers, it is imperative that workers have adequate access to ongoing professional development opportunities.

Just over half the respondents reported professional development opportunities were provided by their work organisations. However, there were jurisdictional and organisational differences. South Australian and Victorian respondents reported higher levels of professional development opportunities compared to their Queensland and New South Wales' counterparts, and non-government workers reported higher levels of professional development opportunities compared to government agency workers. The latter difference is consistent with the finding that more non-government employees had completed AOD specific training programs compared to government employees.

Despite the importance of training as a professional development opportunity, nearly one in five workers reported that their work organisation did not provide access to, or encourage workers to

[8] Further findings from this study are also reported elsewhere (Duraisingam, Pidd, & Roche, in press).

undertake, training opportunities. Limited access to training opportunities appeared mainly due to organisational or funding issues. More than half the total sample, and nearly three quarters of those employed in rural agencies, reported that back-up staff were not provided to allow them to attend training. Due to increasing demands placed on the skill and knowledge levels of AOD workers, the importance of providing access to quality training and other professional development opportunities cannot be overstated.

Clinical supervision was also a professional development area identified as needing attention. While more than half the respondents reported adequate and regular clinical supervision, one in three workers reported that their clinical supervision needs were not being met. These findings are of particular concern as clinical supervision is of critical importance for worker well-being (Hyrkas, 2005; Kavanagh, Spence, Wilson, & Crow, 2002; Milne & Westerman, 2001). Overall, non-government workers were more likely to have received regular clinical supervision compared to government workers, while counsellors and generalist AOD workers were more likely to have received regular clinical supervision compared to medical staff (nurses and doctors).

Differences in professional development opportunities (i.e. training and / or clinical supervision) across occupations, jurisdictions and organisations warrant further attention. With regard to occupational differences it may be that as generalist AOD workers are less likely to have a degree, the need for up-skilling via professional development appears more pressing. A similar situation may explain government and non-government differences, as non-government agencies employed a larger proportion of generalist AOD workers. Jurisdictional differences may reflect differences in funding levels or perceived need for professional development. However, regardless of the reasons for differing levels of professional development opportunities, the difficult and changing nature of AOD work results in a need for ongoing professional development.

Differences in professional development opportunities across occupations, organisations & jurisdictions warrant further attention

Role overload and work stress

While the majority of respondents reported relatively low levels of work stress, nearly one in five workers reported high levels of stress. This is of concern, not only for worker health and well-being, but also for staff retention. The results obtained in the current study are consistent with previous research findings (e.g., Barak, Nissly, & Levin, 2001; Griffeth, Hom, & Gaertner, 2000). That is, stress is strongly associated with low levels of job satisfaction, which in turn are highly predictive of turnover intention.

The strongest predictor of stress was heavy workload

One in five workers reported high levels of work stress

The strongest predictor of stress was excessive workload (role overload). While one in five respondents reported high levels of stress, a much larger proportion reported excessive workloads. Thus, it appears not all workers experience high stress levels as a result of excessive workloads. This may be due to individual differences in the way workers deal with excessive workloads or stress. However, an alternative explanation provided by data obtained in the current study is that workplace factors mediate the relationship between role overload and work stress. High levels of supervisor and co-worker support (workplace social support), job autonomy, professional development opportunities, and low levels of client pressure were all associated with low levels of stress. Thus, the stress levels of some workers with excessive workloads may be alleviated by factors such as social support from supervisors and co-workers and high levels of decision-making latitude. Given that non-government workers reported substantially higher levels of supervisor support compared to government workers, levels of supervisor support may need attention in government agencies that wish to address the stress levels of staff.

Along with excessive workloads, the other main factor most frequently cited by respondents as creating pressure for them at work was staff shortages. Thus, staff shortages may account for the large proportion of workers (more than one in three) that felt they had too much to do at work. Staff shortages may be due to funding limitations, the limited availability of qualified staff, or inability to successfully recruit qualified staff. Either way, for both worker health and staff retention reasons, the excessive workloads of some members / sectors of the AOD workforce require immediate attention. In addition, more females compared to males reported excessive workloads. This finding may reflect differences in actual workload, or the challenge of balancing work and domestic / family demands. Regardless of the reasons, this is an important gender issue that should be addressed.

Client presentations were also identified as contributing factors to work stress. Pressure, or stress, associated with client presentations mainly involved clients with complex presentations and clients who were difficult to deal with. Interestingly, clients with alcohol-related problems caused the least pressure for workers. The most important issue concerning complex presentations involved co-morbidity problems. About

a quarter of all respondents reported that clients with co-morbidity problems (in particular mental health issues) created pressure for them at work. This finding indicates that there is a need to develop greater skills and resources to support clients with co-morbidity issues.

Approximately half the AOD workers surveyed reported high levels of pressure in dealing with violent & aggressive clients

However, of more importance in relation to worker health, safety, and welfare is the pressure of dealing with violent and aggressive clients. Approximately half the AOD workers surveyed reported high levels of pressure in relation to violent and aggressive clients. This finding is consistent with the increasing use of, and reports of violence and psychosis associated with amphetamine-type substances (ATS) (McKetin, McLaren, & Kelly, 2005). This evidence reports an increasing prevalence of ATS use and associated violence and indicates that this will become and increasing problem for the AOD workforce in the future (McKetin, McLaren, & Kelly, 2005).

The high proportion of the workforce reporting pressure concerning violent and aggressive clients is consistent with current data on the Australian workforce in general that identifies those employed in the health industry and / or in health-related professions are more likely to be exposed to alcohol- and / or drug-related abuse or intimidation than those employed in other industries and occupations (Pidd et al., 2006). The relatively large number of AOD workers who report that aggressive and violent clients create pressure for them at work warrants further attention. Given that nurses were the most concerned about these types of clients, this attention may need to focus on activities such as responding to medical crises, detoxification and the dispensing of drug-maintenance therapies.

