



ENHANCING ALCOHOL AND OTHER DRUG WORKERS' WELLBEING: A LITERATURE REVIEW

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About NCETA

NCETA is based at Flinders University in South Australia and is an internationally recognised research and training centre that works as a catalyst for change in the alcohol and other drug (AOD) field. NCETA's areas of expertise include training needs analyses, the provision of training and other workforce development approaches. We have developed training curricula, programs and resources, and provided training programs, to cater for the needs of: specialist AOD workers; frontline health and welfare workers; Indigenous workers; community groups; mental health workers; police officers; and employers and employee groups. The Centre focuses on supporting evidence-based change and specialises in change management processes, setting standards for the development of training curriculum content and delivery modes, building consensus models and making complex and disparate information readily accessible to workers and organisations.

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About Matua Raki

Matua Raki is the national centre for addiction workforce development in New Zealand. We work with organisations and people across the country and around the world to support the addiction workforce minimise addiction-related harm. Matua Raki supports innovation and works towards evidence-based workforce development solutions through a broad range of activities such as policy development, training programs, boosting sector relationships and networking, resource development, research and competency development. We develop effective training initiatives, and place a strong emphasis on consumer involvement. The Centre's vision is for a highly skilled, confident and competent workforce which, supported by a sound infrastructure, will provide accessible and effective services which minimise addiction-related harm and improve health for people with addiction problems and their families and whānau.

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About NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non-government alcohol and other drugs sector in NSW. NADA's vision is a connected and sustainable sector providing quality evidence based programs to reduce alcohol and drug related harms to NSW communities. They represent approximately 100 organisational members that provide a broad range of services including health promotion and harm reduction, early intervention, treatment and aftercare programs. Their members comprise of services that are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery. NADA provides a range of programs and services that focus on sector and workforce development, information management, governance and management support, sector representation and advocacy, as well as actively contributing to public health policy.

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Foreword

The Network of Alcohol and other Drugs Agencies (NSW, Australia) and Matua Raki (New Zealand) are key organisations with responsibility for supporting the alcohol and other drugs/addiction workforce. A healthy workforce is critical in providing effective services to those with complex health and social needs. Together they proposed a research and capacity building project that uses an organisational change management approach to supporting the health and wellbeing of our workforces through a range of supports and interventions.

In order to have an informed approach, the National Centre for Education and Training on Addiction, Flinders University (SA, Australia) was commissioned to conduct a literature review to examine and evaluate the literature related to the health and wellbeing of the alcohol and other drug (AOD) workforces in Australasia. The review describes, summarises, and evaluates the literature in relation to:

- Areas of concern for the workforce (describe the problem)
- Protective factors (including what promotes health and wellbeing)
- Measures and tools used to examine workforce health and wellbeing
- Effective interventions for a healthy workforce.

This review supports, and is consistent with, the legal responsibilities of Australian and New Zealand organisations to ensure that workplaces do not cause harm to the health of employees. The review also forms part of NADA's broader research and capacity building project that uses organisational change management approaches to enhance the health of the NSW non-government organisation (NGO) AOD workforce – reflecting Key Direction #3 of NADA's Strategic Plan 2015-18 (NADA, 2015).

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Executive summary

This report describes key findings from a literature review, together with an outline of contextual issues, related to the wellbeing of alcohol and other drug (AOD) workers.

An overview of the wellbeing status of the Australian and New Zealand and international AOD workforces is provided. As relatively little research has been conducted into the wellbeing of AOD workers, data on workers with similar roles is also discussed.

Approaches to enhancing worker wellbeing and a range of wellbeing measures are provided to assist preventive activities.

What is worker wellbeing?

Worker 'wellbeing' involves the extent to which workers perceive that their lives are going well and the degree to which they enjoy good physical and mental health and are resilient. Worker wellbeing also concerns workers' level of engagement in intellectual endeavours, social relations and emotional attachment.

Why is worker wellbeing an issue?

Worker wellbeing is a key issue facing many organisations in Australia and New Zealand. It is important for several reasons.

The wellbeing of workers impacts client outcomes. By optimising workers' wellbeing, organisations can enhance client outcomes.

Organisations also have legal responsibilities to ensure workplaces do not cause harm to the health of employees.

Worker wellbeing can also have major economic impacts. There are substantial human and financial costs associated with poor worker wellbeing on individuals, organisations and health care systems. Employers bear many of these costs and there is increasing recognition that a healthy workforce is central to achieving organisational goals.

Chronic diseases and lifestyle-related conditions are major contributors to ill health. Workplaces can play an important role in reducing this burden and enhancing workers' wellbeing.

Demographic issues

Life expectancy is increasing. This has two major implications for the AOD Sector. First, the chronic illness and disability associated with an ageing population is increasing demand for health and welfare services and cross-sectoral competition for staff. Second, the ageing of AOD workforces may result in a deterioration of the health and wellbeing of these workforces.

Approaches to worker wellbeing

Contemporary approaches to worker wellbeing include:

- Enhancing the physical safety of workers
- Enhancing the physical welfare of workers
- Reducing the impact of psychological risks
- Worker-focussed health promotion

- Systemic approaches to enhancing worker wellbeing.

Systemic approaches involve:

- The broad range of factors that influence worker wellbeing
- Recognising the need for supportive environments to encourage positive health-related behaviour change
- Appreciating the importance of job satisfaction to worker wellbeing
- Understanding the multiple ways workplaces interact with the characteristics and lifestyles of individual workers to influence wellbeing.

A more comprehensive approach is critically important to effectively impact worker wellbeing.

AOD worker wellbeing

Working in the AOD Sector can be very rewarding. It provides:

- The opportunity to help and work directly with people
- Belief in the value of the work and making a contribution to society
- The opportunity for personal and professional growth and development.

Nevertheless, challenges may exist given the emotionally demanding nature of AOD work, including:

Demographic and societal changes
An aging substance using clientele with additional needs, (e.g., co-occurring physical health conditions, effects of chronic substance use)
New substances and patterns of use (e.g., synthetics / pharmaceuticals / smart drugs)
Recruitment and retention problems in the context of a worldwide shortage of health and welfare workers
Increased prevalence, or awareness, of multiple morbidities among AOD clients, necessitating more holistic and integrated interventions
New, evidence-based prevention paradigms, treatments and pharmacotherapies requiring continual skill updating
Addressing the social determinants of AOD problems
Appropriate cultural responsiveness and competence
The need to work across sectors (e.g., primary care, corrections, social services)
Consumer input into care and involvement of peers
Emphasis on family sensitive practice stemming from a better understanding of the effects of parental AOD and co-occurring problems on children
Recurring service restructuring
Outcomes- (rather than inputs- or outputs-) focussed funding
Increased occupational exposure to violence
Stigma associated with providing services to AOD clients
Lack of resourcing for professional development and upskilling
Management inadequately trained and supported to carry out their role
Pay disparities depending on occupation/professional title and employment in different sectors
Insufficient co-worker and line manager support and absent / limited clinical supervision
Qualifications that have become increasingly academic and less applied, challenging the 'work readiness' of students/those new to the workforce.

Who are the AOD and addiction workforces?

The limited available data suggests the Australian AOD specialist workforce consists of >10,000 workers from diverse occupations, of whom:

- Most are female
- Nearly half are aged 45 years or older
- Almost half are employed part-time
- Average duration of working in the AOD field is approximately 5 years.

The majority of frontline AOD workers hold formal qualifications at certificate (23%), undergraduate / honours (39%), or post-graduate (26%) levels. A substantial proportion (12%) have no formal qualifications.

The Health-funded New Zealand addiction workforce has:

- Approximately 1,400 full time equivalent staff employed in Health-funded addiction services, 55% of whom have worked in the field for more than five years
- Vacancy rates of approximately 4%
- 72% employed in community services, 23% in residential/inpatient services and 2% in other service types
- 68% employed in clinical roles, 16% support worker roles, 1% provide cultural advice and support and 15% are in administrative or management roles.

Workforce wellbeing

Available research largely addresses psychological wellbeing, rather than wellbeing more broadly. Australian and New Zealand research suggests that most AOD workers are faring well from a psychological perspective. Nonetheless, approximately 10-30% of AOD workers are experiencing psychological distress. This appears to be comparable to workers in similar roles.

The following groups were found to be at greater risk of stress and burnout and warrant priority attention:

- Younger workers
- Managers
- Indigenous workers
- Workers with lower educational attainment levels and/or those with a lived experience background.

Alcohol and other drug workers are at significant risk of secondary traumatic stress (STS). However, less than two thirds of Australian AOD workers were found to have received related support, highlighting the need for enhanced clinical supervision and education and training.

What can organisations do to foster AOD worker wellbeing?

Programs to enhance AOD worker wellbeing have not been extensively researched. Nevertheless, there is sufficient evidence of effective approaches from other sectors/disciplines to provide guidance.

Programs to protect and enhance worker wellbeing can be implemented at the level of individuals and / or organisations. See the Table below.

Level of intervention	Examples
Person-directed	Cognitive behavioural approaches designed to enhance job competence, personal coping skills and resilience, encourage connectedness and improve social support or relaxation.
Organisation-directed	Strong supportive leadership. Organisational support. Strong organisations that are client focused and care for the wellbeing of staff. Focus on changing work procedures, adjusting workloads/roles, ensuring sufficient resources, addressing distributive justice issues, enhancing the ways in which organisations work together. It may involve task restructuring, work evaluation, and facilitate good clinical supervision; to decrease job demands, increase job control, or enhance the level of participation in decision-making, mentoring programmes, orientation, and autonomy. These measures empower individuals and reduce their experience of stressors.
Person- and organisation-directed	Combination of the above.

Source: Awa et al. (2010).

Organisation-directed programs, including health promoting organisational policies, complemented by person-directed approaches, are likely to be both sustainable and successful by creating a supportive (organisational) culture of wellbeing.

Effective approaches to enhance AOD worker wellbeing include:

- Worker wellbeing policies
- Multifaceted health promotion programs
- Programs to enhance worker resilience
- Effective clinical supervision
- Ensuring that organisations are well managed
- Encouraging help-seeking behaviours in the workplace
- Programs to prevent and reduce stress and burnout
- Encouraging individual self-care approaches.

Measuring wellbeing

A number of tools were identified to measure worker wellbeing and evaluate the effectiveness of workplace wellbeing programs (see Appendix D).

1. World Health Organization Quality of Life Survey: BREF
2. Workplace Wellbeing Questionnaire by the Black Dog Institute
3. Organisational Readiness to Change
4. General Health Questionnaire (GHQ-12)

5. Shirom-Melamed Burnout Measure
6. Therapeutic Optimism Scale
7. The Secondary Traumatic Stress Scale
8. The Professional Quality of Life Scale (ProQOL)
9. Utrecht Work Engagement Scale (UWES)
10. Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)
11. ACT Government Health and Wellbeing Survey
12. Tasmanian Government Health and Wellbeing Survey.

Of the above measures the World Health Organization Quality of Life Survey: BREF is the most relevant to AOD organisations, however if used in conjunction with a range of other measures may result in a survey that is too lengthy. An alternative is the European Health Interview Survey-Quality of Life 8-item index.

Limitations

The available research largely derives from cross-sectional studies which:

- Generally rely on self-report
- Cannot analyse changes over time
- May not provide a representative sample of all workers.

Caution is warranted in applying international findings to the Australian/New Zealand context. There is also a lack of comparator benchmarks with no clear indication of 'normal' or 'acceptable' levels of worker wellbeing. Using standardised wellbeing assessment tools will enable comparisons with other sectors.

Conclusion

The wellbeing of AOD workers has not been extensively researched. Research to-date largely addresses psychological wellbeing, rather than wellbeing more broadly. Available Australian and New Zealand research suggests most AOD workers are faring well from a psychological perspective comparable to workers in similar roles.

Alcohol and other drug workers perform a wide variety of roles in diverse organisations, with variable management capabilities and levels of organisational support. Workers also come from disparate professional backgrounds, have different qualifications, and support a range of client groups. Therefore, their work experiences, health enhancing behaviours and levels of wellbeing may vary substantially.

Strategies to enhance worker wellbeing should be designed and implemented at the organisational level and based on actual levels of worker wellbeing and the characteristics of particular organisations. Younger, less experienced workers, managers and those lacking formal qualifications should be a priority for programs aimed at enhancing psychological wellness. Approaches which use organisational-directed measures, supplemented by individual-directed measures, appear to be most effective. The tools provided in this report will help support that process.

1. Introduction

Protecting and enhancing AOD worker wellbeing is central to AOD workforce development approaches in Australia and New Zealand.

This report presents key findings of a literature review undertaken to examine:

- Available evidence concerning the wellbeing of Australian and New Zealand AOD workers
- Approaches to protect and enhance worker wellbeing
- Tools to measure wellbeing.

