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RESEARCH

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Staying motivated by anchoring on values: a mixed methods study on the workplace well-being and addiction beliefs of substance use professionals in Singapore

Jing En Cher[1], Joanna Barlas[1,3*], Maria Hennessy[1], Jonathan E. Ramsay[1,2,3] and Sherry Aw[1]

Abstract

Purpose Professionals providing substance use treatment services often report poor workplace well-being. Moreover, professionals' beliefs about addiction may influence their view of clients, treatment delivery and their well-being at work. Most research has been undertaken in Western countries, hence this study investigated workplace well-being and addiction beliefs of substance use (SU) professionals in Singapore.

Methods A mixed-methods design was employed. Fifteen participants completed questionnaires related to their well-being at work and addiction beliefs, before participating in a semi-structured interview.

Results Descriptive analyses revealed that most participants experienced a moderate level of satisfaction with their work and moderate burnout. Reflexive thematic analysis generated four themes: (1) deriving and maintaining meaningfulness; (2) clarity of role and support for effective performance; (3) holding a multidimensional and nuanced view of addiction promotes satisfaction and motivation; and (4) navigating systemic challenges. Workplace well-being was negatively impacted by perceptions of organisational and systemic challenges.

Conclusions SU professionals derived satisfaction and stayed motivated by crafting their work to re-align with their personal values and beliefs, finding role-clarity, adopting a multidimensional and flexible model of addiction and having external support. Implications highlight the role that organisational training, supervision and career development can play in supporting SU professionals.

Keywords Well-being, Job satisfaction, Job crafting, Substance use, Addiction beliefs

*Correspondence:
Joanna Barlas
Joanna.barlas@jcu.edu.au
[1]School of Social and Health Sciences, James Cook University, 149 Sims Drive, Singapore 387380, Singapore
[2]College of Interdisciplinary and Experiential Learning, University of Social Sciences, Singapore, Singapore
[3]Margaret Roderick Centre for Mental Health Research, James Cook University, Douglas, QLD 4811, Australia

Introduction

Mental health is not solely the absence of mental disorder but includes the capacity of individuals to feel good and to function well across multiple life domains, such as within their families, communities, and workplaces [1]. In particular, workplace well-being is a key global priority with systemic impact on individuals, organisations, cultures and economies [2, 3]. Factors impacting workplace well-being exist at the individual (e.g., role-clarity and fit, psychological flexibility), organisational (e.g., organisational culture and leadership), and systems levels (e.g., professional and industry standards) [4].

Working with individuals who use drugs is particularly challenging, and there are known mental health concerns for this occupational group, as well as recruitment and retention issues. These include high levels of emotional exhaustion and burnout, reduced quality of life, and related high turnover rates [5–7]. Similar to the broader organisational psychology field, most research with substance use (SU) professionals is derived from Western, educated, industrialized, rich and democratic (WEIRD) countries [8]. There is therefore a need to expand such research in Asian contexts, given differences in the management of, and cultural views towards, individuals who use substances [9]. With its zero-tolerance approach to illicit drug use [10], Singapore represents a unique setting in which to consider the professional well-being of its SU professionals.

For context, Singapore is a democratic, multicultural nation in Southeast Asia, with a population of approximately 5.6 million people [11]. Global Burden of Disease data indicates that alcohol and drug use disorders represent 1.1% of the total disease burden in Singapore [12], which is lower than the global average, as is the percentage of the Singaporean population with drug use disorder at 0.86% [13]. Singapore has strict laws that prohibit the possession, consumption, and trafficking of controlled or specified drugs [14]. These laws (e.g., compulsory treatment for drug users and use of the death penalty for drug trafficking) were initially introduced to control the widespread use of opium in the 1970s [15]. Singapore's Central Narcotics Bureau (CNB) cites the country's proximity to drug-producing regions, along with the potential economic and social threat of a drug epidemic, as key reasons for its strict approach—particularly given Singapore's reliance on cultivating a skilled and dependable workforce to support national development [10].

One consequence of this approach is that rehabilitation of individuals with drug use disorders occurs within the correctional system rather than the mental health system. It is also mandatory for health practitioners to report drug use. This suggests that SU professionals working in Singapore will face complex emotional and ethical demands as they navigate tensions between care, control, and accountability. Similar challenges have been documented among probation practitioners, who are required to balance empathy with authority while managing emotional labour under institutional and societal display rules [16], as well as among mental health professionals who work with individuals on community treatment orders [17].

Effective drug treatment is dependent upon a multitude of factors, such as leadership, resourcing, treatment staff and the overall workplace climate, which together shape the quality and consistency of care and in turn treatment engagement and outcomes [18, 19]. However, previous research indicates that SU professionals have high annual turnover rates ranging from 18.5% to 47% [7, 20]. Contributing factors include high levels of burnout, diminished job satisfaction, organisational commitment, health problems, reduced productivity, and turnover intention [21, 22].

Both individual and organisational factors underlie the poorer well-being of SU professionals. Individual factors include the nature of helping work generally and additional challenges specific to addiction work, such as managing the chronicity and high frequency of relapse, co-morbid physical and mental health conditions, co-occurring housing and financial problems, and stigma [22–24]. These challenges often lead to lack of treatment progress, including high attrition, driving organisations to offer high levels of resources [24]. In terms of organisational factors, addiction professionals often have high caseloads, substantial administrative work, and inadequate compensation, which contributes to the dissatisfaction, stress and exhaustion experienced [20, 25]. Burnout has been shown to correlate with both job demands [21] and high caseloads [26].