More than three quarters of the AOD workforce reported high levels of job satisfaction

Overall job satisfaction

Levels of job satisfaction are particularly important for workforce retention rates, as the results of the current study indicate that job satisfaction was the most important predictor of turnover intention. Consistent with the international research reporting high levels of job satisfaction in the Canadian and U.S. workforces (Evans & Hohenshil, 1997; Ogborne & Graves, 2005), more than three quarters of the Australian AOD workforce surveyed reported high levels of job satisfaction. This is despite nearly half the respondents being dissatisfied with the level or

perceived equity of their pay, and nearly a quarter being dissatisfied with their contractual arrangements. The most satisfying aspects of AOD work, as reported by respondents, were due to altruistic factors such as successful client outcomes, one-to-one client interactions, and doing work that was of value to society. Statistically, the strongest predictor of job satisfaction was job autonomy, followed by workplace social support, professional development opportunities and client-related pressure.

These findings have important implications for recruitment and retention strategies. It appears that the level of pay received is not the most satisfying component of AOD work. Rather, most workers are intrinsically motivated by the feelings of satisfaction they receive when contributing to successful individual (client) and societal outcomes. However, to enhance these levels of job satisfaction, workers need to have a large degree of decision-making latitude in their work responsibilities and how they perform their job. Limiting job autonomy, providing inadequate workplace social support, and not providing adequate access to professional development opportunities contribute to lower levels of job satisfaction, which in turn can influence turnover intention.

Job autonomy may be particularly important in this regard as it has been identified in previous research as an important variable in worker well-being (De Jonge et al., 2001; Demerouti, Bakker, De Jonge, Janssen, & Schaufeli, 2001; Dollard & Winefield, 1998; Dollard, Winefield, Winefield, & De Jonge, 2000; Karasek & Theorell, 1990). The results of the current study confirmed this by indicating that job autonomy not only played a role in predicting job satisfaction, but was also a significant predictor of work stress.

One in three workers intended to look for a new job in the next 12 months. One in five workers intended to leave the AOD field

Retention issues

Of the 1,345 workers who participated in the current study, nearly half were over 45 years of age. This finding, in itself, is of particular concern for the future of the AOD sector. While a lack of previous data concerning the ageing of the AOD workforce makes it difficult to draw any definitive conclusions regarding this issue, current data indicates that while the Australian workforce in general is ageing, compared to most other industries a much larger proportion of workers in the AOD sector are mature aged (ABS, 2005). Unless younger workers can be recruited into AOD work, the AOD sector may face a severe lack of experienced and qualified workers over the next 10-20 years, when large numbers of the current workforce reach retirement age.

Of more immediate concern however, is the data obtained on the number of years respondents had worked in the AOD field. While there was a wide range for reported length of service, more than half those surveyed had worked in the AOD field for five or less years. While previous data on the AOD workforce is scarce, this finding tends to confirm anecdotal evidence of relatively high turnover rates within the AOD sector (e.g., Pierce & Long, 2002). Consistent with this finding, over half those surveyed reported that they had thought about leaving their job, one in three intended to look for a new job in the next 12 months, and one in five intended to leave the AOD field.

As previously outlined, job satisfaction was the most important predictor of turnover intention. However, other factors such as high levels of work stress, low levels of workplace social support, dissatisfaction with pay and perceived pay inequity, and high levels of client-related pressure all had a direct role in predicting respondents' intentions to leave their current job and / or the AOD field.

While pay satisfaction / equity issues played a relatively minor role in directly predicting turnover intentions, the importance of remuneration / reward issues should not be underestimated. When asked about strategies to retain workers and barriers to working in the AOD field, the most frequently cited strategies were salary increases and more recognition / appreciation of effort, while the most frequently cited barrier was low salary and poor benefits. Thus, while pay satisfaction / equity was not the strongest predictor of turnover intentions, respondents believed salary increases were an important retention strategy and inadequate pay was the main reason for recruitment difficulties within the AOD field.

Similarly, while levels of workplace social support and client-related pressure were not the strongest predictors of turnover intention, the importance of these factors cannot be overlooked. Workplace social support and client-related pressure had a direct influence on turnover intention and an indirect effect via their influence on job satisfaction levels.

Together, these findings have implications for retention strategies. While funding issues may limit the ability of individual workplaces to address salary levels and associated pay satisfaction / equity issues, they can nonetheless readily implement strategies to provide greater recognition and appreciation for work effort. Similarly, individual workplaces have a large degree of control over factors such as workplace social support. Implementing strategies to increase levels of co-worker and supervisor support are likely to also have a positive impact on retention rates.

Alcohol-related workloads

While the focus of the current study was on job satisfaction, work stress, and retention levels of the AOD workforce in general, attention was also given to workers who mainly dealt with clients whose predominant drug issue was alcohol.

Overall, more than a third of respondents reported that their current workload mainly consisted of clients with alcohol-related issues. However, more than three quarters of those working in remote areas reported mainly alcohol-related workloads.

This finding is consistent with alcohol-related data indicating larger proportions of rural Australians consume alcohol at risky or high risk levels compared to those in metropolitan areas (Pidd et al., 2006). The disparity in alcohol-related workloads between rural and metropolitan AOD workers may have some implications for professional development opportunities around alcohol-related work given that the vast majority of rural workers also reported limited access to training opportunities. On a positive note, little client-related pressure was associated with alcohol clients, and high alcohol-related workloads were associated with high levels of job satisfaction and low levels of turnover intention.