1.1 The context

1.1.1 Worker wellbeing: An individual, organisational and economic issue

Worker wellbeing is a key issue facing many organisations in Australia and New Zealand. It also has implications for the economies of these countries. The financial and human costs of poor levels of worker wellbeing to individuals, organisations and health care systems are becoming unsustainable. This is particularly relevant in relation to the impact of chronic diseases on workers (PricewaterhouseCoopers, 2010). With non-communicable and chronic illnesses increasing worldwide, approximately 10% of the gross domestic product of developed countries is now expended on health care (The World Bank, 2016).

Life expectancy is rising in many countries. In New Zealand in 2004, for example, the median age of the population was 35, by 2051 it will reach 46 (Cornwall & Davey, 2004). The chronic illnesses and disabilities associated with an ageing population increase demand for both acute and long-term health services and results in greater cross-sectoral competition for staff. The Australian and New Zealand AOD workforces are also ageing and will experience a concomitant decline in their health status.

Fulfilling employment has psychological and physical benefits for workers. Conversely, unemployment, under-employment and stressful and unhealthy working conditions adversely impact wellbeing (PricewaterhouseCoopers, 2010). There is also growing recognition that workplaces not only play an important role in enhancing workers' wellbeing, but that a healthy workforce is central to achieving organisational goals. This applies equally to AOD agencies as to other organisations.

Employers bear many of the costs associated with ill health among workers. The estimated annual cost of sickness absenteeism to Australian employers is \$A7 billion, with the cost of presenteeism (i.e., not fully functioning at work) almost \$A26 billion (PricewaterhouseCoopers, 2010). In 2004-05 absenteeism in New Zealand cost approximately \$NZ 0.205 billion per annum and presenteeism approximately \$NZ4.08 billion (Holt, 2010).

In 2007, the cost of work-related mental stress to the Australian economy was nearly \$15 billion and the direct cost to employers of stress-related absenteeism and presenteeism was over \$10 billion (LaMontagne, Sanderson, & Cocker, 2010). These figures do not include hidden costs associated with re-staffing and re-training that result from associated staff turnover.

Moreover, these findings are likely to underestimate the overall cost to the economy because mental stress also contributes to a number of other health conditions (LaMontagne et al., 2010; Medibank Private, 2008).

In 2007, 5.8% (\$730 million) of the total societal cost of depression in the Australian workforce was attributable to job strain. The majority of the employment-related costs were incurred by employers and comprise a significant burden on the Australian economy that is potentially avertable (LaMontagne et al., 2010).

1.1.2 Risk factors and ill health in the Australian and New Zealand populations

A significant proportion of the Australian and New Zealand populations experience ill health or have risk factors for ill health. This is a substantial cost to organisations and workplaces, including AOD agencies, and provides an excellent opportunity for remediation.

Australia: Prevalence of risk factors and ill health

The majority of (96%) working-age Australians have one or more of the following health risk factors: smoking; risky alcohol consumption; obesity; physical inactivity; low fruit/vegetable consumption; high blood pressure; or high blood cholesterol. Three-quarters report multiple risk factors. Working-aged people with three or more risk factors have significantly greater odds of not being in the labour force compared with those without risk factors. Work absence rates are much greater for workers with at least one risk factor and at least one chronic disease, compared with those with no risk factors or chronic disease (Australian Institute of Health and Welfare, 2010).

In 2014-15, 17.5 % of Australian adults (4.0 million) suffered from mental/behavioural conditions (Australian Bureau of Statistics, 2016). Of the 16 million Australians aged 16-85 years, almost half (45% or 7.3 million) have had a mental disorder at some point in their life. One in five (20% or 3.2 million) Australians had a mental disorder in the previous 12 months (Australian Bureau of Statistics, 2008).

In 2014-15, 63.4% of Australian adults (11.2 million people) were overweight or obese and the prevalence of common physical health problems among the Australian population was:

- Arthritis 15.3%
- Asthma 10.8%
- High cholesterol 7.1%
- Diabetes 5.1%
- Heart disease 5.2%
- Hypertension 11.3%.

New Zealand: Prevalence of risk factors and ill health

Over one-third (38%) of all health lost¹ among the New Zealand population stems from known modifiable risk factors. Dietary risks are the leading specific cause of health loss. Risk factors contributing to health loss include:

- Having higher than optimal body mass index 9.2%

¹Defined as disability-adjusted life year (DALY) and health adjusted life expectancy (health expectancy). The DALY is the unit of health loss. One DALY represents the loss of one year lived in full health. Health expectancy is a generalisation of life expectancy that takes account of time lived in different health states, defined by level of functioning (disability). Therefore health expectancy can be considered as the number of years the average person can expect to live in full health.

- Tobacco use 8.7%
- High blood pressure 8.3%
- High blood glucose (including both diabetes and pre-diabetes) 5.7%
- High total blood cholesterol 4.5%
- Low levels of physical activity 3% of (New Zealand Ministry of Health, Manatū Hauora, 2016a).

In New Zealand in 2015/16, among those aged 15+ years, the population prevalence of:

- Arthritis was 16.7%
- Asthma was 10.8%
- High cholesterol was 11.5%
- Diabetes was 5.8%
- Ischaemic heart disease was 4.6%
- Hypertension was 16.6%.

In the same year, 66.8% of New Zealanders were overweight or obese and 18.8% had a mood and/or anxiety disorder (New Zealand Ministry of Health, Manatū Hauora, 2016b).

Mental health disorders, as a group, are the third-leading cause of health loss for New Zealanders (11.1% of all health loss), and the main conditions are: anxiety and depressive disorders (accounting for 5.3% of health loss), alcohol use disorders (2.1%) and schizophrenia (1.3%) (Mental Health Foundation, 2014).

In summary, as Australian and New Zealand AOD workforces continue to age, chronic diseases are likely to become increasingly prevalent. As a result, worker wellbeing will become a growing issue for AOD workplaces and it is important that these services become wellbeing-promoting workplaces. This will not only enhance the wellbeing of their workers but also improve client outcomes and increase the attractiveness of AOD services as employers.

1.1.3 Employers' responsibilities

In addition to the importance of minimising the costs associated with ill health in the workplace, AOD organisations have legal responsibilities to ensure workplaces do not cause harm to the health of employees. The (New Zealand) Health and Safety at Work Act (2015), (NSW) Work Health and Safety Act and Regulations (2011) and similar legislation in other Australian jurisdictions, mandate the prevention of workplace harms. This includes psychological harm from behaviours such as bullying, overwork and harmful managerial approaches (Medibank Private 2008).

1.1.4 Understanding worker wellbeing

Worker 'wellbeing' refers to the extent to which AOD and other workers perceive that their lives are going well. It incorporates the degree to which they enjoy good physical and mental health and are resilient. Wellbeing involves workers' level of engagement in living and involvement in a broad range of human activities including intellectual endeavours, social relations and emotional attachment (Centers for Disease Control and Prevention, 2016a).

From this perspective, worker wellbeing stems from feeling stimulated, rewarded and secure (Andrews & Withey, 1976; Campbell, 1976; Centers for Disease Control and Prevention, 2016a; Ryff & Singer, 1998; World Health Organization Quality of Life Assessment Group, 1995). At the core of these perspectives is a focus on the individual's perception of their life

circumstances and expectations (Veenhoven, 2010). This is discussed later in the context of positive psychology.

Over recent years, the following changes have occurred in our understanding of worker wellbeing.

1. *Worker wellbeing is multifaceted*

There is a growing appreciation of the multiple aspects of worker wellbeing. Historically, many workplace health and wellbeing-related activities tended to focus on a single illness or risk factor (e.g., stress or prevention of heart disease) or on changing personal health practices and behaviours (e.g., smoking or diet). Increasingly, more holistic approaches to worker wellbeing are being adopted which address a range of risks to worker wellbeing (World Health Organization 2016).

2. *Worker wellbeing has multiple determinants*

Workers' wellbeing has multiple determinants. As a result, worker-focused interventions now incorporate more comprehensive approaches that acknowledge the combined influence of personal, environmental, organisational policy, community and societal factors on employee wellbeing (World Health Organization 2016).

3. *Worker health and workplace injury links*

The relationship between health-related behaviours/problems and workplace injuries are now better understood. For example:

- Obesity is associated with an increased rate of workplace injury, (Dong, Wang, & Largay, 2015), the number of workdays lost and injury medical costs (Østbye, Dement, & Krause, 2007; Australian Safety and Compensation Council, 2008; Chau, Bhattacharjee, Kumar & Group, 2009)
- Smoking is associated with increased injury rates (Dong, Wang, & Largay, 2015; Wen et al., 2005; Chau et al., 2009)
- Musculoskeletal conditions are associated with increased injury rates in those aged 45 and older (Chau et al., 2009)
- Sleeping problems are associated with increased workplace injuries (Kling, McLeod, & Koehoorn, 2010; Uehli, et al., 2014).

Enhancing the wellbeing of workers is not only a worthy aim in itself, it can reduce the risk of injury.

4. *The importance of resilience*

Worker resilience, refers to the ability to maintain personal and professional physical and emotional wellbeing in the face of on-going work stress and adversity (McCann et al., 2013). Resilience has been likened to the elasticity and malleability of certain metals. Cast iron, for example, is hard and brittle and breaks easily. On the other hand, wrought iron is soft, malleable and adaptable and bends without breaking. Malleable metals, like resilient people, can withstand increased levels of strain and hardship (Lazarus, 1993).

Resilience is sometimes defined according to individual qualities, traits or characteristics. These include:

- Resourcefulness and flexibility
- A strong sense of self and self confidence
- Curiosity

- Self-discipline and level-headedness
- Emotional stamina
- Strong problem-solving abilities (Jackson, Firtko, & Edenborough, 2007).

There is emerging evidence that resilience-promoting work environments for health and welfare workers can reduce the negative, and increase the positive outcomes stemming from working in potentially demanding environments (McCann et al., 2013).

Recognition of the importance of resilience stems from the positive psychology movement that focuses on building strength, resilience and positive emotions. It shifts the focus from clinical problems to the promotion of wellbeing and satisfying lives filled with meaning, pleasure, engagement, positive relationships and accomplishment. From this perspective, positive psychology is the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions (Gable & Haidt, 2005, Seligman & Csikszentmihalyi, 2014). Positive emotions are important because they broaden thought / action repertoires, and in doing so, build enduring personal resources, including physical, intellectual, social and psychological assets (Fredrickson, 1998).

1.1.5 Paradigm shifts in approaches to worker wellbeing

There have been a number of paradigm shifts in understanding, and approaches to, worker wellbeing.

1. Enhancing the physical safety of workers

The implementation of measures to enhance the physical safety of workers had its genesis in the early 1800s in England. This led to implementation of safety guards and other measures to reduce the risk of death and injury associated with machines and chemicals developed and used during the industrial revolution. Workers' physical safety remains very important but represents just one component of overall worker wellbeing. In many health and welfare settings, physical safety has again become more prominent especially where workers face increased threats of violence.

2. Enhancing the welfare of workers

By the mid-1800s, some employers introduced measures to enhance worker welfare. This included the provision of on-site toilets and eating rooms. This focus on factors contributing to worker welfare remained relatively narrow until the middle of the 20th century.

3. Considering worker welfare more broadly

By the mid-20th century, other aspects of worker wellbeing were gaining increasing attention. In particular, the rising toll of stress-related workers' compensation claims led to greater prominence being given to workers' psychological welfare. In the helping professions, in which emotional labour forms a large part of workers' roles, problems of stress and burnout were becoming increasingly prominent. At the same time, there was increasing recognition of the need to enhance workers' wellbeing by improving their health-related behaviours.

4. Narrow, worker-focussed health promotion

The increasing awareness of health behaviour-related factors that could impact worker wellbeing led to the implementation of a range of health promotion programs. These were often single issue-focussed and generally aimed at changing workers' health risk-related behaviours relating to diet, exercise, smoking, alcohol consumption, diabetes and hypertension. These approaches often fail to have sustained impacts because they do not

take into consideration the importance of supportive environments in facilitating and sustaining behaviour change.

5. *Systemic approaches to enhance worker wellbeing.*

Contemporary approaches to enhance worker wellbeing are commonly predicated on a more sophisticated understanding of:

- The broad range of factors that influence worker wellbeing
- The need for supportive policies and environments to encourage positive health-related behaviours
- The importance of job satisfaction to worker wellbeing
- The range of ways in which characteristics of workplaces interact with the characteristics and lifestyles of individual workers to influence wellbeing.

Adopting this more comprehensive approach to enhancing worker wellbeing is critically important to having lasting influences on worker wellbeing.

1.2 Summary of contextual factors and implications for the AOD Sector

Countries such as New Zealand and Australia are facing epidemics of chronic illnesses (Centers for Disease Control and Prevention, 2016b). This comes at substantial costs to workers, organisations and economies and AOD workers and agencies are not immune to this trend. Implementing evidence-based wellbeing enhancement programs targeted at problems which are of relevance to given workforces can be highly effective.