Alongside this research focusing on factors relating to poorer workplace mental health, some studies have investigated factors that promote well-being and improve engagement at work and retention rates for SU professionals. Employee well-being comprises three core components: subjective well-being, psychological well-being, and workplace well-being, which includes job satisfaction and work-related affect [27]. Amongst SU professionals, individual factors such as passion for the work [28], working with client complexity and being able to witness and facilitate change [23] and resilience [29] are associated with higher motivation, work engagement, and job satisfaction. At an organisational level, factors such as role clarity and leadership quality [29], management communication [5], participatory management structures [30] and working in an environment open to change [21] are associated with workplace well-being. At a systems level, having opportunities for growth [29, 31], feeling respected [21] and feeling supported at work [21, 29,

31] positively impact workplace well-being and reduce intentions to quit.

Specific to SU work, the beliefs held by professionals may play a role in influencing their approach to their work which could, in turn, impact their well-being. Two traditional views of addiction are the disease versus free-will model, which differ in the extent to which the person is seen as responsible for acquiring and recovering from addiction [32, 33], although more recently a biopsychosocial model of addiction has been proposed [34]. It has been argued that adopting a disease model reduces stigma and increases treatment seeking [35] whilst critics argue it decreases personal responsibility for change [36]. In relation to the impact of addiction beliefs on workplace well-being, existing evidence is very limited. One study found that SU professionals who believed in the disease model of addiction, as compared to those who believed in the free-will model of addiction, had lower levels of emotional exhaustion [37].

Historically, there have been some cultural differences in how addiction is viewed; American SU professionals more strongly believe in the disease model [38, 39] whilst UK SU professionals were found to prefer the free-will model [38]. In two qualitative studies, clinicians and neuroscientists in Australia accepted the importance of neuroscientific research in understanding addiction, however they believed that a purely brain disease model neglected important environmental, psychological, and social factors that underlie addiction and were important considerations in treatment [40, 41]. More recently, a systematic review found that drug and alcohol treatment providers in Western countries do not subscribe to a particular addiction model but instead endorsed the disease, moral, free-will, and social models of addiction concurrently [42]. It was argued that holding several models simultaneously allowed SU professionals to employ a multi-treatment approach that could target all relevant factors related to an individual's addiction. There is no such research outside of WEIRD countries and therefore little is known about the views of professionals in Asia towards individuals who use drugs, their subscribed models of addiction and how their beliefs might affect their workplace well-being.

Rationale for current study

To date, there is no research investigating the experiences of SU professionals in Singapore, who are in the unique position of working within services that straddle both addiction and forensic contexts. Most of the previous studies were conducted in WEIRD countries such as the United States and Australia where both patterns of substance use and approaches to substance use work differ. Given Singapore's approach towards managing individuals who use illicit drugs [14] and the likely challenges of balancing between the dual roles of supporter and custodian [17], existing research cannot inform us about the workplace well-being and addiction beliefs of SU professionals in Singapore. There is therefore a need to understand how satisfied SU professionals in Singapore are with their work and explore whether similar or different individual, organisational and system level factors influence their workplace motivation, work engagement and job satisfaction. Culturally, it would also be important to understand how addiction professionals in Singapore apply their addiction beliefs to their work and the ways in which their addiction beliefs affect their well-being at work.

The present study sought to investigate the workplace well-being and addiction beliefs of SU professionals in Singapore, adopting a mixed-methods approach to answer the following research questions;

1. How satisfied are SU professionals in Singapore with their work?
2. What helps SU professionals in Singapore stay motivated in their work?
3. What are SU professionals' beliefs regarding addiction in Singapore?
4. How do SU professionals' beliefs about addiction influence their workplace well-being?

Methodology

A sequential explanatory (quant) QUAL design was employed to answer the research questions [43]. Questionnaires aimed to establish the workplace well-being levels of SU professionals and whether they believed in the disease model or free-will model of addiction. Subsequent semi-structured interviews aimed to understand the nuances of their satisfaction through exploring motivating factors in their work as well as how their addiction beliefs influenced their well-being at work. Interview data were then cross-referenced with scores on the questionnaires to identify meaningful correspondences between the quantitative and qualitative data.

Participants

The sample comprised 15 participants from three organisations in Singapore who provide support for individuals who use drugs in the community. Eleven of the 15 participants were from one of these agencies, whilst the remaining four were from the other two agencies. Participants were on average 31 years old ($SD = 5.9$), and the majority of participants were female (66.7%), ethnically Chinese (60%), and degree holders (73.3%). They had an average of 3.4 years ($SD = 1.8$) of work experience, and most had a caseload of 20 to 29 individuals (53.3%) (see Table 1). Drawing on the first author's knowledge of the field, the participants were considered broadly representative

Table 1 Distribution of participants' demographics

Demographics	*n*	%
Gender		
Female	10	66.7
Male	5	33.3
Ethnicity		
Chinese	9	60
Malay	3	20
Indian	3	20
Highest educational level		
Diploma	1	6.7
Degree	11	73.3
Postgraduate	3	20
Caseload		
< 10	2	13.3
10–19	2	13.3
20–29	8	53.3
30–39	3	20

Note. $N = 15$

of the SU professional population in terms of age, gender, and ethnicity. The sample was further estimated to comprise approximately 10% of the total SU professional population.

The determination of the sample size was guided by Braun and Clarke's recommendations which emphasise pragmatism – considering the size of the population from which participants were recruited – and the breadth and depth of the research question, rather than relying on principles like saturation commonly used in other qualitative approaches [44]. During participant recruitment, we approached all community organisations that provide support for individuals who use drugs in Singapore. Furthermore, the research questions each had a narrow focus, and we deliberately sought individual participants' perspectives consistent with the ontological position of reflexive thematic analysis. Therefore, we set ourselves an initial target of a sample range between 10 and 20 participants, which is in line with other qualitative studies using this approach [45].

Materials

Participants' workplace well-being and addiction beliefs were measured quantitatively using three questionnaires and a semi-structured interview schedule was developed.

The Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue Version 5 [46] is a 30-item scale that consists of three subscales each with 10 items; (1) Compassion Satisfaction (CS) which refers to the pleasure experienced from being able to carry out one's work well; (2) Burnout (BO) which refers to the difficulties and experience of hopelessness in carrying out one's work; and (3) Secondary Traumatic Stress (STS) which refers to the distress experienced due to exposure to the traumatic experiences of the clients. Participants rate on a five-point Likert scale (from 1 "never" to 5 "very often) how frequently they had certain experiences (e.g. "I believe I can make a difference through my work"). Scores are calculated for each of the three subscales. ranging from 10–50 with higher scores indicating more frequently experiencing satisfaction, high levels of burnout, and higher levels of secondary traumatic stress respectively. Developing authors reported moderate to high reliability across the subscales (Cronbach's alpha (α) = .88, BO α = .75 and STS α = .81).

The Drug and Drug Problems Perceptions Questionnaire (DDPPQ) [47] is a 20-item scale that measures professionals' attitude, satisfaction and competence in working with individuals who used drugs. It consists of the five subscales: (1) Role Adequacy (7 items, possible score range 7–49), (2) Role Legitimacy (2 items, possible score range 2–14), (3) Role Support (3 items, possible score range 3–21), (4) Role-related Self-esteem (4 items, possible score range 4–28), and (5) Job Satisfaction (4 items, possible score range 4–28). Items are rated on a seven-point Likert scale from 1 (strongly agree) to 7 (strongly disagree). An example item is "I feel I have a working knowledge of drugs and drug related problems". Total scores were calculated for each subscale and the whole scale (possible score range 20–140). Higher scores indicated a more negative view of each of the job-related aspects. Developing authors reported high reliability (α = 0.87).

The Addiction Belief Scale (ABS) [33] is an 18-item scale that measures the extent to which a person believes in the disease or free-will model of addiction. Items are rated on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) and the nine free-will items are reverse scored. Total scores range between 18 and 90 with higher scores indicating stronger belief in the disease model of addiction. Developing authors reported high reliability (α = 0.91).

The interview questions were developed with reference to the scales used and the existing literature. The first set of interview questions aimed to better understand their ProQOL and DDPPQ scores by exploring their experiences of satisfaction and dissatisfaction at work, the challenges they faced, and their motivation to work. As the literature is largely focused on the negative aspects of the well-being of addiction professionals, the interview questions were designed to explore the positive aspects of well-being as well. The second set of interview questions aimed to better understand the participants' ABS scores by exploring their addiction beliefs and their relation to their well-being at work. While the interview questions served as a semi-structured guide for conducting the interviews, probes were used where necessary to better understand the participants' experiences.

Procedure

The James Cook University Human Research Ethics Committee approved this research (HREC Approval Number: H8329). Recruitment was targeted at professionals who were currently working as SU counsellors/therapists/psychologists/social workers/caseworkers/case managers in a social service agency in Singapore, or those who had been in such roles in the previous three years. The inclusion criteria were: (1) adults above the age of 21 years old, (2) of any gender, (3) currently working or have worked with clients with SU problems in the last three years, and (4) able to read, write, and communicate in English. The fourth inclusion criterion was necessary as we lacked the resources to translate questionnaires or to conduct interviews in languages other than English. However, since English is the primary language in Singapore and we were recruiting professionals, it was unlikely that this would exclude many potential participants. SU professionals in Singapore may sometimes communicate with individuals on their caseloads in other locally used languages but would communicate with other professionals in English.

Participants were recruited through advertisements distributed to three community agencies providing substance abuse treatment services, two of which agreed to share the advertisement, supplemented by snowball sampling. Participants contacted the first author to express interest in participating and were then invited to a 1 h and 40 min session at their workplace or via Zoom (due to the Covid-19 pandemic) where they first read through the information sheet and gave their informed consent. They then completed the demographics form and the three questionnaires. The first author scored the questionnaires in-situ prior to conducting the semi-structured interview. The interviews were audio recorded and transcribed.

Data analysis and trustworthiness

The preliminary quantitative data were analysed through descriptive statistics, consistent with recommendations for quant-QUAL designs [48], and the qualitative data were analysed using reflexive thematic analysis by the first and second authors [49, 50]. The remaining authors were involved in conceptualising and writing up the study but were not actively involved in the qualitative data analysis.

Reflexive thematic analysis was chosen because it utilised the researcher's subjectivity as a resource and allowed fluid, in-depth, and reflective engagement with the data, which facilitated the generation of rich and meaningful themes in understanding participants' experiences. The first author was a clinical psychologist-in-training who concurrently worked as a caseworker in a community agency which provided support for individuals who used drugs, whilst the second author was clinical psychologist and lecturer in clinical psychology who has previous experience working with individuals who used substances in forensic mental health services in the UK. While recognising the position of being an insider researcher, the first author adopted a critical realist position in which participants' narratives were treated as true and inherent yet influenced by their contexts and experiences.

After familiarisation with the transcripts, initial codes were generated with reference to the research questions. Subsequently, the initial codes were categorised broadly, and preliminary themes were developed. The final themes were then developed through reviewing potential themes and re-grouping initial codes such that they were internally homogenous and externally heterogeneous. While the first author principally engaged with the data through the phases outlined, the second author supported the first author in enhancing reflexivity and interpretative depth of the data through further reflections and questions in weekly discussions of the generated codes and themes.

The credibility of the analysis was strengthened through triangulation between the qualitative and quantitative data and journaling of insights and reflections throughout the data collection and analysis phases, including assumptions held by both authors, which helped in deepening reflexivity [51]. We used Braun and Clarke's tool for evaluating thematic analysis manuscripts for publication to ensure they were adhering to best practice recommendations for reflexive thematic analysis [44]. We also used the Mixed Methods Appraisal Tool, specifically the sections applicable to qualitative studies, quantitative descriptive studies, and mixed methods studies, to ensure the overall rigor of the research and the trustworthiness of our findings [52].