AOD services for Indigenous clients

The majority of respondents reported that the agency they worked for dealt with Indigenous clients. While most of these workers reported that there was a need for Indigenous services in their area, two thirds reported that this need was not being met. Of particular concern was the finding that those who felt they were not culturally competent to deliver Indigenous services and those that did not have adequate access to appropriate Indigenous resources, reported significantly lower levels of job satisfaction than those who were culturally competent and had access to appropriate resources. Given that job satisfaction was the most important predictor of turnover intention, this finding has substantial implications for retention strategies in agencies that provide Indigenous services.

Conclusions

The current study found that Australian AOD workforce appears to be faring quite well in terms of job satisfaction and levels of work stress. The majority of those surveyed reported relatively high levels of job satisfaction and relatively low levels of work stress. This finding is particularly important given that work stress was strongly associated with job satisfaction, which in turn was highly predictive of turnover intention.

However, caution needs to be applied to the findings of the current study as it may have underestimated the extent of the retention and recruitment issues facing the AOD field for several reasons. First, while the response rate to the survey was adequate, a large proportion of the workforce did not respond and one reason frequently given by potential respondents was that they were too busy to do so. Thus, those with heavy workloads, higher stress levels, and low job satisfaction levels may not have responded to the survey.

Second, the survey did not include those who had actually left the AOD field or those who are potential recruits to the field. A survey of ex-workers and potential recruits may provide a more complete description of retention and recruitment issues.

Finally, while surveys of current workers, ex-workers, and potential recruits may provide a clear indication of individuals' perceptions of factors associated with retention and recruitment, it says little about systemic and organisational barriers to retention and recruitment levels such as labour market conditions, disparities between qualifications, inequities between salaries in different organisations, differences between various industrial awards and classifications, and so on.

Data obtained in the current study indicates that these factors are important issues. For example, the study identified high levels of perceived pay inequity amongst respondents, particularly non-government workers, and substantial differences in education / qualification levels.

Despite these limitations, the results of the current study have important implications for strategies designed to improve retention levels and the well-being of the workforce. Consistent with previous research (e.g., Barak, Nissly, & Levin, 2001; Griffeth, Hom, & Gaertner, 2000), the current study found that work stress and job satisfaction play an important role in workers' turnover intentions.

Similarly, the current study supports previous research (e.g., Cotton, 1993; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998) in that many of the same organisational and workplace factors influence both work stress and job satisfaction levels.

Strategies to reduce levels of worker stress & increase retention levels need to focus on reducing workloads, promoting workplace support, dealing more effectively with clients, increasing opportunities for professional development, & providing fair rewards & recognition

Factors identified by the current study that were associated with high levels of work stress, low levels of job satisfaction, and strong turnover intentions were: role overload, lack of workplace social support, high levels of client-related pressure, lack of professional development opportunities, and pay dissatisfaction and inequity. Strategies that aim to reduce levels of worker stress and increase retention levels need to focus on these factors (see also Skinner & Roche, 2005).

REFERENCES

Abrams, M. N. (2004). Employee retention strategies: Lessons from the best. *Healthcare Executive, 19,* 18-22.

ABS (2005). *Australian Social Trends.* Canberra: Australian Bureau of Statistics, Cat No 4102.0.

Alcohol and Other Drugs Council of Australia (ADCA) (2003). *Workforce development policy document.* Canberra: Alcohol and other Drugs Council of Australia (ADCA).

Ask, A., Ashenden, R., Allsop, S., Cormack, S., Addy, D., & Beel, A. (1998). *Education and training programs for frontline professionals responding to drug problems in Australia: A literature review.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Ask, A., & Roche, A. M. (2004). *Clinical supervision: A practical guide for the alcohol and other drugs field.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Australian and Other Drugs Council of Australia (ADCA) (2003). *Workforce development policy document:* Australian and other Drugs Council of Australia (ADCA).

Bakker, A. B., Demerouti, E., & Verbeke, W. (2004). Using the job demands-resources model to predict burnout and performance. *Human Resource Management, 43,* 83-104.

Bakker, A. B., Schaufeli, W. B., Sixma, H. J., Bosveld, W., & Van Dierendonck, D. (2000). Patient demands, lack of reciprocity, and burnout: A five-year longitudinal study among general practitioners. *Journal of Organizational Behavior, 21,* 425-441.

Barak, M. E. M., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social Science Review, 75*(4), 625-661.

Baruch-Feldman, C., Brondolo, E., Ben-Dayan, D., & Schwartz, J. (2002). Sources of social support and burnout, job satisfaction, and productivity. *Journal of Occupational Health Psychology, 7,* 84-93.

Beehr, T. A., Jex, S. M., Stacy, B. A., & Murray, M. A. (2000). Work stressors and coworker support as predictors of individual strain and job performance. *Journal of Organizational Behavior, 21,* 391-405.

Benson, G. S. (2003). Examining employability: Effects of employee development on commitment and intention to turnover. *Academy of Management Best Conference Paper* C1-C6.

Brewer, N., & Skinner, N. (2003). Work motivation. In M. O'Driscoll, P. Taylor & T. Kalliath (Eds.), *Organisational Psychology in Australia and New Zealand* (pp. 150-168). Melbourne, Victoria: Oxford University Press.

Brown, K. A., & Mitchell, T. R. (1993). Organizational obstacles: Links with financial performance, customer satisfaction, and job satisfaction in a service environment. *Human Relations, 46*(6), 725-757.

