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Canada

THE RETENTION OF CHILDREN'S MENTAL HEALTH WORKERS IN NORTHERN ONTARIO

By

Sydney Jean Parlour

Bachelor of Science with Honours, Springfield College, 1973

THESIS

Submitted to the Department of Psychology

in partial fulfilment of the requirements

for the Masters of Arts degree

Wilfrid Laurier University

1990

Sydney Jean Parlour 1990

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Abstract

In this qualitative study, I explore with Northern Ontario children's mental health administrators and clinicians their concerns about employee retention, given the high costs of turnover in human (providers and consumers) and financial terms. I use an ecological framework, borrowed by community psychology from the biological sciences, whereby retention is considered to be not only a work-related phenomenon but also influenced by a variety of non-work factors.

In the belief that employee retention is best understood from a holistic, multi-level perspective, I review literature from a variety of related areas. I consider the characteristics of rural life, practice and practitioners; the antecedents and effects of burnout among human service workers; the constituent elements of Quality of Life and Quality of Work Life; relevant job satisfaction and dissatisfaction research; the impact of management and leadership styles, including the role of gender; and research pertaining to turnover and retention in human service organizations and in rural areas.

To better comprehend the unique qualities of life and work experiences that may impact on personal turnover or retention decisions in Northern Ontario, I used open-ended questions to interview 14 administrators and 41 clinicians. As well, 16 clinicians participated in the mail survey portion of the research. The data were analyzed on the basis of comparison groups defined by the gender of the participant, the size of the community in which the participant worked, the participant's place of origin, and the gender of the participant's executive director.

The results indicated that, while high turnover was an immediate concern to some but not all agencies, retention was perceived to be of long-term interest to most agencies, given problems with recruitment and with maintaining competitive salaries. Workers identified factors contributing to their life satisfaction and dissatisfaction, and to their job satisfaction and dissatisfaction. While clinicians generally seemed more satisfied than not with life outside of work, they expressed more dissatisfaction with their jobs, except those working for female

directors. These clinicians cited an empowerment philosophy within their organizations as contributing to their high level of job satisfaction. Gender-related concerns were also raised by a number of participants.

Suggestions for change from participants focused on increased learning opportunities and job supports, a reduction in job stresses and gender-related concerns, and improved recruitment practices, communications, personnel policies, and salaries, encompassed within an empowering work environment. Changes were also offered at the individual, community, and government levels. I conclude by also recommending organization development as a useful tool in assessing each agency's overall effectiveness with personnel and with service consumers. Future research would do well to more thoroughly explore, within a rural organizational context, the burnout phenomenon and the relationship of gender, management style and job satisfaction.

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Origins and Nature of the Research

The idea for this study came about from my own life and work experiences in Northern Ontario, particularly during my five year stay in Wawa, a community of 4500 situated three hours north of a city of 80,000. During my employment there, co-workers came and went, most staying only six months or so. They seemed very happy to return to cities like Montreal and Toronto after giving the northern experience a try. Their clients, in the meantime, were left on a waiting list until either another clinician was hired or I had room on my caseload. In either case, it meant another adjustment period and additional time to establish a trusting relationship. Unfortunately, many families and teens simply withdrew from the program rather than start over.

I began to wonder why I was content to stay in this little community, what was different about me that I enjoyed the small town atmosphere and by some standards, the rugged lifestyle. I questioned if maybe I was trying to escape from something, if I was in a place like Wawa because I was an underachiever and was afraid to risk a "really good job" in a large urban agency surrounded by expertise. Was my job in this community actually a dead end; was this a job for "losers" only? Were co-workers leaving because they had made this discovery while I remained blind to it, or worse yet, content with that reality?

I seemed, at that point, to be on the verge of accepting and perpetuating the common negative stereotype of the North as second best, as discussed by authors like Bennett (1985) and by my research participants themselves. Yet, when I reflected on my own origins, growing up in very small towns across the U.S. because my father loved the outdoors, it then seemed perfectly natural that I would feel comfortable in a community like Wawa, that I would not miss all the urban conveniences and opportunities that I had never grown up with. Was the answer to retention as simple as that?

I also reflected on what seemed to be happening to the consumers of the agency's mental health services, in the midst of this regular turnover and resultant service disruption. Why should a child or a family be any less deserving of the best possible care and service just because they happen to live in a small northern community rather than in a major metropolitan centre that more easily attracts the "experts"? I felt the quality of northern services must be of equal concern to funders and administrators as was the quality of services in the larger, more visible agencies in Southern Ontario. A primary goal of this research, therefore, is to re-open the issue of quality of service in the North. I saw the high employee turnover rates in my own setting as disruptive to the therapeutic process and limiting the therapeutic effectiveness of the services. Was this disruption unnecessary and avoidable?

The other experiences which contributed to my interest in this research, and which I did not acknowledge were factors until I was well into writing the discussion section, were my own encounters with bureaucratic structure. Having once been demoted, and having seen several female colleagues and good friends fired and treated insensitively, I have experienced loss at the hands of bureaucracy. Today, after some years of working through the stages of healing, my desire is in wanting to find ways that will encourage organizations to recognize the value of their staff, to foster the empowerment of their workers, and to develop structures and processes that reflect these attitudes. These goals may not seem at first to relate directly to retention, but, over the course of this research, I have come to believe that they mean a great deal.

Thus, from these experiences over a ten-year span, I have formulated the intent and design of this research project: I want to explore whether employee turnover and retention are genuine concerns across Northern Ontario children's mental health centres, to discover the nature and cause of these concerns from the workers and their employers, and to determine where change needs to take place. I have considered the participants, both workers and administrators, as possessing special expertise with regard to their own work and administrative

situations and their possible improvement. Therefore, my commitment has been to understand each participant's perspective and convey these perspectives and realities as accurately as possible. Thus, whenever possible, I have tape-recorded each interview and have used as many direct quotations as space allows. It was and continues to be my hope that the voices of these participants will attract the attention of their co-workers, their employers, their community leaders, and their government officials, and that their words will foster greater understanding and the motivation for further assessment and change.

Throughout this document, I share with the reader, as demonstrated in these opening pages, some of my personal experiences and reflections as they evolved during the course of this project. This level of personalization in my reporting style, including use of first-person pronouns, reflects my belief that, as researcher, I cannot (and do not desire to) remain outside the research context. Thus, a small portion of the data consists of information describing how this study was conceived, significant occurrences as it was carried out, and my thoughts concerning how best to balance the powerful nature of the data with a readable, non-offensive presentation. A personalized reporting style should not be interpreted as indicative of a researcher's uncertainty about his/her methodology or results, nor as a sign of vulnerability or weakness. The data from this inquiry convey to the reader a clear and poignant message that is undeniable. The imparting of this critical message must necessarily reflect my roles, as investigator, participant, and reporter, in the research process.

I also believe it is essential that the reader be aware that, as is admissible within qualitative methodology, this research is value-bound. As the inquirer, my values are expressed in this research in the form of my choice of problem and how I have framed that problem (Lincoln & Guba, 1985). As well, my choice of a naturalistic research paradigm and my bias as a feminist researcher have guided my investigation of the particular problem of turnover and retention in Northern Ontario children's mental health centres. By stating openly that this research is not value-free, I am simply stating what I believe to be the reality of all research.

I affirm my goal of intellectual fairness with regards to this research and have strived to take the necessary steps to ensure the trustworthiness of the data (see Methods section). As Lincoln and Guba (1985) have stated, "Surely it is better to be aware of how one's values can influence one's judgment than to deny that such influence could be occurring at all" (p. 185).

Introduction to the Review of the Literature

Mental health workers in rural and remote areas have been considered by some to be most fortunate to have the opportunity to live and work in a quiet, peaceful setting with relatively few problems compared to urban areas (e.g., Huessy, 1972). Other writers have presented a very contrasting view of rural practice, sympathizing with those staff who have only limited contact with "civilization" and who must contend with deprivation and the sometimes "bizarre" behaviours and attitudes of rural citizens (e.g., Berry & Davis, 1978). In truth, the perceptions which rural mental health workers hold of their living and working conditions probably lie somewhere between these two extremes. It is my contention that a unique blend of factors enters into each individual worker's own definition of what constitutes "quality of life" and "quality of work life" in a rural or remote area, such as the region of Northern Ontario. How each definition is characterized, what factors weigh more heavily than others, likely differs for each individual. The result of the ongoing comparison between the worker's perceptions of her/his life at any one time and the career and lifestyle expectations s/he has held goes far toward determining whether the worker chooses to stay in the setting or to move on.

The process described above is not unique to workers in rural or remote areas and indeed goes on with individuals in all walks of life, living and working in a variety of contexts. What makes this life/work assessment process so critical for the rural/remote context are several realities that citizens and service providers living and working in rural or remote communities experience first hand: the scarcity of health and social service resources; the

difficulty attracting service providers to rural or remote areas; the high frequency of turnover among service providers; and the resulting disruption and discontinuity of service to their citizens.

The research I have conducted was designed to focus on one aspect of the rural/remote social service delivery system across Northern Ontario, that is, the retention of staff either newly acquired or in place for a period of time or, conversely, the minimizing of counsellor turnover. For the purposes of this research, 'retention' refers to the condition of maintaining staff members in one particular work setting or agency over time, while 'turnover' implies staff leaving the employment of an agency for any number of reasons. I believe this research is critical from the standpoint of not only the rural/remote mental health administrator and front-line worker, but also the rural and remote communities and citizenry who deserve the highest quality service possible.