Results

Quantitative results are summarised in Table 2, which provides an overview of participants' scores on the ProQOL, DDPPQ, and Addiction Belief Scale. These results offer context for interpreting the subsequent qualitative themes (presented in Table 3) by illustrating general trends in participants' self-reported professional quality of life, perceived role adequacy and support, and underlying beliefs about addiction. As the scores on the ProQOL and ABS showed limited variance, only DDPPQ scores (converted to T-scores and categorised into 'low', 'moderate' and 'high') were used in the mixed-methods analyses. The themes were cross-referenced with DDPPQ scores and participants' demographic data. Meaningful interpretations generated from the cross references are included in the narrative below.

Table 2 Distribution of questionnaires' scores

Questionnaires	Mean (SD)	Low (*n*/%)	Moderate (*n*/%)	High (*n*/%)
Professional Quality Of Life Scale (ProQOL)				
Compassion Satisfaction	35.0 (5.3)	1 (6.7)	14 (93.3)	0 (0)
Burnout	25.1 (2.1)	1 (6.7)	14 (93.3)	0 (0)
Secondary Traumatic Stress	19.1 (4.5)	12 (80)	3 (20)	0 (0)
Drug and Drug Problems Perception Questionnaire (DDPPQ)				
Role Adequacy	17.8 (3.3)	3 (20)	7 (46.7)	5 (33.3)
Role Legitimacy	4.1 (1.8)	4 (26.7)	8 (53.3)	3 (20)
Role Support	7.1 (2.5)	3 (20)	9 (60)	3 (20)
Role-related Self-esteem	8.7 (3.7)	3 (20)	9 (60)	3 (20)
Job Satisfaction	10.1 (2.3)	5 (33.3)	7 (46.7)	3 (20)
Total	47.8 (8.2)	2 (13.3)	9 (60)	4 (26.7)
Addiction Belief Scale [a]	47.7 (5.3)	-	-	-

Note. $N = 15$

[a]The norm population mean of the Addiction Belief Scale is 54.1 with a standard deviation of 13.55

Table 3 Themes and sub-themes generated from reflexive thematic analysis

No.	Themes	Sub-themes
1	Deriving and maintaining meaningfulness	a) Deriving meaningfulness b) Challenges to meaningfulness
2	Clarity of role and support for effective performance	a) Recognising limits of helping and having strong boundaries b) Support from others
3	Holding a multidimensional and nuanced view of addiction promotes satisfaction and motivation	NIL
4	Navigating systemic challenges	a) Conflict with values and beliefs b) Finding power by aligning values and beliefs

Overall, ProQOL results indicated that the majority of participants had a moderate level of compassion satisfaction, moderate level of burnout, and low levels of secondary traumatic stress. The DDPPQ results indicated that the majority of participants viewed themselves as competent and legitimate in their role, having good formal and informal support, being able to carry out their work well and were satisfied with their work with individuals who used drugs. Hence, the quantitative results suggest that participants were generally satisfied with their work, reported relatively balanced emotional engagement with their work, and felt largely motivated and professionally secure.

In contrast, the ABS showed minimal variation with all participants scoring within one standard deviation of the original sample mean, indicating that no participants had a strong inclination towards either the disease or free-will model of addiction. This suggests that the addiction beliefs of these SU professionals in Singapore were less varied than their counterparts in Western countries.

The generated themes (Table 3) describe the factors that motivated participants to choose and stay in the profession despite the challenges they faced in working with individuals who used drugs, and the organisational and systemic challenges.

Theme 1: Deriving and maintaining meaningfulness

This theme encompasses the motivation and meaning participants derived from working with individuals who use drugs and the challenges they faced in maintaining the meaningfulness.

Deriving meaningfulness

Participants derived meaningfulness from a pre-existing personal interest in understanding offending and drug-taking behaviours, the profession's alignment with their personal values, and the opportunity to connect with people meaningfully. Participants were able to act in accordance with their spiritual and relational values, including compassion, kindness and authenticity. Participants derived satisfaction and motivation from engaging with individuals who used drugs by getting to know their personal stories and helping them grow. Going beyond superficial interactions and being able to have genuine connections with these individuals was a rewarding experience for the participants and they felt trusted and privileged to be a part of their lives.

> *So, like I said that somehow for those who are willing to share and all that sort of thing. To us, we are vicariously actually living their lives. And in so doing it is a privilege, you know, that we actually get to see this area. That like I said, normally people won't get to see.*

Challenges to meaningfulness

The interpersonal dynamics of working with individuals who used drugs and the organisations' leadership, and culture posed challenges to participants' experience of meaningfulness. Firstly, the complex presentation of individuals who used drugs (which included the chronicity and high relapse rate of drug addiction, co-existing issues of mental health conditions, antisocial traits, and practical issues) disrupted the interpersonal connections between the participants and the individuals who used drugs due to their poor treatment attendance or unwillingness to engage during the session.

> *Yeah, so I guess when clients don't come in, I would sort of reflect like it, was it something that, something wrong that I said like previously that made them not want to come back and see me again … did I not do*

something that could have helped them even more and yeah, and if I find out or they really relapsed, right, then I would also feel very guilty for not maybe spotting some signs or like possible triggers that they could have avoided, yeah.

It is noteworthy that those participants who had more years of experience and were more satisfied (based on their DDPPQ scores) did not speak about such interpersonal challenges. This could be due to their recognition of their limits of helping and being able to establish strong boundaries, which are described in Theme 3.

Secondly, participants perceived that their organisations' policies made it challenging for them to meet with and support clients who were relapsing, as the policies prioritised reporting relapses. Such procedures frustrated the participants because they were unable to engage and render help to their clients once they relapsed and because they believed repeated incarceration would impede rather than support the individual's recovery. Hence, this conflicted with the way in which they derived meaning from their work and contradicted their understanding of the treatment of addiction, specifically on managing lapses.