Buunk, B. P., & Schaufeli, W. B. (1993). Professional burnout: A perspective from social comparison theory. In W. B. Schaufeli, C. Maslach & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 53-69). Washington, DC: Taylor & Francis.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98,* 310-357.

Commonwealth of Australia (2004). *The National Drug Strategy: Australia's integrated framework 2004-2009.* Canberra: Department of Health and Ageing.

Cordes, C. L., & Dougherty, T. W. (1993). A review and integration of research on job burnout. *Academy of Management Review, 18,* 621-656.

Cotton, J. L. (1993). *Employee involvement: Methods for improving performance and work attitudes.* Thousand Oaks, CA: Sage.

Cotton, J. L., & Tuttle, J. M. (1986). Employee turnover: A meta-analysis and review with implications for research. *Academy of Management Review, 11,* 55-70.

De Jonge, J., Dormann, C., Janssen, P. P. M., Dollard, M. F., Landerweed, J. A., & Nijhuis, F. J. N. (2001). Testing reciprocal relationships between job characteristics and psychological well-being: A cross-lagged structural equation model. *Journal of Occupational and Organizational Psychology, 74,* 29-46.

De Jonge, J., & Schaufeli, W. B. (1998). Job characteristics and employee well-being: a test of Warr's vitamin model in health care workers using structural equation modelling. *Journal of Organizational Behavior, 19,* 387-407.

Demerouti, E., Bakker, A. B., De Jonge, J., Janssen, P. P. M., & Schaufeli, W. B. (2001). Burnout and engagement at work as a function of demands and control. *Scandanavian Journal of Work Environment and Health, 27,* 279-286.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology, 86,* 499-512.

Dollard, M. F., & Winefield, A. H. (1998). A test of the demand-control / support model of work stress in correctional officers. *Journal of Occupational Health Psychology, 3*(3), 243-264.

Dollard, M. F., Winefield, A. H., & Winefield, H. R. (2003). *Occupational stress in the service professions.* London: Taylor & Francis.

Dollard, M. F., Winefield, H. R., & Winefield, A. H. (2001). *Occupational Strain and Efficacy in Human Service Workers: When the Rescuer becomes the Victim.* London: Kluwer Academic Publishers.

Dollard, M. F., Winefield, H. R., Winefield, A. H., & De Jonge, J. (2000). Psychosocial job strain and productivity in human service workers: A test of the demand-control-support model. *Journal of Occupational and Organizational Psychology, 73,* 501-510.

Duraisingam, V., Pidd, K., & Roche, A. M. (in press). The impact of work stress and job satisfaction on turnover intention: A study of Australian specialist alcohol and other drug workers. *Drugs: Education, Prevention and Policy.*

Ellickson, M. C., & Logsdon, K. (2002). Determinants of job satisfaction of municipal government employees. *Public Personnel Management, 31*(3), 343-358.

Evans, W. N., & Hohenshil, T. H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly, 15*(2), 1-13.

Farmer, R. (1995). Stress and working with drug misusers. *Addiction Research, 3*(2), 113-122.

Farmer, R., Clancy, C., Oyefeso, A., & Rassool, G. H. (2002). Stress and work with substance misusers: The development and cross-validation of a new instrument to measure staff stress. *Drugs: Education, prevention and policy, 9,* 377-388.

Frank, F. D., Finnegan, R. P., & Taylor, C. R. (2004). The race for talent: Retaining and engaging workers in the 21st century. *Human Resource Planning, 27,* 12-25.

Freeman, T., Wolinski, K., O'Neill, M., & Roche, A. (2002). *Alcohol consumption in Australia: Patterns, responses and workforce development issues. A literature review.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Gallon, S. L., Gabriel, R. M., & Knudsen, J. R. W. (2003). The toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey. *Journal of Substance Abuse Treatment, 24,* 183-196.

Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology, 7*(3), 235-241.

Griffeth, R. W., Hom, P. W., & Gaertner, S. (2000). A meta-analysis of antecedents and correlates of employee turnover: Update, moderator tests, and research implications for the next millennium. *Journal of Management, 26,* 463-488.

Guerts, S. A., Schaufeli, W. B., & De Jonge, J. (1998). Burnout and intention to leave among mental health-care professionals: A social psychological approach. *Journal of Social and Clinical Psychology, 17*(3), 341-362.

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior and Human Performance, 16,* 250-279.

Hart, G. M. (1982). *The process of clinical supervision.* Baltimore, MD: University Park Press.

Hom, P. W., & Griffeth, R. W. (1995). *Employee Turnover.* Cincinnati, Ohio: South-Western Publishing.

Hyrkas, K. (2005). Clinical supervision, burnout and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing, 26,* 531-556.

Jackson, S. E., & Schuler, R. S. (1985). A meta-analysis and conceptual critique of research on role ambiguity and role conflict in work settings. *Organizational Behavior and Human Decision Processes, 36,* 16-78.

Judge, T. A., Thoresen, C. J., Bono, J. E., & Patton, G. K. (2001). The job satisfaction-job performance relationship: A qualitative and quantitative review. *Psychological Bulletin, 127*(3), 376-407.

Kadushin, A. (2002). *Supervision in Social Work* (4th ed.). New York: Columbia University Press.

Kalliath, T., & Beck, A. (2001). Is the path to burnout and turnover paved by a lack of supervisory support? *New Zealand Journal of Psychology, 30*, 72-78.

Karasek, R. A. (1979). Job demands, job decision latitude and mental strain: implications for job design. *Administrative Science Quarterly, 24,* 285-308.

Karasek, R. A., & Theorell, T. (1990). *Healthy work: Stress, productivity and the reconstruction of working life.* New York: Basic Books.

