Sheffield Hallam University

The Well-Being of Alcohol and Other Drug Counsellors in Australia: Strengths, Risks, and Implications

BEST, David <http://orcid.org/0000-0002-6792-916X>, SAVIC, Michael and DALEY, Peter

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The well-being of alcohol and other drug counsellors in Australia: strengths, risks and implications

David Best PhD[1,2]

Michael Savic PhD[2]

Peter Daley BSc[2]

[1] Sheffield Hallam University, Sheffield, UK

[2] Turning Point, 46-54 Gertrude Street, Melbourne, Victoria, Australia

Abstract [A head]

Working with alcohol and other drug (AOD) using populations in treatment services is a demanding job that has been associated with a susceptibility to stress and burnout in the workforce. The current study used an online survey methodology in Victoria, Australia, to examine staff well-being and burnout in a cohort of 228 workers in AOD specialist services in Victoria, 151 of whom hold client caseloads. While there was a strong negative association between stress and burnout, and inverse associations with work satisfaction and well-being, the focus of the current analysis was what predicted positive well-being in workers. This was associated with four factors – lower levels of emotional exhaustion and cognitive weariness (both aspects of burnout), higher levels of opportunities for professional growth and a greater support network in the worker's own life with which to discuss things. Thus, positive well-being is not only linked to lower burnout, and to greater perceived development opportunities, but also to the support systems workers have access to.

Correspondence to:

Professor David Best

Department of Law and Criminology

Sheffield Hallam University

Collegiate Crescent

Sheffield, UK, S10 2BQ

Telephone: +44 114225 5435

E-mail: D.Best@shu.ac.uk

Introduction [A head]

Counsellor well-being in the AOD sector is a significant concern and has traditionally been measured with burnout (end point) instruments and measurement of organisational (interventional point) factors which may contribute to burnout. Burnout is a phrase coined by Freudenberger (1974) and has been defined as: 'The process of physical and emotional depletion resulting from conditions at work or, more concisely, prolonged job stress' (Osborn, 2004, p319). Maslach and Jackson (1986) have described burnout as a syndrome comprising three core elements of emotional exhaustion, depersonalisation and reduced personal accomplishment. Although some have medicalised the concept, calling it a 'syndrome', it is not recognised as a diagnosis in classification systems like the DSM and ICD.

Burnout is associated with a range of health issues for clincians, as well as poor job performance, absenteesim and turnover. Various factors are thought to contribute to burnout, including demanding clients, the work envrionment, job factors, and clinician socio-demographic factors, Burnout has been found to effect around one in three AOD workers (Reissner et al, 2009; Oyefeso *et al*, 2008), which is moderately high when compared to workers in similar fields (Reissneret al, 2009).

It is fair to say that part of the interest in burnout relates to an economic and productivity imperative for organisations. For instance, organisations may be particularly interested in preventing burnout to maintain or increase productivity. Sometimes ironically, the well-being of clinicians and the quality of care they provide to clients seems to have been overshadowed by a focus on productivity. By well-being, we are referring to a broader notion of health that is not just about the absence of disease or symptoms.

A focus on burnout omits the dynamic of work and the rest of life and its relationship to counsellor well-being. In the AOD sector in Australia, Duraisingam et al (2007) have argued that occupational well-being is associated with job satisfaction, organisational commitment and lack of stress and burnout. This has significant implications for the organisation as workers are more likely to think about leaving their jobs if they lack commitment to the organisation, are dissatisfied with their work, experience chronic stress and insufficient support (Barak et al, 2001). However, positive well-being and life quality has received limited exploration in the AOD field.

The aim of the current study is to describe job satisfaction, stress, burnout and well-being in a

cohort of AOD workers in Victoria, Australia. Predictors of well-being are calculated to attempt to identify positive strength factors in this population. We also wanted to explore asoociations between counsellor well-being and therapeutic optimism, which is about how optimistic workers are that the treatment they provide can make a difference to clients, and which has been linked to client outcomes (Byrne *et al*, 2006).

Method [A head]

An invitation to complete an online survey on well-being was communicated through the email list of the peak body for AOD services in Victoria. This list is widely subscribed to by AOD workers and managers in Victoria. The project received ethics approval from the Eastern Health Research and Ethics Committee and the online survey took less than 20 minutes to complete on average.