Participants perceived problems with organisational leadership which they saw impacting decision making and planning for manpower and staff development. Participants explained that the quality of clinical support, poor supervisor fit, limited feedback and guidance from supervisors, lack of formal training provision, and unclear professional development pathways left them feeling frustrated, lost, stagnant and demoralised.

I feel like there's not enough structure there to support the development of the staff, the training of the staff, the competency of the staff. So I feel like I want to grow and learn. The knife still can be sharpen, but I'm not getting that from the organisation.

Consequently, not being able to pursue growth impeded deepening of their interest and affected their perceived competence in helping individuals who used drugs effectively. Participants coped by being self-reliant in sourcing relevant training courses to attend, charting their own career paths, and pursuing higher education independently.

Due to the reported lack of manpower and poor resource planning, participants believed that they were given an excessive number of cases to manage, which also translated to a high amount of administrative work. Therefore, in order to cope, participants found they had to reduce the amount of time and effort spent on client-engagement, adjust their expectations with regard to their ability to meet deadlines, and sacrifice their personal time. Consequently, having less time and energy for individual interventions affected their view of their competence and conflicted with their motivation of helping clients to improve their lives.

I think the caseload … I'm holding, like, 37 clients … and then on top of that, we have, like, 1 to 2 family members to 1 client. So that is, like, 90 something people you see, so I think that sometimes I, even as a worker, I struggle to find time for certain clients … when in actual fact, I should be giving my time equally to all.

Taken together, the realities of the interpersonal dynamics and navigating organisational management practices, particularly in the earlier years of their career, conflicted with participants' desire to grow professionally and provide effective support resulting in feelings of frustration, guilt and helplessness which then contributed to their dissatisfaction.

Theme 2: Clarity of role and support for effective performance

This theme describes how participants managed the challenges faced in their work and how they strived to be competent in their role as a SU professional.

Recognising limits of helping and having strong boundaries

In terms of recognising limits of help, participants, particularly those who had fewer years of experience, described the need to redefine the meaning of progress and moderate their expectations of their ability to help. Some participants had the initial belief of being able to help individuals stop using drugs once they were released from prison despite the occurrence of relapse being the norm rather than the exception. Hence, the unrealistic definition of progress and sole focus on the outcome contributed to their dissatisfaction. By redefining their view of progress such that it matched reality and focussing on the process rather than the outcome, participants were better able to derive satisfaction and motivation in their work.

When I first joined, working with them, I thought that I will only be satisfied if they're totally drug free, they never come back five or six years or even for one or two years. But I realized that, you know, this takes time. You know, it's a lot of work.

Participants spoke about learning to broaden their view of the reasons that contributed to lack of progress or engagement, such as recognising the contribution of factors related to individual autonomy and situational

factors, which helped in reducing the personalisation of responsibility.

> *I feel like ultimately, my, my job as a caseworker is to put all this in front of them and to show them that these are options and these are certain choices that the clients can make. And that has fulfilled my job responsibility … if they choose not to take any of these options … I don't think it's fair that I should be blaming myself.*

Therefore, by redefining the meaning of progress and moderating their expectations of their ability to help, participants gained clarity about the role and responsibilities of a SU professional which allowed them to implement appropriate boundaries to protect their well-being.

Support from others

Finally, given the challenges involved in working with individuals who used drugs—which stretched the participants physically, emotionally, and cognitively—participants explained that having emotional and clinical support from others, both within and outside of their organisation, helped in managing the challenges faced and built their competence as a SU professional.

> *When I get frustrated … I just rant and, you know, being able to, like, get things off my chest, it's great sometimes, so, you know, not too bothered by the heaviness.*

Theme 3: Holding a multidimensional and nuanced view of addiction promotes satisfaction and motivation

All participants were aware of the disease and free-will models of addiction, but most of them did not subscribe to a particular model, instead adopting a mixed and flexible approach in understanding addiction. Participants valued the disease model of addiction due to its acknowledgement of biological and environmental factors in causing addiction which helped to shift the blame away from the individuals who used drugs and promoted empathy and help from others. However, participants believed that viewing addiction as a disease confined the understanding of addiction to the health dimension and limited the treatment to medical interventions. Moreover, some participants believed that adopting the disease model of addiction might absolve the responsibility of recovery from the individuals who used drugs which then erodes their intrinsic motivation to work towards recovery.

> *Because I feel like if I tell them that, it (drug addiction) is a disease, I feel like after a while they will just take it as an excuse, like there is something wrong with me what, individuals who used drugs there is something wrong mah, so I am not going to change.*

Participants found the free-will model more empowering to help individuals who used drugs to change due to the model's acknowledgement of the person's ability to stop taking drugs. By viewing addiction as a choice, participants focused their intervention on helping individuals who used drugs develop their competence in overcoming their drug addiction and promote their intrinsic motivation for change. Participants described feeling more hopeful about the potential to change, which in turn enhanced their motivation as well.

> *Like, because they do have control then they have the power to change things … it's more like they have the ability to do it. Yeah, and I guess that that is what helps me in my work with them.*

In contrast, some participants spoke about the disadvantages of adopting the free-will model which included promoting judgment towards the individuals who used drugs due to the perception that they chose to take drugs voluntarily which then led to less empathy and support from others. Moreover, some participants believed that viewing drug use as a choice limits the power of the professionals in effecting change as the ability to stop using drugs lies solely with the individuals who used drugs hence dampening the professionals' motivation.

Overall, most participants acknowledged the validity and helpfulness of aspects of both models of addiction, did not see them as mutually exclusive, and applied them strategically in their work. Participants endorsed the contribution of both external and internal factors in influencing an individual's use of drugs and spoke about understanding addiction through a biopsychosocial model that recognises the contribution of biology, psychological and social factors in causing addiction. Therefore, participants acknowledged the relevance of both the disease and free-will models in understanding addiction, and preferred to view it as being multidimensional.