Kavanagh, D. J., Spence, S. H., Wilson, J., & Crow, N. (2002). Achieving effective supervision. *Drug and Alcohol Review, 21,* 247-252.

Knudsen, H. K., Johnson, J. A., & Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centres: Effects of management practices. *Journal of Substance Abuse Treatment, 24*(2), 129-135.

Koeske, G. F., & Koeske, R. D. (1989). Workload and burnout: Can social support and perceived accomplishment help? *Social Work, 34,* 243-248.

Koeske, G. F., & Koeske, R. D. (1993). A preliminary test of a stress-strain-outcome model for reconceptualising the burnout phenomenon. *Journal of Social Service Research, 17,* 107-135.

Kupperschmidt, B. R. (2002). Unlicensed assistive personnel retention and realistic job previews. *Nursing Economics, 29,* 279-283.

Landau, J., & Abelson, M. (1994). Recruitment and retention. In M. D. Fottler, S. R. Hernandez & C. L. Joiner (Eds.), *Strategic management of human resources in health services organizations* (2nd ed., pp. 265-298). New York: Delmar.

Lee, C. H., & Bruvold, N. T. (2003). Creating value for employees: Investment in employee development. *International Journal of Human Resource Management, 14*(6), 981-1000.

Lee, R. T., & Ashforth, B. E. (1993a). A further examination of managerial burnout: Toward an integrated model. *Journal of Organizational Behavior, 14,* 3-20.

Lee, R. T., & Ashforth, B. E. (1993b). A longitudinal study of burnout among supervisors and managers: Comparisons between the Leiter and Maslach (1988) and Golembiewski et al. (1986) models. *Organizational Behavior and Human Decision Processes, 54,* 369-398.

Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology, 81,* 123-133.

Leiter, M. P., Harvie, P. L., & Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science and Medicine, 47,* 1611-1617.

Libretto, S. V., Weil, J., Nemes, S., Linder, N. C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs, 36*(4), 489-497.

Lonne, R. L. (2003). Social workers and human service practitioners. In M. F. Dollard, H. R. Winefield & A. H. Winefield (Eds.), *Occupational Stress in the Service Professions.* London: Taylor & Francis.

Malcolm, A. (2001). Training up the workforce. *Connexions*, 20-22.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52,* 397-422.

McCormick, E. J., & Ilgen, D. R. (1980). *Industrial psychology* (7th ed.). Englewood Cliffs, NJ: Prentice-Hall.

McKetin, R., McLaren, J., & Kelly, E. (2005). *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences.* Sydney: National Drug Law Enforcement Research Fund Monograph Series No 13.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment,* 25, 1-5.

Milne, D., & Westerman, C. (2001). Evidence-based clinical supervision: Rationale and illustration. *Clinical Psychology and Psychotherapy, 8,* 444-457.

Muchinsky, P. M. (1993). *Psychology applied to work* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Mulvey, K. P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment, 24*, 51-57.

Ogborne, A. C., & Graves, G. (2005). *Optimizing Canada's addiction treatment workforce: Results of a national survey of service providers.* Ottawa: Canadian Centre on Substance Abuse (CCSA).

Pidd, K., Berry, J. G., Harrison, J. E., Roche, A. M., Driscoll, T. R., & Newson, R. S. (2006). *Alcohol and work: Patterns of use, workplace culture and safety.* Canberra: Australian Institute of Health and Welfare (AIHW cat. no. INJCAT 82).

Pierce, L., & Long, V. (2002). The NADA workforce development project. In A. M. Roche & J. McDonald (Eds.), *Catching clouds: Exploring diversity in workforce development in the alcohol and drugs field* (pp. 51-54). Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Pirie, D. (2003). *An evaluation of the rate, incidence and contributing factors of burnout in alcohol, tobacco and other drug services (ATODS) workers within a state government health department.* Unpublished Masters, University of Queensland, Brisbane.

Pitts, J. A. (2001). Identifying workforce issues within the alcohol and other drugs sector: Responses to a national survey. In A. M. Roche & J. McDonald (Eds.), *Systems, settings and people: Workforce development challenges for the alcohol and other drugs field* (pp. 31-36). Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Price, L., & Spence, S. H. (1994). Burnout symptoms amongst drug and alcohol service employees: Gender differences in the interaction between work and home stressors. *Anxiety, Stress, and Coping, 7,* 67-84.

Roche, A., O'Neill, M., & Wolinksi, K. (2004). Alcohol and other drug specialist treatment services and their managers: Findings from a national survey. *Australian and New Zealand Journal of Public Health, 28,* 252-258.

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

Roche, A. M. (2002a). *Workforce Development Issues in the AOD Field.* Adelaide, South Australia: National Centre for Education and Training on Addiction, Flinders University.

Roche, A. M. (2002b). Workforce development: Our national dilemma. In A. M. Roche & J. McDonald (Eds.), *Catching clouds: Exploring diversity in workforce development in the alcohol and other drugs field.* (pp. 7-16). Adelaide, South Australia: National Centre for Education and Training on Addiction, Flinders University.

Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior, 25,* 293-315.

Schaufeli, W. B., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical analysis.* London: Taylor & Francis.

Schaufeli, W. B., Van Dierendonck, D., & Van Gorp, K. (1996). Burnout and reciprocity: Towards a dual-level social exchange model. *Work and Stress, 10,* 225-237.

Schubert, K., Pond, A. N. S., Kraft, M. K., & Aguirre-Molina, M. (2004). The adolescent addiction treatment workforce: Status, challenges, and strategies to address their particular needs. *Journal of Psychoactive Drugs, 36*(4), 483-488.