What follows is a description of many of the current threats posed to the wellbeing of AOD workers in particular.

2. Challenges to AOD worker wellbeing

Alcohol and other drug workers are the sector's greatest resource. Ensuring their health and wellbeing and maximising opportunities for them to perform at an optimal level is therefore essential (Skinner & Roche, 2005).

Working in the AOD sector can be very rewarding. Sources of job satisfaction and reward for workers include:

- The opportunity to help and work directly with people
- Belief in the worth of their work in terms of making a contribution to society
- The opportunity for growth and development at personal and professional levels (Gallon, Gabriel, & Knudsen, 2003).

Nevertheless, working in the sector can present some challenges.

Changes in global economic realities are transforming the nature of work from physical tasks to more mental and emotional endeavours (Ruotsalainen, Serra, & Marine, 2008). Concurrently, the world of work is increasingly characterised by work intensification where more is expected of workers, but invariably with fewer resources, which can reduce the time available for workforce development activities (Skinner & Roche, 2005). These contemporary changes in work roles and practices place particular pressures on those involved in emotionally demanding work, such as the AOD workforce (Evans et al., 2006; Paris & Hoge, 2010; Roche, Duraisingam, Trifonoff, & Tovell, 2013; Rossi et al., 2012; Rössler, 2012; Volker et al., 2010).

Human service working environments generally have relatively low practitioner autonomy, high demands and low workload control, and can place workers at increased risk of psychological morbidity (Farmer, 1995; Skinner & Roche, 2005; Söderfeldt, Söderfeldt, Ohlson, Theorell, & Jones, 2000).

The most common workplace stress for AOD workers is the stress associated with workload and time pressures. Other stressors include concerns about:

- Whether their work is making a difference
- Whether they have the necessary skills and are effective in their role
- Whether their work is valued and adequately remunerated
- Workplace conflict, lack of supervisory and collegial support and job uncertainty (Marel, et. al, 2016).

The AOD workforce faces a range of other challenges including:

1. Demographic and societal changes
2. An aging substance using clientele with additional needs, (e.g., co-occurring physical health conditions, effects of chronic substance use)
3. New substances and patterns of use (e.g., synthetics / pharmaceuticals / smart drugs)
4. Recruitment and retention problems in the context of a worldwide shortage of health and welfare workers
5. Increased prevalence, or awareness, of multiple morbidities among AOD clients, necessitating more holistic and integrated interventions
6. New, evidence-based prevention paradigms, treatments and pharmacotherapies requiring continual skill updating
7. Addressing the social determinants of AOD problems

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8. Appropriate cultural responsiveness and competence
9. The need to work across sectors (e.g., primary care, corrections, social services)
10. Consumer input into care and involvement of peers
11. Emphasis on family sensitive practice stemming from a better understanding of the effects of parental AOD and co-occurring problems on children
12. Recurring service restructuring
13. Outcomes - (rather than inputs- or outputs-) focussed funding
14. Increased occupational exposure to violence
15. Stigma associated with providing services to AOD clients
16. Lack of resourcing for professional development and upskilling
17. Management inadequately trained and supported to carry out their role
18. Pay disparities depending on occupation/professional title and employment in different sectors
19. Insufficient co-worker and line manager support and absent / limited clinical supervision
20. Qualifications that have become increasingly academic and less applied, challenging the 'work readiness' of students/those new to the workforce.

Strategies and interventions to maintain and enhance the wellbeing of AOD workers are critically important, not only for workers themselves but for organisational functioning. They are also important for client engagement and outcomes (Landrum, Knight, & Flynn, 2012; Skinner & Roche, 2005). Evidence indicates that worker wellbeing, including levels of burnout, influence client / patient outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Hanrahan, Aiken, McClaine, & Hanlon, 2010; Poghosyan, Clarke, Finlayson, & Aiken, 2010; Shanafelt et al., 2010; Shirom, Nirel, & Vinokur, 2006; Stimpfel, Sloane, & Aiken, 2012; Teng, Shyu, Chiou, Fan, & Lam, 2010). A key way that organisations can enhance client outcomes is by optimising the wellbeing of their workers.

As the intensity of work increases, so too do the risks of threats to wellbeing and subsequent loss of experienced / competent staff (Duraisingam, Pidd, & Roche, 2009; Skinner & Roche, 2005). Staff losses are highly problematic in light of the current global health workforce crisis that has resulted from insufficient health workers (World Health Organization, 2011). Staff turnover is also costly, can create gaps or disruptions to service delivery and is disruptive to therapeutic relationships (Substance Abuse and Mental Health Services Administration, 2013). Staff who remain in organisations with high turnover can experience higher work demands and feel unsupported by their organisations (Knight, Becan, & Flynn, 2012).

As noted above, AOD workers also encounter high levels of stigma (Room, 2005; Skinner, Feather, Freeman, & Roche, 2007; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). People with substance use problems are among the most stigmatised groups in the community (Phillips & Shaw, 2013), exacerbating barriers to accessing care and support (Ahern, Stuber, & Galea, 2007; Gray, 2010). Working with stigmatised clients also impacts workers. 'Stigma by association' can have a range of adverse effects, such as a loss of self-esteem and psychological distress (Bos, Pryor, Reeder, & Stutterheim, 2013). It can also act as an impediment to attracting and retaining AOD workers (Duraisingam, Pidd, Roche, & O'Connor, 2006).

Australia's National Alcohol and other Drug Workforce Development Strategy called for the implementation of measures to reduce the stigma associated with working in the AOD field (Intergovernmental Committee on Drugs, 2014).

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Workplace bullying can represent a threat to the wellbeing of AOD workers. Workplace bullying refers to repeated, unreasonable behaviour directed towards a worker or group of workers that creates a risk to health and safety. It can cause significant psychosocial harm to workers experiencing or witnessing such behaviour. The effects of workplace bullying vary, but may include:

- Stress, anxiety or sleep disturbance
- Mental health issues such as depression
- Reduced quality of family and home life
- Increased absenteeism and staff turnover
- Reduced work performance (Comcare, 2016).

The presence of bullying in the workplace can be a result of a poor workplace culture supported by an environment which allows such behaviour to occur. Inadequate people management skills and lack of supportive leadership can compound the problem. The issue of bullying within AOD workplaces has not been studied in the Australian or New Zealand contexts. Therefore the extent of bullying that is occurring is unclear. Nevertheless, this a factor which warrants consideration when attempting to maximise worker wellbeing (Comcare, 2016).

The evidence is unambiguous concerning the threats to AOD worker wellbeing. Key risk factors include:

- Working in organisations with insufficient clarity of agency mission, poor leadership or centralised decision-making (with hierarchical power structures in which employees are not free to make relevant decisions about their work) and bullying
- Distributive injustice (lack of fairness in workload and reward distribution)
- Procedural injustice (lack of fairness in organisational decision-making)
- Worker alienation and tension
- Case complexity and high workloads
- Low levels of job satisfaction and perceptions of low occupational prestige and poor remuneration
- Insufficient co-worker and supervisor support, and absent or limited access to quality clinical supervision
- Insufficient opportunities for professional growth
- Exposure to high numbers of traumatised clients
- Tensions over work demands.

2.1 Who is the AOD workforce?

Alcohol and other drug workers are those workers whose primary role involves preventing, and responding to, AOD-related harm. This includes both the paid and unpaid workforce and peer support workers. It excludes the broad range of healthcare, welfare, law enforcement, education and related workers who have important roles to play in reducing AOD harm, but for whom it is not their primary role.

What follows are the results from a range of surveys of Australian and New Zealand AOD/addiction workers.

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2.1.1 Australian national surveys

Little recent data are available on the characteristics of the Australian AOD specialist workforce; however, the best estimates suggest that it consists of more than 10,000 workers from a diverse range of occupations (Wolinski, O'Neill, Roche, Freeman, & Donald, 2003).

In 2006, key features of the specialist AOD workforce included the following:

- AOD specialist workers were mostly female (66%)
- Nearly half were aged 45 years or older
- 30% - 54% of workers were employed part-time
- Average duration of working in the AOD field was approximately 5 years
- Occupational groups were generalist AOD workers (40%) nurses (31%), psychologists, (10%), social workers 8%, counsellors 5%, doctors 3% and others 3% (Duraisingam, Pidd, Roche, & O'Connor, 2006).

The majority of frontline AOD workers held formal qualifications at certificate (23%), undergraduate / honours (39%), or post-graduate (26%) levels. A substantial proportion (12%) had no formal qualifications. The most common forms of AOD-specific education and training received by workers were accredited or non-accredited short courses. (Duraisingam et al., 2006).

2.1.2 New South Wales

A 2013 survey of the NSW NGO AOD workforce identified the following characteristics:

- Average age was 45 years
- Predominantly female (59%)
- Average of 7.7 years AOD experience (5.1 years with their current organisation)
- Almost half (48%) held a university qualification and 57% held a specific AOD qualification
- 82% of staff were from an organisation providing residential rehabilitation
- Less than 10% identified as being from an Aboriginal or Torres Strait Islander background
- 13% were from a culturally and linguistically diverse background (Network of Alcohol and other Drugs Agencies, 2014).

The most common position titles held by NSW AOD workers were:

- AOD Worker (20%)
- Other (counsellor, case manager, case worker, teacher, educator, family support worker, program coordinator, program development, team leader) (17.4%)
- Residential support worker (12%)

- Alcohol and other drugs counsellor (9%) (Network of Alcohol and other Drugs Agencies, 2014).

2.1.3 Australian Capital Territory

In 2006, a survey of 134 ACT AOD specialist treatment workers found that the majority (82%) were employed in non-government organisations (McDonald, 2006). Nearly two-thirds (65%) were female and 35% were aged 40-49 years. Over half (59%) were aged 40 years or over. The majority (79%) were permanent employees and 75% were in full-time employment. Nearly half (44%) were generic AOD workers, 29% were employed in management or administration roles, 7.8% were nurses, 7.2% were social workers and 3.6% were psychologists.

The number of years spent working in the AOD field ranged from 1 to 25 years (median 5 years). Nearly half (43%) of the workers held undergraduate or postgraduate qualifications, while 18% held no formal qualifications.

2.1.4 South Australia

In 2007, a survey was undertaken of 44 South Australian NGOs with AOD programs (Tovell, Roche, & Trifonoff, 2009). Of the 167 workers surveyed, 59% were 40 or more years old and 67% were female. Just over half (58%) were employed full time and 63% were in permanent employment. Nearly one in three (31%) were generalist AOD workers, 14.5% were managers, 14% were social workers, 5.7% were administrators and 1.3% were nurses. More than half of those surveyed (59%) were engaged in a direct client services. Mean length of service in the AOD field was six years and mean length of service with their current work organisation was 3.6 years. More than half (55%) held undergraduate or postgraduate qualifications (Tovell et al., 2009).

2.1.5 Victoria

A 2008 survey of 492 Victorian AOD workers found that 59% of respondents were over the age of 40 years, and 65% were female. Of the sample, 44% were AOD workers. Nurses made up 8%, 6.5% were outreach workers and 1% were psychologists. Nearly two-thirds (61.4%) were employed full time and the largest proportion of workers (36%) had worked in the AOD field for 5-10 years. In addition, 62% held undergraduate or postgraduate qualifications, while 56% had AOD qualifications at the certificate IV or diploma level (Connolly, 2008).

2.1.6 Western Australia

A 2007 survey of 207 Western Australian NGO AOD workers included workers from 35 services. The survey found that:

- Only 4% earned above the average weekly earnings of all workers
- 45% held undergraduate or postgraduate qualifications
- 35% expected to leave the Sector within two years
- The Sector was experiencing substantial recruitment and retention difficulties (Western Australian Association for Mental Health, et al., 2008).

In summary, there are two consistent findings across the surveys of Australian AOD workers that have been undertaken. Most of the Australian workforce is over 40 years of age and it is predominantly female. This is noteworthy because more female AOD workers compared to males reported that their workloads were excessive (Duraisingam et al., 2006).

This finding may reflect differences in actual workload, or the challenge of balancing work and domestic / family demands.

The latter is an important issue for women, particularly those who are working full time. Many Australian women perceive that their work-life circumstances are deteriorating and a growing proportion feel increasingly time pressured (Gregory et al., 2013).

2.1.7 New Zealand

A number of surveys have collated information on the composition of the New Zealand addiction workforce, the latest being the *More Than Numbers* stocktake of the country's Health-funded adult mental health and addiction workforce (Te Pou o Te Whakaaro Nui, 2015). The survey identified almost 200 services across 17 District Health Boards (DHB) and 77 NGOs contracted to deliver addiction (AOD and gambling) services. The actual number of services providing addiction support is likely to be greater when considering those that are also funded through sources such as the Ministries of Corrections and Social Development, private or philanthropic funding, or from services provided through primary care, Whanau Ora, to youth or elderly.