In reviewing the literature pertinent to this research, I have focused on several areas. The characteristics of "rurality" and of rural/remote areas naturally vary across communities, regions and countries. Most of the current literature offers American perspectives on rural life, but over the last 20 years there has been more written describing the Canadian rural context. I will review, by means of a content analysis, both the American and Canadian perspectives on rural life and on the characteristics of rural mental health service delivery in each country. There is also a literature that describes the necessary attributes for surviving and prospering in a rural or remote community, as a citizen as well as a rural service provider. Again both the American and Canadian contexts will be considered.

Very little research has been conducted relating specifically to retention of professional staff in rural and/or remote areas. Retention has been identified by several authors (Heyman, 1983; Hargrove, 1982b) as a major concern deserving of much more research attention. Turnover has been written about more extensively, though seldom in the context of social

service provision. A review of the limited literature regarding retention and turnover will be presented.

The issues of burnout and job-related stress have been very popular topics relating to the social service sector over the last 15 years. Concerns about effectiveness on the job and quality of service, as well as the mental health of individual staff, have prompted a great deal of research attention and theorizing as to causes and cures (e.g., Pines & Aronson, 1981; Beck, 1987). From a cursory overview of the literature on the nature of rural practice, as well as from first-hand experience, I have concluded that the burnout literature is very relevant to a discussion on minimizing turnover within the ranks of rural mental health workers.

As mentioned earlier, a worker's ongoing assessment of her/his satisfaction both on and off the job is a complex process but fundamental to the ultimate decision to stay or to leave. I will provide an overview of some of the current definitions and models of the concepts "Quality of Life" (QOL), "Quality of Work Life" (QWL), and job satisfaction. I will also incorporate some views on the importance of management/leadership styles to job satisfaction, and briefly describe several models of assessing leadership effectiveness. I will also include in this discussion the role of gender in management, both because of my interest in the feminist perspective in this research and because my preliminary data indicated that the gender, or the gender-related style, of the primary leader in the organization seemed to be a factor in some workers' assessment of their job satisfaction.

Finally, given that my research is designed to "give a voice" to people on the front-line of Northern Ontario's children's mental health agencies, as well as to their managers and administrators, I used face-to-face interviewing as my primary research method. Therefore, I briefly discuss the interview as a social research method and comment on the impact of gender on the interview process. I also discuss the human service organization as a work and research setting.

The relationship between employee retention research, typically considered the territory of business and management studies, and community psychology may initially seem unclear. Community psychology as a discipline evolved from a change in the orientation of clinical psychology from treatment to prevention in the mid 1960's. Psychologists began to question if their interventions could take place sooner to possibly avoid the occurrence of future problems. Some also recognized the value of moving away from a strictly person-centred approach to the investigation of problems and instead focusing more on people's interactions with the physical and social environments. The usefulness of such an ecological approach to psychology was that it helped to explain the ways in which environmental and community characteristics affect the behaviour and psychological well-being of people (Heller et al., 1984).

The principles of interdependence (change in one sphere will cause change in all other parts of the system), the cycling of resources (the beneficial transfer of community resources affects community functioning), adaptation (the strengthening of community resources can support people in transition), and succession (community change is directional and must be considered in planning interventions), were borrowed from biological science and were proposed by Kelly (1971) and others to guide the interventions of community psychologists. Community research and intervention can occur at various levels of the environment, such as the individual, the work place, the community, and the arena of government, since all levels surround a person and can influence the behaviour of a person who can, in turn, actively influence her/his environments.

A community psychology orientation suggests, then, that success in an environment is the result of a good match between the individual and that environment. Voluntary turnover, the decision by an employee to leave an organization, could, in many instances, be seen as the result of a poor fit between an individual and any number of levels of her/his environment. Retention, as a concept, is a view of the same issue (turnover) but in preventive terms. Its

overall achievement, from the perspective of a community psychologist, depends not only upon the acknowledgement of person-environment fit, but also upon the development of strategies that encompass the four ecological principles at all levels of environmental analysis.

One of the strategies to encourage retention could well be the development of a psychological sense of community, considered by Sarason (1974) to be "the overarching value giving justification and direction to community psychology" (p. 15). Four elements are commonly considered as enveloping a sense of community: membership or a feeling of belonging in a community, mutual influence within a group or community, a sharing and fulfilment of individual values by a group or community, and a shared emotional connection or a shared history (Heller et al., 1984). The creation of such a feeling of relationship with one's "community", whether it be in the home, with friends, in the work setting, or in the town itself, may end up having a great deal to do with an employee's or individual's decision to stay on the job in the community.

On the relevance of rural research to the field of community psychology, Heyman (1986) discussed the slow evolution of rural community psychology since 1979, when the Division of Community Psychology (Division 27) of the American Psychological Association first acknowledged its neglect of rural issues. A year later the Division formed a Task Force to deal solely with rural issues. Also in 1980 the Journal of Rural Community Psychology was born. The other community psychology journals also began to publish articles specific to rural concerns around that same time, and in 1986 the American Journal of Community Psychology devoted a special issue to rural community psychology.

On the Canadian scene, the Canadian Journal of Community Mental Health has consistently published research relevant to rural community psychology. Ritchie (1982) outlined some of the key issues facing community psychologists working in rural areas in Canada and proposed a model of rural Canadian community psychology. Such a model recognizes distinctive rural Canadian values, cultures, languages, and sources of strength. Ritchie proposed

four areas of activity to characterize Canadian rural community psychology's future directions: applied research, communications, transportation, and support systems.

Again from a Canadian perspective, Nickels (1972a) offered some thoughts regarding a role for rural Canadian community psychology:

> ...man cannot view his fellow man under isolation, i.e., apart from the ongoing and reciprocal impact he has on life and life has on him.
>
> Community psychology takes traditional psychology and incorporates it into a new and fuller framework of involvement in the social problems of the day. It takes account of the fact that social man moulds and is moulded by various communities with which he becomes associated. It recognizes that in order for a person to know himself, he must understand himself, his communities, and the dynamic interactions between himself and these communities. Similarly, in order for a person to determine the direction and quality of his life, he must be creative, innovative, and influential in regard to these communities as well as himself.
>
> Ironically, one aspect of community living almost typifies isolation itself. I refer to community living in the northern regions of Canada. The North is viewed as a frigid isolation chamber without equal, and northerners are portrayed as isolated and ... as loners living and surviving by "doing their own thing"... I am convinced that the North and northerners ...will be that way no longer. With every new person that goes to the North, the North changes.
>
> One broad area in which a community psychology of the North can play a major role is that of mental health and social adaptation...from the viewpoint of community living. (pp. 3-4)

My research regarding the retention of children's mental health workers in Northern Ontario thus is very relevant to the field of community psychology, given the applied, participatory nature of the research and its focus on multiple levels of analysis: individual-small group, program-organizational, and social-community (Nelson, 1983). This study of the effects of social and environmental factors on behaviour as it occurs at these different levels, that is, using an ecological approach, will hopefully lead to new modes of practice that can be adopted by individuals, agencies, communities and government funders to help the North support and retain its valuable human resources.

Review of the Literature

Rurality - Characteristics

Defining what is meant by the term "rural" is dependent on the purpose to be served by the definition. "Rural" can be defined in terms of geographic parameters, population statistics, a particular way of life, a predominant economic base, or as "any place that is not urban". Such a confusing array of definitions makes it difficult to describe what, then, characterizes a rural area - - and rightfully so, as it is a misconception to believe that all rural areas are alike or even vaguely similar (Heyman, 1983). Indeed, rural areas are just as varied, if not more varied, than urban ones (Collier, 1984), given their geographic, demographic and economic diversity. Tremendous change is taking place in every aspect of rural life: economic, social, political, cultural and spiritual (Hargrove, 1982a). The apparent demise of the family farm and the numerous examples of the "boom or bust" phenomenon in areas once rich in natural resources are examples of the constant change that rural citizens live with, change that threatens their security and that can mean a sense of loss of control over their lives (Hargrove, 1982a). Given that many factors critical to the quality of life in rural areas cannot be controlled, for example, the weather, the geography, and world-wide economic trends, people can come to feel that little if anything in their lives is secure, a perception that can have psychological consequences affecting the mental health of individuals and communities.

Numerous authors (e.g., Buxton, 1973; Flax et al., 1978) have pointed out the importance of recognizing the differences between rural and urban areas in order to develop the most appropriate and effective services per location. Focusing on the rural context, Hargrove (1982b) explains that:

> Because the environment heavily influences both the problems that mental health professionals seek to prevent and treat as well as the attitudes, values,

> work habits, and effectiveness of those professionals, more serious attention to the understanding of that environment for mental health practice is critically needed. Otherwise, the rural quality of life, rural people, and rural culture will not be given the attention that is due. (p.182)

The majority of literature concerning rural mental health practice seeks to describe the characteristics of the context in which workers are expected to live and practice. Table 1 provides a sample of the vast array of characteristics, some complementary, some contradictory, used to describe rural communities and peoples in the literature coming out of the United States. Table 2 samples descriptions from the Canadian literature, with some interesting differences compared to the U.S. However, due to the fact that there has been a relative lack of research concerning rural populations in either country, it seems that little is really known about rural life experiences (Zapf, 1985; Melton, 1983). Thus the literature may still in part reflect some of the myths and stereotypes that have both idealized and degraded rural life.

Given that much less has been written about the characteristics of rural Canada, Table 2 reflects the perceptions of only a handful of authors. Canadian thinking about rurality tends to be very regionalized. As well, the term "north" tends to be used as subjectively as "rural", meaning something very different for a resident of Toronto compared to a resident of Kenora or of Whitehorse.