Shand, F. L., & Mattick, R. P. (2001). *Clients of Treatment Service Agencies: May 2001 Census Findings* (No. 47). Canberra: Australian Government Publishing Service.

Shanley, C. (1992). Clinical supervision: An untapped resource for the alcohol and other drug field. In J. White (Ed.), *Drug problems in our society: Dimensions and perspectives.* Adelaide, South Australia: Drug and Alcohol Services Council (DASC).

Shoptow, S., Stein, J. A., & Rawson, R. A. (2000). Burnout in substance abuse counselors. Impact of environment, attitudes, and clients with HIV. *Journal of Substance Abuse Treatment, 19,* 117-126.

Skinner, N., Freeman, T., Shoobridge, J., & Roche, A. M. (2003). *Workforce development and the alcohol and other drugs field: A literature review of key issues for the NGO sector.* Adelaide, South Australia: National Centre for Education and Training on Addiction, Flinders University.

Skinner, N., & Roche, A. M. (2005). *Stress and burnout: A prevention handbook for the alcohol and other drugs workforce.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Smets, E. M. A., Visser, M. R. M., Oort, F., Schaufeli, W. B., & De Haes, H. C. J. M. (2004). Perceived inequity: Does it explain burnout among medical specialists? *Journal of Applied Social Psychology, 34,* 1900-1918.

Sparks, K., Faragher, B., & Cooper, C. L. (2001). Well-being and occupational health in the 21st century workplace. *Journal of Occupational and Organizational Psychology, 74*(4), 489-509.

Spector, P. E. (2000). *Industrial and organizational psychology: Research and practice* (2nd ed.). New York: Wiley.

Spector, P. E., & Jex, S. M. (1998). Development of four self-report measures of job stressors and strain: Interpersonal Conflict at Work Scale, Organisational Constraints Scale, Quantitative Workload Inventory, and Physical Symptoms Inventory. *Journal of Occupational Health Psychology, 3,* 356-367.

Stockwell, T., Heale, P., Dietze, P., Chikritzhs, T., & Catalano, P. (2001). *Patterns of alcohol consumption in Australia.* Perth, Western Australia: National Drug Research Institute (NDRI).

Tett, R. P., & Meyer, J. P. (1993). Job satisfaction, organizational commitment, turnover intention, and turnover: Path analyses based on meta-analytic findings. *Personnel Psychology, 46,* 259-293.

Torres, M. I., Mattick, R. P., Chen, R., & Baillie, A. (1995). *Clients of Treatment Service Agencies: March 1995 Census Findings.* Canberra: Australian Government Publishing Service.

Vagg, P. R., & Spielberger, C. D. (1998). Occupational stress: Measuring job pressure and organizational support in the workplace. *Journal of Occupational Health Psychology, 3,* 294-305.

Victorian Alcohol & Drug Association (VAADA) (2003). *Alcohol and other drug workforce development in Australia: The assessment of needs and the identification of strategies to achieve sustainable change. Summary jurisdictional reports.* VAADA.

Victorian Alcohol and Drug Association (VAADA) (2003). Hitting the ground running: Induction for new workers in the alcohol and drug sector. A VAADA discussion paper. Retrieved 12 January, 2005, from http://www.vaada.org.au/Induction%20paper.doc

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

Warr, P. (1994). A conceptual framework for the study of work and mental health. *Work and Stress, 8,* 84-97.

Wolinksi, K., O'Neill, M., Roche, A. M., Freeman, T., & Donald, A. (2003). *Alcohol and other drug treatment agencies: A national workforce development survey.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Wolinski, K., O'Neill, M., Roche, A. M., Freeman, T., & Donald, A. (2003). *Workforce issues and the treatment of alcohol problems: A survey of managers of alcohol and other drug treatment agencies.* Canberra, Australian Capital Territory: National Alcohol Strategy 2001 to 2003-04 Occasional Paper. Commonwealth of Australia.

APPENDIX

SURVEY INSTRUMENT

RECRUITMENT, REWARD & RETENTION

The 3Rs of Workforce Development

An examination of the workforce development needs of Alcohol and Other Drug (AOD) specialist workers

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

NCETA
Australia's National Research Centre on AOD Workforce Development

About the questionnaire

The following survey aims to obtain your views regarding the range of factors that impact upon recruitment, job satisfaction/reward, and retention in the alcohol and other drug (AOD) field. This national study will include AOD specialist workers across government and non-government agencies. Your responses will help develop effective strategies to recruit, reward and retain workers in the AOD field.

The National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, is being funded by The Alcohol Education and Rehabilitation Foundation (AERF) to undertake this important study.

You do not need to put your name or the name of your organisation on the survey as it is completely confidential and anonymous. This survey has received ethics approval from Flinders University Social and Behavioural Research Ethics Committee. Please note that participation is voluntary.

It would be helpful if you could answer all questions. The questionnaire takes approximately 20 minutes to complete.

Once you have completed this questionnaire, please return it in the accompanying self-addressed envelope.

For each questionnaire that is completed and returned to NCETA, an amount of $2 (maximum value $1,000) will be donated to the Tsunami Disaster – Krabi Hospital Fund, Flinders Medical Centre Foundation. For more information about this appeal, please see website: www.flinders.sa.gov.au/fmcfoundation

To check the latest news about the 3Rs Project and the amount of donations collected to date, please visit our website at www.nceta.flinders.edu.au.

We thank you in advance for your generous participation in this national study. If you have any enquires, please contact the principal researcher:

Dr. Ken Pidd Ph: 08 8201 7535 email: ken.pidd@flinders.edu.au

Yours sincerely,

Professor Ann Roche
Director of NCETA

This questionnaire examines your views on working in the alcohol and other drug (AOD) field. It would be helpful if you could answer all questions.