> *So it's a mixture of biopsychosocial, that it is not fully like biological lah like there are neural networks, there are certain biological factors that make you more prone to addiction etc., or like some that are reinforced in your brain but it is not just completely biological as well.*

In applying the multidimensional model of addiction to their work, participants explained that the weightage given to the biological (disease model), psychological (free-will model) or social factors in causing addiction was dependent upon a client's context and

history. Participants considered the period of involvement with drugs and frequency of drug use to determine the extent of dependency on drugs.

> *So, when I work with clients, sometimes the client profile fits, like one side more than the other. Yeah, then it's, it's not really like adapting my beliefs to fit whichever profile they are, but it is more of, I guess, whichever model fits them better, fits their experiences better.*

Hence, with the flexibility in applying the multidimensional model of addiction in accordance with the level of dependency on drugs, participants described how it helped to facilitate individualised and targeted interventions and promoted effectiveness of interventions.

> *So for those who are not, I mean, still sober, then I'll take a different approach with them. Then I would help them to see that there are other ways of coping … So then it's more like, looking at the environment, support factor protective factors, looking at motivation, looking at their challenges, how to how to manage their challenges, how to manage their emotions, depending on whether they got trauma … if they already relapsed, currently addicted. Then I would tell him to go I mean, as I told you previously right, I wouldn't want him to go back into the system because it doesn't serve any purpose, to me. So that's why I've always ask them to go to [name of specific organisation].*

By understanding individual risk factors and recognising the interventions' effectiveness, participants were more hopeful in their ability to help facilitate change which promoted their satisfaction and motivation.

Theme 4: Navigating systemic challenges

This theme describes the participants' perceptions of the ways in which Singapore's approach to substance use management impacted their workplace well-being and how they persevered despite the challenges.

Conflict with values and beliefs

Participants expressed misgivings over the incarceration of individuals who used drugs as they believed that it sometimes impeded recovery from drug addiction, while also having the potential to cause other negative impacts on individuals who used drugs. As participants recognised that addiction is a chronic and high relapse condition, they expressed concern that individuals who relapsed would be reincarcerated. Participants believed this compromised the treatment of addiction by discouraging individuals who used drugs from seeking help during lapses out of fear of being incarcerated. Moreover, participants believed prison culture had a negative impact on the individuals' self-esteem which further worsened their mental health, disrupted their adjustment, and weakened their ability to cope without the use of drugs.

> *They would have to deal with the impacts of incarceration again lah, being institutionalised and everything that could make you lose your sense of self and the longer the period of incarceration the longer period of losing what it means to take control of your life and what it means to live with the community outside.*

In addition, participants perceived ongoing consequences from being incarcerated due to the identity of being an 'ex-offender' and the associated stigma which could negatively affect access to resources in the community and, in turn, their families as well.

> *Because of their ex-offender status, they can't even get a proper job, then I feel that it will just perpetuate a lot of things la like poverty, the lack of access to resources because you are, you don't have money to provide for your family, like for example, your kids, and then your kids are also always gonna be stuck in that cycle… I feel like it just perpetuates the cycle.*

Taken together, participants believed that incarcerating individuals who relapse compromises aspects of treatment and perpetuates some of the challenges of recovery. This incongruence between systemic requirements and the desire to help contributed to feelings of discomfort and helplessness, which negatively impacted well-being.

Finding power by aligning values and beliefs

Some participants described feeling hopeless and powerless when they had to execute directions from the penal system which conflicted with their personal values and beliefs.

> *I guess feeling like just giving up lor. Yeah okay, the system is like that then don't bother trying, yea so having that sense of hopelessness when I journey with clients also, like knowing like there are certain avenues or certain ideas that maybe eh this could work out, but it's like, I also feel like eh actually very hopeless lah don't bother thinking about that ya.*

To meet the challenges of working within the penal system while striving to effectively help individuals who used drugs, participants who were more satisfied and viewed their role more positively (based on their DDPPQ

scores) spoke about holding onto personal beliefs that aligned with their values. They normalised the experience of addictive behaviours and saw individuals who used drugs as people who deserve to be treated equally and given fair treatment. By holding onto these beliefs, participants expressed hope that they could continue to play a role in changing the way the organisation and system functioned to better support individuals.

> *I think until I see changes, like, a bit of change in the system, then I'm okay I think, but other than that I will try to be here as long as I can, to see, to see the improvement in the systems and, and how we can, you know, actually do this.*

Hence, destigmatising addiction and humanising individuals who used drugs aligned with the participants' values of connecting with, and helping individuals who used drugs, which then promoted their satisfaction and motivation.

Discussion

This explanatory sequential mixed methods study aimed to understand the workplace well-being and addiction beliefs of SU professionals in Singapore. The results of the quantitative survey indicated that the participants were mostly satisfied with their work. However, the findings from the qualitative analysis gave a more nuanced and detailed account of how their motivation for this work peaked and dipped in response to various challenges and indicated that their satisfaction with work was not universal. Rather, their satisfaction differed in relation to the work with the individuals who use drugs, their experience of their working environment, and their view of the system. The generated themes shed light on how participants adapted and responded to these individual, organisational, and systems-level challenges in order to stay motivated and preserve their well-being at work. The findings will be discussed in relation to workplace well-being research, in particular job crafting [53], and work well-being initiatives [54] which, to the authors' knowledge, have yet to be applied specifically to SU professionals. The concept of job crafting was not part of our initial study design but emerged inductively through the data analysis. Job crafting refers to the process by which individuals proactively shape aspects of their work—such as tasks, relationships, or perceptions—in order to enhance meaning, engagement, or fit with personal strengths and values [53].