Canada is largely a country of wilderness. Its population density, according to the 1986 census, was 2.8 persons per square kilometre (Statistics Canada, 1986). Yet citizens living in concentrations of 100,000 or more made up 52% of the country's population in 1981, with urban inhabitants in total amounting to 75.7%, making Canada the sixteenth most urbanized country in the world (Statistics Canada, 1984). Rural inhabitants accounted for close to 24% of the total population (Statistics Canada, 1984). It is important to note the definitions of

Table 1

Characteristics of Rural America

The People

1. Closed, suspicious of outsiders, clannish (e.g., Hollingsworth & Hendrix, 1977)
2. Sexism and authoritarianism are prevalent (e.g., Berry & Davis, 1978)
3. Have their own natural helping systems; relationships are of greater intensity (Johnson, 1976)
4. Values are in conflict with those of the larger society (e.g., Flax et al., 1978)
5. Conservative life style; value tradition, independence, self-reliance and living life at a slower pace (Waltman, 1986)
6. Not accepting of traditional mental health intervention (e.g., Hollingsworth & Hendrix, 1977)
7. Outmigration of the young, educated (Flax et al., 1978)
8. Experience freedom and isolation simultaneously (Keller & Murray, 1982)

The Community

9. Lack of anonymity and confidentiality (e.g., Benson & Bilby, 1976)
10. Overlap of roles played by rural citizens (Webster & Campbell, 1976)
11. High percentage of residents living in poverty, have high unemployment or underemployment, and have poor quality education (e.g., Farley, 1982)
12. Have serious medical and social problems but have very few resources or services with which to deal with these problems (e.g., Kahn et al., 1976; Weber, 1980)
13. Audibility gap: people with problems not heard or well served (e.g., Farley, 1982)
14. Typically multi-ethnic (e.g., Ginsberg, 1976)
15. Unspecialized and relatively homogenous (Flax et al., 1978)
16. Complex systems, dynamics (e.g., Jeffrey & Reeve, 1978)
17. Higher dependency ratio, i.e., young and elderly (e.g., Demerath, 1976)
18. Unique rural stressors, e.g., geography, unstable economies, developmental change (Kenkel, 1986)

Table 2

Characteristics of Rural Canada

The People

1. Few cultural opportunities (Abrahamson, 1980)
2. Relative geographic and psychological isolation (C.A.S.S.W., 1976)
3. Mistrust of central government authority (McKay, 1987)
4. Strong sense of belongingness, community identity, mutual aid, self-sufficiency (Zapf, 1985)
5. Strong social controls (C.A.S.S.W., 1976)
6. "Cabin fever", being "bushed" (Nickels & Ledger, 1976)

The Community

7. More variability than commonality - geographically, climatically, demographically, culturally (Abrahamson, 1980)
8. High levels of poverty, unemployment, outmigration of youth and women, economic dependency and instability (e.g., McKay, 1987)
9. Inadequate housing, health care, educational opportunities, social services (Abrahamson, 1980)
10. Dependence on primary resource industries, foreign-owned, unstable; boom and bust communities (McKay, 1987)
11. Less diversified occupational structure (Abrahamson, 1980)
12. Transportation, communication barriers (Zapf, 1985)
13. Lack of control over decisions, policies affecting them (C.A.S.S.W., 1976)
14. Victimized by "urban bias" (e.g., Ritchie, 1982)
15. Frontier, a "man's world" (Nickels & Ledger, 1976)

General

16. Pattern of dominance over native peoples (McKay, 1987)
17. 90% of total land area is uninhabited (Zapf, 1985)
18. Inadequate census information regarding rural Canada (Abrahamson, 1980)
19. Domestic Third World characteristics (Zapf, 1989)

"urban" and "rural" currently used by Statistics Canada to arrive at these figures. An urban area is defined as having a population concentration of 1000 or more with a minimum density of 400 people per square kilometre. Rural areas consist of all territory lying outside of urban areas. Thus small Northern Ontario communities such as Homepayne (population 1840) and Sioux Lookout (population 3095) are considered to be urban areas by Statistics Canada (1986).

Compared to the rest of Canada, Ontario had the highest percentage of rural population growth in 1981, at 85.7%. In total, Ontario gained 4.4% in population from 1976-1981 and 5.5% from 1981 to 1986. Yet Northern Ontario lost 0.7% of its population from 1976-1981 and 3.9% of its population between 1981 and 1986, the figure reaching as high as an 11.1% drop in population for the Kenora District between 1981 and 1986. Compared to a population density of 9.9 persons per square kilometre for all of Ontario, Northern Ontario's population density in 1986 was 1.02. Eighteen per cent of the population in Northern Ontario as of 1986 was French-speaking or bilingual, compared to 6% across all of Ontario. Northern Ontario also accounted for 50% of the total number !wellings on Reserves across Ontario. (All figures are from the 1981 and 1986 Census, Statistics Canada).

Canada, then, seems to be a country of contradictions in terms of its rural and urban identities. It is considered by some definitions to be a modern urban country, based on the high percentage of its population living in urban centres. Yet it is also a country featuring vast stretches of uninhabited lands. Northern Ontario, on a smaller scale, can be similarly characterized as displaying a combination of urban and rural traits whicl are very distinct from other areas of Ontario. Large urban communities in the North can, for example, be considered "remote" relative to the concentration of industry, government and population in Southern Ontario. Diversity, in all respects, is as dominating a feature in the rural contexts of our country as it is assumed to be in our cities. Bell (1980) has found it useful to think about the vast and varied regions of rural Canada in terms of a statement by the philosopher, Korzibski. He said: "The map is not the territory", meaning that there is a profound difference between

our concept or idea of something and the actual reality out there. Rural research is one means by which we can strive to learn more about the many realities that make up our country.

Finally, several authors have discussed various reasons why Canadians might choose to relocate in a rural area or move north relative to their home community. Lotz (1970) was of the opinion that factors such as economics, the escape from urban depersonalization and seeking adventure enter into the decision. The motives offered by Willis (1960) are quite similar, as he cited being young, enterprising and needing money, having a degree of missionary spirit, and seeing the North as a place to escape to. The connotation of both authors' remarks implies a spontaneous, spur-of-the-moment decision-making process and a temporary and transitory existence. If this is indeed the case, it is no wonder that retention and turnover are concerns of northern employers (e.g., see Cram, 1972; MCSS, 1988). However, specific to Northern Ontario, Polatajko and Quintyn (1986) conducted a study of the factors affecting the decisions by occupational therapists to come north. They determined that the northern lifestyle, the job opportunities, the partner's employment, and family proximity were the primary factors influencing those professionals to select the North. These findings point to a more carefully thought out selection process, one which seemed to incorporate the notion of "fit" with one's surroundings.

Mental Health Practice in Rural Areas - Characteristics

When considering the factors that help to influence a rural mental health worker's decision to accept a job, to stay on the job, or to leave, it is important to consider the nature of the work and working environment. What is it like to be a mental health worker in a rural or remote area? What is expected? What is important to know and to do, to be successful, to be accepted? What are the rewards and the drawbacks?

In scanning the literature on rural mental health and rural social work practice, both American and Canadian, I discovered, for the most part, a good deal of consistency across

authors in their descriptions of rural practice. Table 3 summarizes the key findings in the American literature and Table 4 does the same for the Canadian literature.

The most consensus among authors was regarding both the unique nature of rural practice compared to urban practice, and the "generalist" nature of rural practice. In most cases authors agreed that urban service delivery and theoretical models used by urban-trained workers have little positive effect in rural settings. Jones et al. (1976) stated succinctly that, "Since rural areas have unique problems, one must avoid the uncritical application of the urban model of service delivery..." (p.179).

I uncovered a variety of descriptions of a "generalist" practice, it being characterized as a "jack (or jill) of all trades, master of none", and as requiring treatment competencies, supervision skills, administrative skills, public relations expertise, and political know-how (Miller & Ostendorf, 1982). An understanding of people within the context of their total environment and the social factors in their lives was also considered an important element in generalist practice (Dunbar, 1982).

Of most relevance to this research are those issues or factors that either adversely impact on the quality of the staff person's life and work or that, conversely, attract and bring satisfaction. From a 1978 meeting of rural service providers in Wisconsin, Carr (1982) reported that the group identified what they felt were the five most important problems related to rural mental health service delivery. This list included the following: a) lack of transportation; b) inappropriate government rules and regulations; c) recruitment and retention of professional personnel; d) lack of planned coordination of human service programs; and e) lack of effective advocacy.