Other surveys included the National Telephone Survey of the Addiction Treatment Workforces (1998, 2004 and 2008) (Adamson et al., 2008); the Addiction Service: Workforce and Service Demand Surveys (Matua Rakī, 2010 and 2011) (Matua Rakī, 2011) and the Matua Rakī Review of Publication, Resources and Events: Evaluation Reports from 2012 and 2014 (Matua Rakī, 2015).

Based on the findings of these surveys, key features of the New Zealand addiction workforce include the following:

- There are approximately 1,400 full time equivalent staff employed in Health-funded addiction services
- Vacancy rates are approximately 4%
- 48% of the workforce are employed in DHB services and 52% in NGOs
- 72% are employed in community services, 23% in residential/inpatient services and 2% in other service types
- 84% of the addiction workforce are employed in mainstream services, 13% in Kaupapa Māori services, 3% in Pasifika and 1% in Asian-focussed services
- 68% have clinical roles, 16% support worker roles, 1% provide cultural advice and support and 15% are in administrative or management roles
- 22% of the clinical workforce were reported as Māori, 6% as Pasifika and 3% as Asian
- 55% had worked in the field for more than five years.

The New Zealand addiction sector workforce has diverse roles and experience. Those with lived experience of addiction have historically comprised much of the workforce, however there has been a 'professionalisation' of the workforce in recent years. The national telephone surveys reported an increase in those holding a postgraduate qualification from 16% in 1998 to 47% in 2008. In 2008, 33% of survey respondents were in recovery (Adamson et al., 2008). Approximately 86% of the workforce have professional registration (Matua Rakī, 2011). There are also indications of an increase in those holding 'no addiction-related qualifications' which may reflect an increase in peer support workers (Matua Rakī, 2015).

3. Methods and terminology

A literature search was conducted using several major electronic databases: Premedline, Medline, Embase, PsycINFO, Nursing and Allied Health Database, Informit Health Collection, Cochrane Data Base, and Pubmed. Hand searches of study reference lists and searches of the grey literature were also conducted using conventional electronic search engines, such as Google and Google Scholar.

3.1 Key terms

This literature review employs a number of key conceptual terms, including:

Worker 'wellbeing' which refers to the extent to which AOD and other workers perceive that their lives are going well. It incorporates the degree to which they enjoy good physical and mental health and are resilient. Wellbeing involves workers' level of engagement in living and involvement in a broad range of human activities including intellectual endeavours, social relations and emotional attachment.

Health: Health is an important component of wellbeing. One definition is that developed by the World Health Organization:

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organization, 1946 p1).

Resilience: Is the ability to maintain professional and personal wellbeing and cope well with ongoing work stress and adversity (McCann et al., 2013). Resilience can be innate or developed through learnt behaviours, thoughts and actions. Factors that enhance resilience include positive attitudes, optimism, the ability to regulate emotions, positive self-view, confidence in one's own strengths and abilities, communication and problem solving skills. Also important is the capacity to manage strong feelings and impulses and the ability to see problems as challenges (McCann et al., 2013).

Stress: is defined as a range of processes that involve perceiving, appraising and responding to harmful, threatening or challenging situations. Not all stress is harmful. Mild to moderate levels of stress, which are within a person's coping range, can be a positive influence. However, stress that exceeds a person's coping capacity can result in threats to physical and psychological wellbeing. It can result in responses across the following domains:

- Psychological (e.g., anxiety)
- Physical (e.g., increased blood pressure)
- Behavioural (e.g., sleeping difficulties, irritability) (Roche & Nicholas, 2016).

Burnout: is a persistent, negative, work-related state of mind in otherwise healthy individuals. It is a specific form of psychological stress rather than a clinical diagnosis (Firth-Cozens & Payne, 1999). Burnout is primarily characterised by emotional exhaustion, accompanied by distress, a sense of reduced effectiveness, decreased motivation and the development of dysfunctional attitudes and behaviours at work. It often results from a misfit between job intentions and reality, but can be mediated by personal coping skills (Cooper, Dewe, & O'Driscoll, 2001; Schaufeli & Buunk, 2003).

Three core dimensions of burnout have been identified:

- Emotional exhaustion (feeling overextended and drained of emotional and physical resources)
- Depersonalisation (negative, detached or cynical view of one’s work)
- Reduced personal accomplishment (low sense of achievement, feelings of incompetence, low self-efficacy) (Maslach, Schaufeli, & Leiter, 2001).

Stress, compassion fatigue and burnout can be considered as a continuum in which excessive stress can lead to compassion fatigue and ultimately burnout. The differences between stress and burnout are outlined in Table 1.

Table 1: Differences between stress and burnout (HelpGuide.Org, 2016)

Differences between stress and burnout	
Stress	Burnout
Characterised by over-engagement	Characterised by disengagement
Emotions are over-reactive	Emotions are blunted
Produces urgency and hyperactivity	Leads to helplessness and hopelessness
Loss of energy	May lead to loss of motivation, ideals, hope
Can lead to anxiety disorders	Leads to detachment and depression
Primary damage is physical	Primary damage is emotional
May lead to life-threatening illnesses	May make life seem not worth living

Compassion fatigue: In the helping professions, longer-term exposure to excessive stress can lead to compassion fatigue, which manifests as a lessening of compassion over time. This is a common response when caring, empathic workers are exposed to excessive workplace stress. It is sometimes known as vicarious traumatic stress. However, compassion fatigue tends to have a more gradual onset, whereas vicarious traumatic stress usually has a more rapid onset in response to a particular event (Roche & Nicholas, 2016).

Secondary Traumatic Stress (STS): Refers to the occurrence of posttraumatic stress symptoms following indirect exposure to traumatic events. Indirect exposure typically occurs via a close personal or professional relationship with traumatised people who recount traumatic experiences. Secondary Traumatic Stress manifests as intrusive imagery, avoidant responses, physiological arousal, distressing emotions, and functional impairment (Bride & Figley, 2007).

4. The wellbeing of alcohol and other drug workers

A limited range of research studies have focussed on the wellbeing status of AOD workers. Research conducted to-date included:

- Australian AOD workers and managers
- AOD workers providing services to Indigenous Australian and Māori clients
- Other international research.

4.1 Australian research: Workers

Duraisingam et al. (2009) reported that the majority of AOD workers surveyed had high levels of job satisfaction and low levels of stress. Nevertheless, almost a fifth (19%) reported emotional exhaustion scores indicative of high stress levels. There were no significant commonalities identified among the workers with high stress scores. Approximately one in three workers (31%) intended to leave their work organisation within the next year, while nearly one in five (19%) intended to leave the AOD field. Significant predictors of higher turnover intention were:

- A shorter length of time in the current workplace
- Low job satisfaction
- High work stress
- Low workplace social support
- Perceptions of poor remuneration
- Younger workers and those with fewer years of employment in their current agency were more likely to have a stronger intention to leave.

A more recent Victorian survey of AOD workers employed a range of wellbeing measures (Best, Savic, & Daley, 2016). The results showed high levels of overall job satisfaction and satisfaction with:

- Staffing levels
- Workplace cohesion
- Opportunities for growth.

While there was a group of workers whose wellbeing was poor, generally wellbeing levels were high. This finding was consistent across AOD workers with and without direct client contact. High levels of worker wellbeing were associated with lower levels of emotional exhaustion and cognitive weariness, higher levels of opportunities for professional growth and stronger support networks (Best et al., 2016).

Secondary Traumatic Stress (STS) is reported to occur in 1:5 Australian AOD workers (Ewer, Teesson, Sannibale, Roche, & Mills, 2015). Ewer et al. reported that one in five Australian AOD workers surveyed met the criteria for STS. Workers with STS:

- Were less likely to have completed tertiary education
- Received less clinical supervision each month
- Reported having a larger proportion of clients with a history of trauma in their current service
- Were more likely to have personal direct experiences of trauma
- Had higher stress and anxiety levels.

Despite the high proportion of traumatised clients accessing AOD services, less than two-thirds of AOD workers reported having ever received trauma training (Ewer et al., 2015).

4.2 Australian research: Managers

Only one Australian study of burnout among managers of AOD specialist treatment services has been conducted to-date (Duraisingam, Roche, Pidd, Zoontjens, & Pollard, 2007). It found that nearly a third of managers reported levels of burnout above the midpoint and 8% experienced very high levels of burnout. Thirty percent of managers reported high levels of work-related exhaustion while 17% reported feeling cynical about work. Only a minority reported low levels of professional efficacy.

In relation to turnover intention, 61% of these managers surveyed had thought about leaving their job and 29% planned to look for a new job over the next 12 months. One in five of all managers intended to look for a new job outside the AOD field.

Predictors of wellbeing identified in the study included:

- Perceived reciprocity (the rewards of the work justified the efforts) and perceived senior management competency
- Workplace and organisational support and autonomy
- Lack of role ambiguity
- A safe and pleasant work environment
- Having a balanced workload (Duraisingam et al., 2007).

Compared to older managers, a significantly larger proportion of younger managers reported:

- Higher levels of exhaustion
- Intention to quit and role conflict
- Lower levels of perceived managerial competence due to a lack of management training and skills (Duraisingam et al., 2007).

Compared to more experienced managers, a significantly greater proportion of less experienced managers reported:

- Difficulties in managing a diverse workforce
- Greater uncertainty in their work roles and less perceived competence as a manager
- Inadequate workplace support generally and specifically concerning professional development
- Less job autonomy and a lack of financial rewards for performance (Duraisingam et al., 2007).

4.3 AOD workers providing services to Indigenous Australian and Māori clients

Alcohol and other drug workers providing services to Indigenous clients can face particular challenges. In Australia, a national online survey was conducted to examine organisational, workplace and individual factors contributing to levels of stress and wellbeing among these workers (both Indigenous and non-Indigenous) (Roche, Duraisingam, Trifonoff, & Tovell, 2013). It found workers typically experienced above average levels of job satisfaction and

relatively low levels of emotional exhaustion. However, 1 in 10 reported high levels of emotional exhaustion which was a key predictor of turnover intention.

For Indigenous respondents, work factors accounted for 30% of the variance in levels of emotional exhaustion. For non-Indigenous respondents, work factors explained 57% of the variance in levels of emotional exhaustion. Indigenous workers also experienced significantly lower levels of mental health and wellbeing (Roche, et al., 2013).

The findings highlighted the importance of implementing workforce development strategies that focus on achieving culturally appropriate, equitable and supportive organisational conditions for Indigenous AOD workers. Preventing or managing levels of stress, ensuring adequate and equitable salaries and benefits, and providing more opportunities for career and personal growth, may increase job satisfaction and reduce turnover intention among Indigenous workers in the AOD (Roche, Duraisingam, Trifonoff, Battams, et al., 2013).

A review of the workforce development literature pertaining to the Māori addiction treatment field, identified the need for a range of capacity building approaches among Māori addiction workers and mainstream workers providing services to Māori clients (Robertson, Haitana, Pitama, & Huriwai, 2006). The review placed strong emphasis on developing culturally-specific training and support based on Māori values, practices and experiences (Robertson, et al., 2006). Fundamental to Māori wellbeing is the Treaty of Waitangi that provides an important platform for enhancing service provision for Māori. Complementing this are Māori concepts of health that are integral to wellbeing. An example of this is Te whare tapa wha, which concerns the interplay between:

- Wairua (the spiritual)
- Tinana (the physical)
- Hinengaro (the emotional)
- Whanau (the social/family).

4.4 International evidence

Volker et al. (2010) reported that one third of staff working in opioid dependence treatment agencies across six European cities (Athens, London, Padua, Stockholm, Zurich and Essen) experienced severe burnout. Burnout was positively correlated with passive coping strategies (such as withdrawing and not addressing workplace problems) and negatively associated with self-efficacy and job satisfaction. Staff with low levels of work satisfaction showed a 13-fold risk of burnout.

Similarly, a United Kingdom study identified psychological morbidity among 82% of AOD workers surveyed (Oyefeso, Clancy, & Farmer, 2008). Indicators of burnout were also present, with:

- 33% reporting high levels of emotional exhaustion
- 17% reporting high levels of depersonalisation
- 36% reporting feelings of diminished personal accomplishment.

Oyefeso et al's. (2008) findings indicated that AOD workers were more vulnerable to burnout than most other human service professionals. The emotional exhaustion scores of the sample were higher than most human services occupational groups, including teaching, postsecondary education, social services, and mental health, but similar to those seen in medicine (Maslach, Jackson, Leiter, 1996, as cited in Oyefeso et al., 2008).

The prevalence of emotional exhaustion among AOD workers is particularly important because it has repeatedly been linked to turnover intention (Knudsen, Ducharme, & Roman, 2008).

Furthermore, Oyefeso et al. (2008) reported that social workers were at higher risk of emotional exhaustion, compared to nurses employed in the AOD sector. The reasons for this were unclear. Among all substance use workers in the study, three main stressors were identified:

- Alienation (e.g., lack of support from senior staff, feelings of isolation, role ambiguity)
- Case complexity (e.g., dealing with clients with complex needs)
- Tension (e.g., conflicting demands on worktime by others, having too little time to do what is expected and work overload).