As highlighted in the first subtheme of Theme 1, participants were initially drawn to the work due to their personal interest in understanding behaviours outside societal norms and the meaningfulness of work that seeks to remedy them. As they entered the profession, the realities of working with individuals who use drugs and navigating the work environment challenged their pursuit of interest and meaning in this work, as was described in the second subtheme of Theme 1. For these participants, not recognising the limits in helping individuals who use drugs, having weaker boundaries, lower availability of support, lack of opportunities to pursue growth and poor insight into their values and view of addiction appeared to contribute to poorer workplace well-being.

To counter this, participants reported engaging in various aspects of job crafting to maximise their well-being at work. From a relational crafting perspective, and as described in Theme 2, they learnt to recognise their limits of help, establish strong boundaries with their clients (first subtheme), and seek support from others, notably from colleagues and supervisors (second subtheme). From a cognitive crafting perspective, and as described in Theme 3, the participants adopted a multidimensional view of addiction in working with individuals who used drugs and learnt to anchor on their values. From a task crafting perspective, they took initiatives to pursue personal growth to circumvent the lack of opportunities provided to them by their workplaces and improve their psychological well-being [53]. They believed that being able to do so increased their satisfaction and motivation to continue in the profession which ultimately improved their well-being. Hence, being able to adapt to the realities of substance use treatment settings was crucial in facilitating participants' fulfilment of interest and meaning in their work which improved their satisfaction and motivation.

Well-being at the individual level

At the individual level, the present study's findings corroborated with previous studies that found that addiction professionals were committed to their profession due to their interest in addiction work and the rewarding nature of working with individuals who use drugs [23, 28]. Moreover, the present study's finding of professionals deriving satisfaction and motivation from personal and professional growth also aligned with existing studies that found that learning the knowledge and skills of working with individuals who use drugs as well as the vicarious learning from the challenges faced by these individuals positively impacted their satisfaction [31, 55]. This is also in line with theories of self-determination and psychological well-being [56, 57], whereby a need for competence could be met and a sense of personal growth and mastery could be achieved within these work settings, albeit dependent on elements of job crafting [58].

Overall, the results showed that these SU professionals in Singapore were generally satisfied with their client-work with but less satisfied with their work environment

which involved navigating organisational and systemic challenges.

Well-being at the organisational and system level

The issue of high workload among addiction professionals reported in previous studies was echoed in the present study [20, 25], however the present study's finding on the dissatisfaction of SU professionals contrasts with existing research. In prior studies, addiction professionals' dissatisfaction was attributed to the challenges of working with individuals who used drugs rather than reasons related to their work environment [22, 24, 35]. This also explains the apparent contradiction between the quantitative and qualitative findings with regard to work satisfaction. The questionnaire items focus solely on satisfaction with working with individuals who use drugs with no items related to the organisation or the system. Hence, the dissatisfaction described by participants in the interviews were not detected by the quantitative measures that were administered.

As reflected in Theme 1 and Theme 4—which referenced the local context in which the penal system manages individuals who use drugs—participants perceived organisational and systemic requirements as sometimes conflicting with their motivations to remain in this profession. The broader system's emphasis on deterrence sometimes did not align with their own multidimensional and nuanced view of addiction, as well as their personal values of connecting with, and helping, individuals who used drugs. This misalignment between personal and institutional perspectives echoes findings from probation practice, where practitioners also experience tensions between their professional values and the constraints of a system that may not fully acknowledge the complexity of clients' lives [16]. Accordingly, such organisational and systemic realities likely challenged participants' sense of autonomy at work and, in turn, hindered personal growth and achievement of mastery [59].

In terms of the impact of organisational factors on workplace well-being, the findings of the present study were in line with previous research [20, 25] and helped to elucidate possible mechanisms. Due to the high workload as well as the need to meet the organisational expectations (e.g., deadlines and key performance indicators), participants had to limit the amount of time and effort spent on engaging individual clients, which they believed then impacted the effectiveness of their help. As this sense of effectiveness was closely aligned to the meaning, fulfilment, and sense of purpose they looked for in their work, anything that impacted their sense of effectiveness also appeared to negatively impact their well-being at work. This aligns with the wider literature, in which perceived efficacy has been found to exert a positive effect on workplace well-being [60].

In addition to the limited physical and psychological resources required to meet those expectations, the perceived quality of managerial and/or supervisory support rendered to participants, and limited training opportunities led to further self-doubt in their professional competence. They believed that this hindered meaningful connections with their clients and contributed to feelings of frustration, guilt and helplessness. Self-determination theory highlights the importance of autonomy, competence and relatedness [56], and the participants' narratives highlight the participants' difficulties in meeting aspects of these psychological needs in their professional roles. The combination of exhaustion from being overloaded and their psychological needs not being met would then be more likely to lead to burnout. This could also help to explain the positive correlations between burnout and job demands found in a previous study [21] and between high caseload and burnout by [26].

With regard to continued motivation, the present study's findings also aligned with existing literature which highlights the importance of social support, supervision, and self-care practices (e.g., having strong emotional and physical boundaries) in promoting satisfaction and well-being [21, 29, 31]. Using Jarden and Jarden's model [4], it is apparent that the participants were primarily describing using individual (Me) self-care strategies and relational (We) strategies to support their well-being at work with a seeming lack of (Us) strategies.

Well-being and addiction beliefs

Similar to the existing findings these SU professionals in Singapore did not subscribe to a particular model of addiction, instead adopting a multidimensional view [40, 42]. In doing so, the negative consequences of adopting either the disease or free-will model of addiction were mitigated and participants were able to strike a balance between empathising with individuals' drug use and promoting personal ownership of their recovery. This is a highly specific example of cognitive crafting in the context of SU professionals, in which they appear to be changing not only how they perceive their jobs but also the clients they work with, in order to understand and facilitate change in their clients and ultimately feel competent in their roles.