Horejsi (1976) discussed high rates of burnout among rural workers being the result of a number of factors including extensive travelling, the breadth of their duties, and the feeling that they are expected to know a little about every aspect of service but are denied the satisfaction of feeling they are competent in one particular area. The rewards of rural practice

Table 3

Characteristics of Rural American Practice

Opportunities

1. Can effect important social change (e.g., Farley, 1982)
2. Can feasibly conduct a thorough community assessment - history, economy, demographics, politics, power structures, resources, barriers, value base (e.g., Berry & Davis, 1978)
3. Can potentially develop good inter-agency relations (e.g., Wedel, 1969)
4. Can focus on the totality of the community; the system as client (e.g., Horejsi & Deaton, 1977)
5. Can make use of the natural helping systems (Johnson, 1977)
6. Opportunities for autonomy, decision-making responsibilities, working independently (e.g., Jeffrey & Reeve, 1978)
7. Opportunities for continuity of care, long-term follow-up (e.g., Jeffrey & Reeve, 1978)
8. Opportunities for personal and professional growth (Jeffrey & Reeve, 1978)
9. Lack of bureaucracy (Jeffrey & Reeve, 1978)

Drawbacks

10. High burnout rates, turnover rates (e.g., Hargrove, 1982b)
11. Can be costly, ineffective (e.g., Poole & Daley, 1985)
12. High community visibility; lack of privacy; close scrutiny (e.g., Riggs & Kugel, 1976)
13. Numerous confidentiality dilemmas (e.g., Sherman & Rowley, 1977)
14. Assume new, unfamiliar roles; multiple roles; role confusion and ambiguity (e.g., Hollingsworth & Hendrix, 1977)
15. Community initially very judgmental (e.g., Flax et al., 1978)
16. Lack of other professional resources, fragmentation of services (e.g., Poole & Daley, 1985)
17. Always "on call"; maximum exposure with little back-up (e.g., Ginsberg, 1977)
18. Enormous demands and responsibilities (Berry & Davis, 1978)
19. Fewer opportunities for teamwork, peer consultation, supervision (e.g., Horejsi, 1977)
20. Loneliness; professional and personal isolation (e.g., Horejsi & Deaton, 1977)
21. Lack of professional stimulation, resources, associations (e.g., Jeffrey & Reeve, 1978)
22. Scarcity of continuing education, professional development opportunities (e.g., Flax et al., 1978)
23. Extensive travelling over long distances (e.g., Jones et al., 1976)

Table 3 (continued)

24. Chronic staffing shortages, recruitment problems (e.g., Bachrach, 1982)

25. Increased need for staff support (Riggs & Kugel, 1976)

26. Greater utilization of alternative staffing arrangements (D'Augelli, 1982)

27. Limited personal and professional reward (Berry & Davis, 1978)

28. Slow pace (Jeffrey & Reeve, 1978)

General

29. Generalist practice; breadth of duties (e.g., Munson, 1980)

30. Different from urban practices (e.g., Waltman, 1986)

31. Need to have realistic expectations, know community's expectations (Wedel, 1969)

32. Various models of service delivery (travelling clinic, circuit riding, satellite clinic, comprehensive service centres) (Poole & Daley, 1985)

33. Services need to be physically and psychologically accessible and responsive to the community (Miller & Ostendorf, 1982)

Table 4

Characteristics of Rural Canadian Practice

Opportunities

1. Opportunities for community participation, integration of services, health promotion, prevention (Bell, 1980)
2. Provide a generic, multi-functional practice (Millar, 1977)
3. Service a wide variety of human problems, some unique to rural areas (Abramson, 1980)
4. Equipped to deal with concerns of native communities (Collier, 1984)
5. Can utilize social action models (McKay, 1987)
6. Development of sensitivity to and respect for cultural differences (McKay, 1987)
7. Development of sensitivity to intrusiveness of a practice in a remote area (Collier, 1984)
8. Prepared to "unlearn" re prejudices, misconceptions, falsifications (Collier, 1984)

Drawbacks

9. "Only show in town" (Abbott & Kehoe, 1972)
10. Staff assume multiple roles, can result in tension personally and professionally (Abramson, 1980)
11. Staff reluctance to work in isolated areas under difficult economic, social conditions (McKay, 1987)
12. Communications hampered by distance, cultural, experiential and linguistic differences (Abramson, 1980)
13. Lack of accessible specialized services and resources (Abramson, 1980)
14. Adjustments needed re expectations, patterns of behaviour (Abramson, 1980)
15. Urban models with urban-trained staff ineffective (Abramson, 1980)
16. Barriers to provision of services equivalent to those in urban areas: time, space, communications, cost (Abramson, 1980)
17. Lack of co-worker support, limited supervision (McKay, 1987)
18. Transportation difficulties: distances, weather, poor roads, irregular scheduling (Zapf, 1985)
19. High community visibility, personally and professionally (Abramson, 1980)

General

20. Need for thorough community assessment; understanding of economic, political, social development processes (Abramson, 1980)
21. Orientation toward community's goals; shift decision-making power to rural communities (C.A.S.S.W.,1976)
22. Importance of accommodating community's norms and values regarding behaviour, practices, appearance - blending in (Abramson, 1980)

highlighted in the literature tend to centre around the personal nature of the practice, the opportunity for autonomy and greater responsibility, and the unique challenges.

The Rural Mental Health Practitioner - Personal Qualities

The final area of content analysis I have conducted concerns the individual characteristics identified in the literature as being critical to a mental health worker's acceptance and success in a rural practice. Table 5 presents a summary of findings from the American literature and Table 6 summarizes the Canadian literature. Some authors suggest that agencies would do well to screen all applicants for rural positions on the basis of these characteristics in order that the best possible match be made from the beginning. Others propose that such information be incorporated into a comprehensive orientation package to best prepare new staff as to what they will be up against and what will be expected of them. A third position, that specially designed programs for training rural professionals should incorporate all our knowledge of rural practice, has been taken by Carr (1982) and Hargrove (1982b).

In an important study carried out in the Yukon Territories, Zapf (1989) discovered that mental health workers recruited from southern Canada, regardless of sex, age, or marital status, experienced culture shock (e.g., stress and frustration) to a far greater extent than workers hired from local communities. Recovery (e.g., a renewed sense of well-being and confidence) was achieved by most workers after approximately one year on the job, although women and younger workers reported slower recovery than their male and their older counterparts. Zapf concludes that disciplines responsible for training rural mental health workers must broaden their focus, given the cultural complexity of rural Canada. The notion of "poor fit appears to be not an issue of the wrong people in the North as much as a question of the role of conventional social work itself in that setting" (p. 162). The role of training programs should be to instill "realistic expections and clearer understanding of the role one is hired to perform [as this] may reduce the transition stress experienced" (p. 168).

Table 5

Facilitative Personal Qualities for a Rural American Practitioner

Work-related

1. Has a wide variety of professional skills, is a competent generalist (Webster & Campbell, 1977)
2. Can develop good working relationships with key community people, organizations (e.g., Ginsberg, 1977)
3. Can tolerate personal and professional isolation, lack of supervision, consultation; will actively seek supervision when necessary (e.g., Horejsi & Deaton, 1977)
4. Willingness to travel (Horejsi, 1977)

Lifestyle

5. Can function as a part of the community, reside there; respect local institutions (Waltman, 1986)
6. Understands local values, mores; maintains lifestyle consistent with those values (Wedel, 1969)
7. Can anticipate and prepare for adjustment problems, culture shock, limited resources (Riggs & Kugel, 1976)
8. Has made a commitment to rural life (Munson, 1980)

General

9. Is aware of and will utilize informal natural helping networks (Waltman, 1986)
10. Has a knowledge of rural politics and power structures (Buxton, 1973)
11. Understands community's dynamics, processes; recognizes informal pressure groups (Jeffrey & Reeve,1978)
12. Can set realistic goals, go at community's pace (Wedel, 1969)
13. Can tolerate criticism, scepticism, judgment (Berry & Davis, 1978)
14. Can "practice what you preach" (Wedel, 1969)
15. Has desirable personal qualities, is a "good fit" with the community (Hollingsworth & Hendrix, 1977)
16. Can tolerate high visibility, lack of privacy (Sherman & Rowley, 1977)
17. Is sensitive to and creative in handling confidentiality dilemmas (Sherman & Rowley, 1977)
18. Has good communication skills, interpersonal relationship skills (Riggs & Kugel, 1976)
19. Can function independently (Waltman, 1986)
20. Is open to support from others (Riggs & Kugel, 1976)
21. Has potential for creativity, innovation, imagination, flexibility (Wedel, 1969)
22. Is seen as helpful and trustworthy; tactful and energetic (Riggs & Kugel, 1976)
23. Has familiarity, empathy with cultural groups, minority groups, the poor (Riggs & Kugel, 1976)
24. Able to assume new, unfamiliar roles; deal with role ambiguity (Mermelstein & Sundet, 1980)

Table 6

Facilitative Personal Qualities for a Rural Canadian Practitioner

Work-related

1. Has a sense of adventure, of mission about rural practice (Campbell & Findlay, 1980)
2. Is willing to take risks in learning, growing on the job; shows maturity and responsibility (Campbell & Findlay, 1980)
3. Can move from resentment at limitations of professional resources and support, through acceptance, and on to adjustment and innovation (Campbell & Findlay, 1980)
4. Can make judgments under pressure and live with them; has self-confidence (Campbell & Findlay, 1980)
5. Is comfortable with autonomous practice, and with team work (Campbell & Findlay, 1980)
6. Has generalist competencies for clinical and administrative work (W.L.U., 1978)
7. Able to handle confidential situations (Campbell & Findlay, 1980)

Lifestyle

8. Has physical stamina and inner resources for creating her own lifestyle (Campbell & Findlay, 1980)
9. Begins to identify as a community resident, engages in social and recreational milieu of the community (Campbell & Findlay, 1980)
10. Understands the effects of isolation on personal and social development, e.g., cabin fever due to weather, poor transportation (Martin & Callahan, 1980)
11. Able to adapt to culture shock; shows personal stability (Campbell & Findlay, 1980; Zapf, 1989)

General

12. Is curious, sensitive to the community's feedback without being personally threatened; expect testing period (Campbell & Findlay, 1980)
13. Has realistic expectations of rural communities, their limitations, their resources; understands local history, politics, economics, cultures (Campbell & Findlay, 1980)
14. Has patience, flexibility, persistence and humour in considerable quantities (Campbell & Findlay, 1980)
15. Understands the effects of working and living with high visibility; thin line between personal and public life (Martin & Callahan, 1980)
16. Able to handle a variety of personal and professional roles (Zapf, 1985)

Virtually all the literature written concerning rural mental health practice contains some mention of the unique qualities that must be inherent in or at least developed by the rural practitioner if s/he is to survive personally and professionally in a rural area. Thus such qualities cannot be ignored in research concerning retention of workers, as they constitute one of several levels of analysis.