A. Are there aspects of your work that you find particularly satisfying?

Please tick your answer.

Yes ❑ 1
No ❑ 2
Don't know ❑ 3

If Yes, out of the following 8 items, please rank the **top 3** (or more) aspects of your work you find satisfying.

Use the numbers **1 - 3** in order of importance (1 = most important, 3 = least important).

- ☐ Doing work of value to society
- ☐ Successful outcomes for clients
- ☐ One-to-one interaction with clients
- ☐ Career growth
- ☐ Opportunities for personal learning/growth
- ☐ Relationship with co-workers
- ☐ Salary/benefits
- ☐ Other *(please specify in BLOCK LETTERS)*

. . . . . .

B. Do you think your agency/service adequately promotes the retention of (AOD) workers?

Please tick your answer.

Yes ❑ 1
No ❑ 2
Don't know ❑ 3

If No, out of the following 12 items, please rank the **top 3** (or more) strategies that your agency/service could implement to promote retention.

Use the numbers **1 - 3** in order of importance (1 = most important, 3 = least important).

- ☐ More career opportunities
- ☐ More training opportunities
- ☐ Improved physical work environment
- ☐ Flexible working hours
- ☐ Salary increases
- ☐ More recognition/appreciation of effort
- ☐ More supportive workplace
- ☐ Better work benefits (e.g. superannuation, car allowance)
- ☐ Reduced administrative workload (i.e. paperwork)
- ☐ Smaller caseloads
- ☐ Clinical supervision
- ☐ Other *(please specify in BLOCK LETTERS)*

. . . . . .

C. In your opinion, are there barriers to people working in the AOD field?

Please tick your answer.

Yes ❑ 1
No ❑ 2
Don't know ❑ 3

If Yes, out of the following 9 items, please rank the **top 3** (or more) barriers.

Use the numbers **1 - 3** in order of importance (1 = most important, 3 = least important).

- ☐ Lack of encouragement to work in the AOD field (e.g. from peers, educators, family and/or friends)
- ☐ Lack of promotion of AOD related careers
- ☐ Low salary/poor benefits
- ☐ Perceptions of difficult clients
- ☐ Workload (e.g. excessive paperwork, large caseloads, long hours)
- ☐ Limited availability of AOD education/training
- ☐ Stigma/lack of respect for the AOD field
- ☐ Differences between industrial awards
- ☐ Other *(please specify in BLOCK LETTERS)*

. . . . . .

D. Are there factors that create pressure for you at work?

Please tick your answer.

Yes ❑ 1
No ❑ 2
Don't know ❑ 3

If Yes, out of the following 14 items, please rank the **top 3** (or more) factors.

Use the numbers **1 - 3** in order of importance (1 = most important, 3 = least important).

- ☐ Difficult clients
- ☐ Clients with alcohol-related problems
- ☐ Complex client presentations
- ☐ Lack of professional development opportunities
- ☐ Overall workload
- ☐ Inadequate rewards (e.g. pay rates)
- ☐ Conflicting models of care between agencies
- ☐ Conflict between my clinical and administrative roles
- ☐ Staff shortages
- ☐ Uncertainty about future funding
- ☐ Shortage of essential infrastructure (e.g. rooms, computers, cars etc)
- ☐ Lack of workplace support
- ☐ Unsuitable/limited contractual arrangements
- ☐ Other *(please specify in BLOCK LETTERS)*

. . . . . .

E. CLIENTS YOU SEE

Some types of clients can cause pressure. To what extent do the following types of clients that you see create pressure for you?

For each of the following 10 issues please tick the response which best describes the degree of pressure you experience.

	Not applicable	No pressure	A little pressure	Some pressure	A lot of pressure	Extreme pressure
1. Clients with comorbidity problems (e.g. additional mental health disorder)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. Clients with polydrug use	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. Clients with alcohol-related problems	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. Younger clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. Manipulative clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. Demanding clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
7. Violent clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
8. Aggressive clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
9. Uncooperative clients	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
10. Other characteristics *(please specify)*	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

F. WORKPLACE RELATIONS

The following questions address various aspects of your work relationships

Please tick the response which best describes your level of agreement with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. My supervisor is concerned about the welfare of those under him/her	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. My supervisor pays attention to what I am saying	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. My supervisor is helpful in getting the job done	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. My supervisor is successful in getting people to work together	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. My co-workers are competent in doing their job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. My co-workers take a personal interest in me	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
7. My co-workers are friendly	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
8. My co-workers are helpful in getting the job done	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

G. PROFESSIONAL DEVELOPMENT OPPORTUNITIES

Please tick the response which best describes your level of agreement with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. Staff members are encouraged to undertake training courses	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. Professional development planning in this organisation takes into account individual needs and interests	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. Staff members are supported in pursuing qualifications or professional development related to their job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. This organisation provides back-up staff to allow people to attend training	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. This organisation provides staff with access to training	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. Opportunities exist in this organisation for developing new skills	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

H. CLINICAL SUPERVISION

Please tick your answer.