In this study, high levels of alienation and tension predicted emotional exhaustion and depersonalisation, but not psychological morbidity. Diminished personal accomplishment was associated with higher levels of psychological morbidity. Younger workers were found to be particularly at risk of burnout (Oyefeso et al., 2008).

High levels of burnout (in particular depersonalisation) were also identified in a large proportion of US AOD counsellors (Baldwin-White, 2016). Baldwin-White (2016) reported that emotional exhaustion was a significant predictor of whether or not a person would remain in the AOD field. Depersonalisation, confidence in therapeutic success, and negative attitudes towards clients predicted levels of emotional exhaustion. Older workers were less likely to experience emotional exhaustion than their younger counterparts.

Secondary traumatic stress is also a common problem among US AOD workers. One study of 225 members of the National Association of Alcohol and Drug Addiction Counselors (NAADAC) found that 75% experienced at least one symptom of STS in the previous week and 56% met the criteria for at least one of the core symptom clusters of the condition. Nineteen percent met the core criteria for a diagnosis of PTSD (Bride et al., 2009). In other research, more than half (56%) of a sample of 1,000 members of the NAADAC met at least one of the core diagnostic criteria for STS (Bride & Kintzle, 2011). Counsellors with higher levels of STS reported lower job satisfaction and lower occupational commitment. Furthermore, job satisfaction fully mediated the effect of STS on occupational commitment. In other words, enhancing job satisfaction among AOD workers not only reduces STS, but can reduce staff turnover.

Not all international research studies have found high levels of stress and burnout among AOD workers. For example, Garner, Knight and Simpson (2007) found low levels of burnout among 151 drug treatment counsellors from eight state-run corrections-based treatment programs in the US. Six percent of respondents fell into the highest level of the burnout scale scores (the upper one third), whereas 5% were in the lowest level (lower one third). The remaining 89% fell somewhere in the middle. A number of factors significantly predicted staff burnout, with younger age being one of the strongest. Other significant predictors included lower adaptability (e.g., willingness to try new ideas), poorer clarity of agency mission, and higher stress (Garner et al., 2007).

Similarly, Knudsen, Ducharme and Roman (2009) reported low levels of emotional exhaustion and turnover intention among 410 US AOD treatment centre administrators.

Job demands were positively associated with emotional exhaustion, while the ability to conduct long-range strategic planning reduced emotional exhaustion. Emotional exhaustion was positively associated with turnover intention (Knudsen et al., 2009).

Rural and urban differences concerning the major causes of burnout have also been identified among US AOD counsellors (Oser, Biebel, Pullen, & Harp, 2013). Both rural and urban workers identified clients with complex needs, high caseloads, and excessive paperwork as causal factors and co-worker support, clinical supervision, and self-care as protective factors. However, rural workers more commonly cited office politics and low occupational prestige as the major causes of counsellor burnout (Oser et al., 2013).

4.5 Summary: The wellbeing of alcohol and other drug workers

In considering the available literature on AOD worker wellbeing, it is important to recognise that the literature has a relatively narrow focus. The research undertaken to-date almost exclusively focusses on the psychological wellbeing of workers. More specifically, it focusses on the extent to which workers' wellbeing may be threatened by excessive stress and ultimately burnout. The literature provides little insight into the physical wellbeing of workers, which also informs holistic approaches to enhancing AOD workers' wellbeing.

The available evidence suggests that most AOD workers have a relatively high level of psychological wellbeing. Nevertheless, approximately 10-30% of Australian AOD workers may experience excessive stress, burnout and/or STS. Likewise, the international literature indicates that at least a sizeable minority and at times a majority of AOD workers experience substantial threats to their psychological wellbeing.

A prominent theme to emerge from the literature was that younger workers' psychological wellbeing is at increased risk. Prima facie, this could mean that younger workers have not yet developed adequate coping mechanisms to deal with the challenges of AOD work or may not have had an adequate orientation to the workplace/environment. It could also be indicative of attrition bias in the research, with those workers who burn out at an early age moving on to other jobs, and older workers, who have developed coping mechanisms remaining in this field of work. Either way, it highlights that younger workers are particularly in need of approaches to protect and enhance their wellbeing.

Similarly, the available evidence highlights that AOD workers who have not attained high levels of education may face similar threats to their wellbeing. This may have implications for AOD workers who come to the field with a background of lived experience, rather than formal education.

Based on an examination of the relevant literature, Skinner & Roche (2005) developed the following diagrammatic schema of factors that impact key aspects of AOD worker wellbeing: stress and burnout. Three levels of factors were identified as directly or indirectly related to stress and burnout (Figure 1):

- Individual
- Organisational
- System.

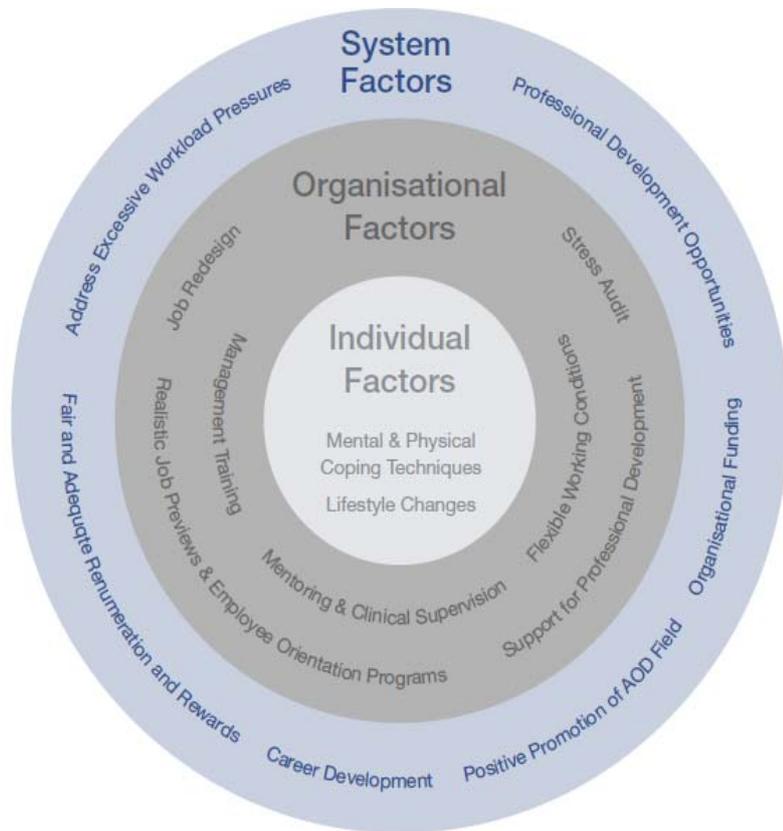


Figure 1: Factors impacting on stress and burnout (Skinner & Roche, 2005)

5. Workers with similar roles to AOD workers

As noted above, there is a relative paucity of research on the wellbeing of AOD workers, particularly in Australia and New Zealand. Thus, a brief examination of wellbeing indicators for health and welfare workers more broadly, and mental health workers in particular, was undertaken for comparison purposes.

5.1 Australian health and community sector workers

One approach to measuring worker wellbeing is the Psychosocial Safety Climate (PSC). The PSC is an indicator of work conditions, employee health and productivity. It provides evidence concerning psychosocial risk factors in the working Australian population and analyses relationships between risk factors and employee health and motivational outcomes. High (positive) rated PSC jobs are manageable, resources are adequate and workers are healthy. A positive PSC also acts as a moderator, reducing the negative impact of psychosocial hazards on employee health and productivity outcomes (Dollard et al., 2012).

To determine baseline levels of worker wellbeing, Dollard et al. (2012) undertook computer assisted telephone interviews (n=5,743) across six Australian states and territories (excluding Queensland and Victoria) to gain information from employed Australians regarding their work and health conditions. Nationally, and in NSW, the health and community services sector fell in the moderate PSC risk range (Dollard et al., 2012). This suggests that the health and community services sector experiences a range of psychosocial risks, including job strain, which may lead to poorer health and productivity outcomes. Nevertheless, they are not in a high-risk category.

However, when examined in terms of level of demands placed on workers and resources available, a different picture emerges. From this perspective, the health and community services sector is one of two high-risk industries nationally, with a particularly poor score for occupational demands (Dollard et al., 2012).

An Australian study examined work-life interaction across healthcare workers' life course. It found that their wellbeing was adversely affected because their employing institutions, systems and cultures were not supportive of their childcare or eldercare needs or with valued social and personal activities. This was clearly linked with work engagement, both in terms of hours worked (e.g., part time or full time) and, for older workers, their intentions to keep working. There was a clear link between unresponsive work-life policies and workers' dissatisfaction and withdrawal/turnover intention (Skinner, Elton, Auer, & Pocock, 2014).

The difficulties experienced by the healthcare workers in the Skinner et al. (2014) study varied according to their age group. The key issues for:

- Younger workers, were that work limited their capacity to form and sustain relationships and enjoy social activities
- For workers with young families, were childcare and financial issues, lack of parental leave, skill loss while on parental leave and difficulties with juggling shift work and caring responsibilities
- Mid-career workers, were caring responsibilities for parents and teenagers and difficulties coping with the strains of shift work

- Workers nearing retirement, were the need for flexible working arrangements to care for elderly parents, other dependent adults and grandchildren and the ability to wind down into retirement (Skinner et.al., 2014).

5.2 Mental health workers

A brief examination of the Australian, New Zealand and international literature concerning wellbeing among mental health workers by work role identified relatively high levels of stress and burnout.

5.2.1 Australian psychologists

High levels of burnout were reported among 167 Australian psychologists by Di Benedetto and Swadling (2014). Four measures of burnout were used:

- Personal burnout: The degree of physical and psychological fatigue and exhaustion experienced
- Work-related burnout: The degree of physical and psychological fatigue and exhaustion that is perceived by the person to be related to their work
- Client-related burnout: The degree of physical and psychological fatigue and exhaustion that is perceived by the person to be related to work with clients
- Overall burnout.

Other variables considered included work-setting, years of experience in that setting, mindfulness and career-sustaining behaviours. Psychologists were found to have low levels of client-related burnout, but elevated levels of personal burnout. More than 14% of participants met the criteria for overall burnout, 35% for personal burnout, 20% for work-related burnout and 12% for client-related burnout. No significant differences in burnout levels were evident between psychologists working in private-practice and non-private-practice settings. Mindfulness reduced risk of burnout and there was a low but significant negative relationship between years of experience in current work-setting and burnout levels. It was concluded that the implementation of strategies to enhance the adoption of mindfulness practices may help prevent burnout in Australian psychologists (Di Benedetto & Swadling, 2014).

5.2.2 Australian psychiatric nurses

Happell, Martin and Pinikahana (2003) compared differences in burnout between 129 Australian psychiatric nurses employed in mainstream services and in forensic environments. Mainstream nurses had higher levels of burnout than forensic nurses on emotional exhaustion (35.8% vs 15.6%), depersonalisation, (24.3% vs 17.6%) and personal accomplishment (23% vs 17.6%).

5.2.3 Australian mental health professionals

As noted above, secondary traumatic stress can be a threat to the wellbeing of AOD workers, given the extent to which they are exposed to clients who have experienced trauma. However, among 152 mental health professionals involved in clinical practice, levels of STS, vicarious trauma (VT) and burnout were found to be low in a study by Devilly, Wright and Varker (2009). In contrast to other evidence, exposure to patients' traumatic material did not affect STS, VT or burnout. Rather, work stressors (such as being new to the area of work) best predicted therapist distress.

5.2.4 New Zealand counsellors

A recent study of 129 New Zealand counsellors found 22% to be at high risk of STS and a 25% prevalence rate for high risk of burnout (Temitope & Williams, 2015). Burnout was the greatest predictor of STS, suggesting that counsellors who were burned out had less energy to manage vicarious stress and were thus more vulnerable to STS. Further, counsellors with low levels of resilience were more susceptible to STS.

In a qualitative study of 22 trauma counsellors from New Zealand (Pack, 2014), vicarious traumatisation was identified as best dealt with through clinical supervision, peer support, humour, spirituality and ongoing training. These strategies were reported to effectively foster a sense of personal and professional resilience in counsellors.

5.2.5 United Kingdom mental health worker studies

Several UK studies of mental health workers have found high levels of stress, emotional exhaustion and burnout.

A survey of 237 mental health social workers (MHSW), found high levels of stress and emotional exhaustion and low levels of job satisfaction (Evans et al., 2006). Forty seven percent of workers showed significant symptomatology and distress. Feeling undervalued at work, having excessive job demands, limited latitude in decision-making, and being unhappy about the roles of MHSW contributed to poor job satisfaction and most aspects of burnout.