Burnout - Job Stress

Burnout is a term that has only surfaced in the mental health and social work literatures in the last 15 years. Freudenberger (1974) is credited with first using the term in the human services context to describe the crippling mental and physical effects of work in the emotionally-charged human services professions. Burnout has since been defined in a variety of ways and has been used synonymously with such terms as "tedium" (Pines & Aronson, 1981), "alienation" (Karger,1981), "job stress" (Paine, 1982) and "frontline collapse" (Munro, 1980).

Extensive literature reviews have been provided by several authors (e.g., Kelly, 1984; Erera, 1983). Beginning such reviews are statements acknowledging the lack of clarity and precision in defining what constitutes burnout. Kelly (1984) uncovered over 50 different behaviours and symptoms reported to be caused by or associated with burnout. Dimensions of burnout most commonly appearing in the literature include physical, emotional and psychological exhaustion, detachment, and decreased performance, all of which seem to develop gradually over time (e.g., Cherniss, 1980; Welch, Medeiros, & Tate, 1982). The consequences of burnout external to the individual worker are also of particular relevance to my research. High staff absenteeism and turnover, ineffective service at best, clients being ill-served or even damaged, and low staff morale constitute some of the damaging ramifications to organizations and clientele (e.g., Farber, 1983; Eisenstat & Felner, 1983). As to the actual causes of burnout, Kelly (1984) determined that the literature seems to converge on two streams of causation. One stream stresses the personality factors that contribute to an individual's susceptibility to burnout,

for example, overcommitment, idealism, and ambition. The second stream focuses on factors related to the job, the job tasks, and the work place, for example, handicaps to provision of service, role conflict and ambiguity, job pressures, and lack of support and positive feedback (Beck, 1987).

According to Kelly (1984) little emphasis has been placed on the interaction between the personality and work place factors, which is a more ecological approach, though there is evidence that this trend has changed since Kelly published (e.g., Cournoyer, 1988). The concept of person-environment fit and its relation to stress in the workplace is now often included in discussions on causation (e.g., Benner, 1984; Cooper & Payne, 1988).

Pines and Aronson (1981; 1988) argued that gender also deserves special consideration in the discussion of burnout. Sex-role stereotyping has had women believing they must be more caring, empathic, and nurturing in both their personal and professional roles, attributes that may make women more vulnerable to the dangers of burnout. In particular, Pines and Aronson pointed to the example of the married career woman. Due to the "unfortunate reality that the woman still carries the burden of the conflict between career and family" (Pines & Aronson, 1981, p.95), she is trying to manage two jobs at all times and is paying the ultimate price for her choice - burnout. Pines and Aronson (1988) identified this role conflict between family and profession as a source of severe stress for this population of women who feel they must "do it all".

In research comparing levels of burnout in professional women versus professional men, Pines and Kafry (1981) found that women had slightly higher levels of burnout overall but, at its most severe levels, four times more women than men suffered the very debilitating consequences of burnout. These women reported feeling they had less autonomy and influence in their job setting, as well as less challenge and variety in their job tasks. They felt thwarted in attempts at self-expression and self-actualization, overtaxed by demands and pressures coming from others, and inadequately rewarded for their work. These findings, coupled with the regular

reports we hear in the media of women suffering from discrimination and harassment in the workplace, illustrate the significance of gender as a factor in any research focusing on the fit between the individual and her/his work environment.

One of the major concerns in the human services regarding burnout has to do with the quality of care provided once burnout is discovered in an organization (Eisenstat & Felner,1983). Eisenstat and Felner identified two key components to the task confronting human service agencies that desire to structure work experiences which enhance the quality of care offered to clients:

> Jobs need to be designed in such a way that workers are not overwhelmed by job-related stressors. Second, and perhaps of equal importance, jobs need to be structured so as to maximize workers' motivations to perform them effectively. (p.144)

The authors concluded, "We need to acknowledge the inextricable link between the job environment for workers and the service environment for clients" (p.151). The service recipient, the **raison d'etre** of any human service organization, must not be overlooked in the consideration of the potential human causalities of burnout among mental health workers.

The amount of empirical research on burnout is surprisingly not that extensive, and is virtually non-existent in rural contexts. I will highlight two studies emanating from family counselling agencies in the eastern United States. How generalizable their findings are to rural agencies is not apparent at this time.

Streepy (1981) designed a study using 108 direct-service providers, the majority of whom were Caucasian, female, and married, to investigate the incidence of worker burnout. She examined worker, client, job, and agency characteristics across 12 agencies. **Worker characteristics** that she found correlated with burnout were "years of experience" (more

experienced workers generally had lower burnout scores) and "attitudes toward their profession" (workers with positive attitudes were less likely to be burned out). The only **client characteristic** that was significantly related to burnout was the frequency of positive feedback (the greater the frequency, the lower the burnout score).

The one variable relating to **job characteristics** that was correlated with burnout in Streepy's findings was the degree of difficulty workers experienced in delivering services to clients. Workers who had greater difficulty providing clients with the help they needed, particularly due to a lack of skills or knowledge, generally had higher burnout scores. Streepy concluded that "the feelings of frustration resulting from workers' dealing with various obstacles to service delivery are most likely contributory factors in the increased emotional exhaustion experienced by burned-out workers" (p. 358). Finally, her data indicated that the only **agency characteristic** associated with burnout was the amount of work pressure (defined as pressure to increase the quantity or quality of work, degree of job security, and degree to which threats or punitive measures are used).

Streepy concluded that her findings had important implications for practice, including the need to provide adequate training and education for workers, to make appropriate job selection contingent on workers' skills and experience, to maintain minimal work pressure by establishing realistic expectations, and to gain agency participation in the identification and development of community resources to overcome obstacles in service delivery. Comparing these results to the characteristics of rural practice listed earlier (e.g., the uniqueness of rural practice, the need for generalist skills and knowledge of rural dynamics, the lack of rural resources and services, the barriers to service delivery), it is clear that her findings are of relevance to rural workers and agencies.

Beck (1987) conducted a study in 17 agencies covering all geographic regions of the U.S. and one in Canada. Two hundred forty-four counsellors, 74 percent of whom were women, participated in a mail survey to examine the consequences of counsellor burnout on client

outcomes and on long-term counsellor retention. From her findings burnout can be associated with: overall job dissatisfaction, handicaps to the provision of services, lack of job rewards, job functions, job pressures, lack of support and positive feedback on the job, the counsellor's internal feelings of overload, and an authoritarian or laissez-faire administrative style. She also found high correlations between burnout and a number of counsellors' characteristics, including overinvolvement with clients' problems, low success in coping with stresses at work and outside of work, increased intent to seek another job, higher client dropout, and loneliness. Beck concluded by stressing the consequences of staff burnout for the agency:

> The cumulative effects on staff morale of an atmosphere that includes dissatisfaction with the agency, its administrator, supervisors, personnel practices, policies, and rewards structure are obvious. Low morale leads to adverse staff selection through selective attrition. **To retain a therapeutically effective counselling staff, it is necessary for agencies to invest wisdom, energy, and ample resources to minimize staff burnout.** (p. 13) [emphasis added]

Burnout in Rural Areas

Despite the lack of empirical research, several authors have speculated as to why there seems to be a high rate of burnout among rural mental health workers. The factor of gender does not, however, enter into these authors' discussions. Hargrove (1982b) was quick to state that life and work in a rural area does not inevitably lead to burnout. He felt that rural practice can be a positive, satisfying, growth-oriented experience for those who are able to cope effectively with multiple role demands. However, the demand placed on one or two people having to handle the total range of clients, consultation, education, public relations and administration can frequently lead to staff depression and burnout. Hargrove (1982b) believed

that rural mental health workers are especially vulnerable to factors such as overinvolvement with clients and overidentification with the job because of their geographic isolation and their resulting inability to compartmentalize the personal and the professional. Finally, Hargrove stated that the rural work setting can inhibit attempts to cope with professional stress and the increased work-related frustration and anxiety. "Burnout can prematurely remove effective professional people from the field" (Hargrove, 1982, p.179).

Horejsi and Deaton (1977) supported Hargrove's contention that extensive demands placed on the rural worker can lead to burnout. Workers' energies and resources become taxed to the limit. Invasions of privacy and high visibility in the community were also cited by these authors as limiting and pressure-inducing. Farley et al.(1982) speculated that burnout also seems to be increased by rural professional isolation.

In terms of the consequences of burnout in rural mental health workers, those cited by Hargrove (1982b) were similar to those generally mentioned in the burnout literature. Cynicism and anger inappropriately directed at clients, extreme rigidity inhibiting the creativity so necessary for rural practice, and withdrawal from what limited peer and supervisory support may be available should spell great concern for rural administrators. Unfortunately, however, because of the physical isolation of rural practice, supervisors or administrators may not detect a problem before clients and agency credibility are damaged.