Measures [B head]

The instrument consisted of a number of standardised tools, which were used to supplement information about participant charactersistics, such as age, sex, country of birth, area of work and professional background, highest education qualification, employment type and hours spent working, caseload, and years of experience working in the AOD sector. Participants were also asked whether they took work home and whether they were interrupted by taking work home. In order to get an indication of workers' social support networks, we included a single item asking 'How many people do you discuss important things with?'.

Well-being was measured using three items from the Treatment Outcomes Profile (TOP) (Marsden et al, 2008). These items ask the participant to rate their psychological health, physical health, and quality of life in the last four weeks on a 0–20 point scale (with high scores indicating high subjective well-being). Although the TOP was developed for measuring treatment ouctomes among clients of AOD services, the three items in question are correlated with corresponding general population measures such as the WHOQOL-BREF and Kessler psychological distress scale (Ryan et al, 2014). For the purposes of some analyses, we summed the three-items to derive a total well-being score, ranging from 0 (poor) to 60 (good).

We measured workers' perspectives on several aspects of their work environment using selected domains from the Texas Christian University Organisational Readiness for Change (ORC) measure (Lehman et al, 2002). In particular, domains measured in this study included staffing (6-items about

the perception of appropriate level of staffing), stress (4-items about the degree to which workplace is stressful), cohesion (6-items about the degree to which there is staff cohesion), growth (5-items about whether there are opportunities for development and growth), and satisfaction (6-items the degree to which people are satisfied with their jobs). Each domain yields a score ranging from 10–50, with higher scores indicating more endorsement of the phenomena of interest.

The Shirom-Melamed Burnout Measure (SMBM) was used to measure burnout (Shirom & Melamed, 2006). It consists of 14 items, and participants are asked to rate how frequently they have experienced loss of energy (and associated feelings) at work, on a scale ranging from 1 (almost never) to 7 (almost always). The SMBM has three subscales: 1) Physical fatigue (6-items), 2) Cognitive weariness (5-items), and 3) Emotional exhaustion (3-items). In addition, an overall burnout score can be computed by averaging all responses. The SMBM is based on conservation of resources theory and takes into account cumulative depletion of personal resources. The SMBM is less occupationally specific than other burnout measures and has the advantage of measuring cognitive weariness (Qiao & Schaufeli, 2011).

Therapeutic optimism was measured using the 10-item Therapeutic Optimism Scale (TOS) (Byrne *et al*, 2006). The TOS was originally validated with mental health clinicians and measures how optimistic workers are that their clients can achieve positive ouctomes. However, with some minor wording changes (eg. replacing 'mental health clinicians' with 'AOD clinicians') the measure appeared to have face validity for use with AOD workers. The TOS asks workers how much they agree with statements on a five-point likert scale. After re-coding the three reverse scored items and then summing items, an overall TOS score of between 10 (low optimism) and 50 (high optimism) is derived. In addition, three subscale scores can be calculated. These measure particular types of outcome expectancies and include: 1) General treatment outcome expectancy, 2) Personal treatment ouctome expectancy, 3) Pessimism or the tendency to anticipate or emphasise undesireable outcomes (Byrne et al, 2006). Where general treatment outcome expectancy relates to clincians' perception of how well treatment will work out for their clients, personal treatment outcome expectancy refers to a clinician's confidence that they can help the client to achieve positive outcomes (Byrne et al, 2006).

Analysis [b head]

Initially, descriptive analysis was undertaken to understand participants' characteristics. Pearson's

correlation and independent samples t-tests were used to explore relationships between variables. Finally, a linear regression was performed to investigate whether factors (independent variables) that were significant at a bivariate level predicted overall well-being (dependent variable). To do this, a composite variable was constructed summing the three 'well-being ladders' that are collected as part of the ATOP scale. This yields a score range of 0–60 with higher scores representing higher levels of well-being.

Results [A head]

Staff sample [b head]

Sample: A total of 228 forms were returned, of whom 151 held client caseloads at the time of the research. The mean age of research participants was 44.3 years (SD=11.2) and the majority were female (71.7%) and Australian-born (81.7%). The most common work areas for the sample were 'direct health and treatment' (n=122, 54.3%), 'social/welfare related work (n=42, 18.7%) and 'service management and/or service development' (n=29, 12.9%). The most common professional backgrounds were 'AOD counselling' (n=54, 25.1%), nursing (n=35, 16.3%) and AOD support worker (n=28, 13.0%). In terms of qualifications, participants were qualified to diploma or graduate diploma level most often (n=105, 47.5%), under-graduate degree (n=34, 15.4%), graduate certificate (n=22, 10.0%) or Masters degree (n=23, 10.4%), suggesting a diverse array of qualifications in this group.