In a study of 445 participants, 44% fell into the high burnout category for emotional exhaustion (Onyett, Pillinger, & Muijen, 1997). Forty-five percent of community mental health nurses, 54% of social workers and 63% of consultant psychiatrists fell into the high emotional exhaustion category. While rates of emotional exhaustion were high, scores for the sample revealed low levels of depersonalisation and high levels of personal accomplishment, both of which are desirable findings. Job satisfaction was associated with team role clarity and team identification.

A study of 121 mental health workers reported a relatively high level of emotional exhaustion and depersonalisation, but an absence of problems with respect to perceptions of personal accomplishment (Prosser et al., 1999).

Similarly, a study of 61 mental health workers reported that 57% experienced a high degree of emotional exhaustion and 42% experienced depersonalisation (Wykes, Stevens, & Everitt, 1997). Despite this, 59% experienced a positive sense of personal accomplishment.

6. What can organisations do to foster AOD worker wellbeing?

Programs to enhance AOD worker wellbeing can be:

- Person-directed (individuals/groups)
- Organisation-directed
- A combination of both person- and organisation-directed.

Programs intended to enhance the wellbeing of AOD workers have not been extensively researched and evaluated. Nevertheless, there is sufficient evidence to provide pointers to effective approaches. These are discussed below.

6.1 Broad-based health promotion policies and programs

Broad-based health promotion programs and policies have the potential to contribute to AOD worker wellbeing.

Organisations may benefit from developing an employee wellbeing policy containing:

- A documented declaration of the organisation's commitment to health and wellbeing
- Clearly defined program objectives that are both realistic and easily measured
- An outline of the various responsibilities for key groups, such as management, organising committee, workers and external providers (ACT Government, 2012).

Examples of organisational wellbeing policies and development tools are available at:

http://www.healthierwork.act.gov.au/wp-content/uploads/2015/01/HW_Policy_Example.pdf

<http://www.rph.org.nz/content/5d7fde89-b4d1-4f7f-ac28-ce806b5157bd.cmr>

https://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwiJvHxj_3SAhVMzVQKHWq6Aq0QFgkMAI&url=http%3A%2F%2Fwww.ttophs.govt.nz%2Fvdb%2Fdocument%2F1119&usg=AFQjCNFoQsCAEdK1tkDhtKapPuN1LPWSg&sig2=pEjx03AthSFrTfAe9KtEXQ

<http://www.wellplace.nz/ideas-and-advice/mental-wellbeing/create-a-mental-wellbeing-policy-and-action-plan/>

https://www.ssc.govt.nz/sites/all/files/worker-wellness-resource-kit_0.pdf

Other guidelines and checklists to support the implementation of workplace wellbeing policies and programs include:

- The Health & Productivity Institute of Australia (n.d.)
- Oldenburg, Sallis, Harris, & Owen (2002)
- Comcare (2010)
- South Australia Health (2014).

A meta-analysis of 18 studies describing 21 workplace health promotion programs found modest impacts (effect size 0.24, 95% CI 0.14 - 0.34) on measures including self-perceived health, sickness absence, productivity at work, and work ability. The programs studied targeted smoking cessation, physical activity, healthy nutrition, and/or obesity. Programs conducted among younger populations or white-collar workers were the most effective and programs that had at least weekly contact with workers were almost four times more effective than other programs (Rongen, Robroek, van Lenthe, & Burdorf, 2013).

Another meta-analysis examined differences in job satisfaction and absenteeism among participants of 17 workplace wellness programs. The mean effect sizes of the programs for absenteeism reduction (.30 $p < .00$ CI .22 - .48) and job satisfaction (.42, $p < .03$ CI .05 - .80) were moderate, but indicated that those participating in wellness programs tended to be absent from work less often and reported higher job satisfaction (Kuoppala, Lamminpää, & Husman, 2008).

Workplace wellness programs can also bring financial benefits for organisations and to the health care system. A meta-analysis of costs and savings associated with such programs found medical costs fell by \$3.27 while absenteeism costs fell by \$2.73 for every dollar spent on workplace wellness programs (Baicker, Cutler, & Song, 2010).

A number of characteristics of effective workplace wellbeing promotion programs have been identified. These include:

- Having active support and participation by organisational leaders
- Having responsibility for program planning, design and implementation shared by employees and management
- Engaging key stakeholders
- Having work environments that are supportive of healthy lifestyles (e.g., onsite fitness facilities, showers and lockers, secure bike storage, smoke-free buildings, flexible working arrangements, healthy catering)
- Participatory program planning and design
- Being multi-faceted (e.g., comprising universal components such as health risk assessment, flu vaccination and targeted components for employees found to be at higher risk)
- Having well-informed and competent internal or external program providers
- Having high levels of program engagement
- Using innovative marketing and communication
- Having effective evaluation and monitoring
- Ensuring program sustainability (The Health & Productivity Institute of Australia, n.d.).

6.2 Clinical Supervision²

Quality clinical supervision is another key approach to enhancing AOD worker wellbeing. In New Zealand, the professional registration body for addiction practitioners, DAPAANZ, expects all practitioners to have professional supervision and that supervisors must be suitably qualified and registered with DAPAANZ.

There is strong evidence that the provision of quality clinical supervision has an important protective effect on AOD workers and links them more closely to the organisation and AOD treatment sector (Roche, Todd, & O'Connor, 2007).

There is also evidence that the quality of clinical supervision received affects the relationship between emotional exhaustion / turnover intention among AOD counsellors (Knudsen et al.,

² There is a distinct difference between clinical supervision and administrative or managerial supervision. The latter is directed at helping the worker to meet organisational goals, expectations and standards. Administrative supervision is typically provided by a worker's manager or supervisor. Clinical supervision is a 'working alliance' between practitioners that is focused on enhancing the clinical effectiveness of the supervisee. See NCETA's clinical supervision resources at http://nceta.flinders.edu.au/workforce/what_is_workforce_development/key-workforce-development-issues/clinical-supervision/

2008). Specifically, the perceived quality of workers' clinical supervision is strongly associated with perceptions of job autonomy, procedural and distributive justice which are, in turn, associated with lower levels of emotional exhaustion and turnover intention. Eby and Rothrauff-Laschober (2012) came to similar conclusions.

More recently, Knudsen, Roman and Abraham (2013) found that quality clinical supervision was strongly correlated with commitment to the treatment organisation as well as commitment to the AOD field among 934 US AOD workers.

These findings suggest that quality clinical supervision has potential to yield important benefits for AOD worker wellbeing and to strengthen ties to both their employing organisation and to the AOD treatment field.

6.3 Organisational management

There is substantial evidence that the quality of organisational management impacts AOD worker wellbeing. Broome, Knight, Edwards and Flynn (2009) reported relatively low levels of burnout among 550 US AOD counselling staff from 94 programs. Important differences between individuals in relation to burnout were reported. Worker characteristics were not significant predictors of burnout or job satisfaction but workers with larger caseloads were more likely to exhibit signs of burnout. Workers' perceptions of the leadership qualities of their managers/supervisors predicted both satisfaction and burnout. Overall, the quality of organisational leadership and equity of work distribution were particularly important influences on worker burnout.

A US sample of almost 700 AOD counsellors in a multi-site study found similar levels of burnout to other mental healthcare providers, but considerably lower burnout levels than other healthcare professions, such as physical and occupational therapy (Vilardaga et al., 2011). High levels of worker job control were associated with low levels of emotional exhaustion. There was a strong association between co-worker support and supervisor support, indicating that if co-workers had supportive line managers, they also tended to be supportive of each other. Therefore, measures that organisations can implement to enhance supervisor and co-worker support are likely to be very beneficial.

Knudsen, Ducharme and Roman (2006) examined the extent to which management practices impacted emotional exhaustion and turnover intentions among AOD workers employed in US therapeutic communities (TCs). Organisational management practices were measured in terms of:

- Centralised decision-making (with hierarchical power structures in which employees were not free to make relevant decisions about their work)
- Distributive justice (how fairly workloads and rewards were distributed)
- Procedural justice (the extent of fairness in organisational decision-making).

After controlling for a range of worker variables, scores related to emotional exhaustion and intention to leave were higher (undesirable) in TCs with greater centralised decision-making and lower in TCs with greater distributive and procedural justice (Knudsen et al., 2006).

An Italian study (Viotti & Converso, 2016) also found that organisational fairness and management support had substantial buffering effects on work-related interference in the private lives of health workers. This buffering effect applied to work stressors caused by excessive work, disproportionate patient expectations and verbal aggression. The study also concluded that a positive social environment in the workplace has similar buffering effects.

6.4 Encouraging help-seeking behaviours in the workplace

Help-seeking is the act of asking others for assistance, information, advice, or support (Hofmann, Lei, & Grant, 2009). Help-seeking behaviours among health and welfare professionals have not been widely researched.

The main factors that influence whether workers seek help from within organisations relate to perceptions of the help-provider's expertise, accessibility, trustworthiness, organisational role and level of organisational commitment (Hofmann, Lei, & Grant, 2009; van der Rijt et al., 2013).

Moreover, employees may be more likely to seek help from higher than lower status individuals, as the former's help is regarded as more useful and constructive (van der Rijt et al., 2013).

Enhancing the mental health literacy of the workforce in general has been found to be an important strategy to encourage help-seeking (LaMontagne et al., 2014). The Mental Health First Aid Program is one of the most effective approaches to enhance workplace mental health literacy (Kitchener & Jorm, 2004, 2006).

Help-seeking is also enhanced by investing in the strength of workplace relationships, ensuring the accessibility of expertise, and fostering a work environment in which employees trust and respect each other (van der Rijt et al., 2013).

6.5 Programs to prevent and reduce stress and burnout

Awa et al. (2010) undertook a review of 25 burnout prevention and intervention studies, of which 17 were person-directed, two were organisation-directed and six were a combination of both program types.

Person-directed programs included strategies such as:

- Cognitive behavioural training
- Psychotherapy
- Counselling
- Adaptive skill training
- Communication skills training
- Social support
- Relaxation exercises
- Recreational music making.

Organisation-directed programs involved strategies such as:

- Work process restructuring
- Work performance appraisals
- Work readjustments
- Job evaluation.

Results indicated that 80% of all programs led to some reduction in burnout.

Person-directed programs generally reduced burnout in the short-term (6 months or less). One of the organisation-directed programs led to a significant positive change in burnout (Halbesleben, Osburn, & Mumford, 2006) while the other had no effect (Boumans & Landeweerd, 1996). A combination of both person and organisation-directed programs had

longer lasting positive effects (12 months and over). In all cases, positive effects diminished over time. Programs addressing person- and organisation-related issues are beneficial and can be enhanced with refresher courses (Awa et al., 2010).

An earlier review of 90 studies involving job-stress programs found that organisationally-directed interventions appeared more effective than individually-directed ones (Lamontagne, Keegel, Louie, Ostry, & Landsbergis, 2007). This finding is consistent with the hierarchy-of-controls principle, which espouses that the further upstream the intervention is situated, the more effective it will be at preventing problems. The review also found that individually-directed approaches are essential to complement organisationally-directed programs.

6.6 Programs to enhance worker resilience

A range of approaches to enhance resilience among health and welfare workers have been identified. Jackson, Firtko and Edenborough (2007) proposed a range of self-development strategies that can help build personal resilience to workplace adversity. These included:

- Building positive nurturing professional relationships and networks
- Maintaining positivity
- Developing emotional insight
- Achieving life balance and spirituality
- Becoming more reflective.

Encouraging the development of vicarious resilience among AOD workers has potential to prevent and address STS. Developing vicarious resilience involves enhancing the capacity to reframe clients' experiences of trauma to enhance workers' resilience and knowledge about approaches to overcome adversity. This can act as a counterbalance to the negative effects of clients' trauma on workers (Hernández, Gangsei, & Engstrom, 2007).

6.6.1 Nurses

A number of individual and contextual factors have been identified that contribute to levels of resilience in nurses including work-life balance, hope, control, support, professional identity and clinical supervision (McCann et al., 2013). Other strategies to enhance resilience among nurses include:

- Engaging in cognitive reframing to promote psychological flexibility
- Developing emotional insight to identify risk and protective factors that facilitate emotional toughness
- Grounding connections with family, friends and colleagues
- Maintaining work-life balance to foster career and personal goals
- Using critical reflection to problem-solve and build the resolve necessary to face future challenges
- Engaging in processes to reaffirm nurses' professional commitment and to find meaning and congruency between their work life and personal beliefs and value system
- Maintaining a positive attitude through humour, laughter, positive thinking techniques, visualisations and positive affirmations
- Engaging in extracurricular activities such as exercise, volunteering and social network groups
- Seeking out trusted mentors to provide professional and personal guidance (Hart, Brannan, & De Chesnay, 2014).