Quality of Life, Quality of Work Life

Quality of Life (QOL)

The concept of "quality of life" has drawn widespread interest in the literature since it first arose out of research on social indicators (e.g., Andrews & Withey, 1976). Researchers have been able to demonstrate that social environments have considerable impact on an individual's way of life. Zautra and Goodhart (1979), defining the term as pertaining to "goodness of life" (p.1), also saw interest being generated in the topic because, "to understand

their own experiences better and make more informed decisions as to the best way to live their lives, people are seeking knowledge about how others find satisfaction and life quality in a rapidly changing world" (p.1). The authors discussed the concept in relation to both social and psychological indicator research. The variety and number of indicators in each category is limitless, and thus depends on each researcher's discretion and preference. The social indicators generally tend to converge around four areas: health, social wellbeing, education and public safety. Zautra and Goodhart described two models used by researchers to assess a community's quality of life utilizing social indicator data. The 'person-environment fit' model "suggests that psychological and social problems arise when people find themselves in a social environment in which they constitute the minority on one or more salient characteristics" (p.4), for example, values, standards and lifestyles. The 'behavioural contagion' model, in direct contradiction to the person-environment fit concept, purports that maladaptive behaviours are, in essence, contagious and will spread if their levels become high enough.

Psychological indicator research focuses on assessing QOL by way of residents' subjective reactions to life experiences, utilizing measures of adjustment and of satisfaction and happiness. The emphasis of each of the five models of analysis for psychological indicators presented by Zautra and Goodhart is on major life events for people and their resulting behavioural adjustments and psychological growth. An epidemiological model focuses on factors in the lives of community residents which may increase the likelihood of mental ill health, while a life-crisis model stresses that outcomes other than illness may result from traumatic life experiences. A competency model views 'quality of life' stemming from opportunities to experience success and mastery over their environment. An adaptation-level model stresses people's tendencies to compare their present experience with their own past experience and with their perceptions of other people's lives, to then determine their present level of satisfaction. Finally, Zautra and Goodhart (1979) suggested a composite model which they called a 'positive mental health model'. They proposed that people need to both diminish and/or adjust to life

crises and increase life satisfaction through gaining successful mastery over their environment. Their 'quality of life' is thus assessed in terms of the extent to which people have fulfilled both their adjustment and competency needs (Zautra & Goodhart, 1979).

Korte (1983), writing specifically about the rural context, defined QOL as an "overall evaluation of the conditions of life as experienced by an individual or a set of individuals" (p.200), and as measured by both objective and subjective indicators. Objective measures describe the quantitative characteristics of people and places, for example, the number of schools, the unemployment rate, and the amount of local parkland. Subjective measures draw from people's perceptions of and satisfaction with their own living conditions. Korte (1983) emphasized the importance, given the pluralistic nature of our society, of considering QOL "through the filter of individual needs, values and preferences", as "our personal values and life-style determine which conditions are to be prized and which deplored" (p.201).

In a rural context, then, the quality of life largely depends on how well the rural environment is meeting the needs of its rural residents, needs that likely differ, to some extent, from those of urban dwellers (Korte, 1983). According to Korte, some of the subjective and objective indicators of rural quality of life are as follows: residential preference (subjective), degree of satisfaction with one's home community (subjective), a variety of economic indicators (e.g., mean income, levels of unemployment, number of people living below the poverty line), services and facilities (e.g., health, education), environmental quality (noise levels, air and water quality, climate), and various social indicators (e.g., nature of social contact, crime statistics, levels of psychological distress and alienation). Korte (1983) concluded that the majority of research on rural-urban differences in 'quality of life' indicates that rural life in the U.S. is not as bad nor as rosy as many suggest.

Nickels (1972b) discussed 'quality of life' in the context of the Canadian North. He used the term to imply "not only a person's mental (or physical) health, but also his adaptation to the world, his satisfaction with it, and his adjustive attempts to either harmonize himself with

it or to alter it for his greater fulfilment" (p.17). He proposed three questions that seem to underlie the assessment of quality of life in northern Canadian communities: 1) what brings people north; 2) what are the causes of people leaving the North; and 3) what do people do and aspire to in the North.

Nickels (1972b) also cited a study by Cram (1972) from McGill University, designed to identify qualities of northern living utilizing 288 mine workers from remote northern communities as participants. An important finding of this research was that "northern jobs must provide the worker, not only with good living conditions and a safe job setting, but also with the realization that the worker has a job worth his efforts, that his value to the job is recognized, that he is fulfilling himself by being on the job, and that he is using his full capabilities while on the job" (p. 26). This finding also points out the overlap between 'quality of life' and the concept of 'quality of work life', in effect a sub-set of QOL which has recently received independent attention in the literature.

Quality of Work Life (QWL)

The term 'quality of work life' was first introduced in the early 1970's, arising from the American business community's interest in learning how to influence the quality of an individual's experiences while on the job (Nadler & Lawler, 1983). At that time there were increasing concerns about the impact of the job and the workplace on the health and well-being of employees and about job satisfaction. That is, there was a recognized need to humanize work (Stone & Meltz, 1988). This change in attitude largely came about because of workplace innovations that were occurring in European industry and the growing threat of international competition in the marketplace.

Despite its reputation as being a somewhat faddish concept, QWL has in the last ten years 'arrived to stay' as a major concern of managers in their attempts to improve their organizations' effectiveness. The definition of the term, however, still varies widely from user

to user. Nadler and Lawler (1983) defined QWL as a "way of thinking about people, work, and organizations" (p.26) that consists of two distinct elements - "1) a concern about the impact of work on people as well as on organizational effectiveness, and 2) the idea of participation in organizational problem solving and decision making" (p.26). Thus the focus of QWL is on 'how work may cause people to do better', as much as it is on 'how people can do their work better'. Activities that comprise QWL programs include participative problem solving at various levels of the organization, work restructuring (e.g., job enrichment, autonomous work groups, technical systems), the creation of innovative reward systems, and improving the work environment (e.g., changes in hours, conditions, the physical environment).

Stone and Meltz (1988) described the key to QWL as being "a change in managerial attitudes and practices, away from an authoritarian style toward a consultative and advisory role" (p. 575). Nadler and Lawler (1983) identified five critical factors that they felt determined the success or failure of QWL programs in the workplace:

1. the perception of need is shared by all involved parties;
2. the need is prominent enough to ensure commitment of time and resources by all parties;
3. a structure for participative problem identification and solving exists or is created;
4. rewards must be built into the processes and outcomes of the QWL activities; and
5. QWL activities will extend to all groups and systems in the organization.

Nadler and Lawler discussed three major ingredients of a QWL program that must be managed well if the program is to be successful. First, projects must be developed at different levels that are able to demonstrate specific and observable actions aimed at change. Second, changes in management systems must take place to better support the projects. Third, the active participation of the senior management group in the QWL activities is critical for the credibility of the program.

Although QWL has long had its roots in the business and corporate world, it only makes sense that it become a valuable tool for managers and employees in the human services, given the high levels of burnout (as discussed earlier), job dissatisfaction, and turnover experienced in such organizations. It is encouraging that the burnout literature has increasingly paid more attention to organizational causative factors and to those strategies that have been effective in reducing the quantity and severity of the problem (e.g., Greenburg & Valletutti, 1980). In the following sections, I provide an overview of significant theory and research pertaining to the concepts of job satisfaction/dissatisfaction, management style, and turnover, and their relevance to employee retention. I conclude my review of the literature by examining retention research that has been carried out in rural areas across Canada and the U.S., and by identifying some of the unique geographic, cultural, and economic challenges specific to the region of Northern Ontario.

Job Satisfaction / Job Dissatisfaction

Job satisfaction is another term that is closely related to the two previously discussed concepts, QOL and QWL, and has been linked in the literature with burnout (e.g., Himle, 1986), turnover (e.g., Mobley, 1977), absenteeism, and physical and mental health (e.g., Hellriegel et al., 1989). Thus, it is understandably an important consideration for organizations. Job satisfaction can be defined as a collection of attitudes towards the job itself (e.g., pay, promotion, supervision, and job tasks) (Hellriegel et al., 1989) and towards elements in the work environment (e.g., company policies, the boss, the co-workers, and the physical environment) (Stone & Meltz, 1988).

Herzberg's (1982) two-factor theory, which he labelled motivation-hygiene theory, proposed that job satisfaction (motivation) is the product of the intrinsic rewards of the work itself or "motivators". Examples of motivators in his schema include achievement, recognition for achievement, the work itself, responsibility, and growth. The second factor, job

dissatisfaction or "hygiene", results from unfair treatment in the work environment, that is, the lack of extrinsic rewards. Thus job dissatisfaction is affected by such factors as an organization's policies and administration, supervision, interpersonal relations of the job, working conditions, pay, status, and security. Herzberg's (1982) theory suggests, therefore, "that the different causes and effects of satisfaction and dissatisfaction are derived from two separate need systems of human beings: motivator (growth) needs and hygiene (security) needs" (p. 313). The implications of this theory for managers and administrators are significant. In particular, motivation-hygiene theory suggests the importance of organizational leaders both understanding the wide-ranging needs of their employees and having the expertise to translate their understanding into humane and effective policies and actions. Herzberg (1982) explained that "the management of people involves two problems: treating them well (hygiene) and using them well (motivation). Both are equally important, but the successful manager must separate his or her strategies for solving the two problems" (p. 314).

In a rural setting, characterized by few if any boundaries between public (work) and private life, the relationship between the concepts of QOL, QWL, and job satisfaction is crucial to an understanding of why people stay or leave such a setting. How and why work life and non-work life are related has been the subject of many theorists (e.g., Wilensky, 1960) and researchers (e.g., Near et al., 1987). Wilensky suggested that people may associate their work and non-work lives either by allowing experiences from one context to spill over into the other or by compensating in one context for negative experiences in the other. Evans and Bartolome (1980) extended the scope of spillover and compensation to include feelings as well as activities, on and off the job. Near's et al. (1987) research determined that job satisfaction/life satisfaction spillover does occur, in both directions. They concluded that their results had implications for employers, in that performance on the job may be partly related to events and feelings outside the workplace. Thus, managers should become more aware of their employees' lives off the job in order to try to prevent negative spillover in either direction. Changes in

organizational structure to reduce pressures and an emphasis on a holistic concern for employees can in turn bring about increased effectiveness and commitment on the job (Near et al., 1987).