While Dodd [37] found that those who believed in the disease model of addiction had lower levels of exhaustion - possibly due to reduced negative judgment of drug users – this model of addiction may also have unintended effects. As described in Theme 3, it can lead to absolution of personal responsibility to recover and dampen professionals' motivation. Hence, embracing both the disease model and the free-will model of addiction helped these participants to be non-judgmental towards the individuals who used drugs while instilling hope in their recovery.

In doing so, it aligned with their values and helped to facilitate meaningful connections with the individuals who used drugs. For these participants it appears that cognitive crafting (how they viewed addiction and individuals who use drugs) facilitated opportunities for relational crafting (how they formed effective working alliances with their clients), which in turn contributed positively to their satisfaction and motivation.

In addition, having a multidimensional view of addiction allowed participants to design more targeted and holistic interventions, such as educating their clients on the biological and psychological impact of drug use, addressing their thinking patterns and setting boundaries in their social network depending on the individual's severity of addiction, as recommended by recent research [61, 62]. Hence, developing a multidimensional view of addiction (cognitive crafting) appeared to enhance treatment delivery by enabling participants to design more holistic and individualised interventions—an approach that can be seen as a form of modifying the type and scope of their work (task crafting). Feeling that they were able to offer meaningful support to clients also improved participants' sense of competence and appeared to contribute to their satisfaction and motivation.

Implications

The results highlight the pertinent factors that professionals, as well as organisations, can focus on to improve the professionals' well-being and sustain their motivation in the work. Developing and implementing organisational (Us) strategies [4] would build on the individual (Me) and relational (We) strategies that participants are already using. Organisations can design or adjust their training programmes or supervision content to improve professionals' knowledge, attitudes and confidence [63] and to help their staff to reflect on and gain awareness of their values and beliefs [64]. Furthermore, SU professionals can be helped to set realistic expectations or goals and boundaries earlier on in their career, as recommended by previous research [65]. Organisations could also strengthen their existing managerial and clinical support and provide clearer professional development plans for staff and opportunities for growth to help professionals fulfil personal needs of learning, growth and competence. As argued already, the sector of SU treatment should work to retain staff throughout their careers as older workers tended to show higher levels of work engagement and are essential for effective leadership and service continuity [66].

In organisational psychology, it is widely accepted that attending to workplace well-being benefits individuals, organisations and systems [54]. In Singapore specifically, it has been shown that attending to staff well-being in public institutions such as the prison services has been beneficial to treatment recipients, providers, and the community, and there would likely be similar benefits if well-being in addiction services was prioritised [67].

Finally, Theme 4 highlights the value of considering the perspectives of SU professionals when reviewing and developing drug-related policies. While Singapore's approach has been shaped by a strong emphasis on deterrence - often cited as contributing to the country's low prevalence of substance use [10] - participants in this study reflected on the complex and enduring impact incarceration can have on individuals who use drugs. They perceived these effects as sometimes limiting the effectiveness of their own work, and in turn affecting their professional satisfaction and motivation. In light of this, some participants expressed interest in the potential value of more rehabilitative approaches to complement existing policy frameworks.

Limitations

Given the small sample size, there are notable limitations regarding the quantitative analyses conducted. First, we relied on reliability data from the original validation studies of the selected measures, as our sample was insufficient to yield robust or meaningful estimates of internal consistency [68]. There was also limited variance in the scores of the ProQOL and the ABS, as such no meaningful mixed methods analyses could examine the relationship between the scores on those questionnaires and the themes gathered.

More generally, social desirability bias might affect the participants' responses to the questionnaires such that they answered the items in a way that would be viewed favourably by others. Hence, they might over-report the positive aspects related to their well-being at work and under-report the negative aspects which might then inflate the scores of the ProQOL and DDPPQ questionnaires. To some extent, the qualitative interview was able to compensate for this limitation.

Finally, given the profile of the participants are SU professionals working in the community, the findings may not be transferable to professionals in other organisational or cultural contexts. For example, SU professionals within the prison system may be more comfortable working within the current approach and may not experience a similar conflict with their values. Therefore, the systemic impact on professionals' workplace satisfaction and well-being in the community may be more negative. Also, given that the majority of the participants were working as a SU professional at the time of the study, they were likely to be more motivated to remain in the profession.

Future directions

Given the lack of sensitivity of the quantitative measures used in this study in measuring the SU professionals'

well-being at work, future studies can employ the use of questionnaires that are specific to the professionals' view of their organisation or the system to gain a more nuanced understanding of their satisfaction at work.

It would also be valuable to interview former SU professionals who had either left their organisations or left the sector altogether, as their experience of workplace challenges and impact on their well-being may offer important insights distinct from those who remained motivated and chose to stay in the field.

Finally, given that the work environment played a big role in the dissatisfaction experienced by SU professionals in Singapore, future studies could look more specifically at how SU professionals cope with the organisational and systemic requirements. This will then better inform professionals on how they can manage the challenges of their work and sustain their motivation.

Conclusion

SU professionals in Singapore are satisfied with their work with individuals who use drugs but are less satisfied with their organisations and working within the system. Professionals were able to derive satisfaction and stay motivated by using elements of job crafting to re-align with their personal values and beliefs, find clarity in their role, adopt a multidimensional and flexible model of addiction, and seek external support.

Author contributions

Each author certifies that their contribution to this work meets the standards of the International Committee of Medical Journal Editors.

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Data availability

The data that support the findings of this study are available from the corresponding authors upon reasonable request.

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Human Research Ethics Committee of James Cook University (Reference: H8329 approved on 17/03/2021). Informed consent was obtained from all participants involved in this study.

Consent for publication

All participants consented to the use of their data, including anonymised direct quotes, being used in research papers submitted for publication or presentation in academic journals or conferences.

Competing interests

The authors declare no competing interests.

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