On average, participants had worked in the field for 9.4 years (SD = 7.7), and had been in their current positions for 4.4 years (SD = 2.3). 62.4% of the sample worked on a full-time basis, averaging a typical working week of 35.2 hours (SD = 10.9 hours). Just under a third (30.1%) reported that they took work home with them and around the same proportion (29.2%) reported that they were interrupted by work at home.

Counsellor well-being [A head]

Basic scores on the Organisational Readiness for Change scale (Lehman et al, 2002) are shown in Figure 1.1.

INSERT FIGURE 1.1 ABOUT HERE

In the ORC scoring system, any scores of over 30 are broad endorsements of the behaviour and so the Victorian workers are reporting slightly elevated levels of stress but also positive ratings of their colleagues, of team cohesion, of opportunities for personal growth and overall workplace satisfaction.

Reported stress [b head]

Not surprisingly, stress is inversely related to overall job satisfaction (r=-0.47, p<0.001), and to staffing levels (r=-0.73, p<0.001), cohesion (r=-0.49, p<0.001), and growth (r=-0.23, p<0.01). In contrast, stress was positively associated with three aspects of burnout – emotional exhaustion (r=0.38, p<0.001), physical fatigue (r=0.58, p<0.001) and cognitive weariness (r=0.33, p<0.001), and strongly linked to the overall burnout score (r=0.51, p<0.001). There was not, however, an association between stress and therapeutic optimism (r=0.02, p=0.83).

Overall job satisfaction [b head]

There were strong associations between the positive dimensions of the ORC and satisfaction – it was linked to positive perceptions about staffing (r=0.56, p<0.001), with perceived cohesion in the team (r=0.64, p<0.001) and with opportunities for personal growth (r=0.50, p<0.001). In contrast, satisfaction was inversely related to total burnout (r=-0.50, p<0.001) and to each of the sub-dimensions. There was also a clear positive association between counsellor satisfaction at work and overall therapeutic optimism (r=0.22, p<0.01) and the sub-scale relating to treatment outcome expectancies (r=0.21, p<0.01).

Burnout [b head]

The three dimensions of burnout were also linked – emotional exhaustion was associated with both physical fatigue (r=0.49, p<0.001) and cognitive weariness (r=0.56, p<0.001). Total reported burnout was strongly linked to low workplace satisfaction (r=-0.50, p<0.001) and in particular workers not being happy about staffing (r=-0.40, p<0.001) and the cohesion in the workplace (r=-0.38, p<0.001). However, there did not appear to be a clear relationship between burnout and therapeutic optimism.

Specific staffing factors and well-being [b head]

Those workers with a client caseload (n=151) reported significantly higher rates of stress at work (mean = 32.7) than those who did not have a caseload (mean = 29.1; t=2.62, p<0.01). There is no clear association between caseload size and either stress or satisfaction, but higher caseload size is associated with more negative perceptions of staffing in the organisation (r=-0.19, p<0.05).

TOP ratings [b head]

On a measure more typically used to rate client well-being in the UK that has been adapted for use in Australia, three single item measures were used to assess well-being on a scale from 1–20. Overall scores for psychological health averaged 14.9 (SD = 4.6), for physical health 14.1 (SD = 4.3) and for quality of life 15.3 (SD = 5.3). The three measures were strongly correlated and so a total score could be calculated (out of 60) with a mean overall TOP well-being rating of 43.7 (SD = 11.7). The total TOP score was inversely related to ORC stress (r=-0.36, p<0.001) and positively associated with overall satisfaction (r=0.39, p<0.001), staffing satisfaction (r=0.34, p<0.001), staff cohesion (r=0.33, p<0.001) and opportunities for growth (r=0.23, P<0.01).

However, TOP total score was also strongly (inversely) associated with total burnout score (r=-0.71, p<0.001) and with each of the three sub-scales – emotional exhaustion (r=-0.40, p<0.001), physical fatigue (r=-0.71, p<0.001) and cognitive weariness (r=-0.59, p<0.001). However, this was not predictive of therapeutic optimism. The only demographic characteristics that were associated with well-being were age (being older was associated with better well-being (r=0.20, p<0.05) and a greater number of people to talk about things with (r=0.20, p<0.05).