Much of the research on job satisfaction in the human services occupations has focused on either social workers or health care providers. The intent has been to determine some of the correlates of job satisfaction to each respective profession in order to increase the quality of care (e.g., Field & Dubey, 1987), reduce turnover (e.g., Madill et al., 1987), and curtail burnout (Jayaratne & Chess, 1982-83). Field and Dubey (1987), limiting their research to leadership styles, surveyed human services employees in a variety of work settings and determined that a "democratic leadership style significantly influenced general and specific job satisfaction" (p.55) among employees. They defined a democratic leadership style as the use of consultative and group participation in decision-making.

Jayaratne and Chess (1982-83; 1986) have significantly contributed to the research in the areas of job satisfaction and burnout within the social work profession. Their nationwide (United States) surveys compared caseworkers and administrators, and looked closely at gender differences in reports of job satisfaction. In their studies they assessed job satisfaction on the basis of seven predictor variables: workload, comfort, challenge, financial rewards, promotional opportunities, role conflict, and role ambiguity.

In a study comparing social work administrators with caseworkers, Jayaratne and Chess (1986) found that the age and gender of the participants played a significant role in relation to job satisfaction. Young social workers, both caseworkers and administrators, were much less satisfied with their jobs. Within the group of administrators, women expressed much more dissatisfaction, especially in the areas of work load and job comfort, than did men.

In an earlier survey of social workers at all levels of employment, Jayaratne and Chess'(1982-83) results indicated that, while there were no gender differences in assessment of overall job satisfaction, male and female social workers did have different frames of reference

when evaluating their jobs. The female participants were significantly less satisfied in the areas of job comfort, financial rewards, and workload. For male social workers, the significant predictors of job satisfaction were job challenge, financial rewards, promotional opportunities, and role ambiguity. For women in the social work profession, job challenge, promotional opportunities, and marital status (married workers recorded higher levels of satisfaction) were the best predictors of their satisfaction with the job (Jayaratne & Chess, 1982-83). Jayaratne and Chess surmised that these gender differences reflect the longstanding traditions in social work of women earning much less than their male counterparts, women being confined primarily to front-line casework positions, and women being perceived as caregivers for whom receipt of financial rewards is of secondary importance. They concluded that any future studies of job satisfaction must further address gender and age differences or risk distorted results. It is my intention to incorporate both of these factors into my research, as it is apparent that they could contribute significantly to an increased understanding of what determines whether an employee stays or leaves.

Specifically in the Northern Ontario context, Polatajko and Quintyn (1986) asked occupational therapists, primarily married women, to rate their levels of job satisfaction and identify both advantages and disadvantages to working in the North. They concluded that the majority of participants were satisfied with their jobs. The main advantage to working in the North, however, was not job-related but was identified as the northern lifestyle. One third or more of the occupational therapists also responded that their professional freedom and the variety of their professional role were advantages. The disadvantages identified by the participants were primarily work-related, however. Limited resources and the lack of continuing education opportunities were most widely mentioned, while isolation, long distances and the cost of travel were cited by one third or more of their participants (Polatajko & Quintyn, 1986). This study again points to the spillover from non-work life into the determination of feelings of job satisfaction/dissatisfaction. In the next section, however, my focus turns to a

feature specific of the workplace, the predominant management or leadership style, to examine what impact it may have on workers and the organization.

Management/Leadership Style

The relationship between the predominant management/leadership style in an organization and job satisfaction has been documented in studies already mentioned (e.g., Near et al., 1987; Field & Dubey, 1987). However, it was not until the significance of management style emerged from my preliminary analysis of the interview data that I decided this issue warranted more attention in my review of relevant literature.

Management style and leadership style are not necessarily synonymous, in that not all managers are leaders and, conversely, not all leaders are in management positions in organizations. Hellriegel et al. (1989) defined management as directing the work of others and being responsible for the results, while leadership was seen as "the process of creating a vision for others and having the power to translate it into a reality and sustain it" (p. 266). The need for leadership at a managerial level is critical in a climate of competition and change, arguably the reality for children's mental health agencies in the North as they struggle with new government directives, community demands, limited resources, and the desirability of Southern Ontario as a work locale.

The skills that have been identified in the corporate world as contributing to effective managerial leadership include visionary skills, effective communication, empowerment, and self-understanding (recognizing one's strengths and weaknesses) (Hellriegel et al., 1989). Conger (1989) cited recent leadership studies that point to empowerment alone as the key to an organization's effectiveness, especially during times of change. Conger defined empowerment as "the act of strengthening an individual's belief in his or her own effectiveness" (p. 18). He believed a manager/leader must be committed to the concept, skilful in assessing staff needs and carrying out empowering practices, and secure in her/himself, in order to successfully

create an empowering work environment. Block (1987), in his book, The Empowered Leader, discussed empowerment in terms of a leader being able to develop antidotes for bureaucracy, the structures and practices of which he believes create feelings of helplessness, vulnerability, and dependency in workers. He discussed in depth the necessary qualities of courage, authenticity and commitment, the importance of encouraging self-expression and of giving others in the organization ownership. Finally, he asserted that the most empowering act for a leader is to be a "living example of how we want the whole organization to operate" (p. 7).

In the human services context, Weiner (1987) discussed the importance of administrators showing leadership in the delicate process of blending worker performance (job satisfaction) with organizational performance (client outcomes). To achieve this, it is imperative that human service administrators maintain a set of values "which emphasize working with people over 'managing' people, values which stress human development over human manipulation" (p. 159). Gowdy (1987) argued that human service administrators must show leadership in transforming their organizations into "humane, empowering environments for workers and clients while enhancing service effectiveness" (p. 172). Her prescription for this transformation focused on the application of QWL concepts in the workplace, including the formation of work groups, job restructuring, participative management, and structural change in the organization.

Managerial leadership has been shown by researchers to play a critical role in contributing to job satisfaction and retention and in the assessment of administrative effectiveness in other human service contexts. As mentioned earlier, Field and Dubey's (1987) research determined that, for human services workers, a democratic leadership style which uses consultative and participatory decision-making, was a significant determinant of job satisfaction, while the exercising of a great deal of control by the leader in the work environment reduced professional autonomy, which workers found aversive. In a study of turnover among nurses, Helmer and McKnight (1989) observed that nurses wanted a sense of participating in their hospital and that the "technique of participatory management...has unlimited potential to involve

nurses in decision-making and problem solving..." (p. 78). They concluded that unless hospitals create an environment of participatory management involving their professional nurses, they will experience even higher turnover.

In a study of rural mental health administrators, Fenell, Hovestadt, and Cochran (1987) determined that leadership ability was the characteristic most commonly associated with the effectiveness of rural administrators. The skills of an effective leader were defined by their research participants to include motivational ability, the delegation of responsibility and effective communication. Seven other characteristics of effective administrators were also identified: rural community understanding; program planning, implementation, and evaluation; relevant professional background and training; political savvy; personnel management ability; budget and fiscal management; and personality attributes relevant to rural life (Fenell et al., 1987). While Fennell's et al. research did not address gender in relation to leadership style, the question of whether women and men experience and perform in their world differently, and how this affects their leadership abilities, has in the last 20 years generated heated discussion (Burke & McKeen, 1988).

The role of gender in managerial leadership has been contested since the 1960's when women first began emerging on the corporate management scene. Researchers have attempted to determine if gender-based differences exist in management style or effectiveness, in the perceptions of managers by co-workers and 'subordinates', in management training and development, and in managerial opportunities at all levels (e.g., Rizzo & Mendez, 1988; Powell, 1988). To add to the confusion of the issue of gender-based differences, there is no concurrence among researchers or theorists, female or male, as to whether differences, if they exist, are good or bad, desirable or, of necessity, to be overcome (e.g., Grant, 1988; Catalyst, 1987).

There has been general agreement that historically the model of successful management has been based on male values and attributes. For example, McGregor (1967) described the good manager as "aggressive, competitive, firm, just. *He* [italics added] is not feminine; *he*

[italics added] is not soft or yielding or dependent or intuitive in the womanly sense. The very expression of emotion is widely viewed as a feminine weakness that would interfere with effective business processes" (p. 23). Researchers have repeatedly confirmed that both women and men have described men as being more similar to good managers than women, and good managers as exhibiting typically masculine traits (Powell, 1988). Thus, women have been faced with the reality that they can fit into an organization only by learning the rules of male-dominated management and becoming more acceptable by male standards.

Only recently have women started to question these strategies and the costs to them that result, and therefore whether the organizations are worth fitting into at all (Burke & McKeen, 1988). Literature is now starting to appear that affirms distinctive management qualities in women, such as their abilities as "visionaries" and "catalysts" (Vinnicombe, 1987). This literature also suggests that organizations will be losing a great deal if these qualities are not acknowledged and valued as important contributions to organizational effectiveness (Vinnicombe, 1987; Grant, 1988). Terms such as "relationality" (Wine, 1982) and "appreciative management" (Smircich, 1985) are also being positively associated with a feminist perspective on management. However, research is yet to be done to determine whether the replacement of a traditionally male-oriented model of management by a women-centred approach would have impact in specific areas of organizational functioning such as limiting turnover and enhancing retention.