	Not applicable	No	Yes
1. Does your organisation offer staff effective clinical supervision?	❑ 0	❑ 1	❑ 2
2. When necessary, do you have access to a clinical supervisor?	❑ 0	❑ 1	❑ 2
3. Is the level of clinical supervision adequate to your needs?	❑ 0	❑ 1	❑ 2
4. Does your supervisor have the skills to deliver effective supervision?	❑ 0	❑ 1	❑ 2
5. Do you receive supervision on a regular basis?	❑ 0	❑ 1	❑ 2

I. RETENTION

Please tick the response which best describes your level of agreement with each of the following statements.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. I find real enjoyment in my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. Most days I am enthusiastic about my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. I feel well satisfied with my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. I have thought about leaving my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. I plan to look for a new job over the next 12 months	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. I intend to search for a new job within the AOD field but outside this organisation	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
7. I intend to search for a new job outside the AOD field	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

J. WORKING CONDITIONS

Please tick the response which best describes your level of agreement with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. I have too much work to do everything well	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. The amount of work I am asked to do is fair	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. I never seem to have enough time to get everything done	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. My job allows me to make a lot of decisions on my own	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. In my job I have very little freedom to decide how I do my work	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. I have a lot of say about what happens in my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
7. I am very satisfied with my pay	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
8. My pay is fair considering what other people in this organisation are paid	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
9. My pay is fair considering what other AOD organisations in this field pay	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
10. I am very satisfied with my working contractual arrangements	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
11. My current workload largely comprises dealing with clients that mainly have alcohol-related problems	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

Please continue……

K. WORKER WELL-BEING

Please tick the response which best describes your level of agreement with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. Working with people all day is really a strain for me	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
2. I feel I'm working too hard on my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
3. I feel frustrated by my job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
4. I feel like I'm at the end of my tether	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
5. I feel emotionally drained from my work	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
6. I feel burned out from my work	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
7. I feel fatigued when I get up in the morning and have to face another day on the job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
8. I feel used up at the end of the workday	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

You are nearing the end. Thank you for your time.

L. WORKING WITH INDIGENOUS CLIENTS

The following questions relate to AOD work with Indigenous clients.

If they are not applicable to you, please go the next page and complete Section M (Demographics).

Please tick the response that best describes your level of agreement with each statement in the following questions.

	No	Not sure	Yes
1. Does your agency provide services to Indigenous clients? *If answered No, go to Section M on the next page.*	❑ 1	❑ 2	❑ 3

	Don't know	No need	Some need	Strong need
2a. How would you describe the need for AOD services for Indigenous peoples living in this area? *If answered No need, go to Q. 3.*	❑ 1	❑ 2	❑ 3	❑ 4

	Don't know	No need	Some need	Strong need
2b. To what extent is this need being met?	❑ 1	❑ 2	❑ 3	❑ 4

	No	Not sure	Yes
3. Do you feel culturally competent to deal with Indigenous AOD issues?	❑ 1	❑ 2	❑ 3

Please explain your answer (using BLOCK CAPITALS)

. . . . . .

. . . . . .

	No	Some but not enough	Yes
4. Do you have access to appropriate Indigenous specific AOD resources?	❑ 1	❑ 2	❑ 3

Please explain your answer (using BLOCK CAPITALS)

. . . . . .

. . . . . .

5. Are there any other issues concerning the provision of AOD services for Indigenous clients which you feel should be addressed?

Please explain your answer (using BLOCK CAPITALS)

. . . . . .

. . . . . .

M. DEMOGRAPHICS

Information is collected for statistical purposes only.
Please tick your answers to the following questions.

1. What type of organisation do you work for?
   - ❑ 1 Government
   - ❑ 2 Non-government
   - ❑ 3 Private
   - ❑ 4 Other (please specify)
     . . . . . .

2. How long have you been working for this organisation?
   . . . . . years . . . . . months

3. How long have you been working in the AOD field?
   . . . . . years . . . . . months

4. What state or territory are you working in? . . . . . .

5. Please indicate the type of geographic location in which your workplace is situated.
   - ❑ 1 Urban
   - ❑ 2 Regional
   - ❑ 3 Rural
   - ❑ 4 Remote
   - ❑ 5 Other (Please specify)
     . . . . . .

6. What is your age? . . . . . years

7. What is your gender? ❑ 1 Male ❑ 2 Female

8a. Which of the following options best describes your current working arrangements?

Permanent	Contract	Casual	Other
❑ 1	❑ 2	❑ 3	❑ 4

8b. Are you working full-time or part-time?

Full-time	Part-time
❑ 1	❑ 2

9. What is your occupation?

- ❑ 1 AOD worker
- ❑ 2 Nurse
- ❑ 3 Psychologist
- ❑ 4 Social worker
- ❑ 5 Doctor
- ❑ 6 Other (please specify)

10. Please indicate the **HIGHEST** formal qualification you have **COMPLETED**.
Please tick your answer.

- ❑ 1 Secondary school – less than Year 12
- ❑ 2 Secondary school – completed Year 12
- ❑ 3 TAFE
- ❑ 4 University Degree Undergraduate or Honours
- ❑ 5 Postgraduate Degree (e.g. Master, PhD.)
- ❑ 6 Other (Please specify in BLOCK LETTERS)

. . . . . .

11. Please indicate **ALL** qualifications you have completed where alcohol and other drugs were the primary focus or a substantial part of the course.
Please tick as many boxes that apply.

- ❑ 1 Non-accredited training courses (including in-service)
- ❑ 2 Accredited short courses
- ❑ 3 TAFE
- ❑ 4 University Degree Undergraduate or Honours
- ❑ 5 Postgraduate Degree (e.g. Master, PhD.)
- ❑ 6 Other (Please specify in BLOCK LETTERS)

. . . . . .

Thank you for completing this questionnaire

Please enclose the questionnaire in the addressed, reply paid envelope provided and return it to NCETA.

If you have any enquires please contact
Dr. Ken Pidd Ph: 08 8201 7535 email: ken.pidd@flinders.edu.au

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