Overall predictors of well-being [A head]

A linear regression was conducted to assess predictors of overall well-being in workers with all of the variables significant at a bi-variate level included in the analysis. The final model was highly significant (F=21.31, p<0.001) and explained 52.4% of the variance in well-being (Adjusted R2 = 52.41) with the following variables retained in the model:

- age
- number of important people to discuss things with
- stress
- cohesion
- satisfaction
- growth

- emotional exhaustion
- cognitive weariness.

In the final model there were four significant variables – two negative factors associated with burnout (emotional exhaustion and cognitive weariness), one positive life factor (people to discuss important things with) and opportunities for professional growth.

Discussion [A head]

While there have been understandable concerns about elevated risks of stress and burnout in the AOD counsellor population (eg. Duraisingam et al, 2007), our study has reported generally positive reports of health and well-being, with significantly elevated scores reported in both the three well-being measures (physical and psychological health and quality of life) and in workplace satisfaction. That is not to suggest that there is not a damaged and at-risk group (as we will discuss in a forthcoming paper), but the general levels of health and well-being are high, both among those with direct client contact and those without.

This is an important point to make as the increased focus on a recovery approach to client care and policy (Best, 2012; White, 2009) would suggest a more general switch to a 'positive' model. In psychology, this is characterised in the work of Seligman and Csikszentmihalyi (2000) on positive psychology and the more recent emergence of a 'positive criminology' movement (see Ronel & Elisha, 2011). To apply this approach within the context of counsellor well-being, would suggest a focus on the individual and collective strengths, resources and supports that workers possess both to assisting colleagues who encounter difficulties but also in supporting and assisting clients. This is also reflected in the generally positive responses to work that were reported – not only the high levels of overall satisfaction with work but also the positive collective perceptions of staffing and colleagues, of team cohesion and also opportunities for personal growth.

The last of these factors was one of the four significant factors in the regression predictors of overall counsellor well-being – suggesting that the perception for professional growth may affect not only satisfaction in the workplace but wider issues of life satisfaction and well-being. Likewise, the current findings also suggest that there is a key social component to counsellor well-being – in the form of the availability of people (in and out of work) to talk to. This is consistent with a strong literature (eg. Jetten et al, 2011) that would suggest that a sense of belonging is important for personal well-being. Finally, there were two burnout factors that adversely affected well-being –

emotional exhaustion and cognitive weariness. The current study showed that many participants take work home and work extra hours and this may not only affect their work but also more broadly their general health and well-being.

What is also important to note is that well-being is influenced by a combination of factors specific to work (opportunities for growth) and those that may straddle work and non-work life (emotional exhaustion, cognitive weariness and social supports). To promote the well-being of workers, it may be important to provide access to supports that span home and work environments and that provide early indicators of burnout for workers. The current study provides only limited support for the suggestion that there is a link between counsellor well-being and therapeutic activity or engagement, as indicated through the measurement of therapeutic optimism. This perhaps indicates that on the whole workers do not let their own well-being interfere with the treatment they provide. While this is encouraging, it is important that further research is conducted to explore the possible impact ofcounsellor well-being, attitudes towards clients and client outcomes.

There are a number of limitations of the current study. We do not have any information about the organisations that the workers were employed in and so cannot measure individual well-being in terms of organisational or workplace cultural factors. Similarly, this study was a cross-sectional survey based on voluntary recruitment and participation in an online space, meaning that we can say little about the representativeness of the sample, nor are we able to validate any of the responses against objective indicators of well-being. The study also lacks predictive validity as we have no indication of how stable or unstable the well-being markers are or what client well-being or outcome indicators they are linked to.

Nonetheless, this study is important in drawing attention to both the variability in scores on counsellor well-being and the predictors of well-being in alcohol and drug workers, both those with direct client contact and those without. There is some indication that those with direct client contact experienced slightly more stress than those that did not but this was not linked to caseload size. The study is predicated on a 'positive' model of understanding counsellor well-being and the study suggests that organisations intent on supporting well-being in their workers should focus on supporting their professional growth and development, but also in enabling workers to have supportive relationships, to look after their health and to guard against emotional and mental burnout.

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Figure 1.1: Counsellor ratings in Victoria

Legend: Figure 1: Worker ratings in Victoria

Categories: Stress, Staffing, Cohesion, Growth, Satisfaction