6.6.2 Social workers

Individual and contextual factors that impact on social workers' resilience include age (older workers were more resilient), gender (males were more resilient), work-life balance, personal and professional identity and quality of supervision support (McCann, 2013). To enhance resilience among social workers, Collins (2008) recommended:

- Education and training in resilience, the management of positive emotions and optimism
- On-going professional development, peer support, sensitive supervision
- Rest and recreation activities.

6.6.3 Psychologists

A number of factors have also been identified that enable psychologists to build and maintain resilience. These were to enhance work-life balance, recreational activities (exercise, hobbies, vacations), personal and professional values and having a sense of purpose (McCann, 2013). Barnett and Cooper (2009) recommended that the psychology profession also develop a culture that aims to maintain psychological wellness as well as:

- Self-care strategies which should not be stigmatised, avoided or utilised only when the practitioner is unwell
- Experienced professionals acting as role models for students and speaking openly about their own struggles with maintaining a healthy work-life balance and the value of on-going self-care activities in their lives.

6.7 Other approaches to enhance AOD worker wellbeing

6.7.1 Organisational approaches

While the number of empirical studies is limited, the literature contains a wide range of practical approaches that can enhance worker wellbeing. These include:

1. Opportunities for career advancement and development
2. Ensuring that staff have realistic job expectations and adequate employee orientation programs
3. Training staff on self-care strategies
4. Competitive salaries and financial and non-financial incentives to enhance staff motivation and morale
5. Clear job descriptions
6. Providing social / emotional and instrumental support for workers and routinely assessing burnout
7. Availability of high quality and supportive supervision
8. Providing effective organisational leadership (e.g., open-door policies with management) flexible work schedules and social events and informal support
9. Ensuring good job conditions (physical safety, job security, autonomy, staffing levels) (Broome, Knight, Edwards, & Flynn, 2009; Paris & Hoge, 2010; Skinner & Roche, 2005)

A number of holistic self-care strategies that can be utilised by AOD workers have been identified, including:

1. Maintaining a balanced diet
2. Allowing time every day for lunch and physical exercise

3. Scheduling regular holidays and other breaks from work (e.g., conferences, education seminars, clinical supervision)
4. Maintaining contact with peers and avoiding professional isolation
5. Maintaining balance between work commitments and family/personal life
6. Being aware of one's own AOD use
7. Using relaxation skills
8. Allocating time for relaxation and leisure activities (Marel, et.al, 2016).

In summary, a key finding from the literature is that a range of wellbeing enhancement programs that are both organisation- and individual-focussed can be effective. Organisation-focussed approaches should be considered the top priority, but need to be supported by individual-focussed measures. The most beneficial programs are likely to be those that are tailored to the characteristics of individual organisations.

7. Worker wellbeing measurement tools

A range of measures and screening tools have been developed to measure the health and wellbeing of workers, as well as more specific aspects of wellbeing. The results obtained from such measures can be useful in understanding factors that impact employee wellbeing, in addition to being utilised for benchmarking purposes, and pre- and post-program assessment. However, most measures identified only assess the mental health aspect of individuals' wellbeing, rather than a more holistic measure incorporating physical health.

These measures were chosen because they are well-established in terms of validity and reliability, and are easy to use. Most have been widely used in a range of organisational wellbeing surveys.

Please note that some of these measures must be purchased before they can be used and/or may have conditions associated with their use.

The tools have been placed into four categories:

- Wellbeing measurement tools
- Mental health measurement tools
- Workplace-oriented tools
- A treatment effectiveness measurement tool.

8. Choosing, planning and evaluating worker wellbeing programs

The available evidence points to a combination of organisation- and individual-focussed programs as being most effective in enhancing worker wellbeing. Organisations will differ in relation to the approaches which are most likely to be effective. Therefore, it is important to have a means of identifying 'best fit' programs for each of the broad range of organisations that make up the AOD sector.

The wellbeing/organisational screening tools identified in Appendix A provide a range of indicators regarding the wellbeing of organisations' individual workers. These could help inform the development of individual-focussed approaches.

However, it is also important to have tools that identify gaps in an organisation's approaches to worker wellbeing. The guidelines and checklists on Page 30 can assist in this regard.

The NCETA Workforce Development Checklist for the AOD Field (Roche & Pidd, 2009) is a tool for mainstream AOD services (see Appendix B).

NCETA has also developed workforce development checklists that are more suitable for AOD workers who provide services to Indigenous clients. See Appendix C for the Indigenous Workforce Development Checklist for Indigenous Workers Working in Indigenous Organisations. See Appendix D for the Indigenous Workforce Development Checklist for Indigenous Workers Working in non-Indigenous Organisations (Bates, Weetra, & Roche, 2010).

All the checklists contain 40 questions that will enable organisations to determine if, and where, they have gaps in approaches to enhancing workforce development and in turn worker wellbeing.

A suggested approach to choosing, planning and implementing a worker wellbeing program appears below.

Stage	Key tasks / issues
Select the most appropriate tool to measure workforce health and wellbeing	Identify the tool which best fits the organisation in question.
Select the NCETA Workforce Development Checklist most appropriate for the organisation	For mainstream services, choose the <i>NCETA Workforce Development Checklist for the AOD Field</i> , while for organisations predominantly providing services to Indigenous clients, one of the <i>Indigenous Workforce Development Checklists</i> would be more suitable. This can help organisations identify gaps in workforce development activities.
Administer the checklist and health and wellbeing measurement tool	Organisations can conduct a self-audit process using the checklist. Great care will need to be adopted in the use of the wellbeing measurement tool to ensure the anonymity of workers. This should be undertaken by an external agency.
Collate results	Identify gaps in organisational measures to prevent, reduce and respond to stress and burnout and promote worker wellbeing.
Design and implement program	The program should be based on the gaps and issues identified.
Re-administer the workforce health and wellbeing tool and NCETA Workforce Development Checklist	Approximately three months after the conclusion of the program, re-administer the tool and checklist.
Evaluate changes in worker wellbeing	Compare the results from the two wellbeing surveys to evaluate program effectiveness.

9. Limitations of the research

There are several limitations to the research cited in this review.

First, much of the research cited stems from cross-sectional studies. While this approach can provide valuable snapshots in time, it has its limitations. These studies:

- Generally rely on self-report (with its inherent limitations)
- Cannot be used to analyse changes over time (because they are a snapshot)
- May not provide a representative sample of all workers (e.g., workers with wellbeing problems may be under- or over-represented in surveys).

The international literature concerning the wellbeing of AOD workers primarily focusses on associations between levels of wellbeing and individual or workplace characteristics. Consequently, there are substantial gaps in our knowledge concerning levels of wellbeing of the AOD workforce as a whole.

Further, much of the literature focusses on the identification of, and responses to, worker wellbeing problems rather than on the promotion of health (as per the WHO definition of health). From this perspective, measures to reduce problems such as excessive stress and burnout, for example, should be supplemented by measures to enhance health more broadly.

It also is important to be cautious about directly applying research findings from international studies of the health and wellbeing of AOD workers to the Australian and New Zealand context.

10. Conclusion

The wellbeing of AOD workers has not been extensively researched. The research that has been undertaken almost exclusively addresses the psychological wellbeing of workers, rather than their wellbeing more broadly.

Available Australian and New Zealand research suggests that most AOD workers are faring well from a psychological perspective. The wellbeing of AOD workers does not appear to be any poorer than that of workers in similar roles.

Nevertheless it appears 10-30% of AOD workers may be experiencing psychological distress. Alcohol and other drug workers are also at significant risk of secondary traumatic stress. It is therefore concerning that only two thirds of Australian AOD workers have received training in this area. These are important issues for the individual workers, their colleagues, employing organisations and clients.

Alcohol and other drug workers are heterogeneous. They perform a wide variety of roles in differing organisations, which have differing management capabilities and levels of organisational support. The workers also come from different professional backgrounds, have different qualifications, and support different client groups. Therefore, their work experiences and the levels of threats to their wellbeing will vary substantially.

Consequently, programs aimed at enhancing worker wellbeing should be designed and implemented at the organisational level and based on actual levels of worker wellbeing and the characteristics of individual organisations. The evidence cited in this Report is supportive of this approach and the tools provided will assist that process.

Workplace health promotion policies and programs, the provision of quality clinical supervision and measures to enhance worker resilience are particularly important strategies to enhance AOD worker wellbeing. Creating resilience-promoting work environments can reduce the negative, and increase the positive outcomes stemming from working in potentially demanding environments.

Despite the relatively high level of psychological wellbeing among AOD workers, a consistent finding across the literature was that younger AOD workers' are at greater risk of stress compared to older workers. While this may reflect a limitation of the research methodology, younger workers should be a primary target of any programs to enhance worker psychological wellbeing.

Much of this report has focussed on the psychological wellbeing of workers. While this is reflective of the available research, programs aimed at preventing problems and improving the wellbeing of AOD workers should be more broadly based and encompass more inclusive definitions of health and wellbeing. There is a considerable body of literature that supports the effectiveness of broadly-based workplace wellbeing programs.

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APPENDIX A

Worker wellbeing measurement tools

1. World Health Organization Quality of Life Survey: BREF

The WHOQOL:BREF is one of the most widely-known generic quality of life measurement instruments and has been rigorously tested to assess its validity and reliability in a range of settings. This instrument measures a range of important aspects of quality of life and conceptualises wellbeing as a multidimensional construct. It includes self-assessments of:

- Physical health
- Psychological health
- Social relationships
- The environment.

The WHOQOL: BREF would be well-suited to form the basis of wellbeing measures for the AOD workforce. Questions from other surveys could be added to the WHOQOL:BREF to focus on wellbeing issues of most relevance to AOD workers and their organisations.

The WHOQOL:BREF can be completed in as little as ten minutes and is available without cost at: <http://depts.washington.edu/seaqol/WHOQOL-BREF>

2. Government health and wellbeing surveys

Online employee health and wellbeing surveys have been developed by the health departments of some Australian states and territories. These online surveys not only assess mental wellbeing but also physical health, lifestyle habits or behaviours and in some cases, readiness to change.

One such survey is the ACT Online Employee Health and Wellbeing Survey, which includes questions about diet, hydration, physical activity, alcohol consumption, smoking habits, mental wellbeing, readiness to change and interest in health/wellbeing initiatives.

This survey is available here: http://www.healthierwork.act.gov.au/wp-content/uploads/2016/03/Copy_of_ACT_online_employee_health_and_wellbeing_survey_March-2016.pdf

The Department of Health and Human Services Tasmania has designed a similar health and wellbeing survey to help collect baseline data on lifestyle behaviours, diet and mental wellbeing. It includes a separate section to examine what workers may want or need in terms of health and wellbeing programs within the workplace. It provides a template that can be customised to suit individual organisations.

It is available at:

http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0003/112980/Poh_Survey_good_health_good_business_20120831.pdf

3. Mental health measurement tools

General Health Questionnaire (GHQ-12)

The General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1988) is a self-administered screening tool for examining psychological distress/wellbeing. The questionnaire measures broader components of psychological ill health and comprises items that examine recent levels of happiness, anxiety, depression and social withdrawal. It has been widely used, both in clinical settings and the general population, and is well validated. However, its major limitation is that it focuses on measures of mental wellbeing. It is therefore less comprehensive than the WHOQOL: BREF.

The GHQ can be purchased at: <https://shop.acer.edu.au/acer-shop/group/SD>

Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

The WEMWBS asks respondents to report their subjective experience of happiness and psychological functioning in the last two weeks. Although not designed specifically to measure wellbeing at work, it is a validated measure that includes current concepts of mental wellbeing and could be used in a work setting, particularly to evaluate the effect of an intervention (Maheswaran, Weich, Powell, & Stewart-Brown, 2012). Positive mental wellbeing scales, such as the WEMWBS, may be better suited to measuring mental wellbeing in non-clinical populations (Maheswaran et al., 2012; Stewart-Brown & Janmohamed, 2008).

The WEMWBS is available at:

<http://www.healthscotland.com/uploads/documents/1467-WEMWBS%20scale.pdf>

4. Workplace-oriented tools

Workplace Wellbeing Questionnaire: Black Dog Institute

The Black Dog Institute, a pioneer in the identification, prevention and treatment of mental illnesses and promotion of wellbeing, developed the Workplace Wellbeing Questionnaire (Black Dog Institute, 2010). The self-report questionnaire takes 5-10 minutes to complete and can be answered online on the Black Dog Institute website. The four areas of workplace wellbeing measured include:

- Job satisfaction (the extent to which one's work is fulfilling, advances skills, increases self-worth and makes life more meaningful)
- Organisational respect for the employee (the degree to which management are trustworthy, ethical, value staff and treats them well)
- Employer care (how supportive and understanding one's boss/leader is)
- Intrusion of work into private life (level of stress/pressure work has on home life and how it impacts self-esteem).

There are [online](#) and [paper](#) versions of the Workplace Wellbeing Questionnaire on the [Black Dog Institute's website](#).

Organizational Readiness to Change (Lehman, Greener, & Simpson, 2002)

The Organizational Readiness for Change questionnaire is an instrument used to assess counsellors' perceptions of themselves and the programs in which they work. It measures a range of dimensions including relationships between staff, organisational climate, client engagement in treatment, agency resources, and organisational stability. Some of these questions can shed light on issues such as staffing, stress, cohesion, growth and satisfaction (Best, Savic, & Daley, 2016).

The Organisational Readiness to Change questionnaire is available at:

<https://ibr.tcu.edu/wp-content/uploads/2016/01/ORC-D4-Aug09-rev.pdf>

Shirom-Melamed Burnout Measure (SMBM) (Shirom & Melamed, 2006)

The SMBM is a 14-point scale that measures burnout. It measures physical fatigue, emotional exhaustion and cognitive weariness. An overall burnout score can be computed by averaging all responses. The SMBM is based on conservation of energy theory and takes into account cumulative depletion of personal resources (Best, Savic, & Daley, 2016).

The SMBM is available at: <http://www.shirom.org/arie/index.html#>

Therapeutic Optimism Scale (TOS) (Byrne, Sullivan, & Elsom, 2006)

The TOS measures the degree to which workers are optimistic that their clients can achieve positive outcomes. It was originally validated with mental health clinicians, however, with some minor wording changes (e.g., replacing the words "mental health clinicians" with "AOD clinicians") the measure appears to have face validity for use with AOD workers (Best, Savic, & Daley, 2016).

The original (mental health worker) TOS is available in the article:

<http://ro.uow.edu.au/cgi/viewcontent.cgi?article=1153&context=hbspapers>

Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis, & Figley, 2004)

The STSS is a self-report measure of secondary trauma. It measures three domains of traumatic stress specifically associated with secondary exposure to trauma: intrusion, avoidance, and arousal.

The STSS is available at:

<http://academy.extensiondlc.net/file.php/1/resources/TMCrisis20CohenSTSSScale.pdf>

The Professional Quality of Life Scale (ProQOL) (Stamm, 2010)

The Professional Quality of Life Scale (ProQOL) is a 30-item self-report questionnaire that measures compassion fatigue (via burnout and secondary traumatic stress), and compassion satisfaction (i.e., the sense of satisfaction and growth that is perceived when helping someone) (Stamm, 2010).

The PROQOL Scale is available at: http://www.proqol.org/ProQol_Test.html

Utrecht Work Engagement Scale (UWES)

Work engagement can be viewed as the conceptual opposite to burnout. The level of work engagement involves measurement of more positive work-related cognitive states, rather than focussing on negative ones. As with burnout, it is a multidimensional construct but is defined as a positive, fulfilling, work-related state of mind characterised by the following features:

- Vigour – high levels of energy and mental resilience, the willingness to invest effort and persistence even when confronted by difficulties
- Dedication – strongly involved in work and feeling a sense of significance, enthusiasm, inspiration, pride and challenge
- Absorption – being happily and deeply engrossed and fully concentrating on work whereby time passes quickly and there is some difficulty in detaching from work (Maslach et al., 2001; Schaufeli, Salanova, González-Romá, & Bakker, 2002).

Engaged workers are energetic and effectively connected to their work activities and perceive themselves to be well able to deal with the demands of their job (Schaufeli, Bakker, & Salanova, 2006).

The UWES is available at:

<http://www.wilmarschaufeli.nl/downloads/test-manuals>

Treatment Outcomes Profile (TOP) (Marsden et al., 2008)

The TOP was primarily developed as a clinical, management and service-commissioning tool to measure change and progress among people undergoing treatment for AOD problems. The survey consists of 20 questions focussing on the areas of major importance to clients' lives. These are:

- Substance use
- Injecting risk behaviour
- Crime
- Health
- Social functioning.

In their survey of wellbeing among AOD counsellors, Best et al. (2016) used three questions from the TOP to measure health and social functioning. These three measures correspond with measures from the WHOQUAL: BREF. If the WHOQUAL: BREF is to be used then there is little reason to also use the TOP, given that the latter was primarily developed for clinical populations.

The Treatment Outcomes Profile is available here: <http://www.nta.nhs.uk/uploads/top-form-2016.pdf>

APPENDIX B

NCETA workforce development checklist for the AOD field

Available at: <http://www.workskillsweb.net/attachments/WFDChecklistBooklet-3.pdf>

 workforce development checklist for the AOD field³

1. Do you regularly undertake training/professional development needs analyses ?				
2. Do you have strategies in place to address knowledge and skills gaps identified in needs analyses ?				
3. Do you have a training/professional development plan in place?				
4. Do you have a strategy in place to identify and implement training/professional development opportunities ?				
5. Do you provide supervisors and managers with supervision/management training ?				
6. Do you have strategies in place to ensure effective training transfer ?				
7. Do you evaluate the impact of training on work practice?				
8. Do you have strategies in place to optimise staff recruitment ?				
9. Do you ensure up-to-date job descriptions are provided to potential new staff?				
10. Do you have employee retention strategies in place?				
11. Do you monitor staff turnover levels?				
12. Do you conduct staff exit interviews ?				
13. Do you conduct regular staff performance appraisals ?				
14. Have you identified key performance criteria for staff positions?				
15. Does your staff performance appraisal process undergo regular evaluation?				
16. Do you have staff reward and recognition strategies in place?				
17. Have you implemented strategies to ensure effective teamwork ?				
18. Have you developed and disseminated clear work team goals and objectives?				
19. Do you have strategies in place to monitor work team performance ?				
20. Do you have strategies in place to provide teamwork performance feedback to work teams?				
21. Do you have work team reward and recognition strategies in place?				
22. Do you have a clinical supervision program in place?				
23. Is your clinical supervision program regularly evaluated ?				
24. Do you have a staff mentoring program in place?				
25. Is your mentoring program regularly evaluated ?				
26. Do you have strategies in place to ensure workers are aware of, and meet, work orientated goals and objectives ?				
27. Do you have strategies in place to build and support workers' commitment to work-orientated goals and objectives ?				
28. Do you have strategies in place to provide feedback on achieving work orientated goals and objectives ?				
29. Do you have strategies in place to monitor staff workloads and levels of work stress ?				
30. Are supervisors/managers trained to be able to recognise signs of work stress in staff?				
31. Do you have strategies in place to deal with work stress ?				
32. Do you monitor levels of staff job satisfaction ?				
33. Do you have strategies in place to optimise job satisfaction ?				
34. Do you have strategies in place to enhance worker wellbeing ?				
35. Do you have policies and strategies in place to ensure organisational support to staff?				
36. Do you have policies and strategies in place to ensure supervisor/management support to staff?				
37. Do you have policies and strategies in place to ensure co-worker support to staff?				
38. Do you apply organisational change strategies when introducing new work practices and procedures?				
39. Do you evaluate organisational change strategies that are introduced to ensure effective work practices and/or procedural change?				
40. Do you regularly evaluate work programs and work practices?				

APPENDIX C

NCETA Indigenous workers WFD checklist for Indigenous AOD workers in Indigenous organisations

Available at:

<http://nceta.flinders.edu.au/files/1512/9800/6355/EN425%20Bates%20et%20al%202010.pdf>

Indigenous Workforce Development Checklist No. 1 Indigenous AOD Workers in Indigenous Organisations			
	Yes	No	N/A
1. Do you regularly consult with Elders in your community?			
2. Does your workplace consult with community to identify current AOD trends within specific Indigenous communities?			
3. Does your workplace assess community needs and invest in developing services accordingly?			
4. Do you feel your workplace is well accepted by the community?			
5. Are Indigenous ways of working incorporated into AOD programs in your workplace?			
6. Are you involved in workplace planning, and community development processes?			
7. Does your workplace have strategies to incorporate Indigenous knowledge into policy and procedures?			
8. Does your organisation facilitate access to culturally relevant training / professional development?			
9. Does your workplace have policies and procedures to ensure worker safety in working with clients?			
10. Do you have an adequate bereavement / compassionate leave policy in your workplace?			
11. Do you have an adequate ceremonial leave policy in your workplace?			
12. Do you have an adequate leave policy in your workplace to participate in NAIDOC week celebrations?			
13. Do your managers/supervisors support networking, building and maintaining community relationships?			
14. Do your clients have access to culturally appropriate AOD services?			
15. Does your workplace have grievance procedures to deal with worker and/or client complaints?			
16. Are you able to access cultural healing practices for clients and workers?			
17. Do your managers/supervisors understand and support community obligation?			
18. Does your workplace have policies and procedures to address racism?			
19. Does your workplace give recognition to Indigenous knowledge, and lived experiences of Indigenous AOD workers?			
20. Does your organisation have mandatory cultural awareness training for non-Indigenous workers?			
21. Does your workplace have processes to recruit appropriate non-Indigenous staff?			
22. Does your workplace have policies to ensure confidentiality?			
23. Do have policies to employ culturally safe practices within your workplace?			
24. Do you incorporate gender appropriate practices in your organisation?			
25. Does your workplace have an Indigenous specified positions?			
26. Does your workplace support/create career paths for Indigenous AOD workers?			
27. Does your workplace have EAP (Emergency Assistance Program) for Indigenous AOD workers to access counselling services?			
28. Does your workplace have a high rate of staff turnover?			
29. Does your workplace regularly evaluate programs and cultural work practices?			
30. Do you have flexible work arrangements?			
31. Do you participate in clinical supervision?			
32. Do your supervisors/managers recognise signs of work stress in Indigenous workers?			
33. Do your managers/supervisors encourage self-care activities to enhance worker wellbeing?			
34. Do you have access to mentoring?			
35. Does your job specification accurately reflect the task you undertake in your role?			
36. Are you adequately supported by non-Indigenous co-workers?			
37. Do you feel your salary is adequate for the work you do?			
38. Do management/supervisors have realistic expectations of your work?			
39. Do you have a manageable workload?			
40. Do you regularly undertake performance appraisals?			

APPENDIX D

NCETA Indigenous workers WFD checklist for Indigenous AOD workers in non-Indigenous organisations

Available at:

<http://nceta.flinders.edu.au/files/1512/9800/6355/EN425%20Bates%20et%20al%202010.pdf>

Indigenous Workforce Development Checklist No.2 Indigenous AOD Workers in non-Indigenous Organisations

	Yes	No	N/A
1. Is consultation with Elders facilitated in your workplace?			
2. Does your workplace consult with community to identify current AOD trends within their local Indigenous communities?			
3. Does your workplace assess local community needs and develop services accordingly?			
4. Do you feel your workplace is well accepted and accessed by the community?			
5. Are Indigenous ways of working incorporated into AOD programs in your workplace?			
6. Are you involved in workplace planning, and community development processes?			
7. Does your workplace have strategies to incorporate Indigenous knowledge into program development for Indigenous clients?			
8. Does your organisation facilitate access to culturally relevant training / professional development?			
9. Does your workplace have policies and procedures to ensure worker safety when working with clients?			
10. Do you have an adequate bereavement / compassionate leave policy in your workplace for Indigenous workers?			
11. Do you have a ceremonial leave policy in your workplace for Indigenous workers?			
12. Do you have a leave policy in your workplace for Indigenous workers to participate in NAIDOC week celebrations?			
13. Do your managers/supervisors support networking, building and maintaining community relationships?			
14. Do your clients have access to culturally appropriate AOD services?			
15. Are you able to access cultural healing practices for clients and workers?			
16. Do your managers/supervisors understand and support your commitment to community?			
17. Does your workplace have policies and procedures to address racism?			
18. Does your workplace give recognition to Indigenous knowledge, and lived experiences of Indigenous AOD workers?			
19. Does your organisation have mandatory cultural awareness training for non-Indigenous workers?			
20. Does your workplace have processes to recruit and retain appropriate non-Indigenous staff in Indigenous focuses AOD programs?			
21. Does your workplace have policies to ensure client confidentiality?			
22. Do you have policies to implement and evaluate culturally safe practices within your workplace?			
23. Does your workplace understand gender appropriate practices for Indigenous clients?			
24. Do you regularly undertake performance appraisals?			
25. Does your workplace have an Indigenous employment strategy?			
26. Does your workplace support/create career paths for Indigenous AOD workers?			
27. Does your workplace have EAP (Emergency Assistance Program) for Indigenous AOD workers to access counselling services?			
28. Does your workplace have a high rate of staff turnover?			
29. Do you evaluate and report on cultural work practices within the organisation?			
30. Do you have flexible work arrangements?			
31. Do you participate in clinical supervision?			
32. Do you have access to mentoring?			
33. Do your managers/supervisors encourage activities to enhance worker wellbeing?			
34. Does your workplace have grievance procedures to deal with worker and/or client complaints?			
35. Does your job specification accurately reflect the task you undertake in your role?			
36. Are you adequately supported by non-Indigenous co-workers?			
37. Do you feel your salary is adequate for the work you do?			
38. Do management/supervisors have realistic expectations of your work?			
39. Do you have a manageable workload?			
40. Do you regularly undertake performance appraisals?			