Turnover and Retention

Turnover and retention have been the subject of much speculation and assumption but of little empirical research specifically within the social services, except in conjunction with other problems such as burnout. Turnover seems by far to be the more popular of the two terms in the literature, possibly suggesting a more fatalistic orientation to the concern about

staffing stability. Retention strategies imply a more primary preventive approach, nipping the potential problem of dysfunctional turnover before it can develop.

Turnover

The costly impact of turnover on all organizations has resulted in a great deal of general research and theorizing in order to better understand the phenomenon (Dalton, Krackhardt, & Porter, 1981), including its relationship to job satisfaction (Mobley, 1977). Based on the traditional categorization of voluntary versus involuntary turnover, models have been developed that attempt to outline the entire withdrawal decision process (see Mobley, 1977; Miller, Katerberg, & Hulin, 1979) and thus shed more light on the mediating variables in the relationship between job satisfaction and the act of leaving the job. Mobley (1977) suggested that a logical, step-by-step process typically takes place once one experiences dissatisfaction, culminating in the decision either to quit or to stay. Along the way, factors such as assessments of the utility of a job search, the cost of quitting, and the alternatives available influence the final decision.

More recently the trend in turnover research has moved attention away from turnover as an entirely dysfunctional event for an organization toward the belief in a polarization of the concept, both in terms of the effects it can have on an organization (e.g., Dalton & Todor, 1979; Dalton, Krackhardt & Porter, 1981; Abelson & Baysinger, 1984) and its avoidability (e.g., Dalton, Krackhardt & Porter, 1981). The terms "functional" and "optimal" have been used to characterize turnover which is beneficial to an organization, for example, by allowing better person-job matches and the introduction of new ideas and skills into an organization (Abelson & Baysinger, 1984). The distinction between "controllable" and "unavoidable" turnover has also been made as part of this effort to more precisely measure the net costs and benefits to an organization in terms of dollars, service quality, morale, etc.

The term "optimal turnover rate" has been coined by Abelson and Baysinger (1984) to describe "the rate consistent with balancing the organizational costs of turnover against the organizational costs of reducing it..." (p. 332), a rate that will differ across organizations and will generally be nonzero. These authors proposed an "optimal turnover process model" that takes into consideration the individual, organizational, and environmental factors that influence an employee's view of the costs and benefits associated with quitting one job and starting another (Abelson & Baysinger, 1984).

The optimal approach of Abelson and Baysinger assumes that functional turnover for an organization depends on the employee's performance and on the organizational retention/turnover costs related to that employee's retention/turnover behaviour. It can have, therefore, major implications for the management of turnover in organizations, including the allocation of resources for retention. Employers "may want to examine retention and turnover costs as well as employee performance levels when deciding whether or not to meet employee retention demands or when evaluating the turnover performance of particular organizations" (Abelson & Baysinger, 1984, p.340). This is in contrast to the traditional thinking that turnover should be controlled by identifying employees' demographic characteristics (e.g., age, tenure, marital status) and personal attitudes (e.g., job satisfaction, organizational commitment) that are closely related to turnover, and then managing these to reduce turnover (Abelson, 1986). Abelson suggested that organizations using this traditional approach have acquired inaccurate predictions of turnover and tend to treat the turnover of good and poor employees in the same fashion.

Regardless of the approach taken to understanding turnover, Abelson (1986) pinpoints the crux of all the attention given the issue: "By better managing and controlling the turnover problem. more time will be available for other pressing needs because competent staff will remain within the organization" (p.70).

Retention

Given that a general review of the retention literature would contribute little more to the above information on turnover, I will summarize in this section what limited theorizing and empirical research exist that address the retention of mental health staff, both in Canada and the U.S. Numerous authors who have addressed rural mental health concerns (e.g., Heyman, 1983; Melton & Childs, 1983; Hargrove, 1982b) have acknowledged the lack of rural retention research. "The question of who remains and thrives in a rural area is an important one. In the long run ...[the answers] may hold the most benefit for those who need rural mental health services" (Hargrove, 1982b, p. 173).

In the rural literature retention and turnover have been linked to a number of concerns, some unique to rural practice, some not. Burnout is most commonly mentioned as a factor that commonly results in voluntary or involuntary decisions to leave rural areas (e.g., Hargrove, 1982b). Inadequate professional preparation for working in a rural context, resulting in new graduates having false expectations about their roles and lives in rural settings, is another commonly cited cause of turnover among rural professionals (e.g., Herrero, 1980; Cross & Dengerink, 1982; Hargrove, 1982b). Poor recruiting practices were also mentioned by Miller and Ostendorf (1982) as decreasing the chances for a good fit between the prospective new worker and the job and community at hand. They suggested that a candidate deserves the opportunity to explore with the employer the ramifications of living and working in a rural setting and the complete and accurate details of the position. Discussions with staff already in the setting and with key members of the community can also greatly assist both the candidate and the employer to determine the quality of the fit. John Wanous (1973; 1978; 1980; 1989) has also researched and written extensively about the importance of the "realistic job preview" (RJP) at the recruitment stage for increasing job survival, that is, retention.

Carr (1982) developed a list of eleven selection criteria to be used to optimize the chances of employers to select successful rural mental health staff who are likely to remain on

the job. His list was the result of a thorough literature review and interviews with people knowledgeable in rural mental health practice. He suggested the following person-centred criteria be considered:

1. have a predisposition to small community living
2. be relatively older and more mature
3. be patient-oriented versus professional/prestige-oriented
4. have a significant other (e.g., spouse or friend) with whom to share the experience
5. have alternative interests consistent with the locale
6. show evidence of an individual desire for new experiences
7. have self-confidence, tolerance for risk-taking
8. be a survivor, resourceful, autonomous
9. be open, flexible, empathic, adaptive
10. tolerate stress of visibility and control intrusions
11. have an array of general skills, be competent (from Carr, 1982, p. 117)

These criteria, closely resembling the list of individual characteristics put together in Tables 5 and 6, may well serve as a valuable starting point for rural administrators in their search, but, as the literature reviewed thus far has shown, organizational and environmental factors play very major roles in a worker's assessment of her/his satisfaction with her/his life and work and ultimately with her/his decision to remain or not. In hospital studies, for example, Spencer (1986) concluded that "the more an organization gives employees the opportunity to voice dissatisfactions over aspects of their work in order to change dissatisfying work situations, the greater the likelihood its employees will remain with the organization" (p. 498).

Two studies, one set in rural Wyoming (Elkin & Boyer, 1987) and the other in rural Alberta (Thompson & Barr, 1984) make up the accessible research that has been conducted on

rural mental health staff retention. Elkin and Boyer (1987), surveying forty workers throughout rural Wyoming, discovered that definitely eight and possibly two others of the 40 would next choose to work in an urban centre. Because their research focused on satisfied workers only, they went on to identify the professional interests and personality characteristics that typified the remaining group of 30 practitioners, 22 males and eight females. Their results were consistent with those personal characteristics identified by Carr (1982) above and throughout the literature, for example, being comfortable with and challenged by the practice, and tolerating and resolving frustrations. Elkin and Boyer (1987) concluded that, "the most promising candidates for successful rural practice are people who have previously demonstrated adaptability to the rural environment or who possess personality characteristics and preferences similar to this group" (p. 38).

One interesting finding by Elkin and Boyer concerns perceived differences in community expectations for male versus female practitioners. Five of the eight women and nine of the twenty-two men felt there were differences, though there was no consensus as to the nature of these differences. Responses on which there was agreement by at least two participants included: the male therapist was expected to be in charge in team efforts, female therapists were automatically and negatively labelled 'feminist', it was more difficult for the female to establish credibility, and men received promotions more quickly. The eight female workers also identified a number of strategies they found necessary for rural survival: being competent and hard-working, not giving in to difficult situations, acting and looking 'professional', keeping a low profile while still being assertive, and seeking support from female peers (Elkin & Boyer, 1987).

Thompson and Barr (1984) utilized their own experiences as well as data from another Alberta study (Didow, 1980) to determine the major recruitment and retention issues relative to rural Alberta. Didow had collected data that revealed a vacancy rate of 24% for rural mental health positions in Alberta, compared to 10% for urban jobs. Thompson and Barr cited the

chronically high vacancy rate as creating a temptation for administrators to relax their hiring standards. In response to such a temptation, they suggested several principles must be considered:

1. staffing continuity is important in rural areas
2. rural staff should be better qualified than urban workers
3. rural staff require more back-up and staff development than urban workers
4. there should be no diminution of clinical standards because of rural location

(Thompson & Barr, 1984, p.157)

Thompson and Barr went on to identify nine areas of concern which they observed as having a negative impact on retention in rural Alberta:

1. a lengthy and sometimes haphazard recruiting process
2. lower salaries
3. urban bias of practitioners
4. professional isolation (reported as the greatest disadvantage by 50% of Didow's respondents)
5. personal isolation
6. barriers to recruitment advertising
7. inadequate staff development opportunities (reported as greatest concern by 30% of Didow's respondents)
8. burnout
9. lack of career development, promotional opportunities

Together with other rural mental health experts from across western Canada, Thompson and Barr developed a list of recommendations, rank-ordered by importance, for administrators and funders to consider when attempting to alleviate retention problems. The recommendations

include arranging on-site interviews, encouraging a true interdisciplinary team approach to practice (e.g., sharing skills, support), reducing the vacancy time after resignation (by maintaining a list of eligible candidates, regionalizing recruitment, beginning recruitment sooner), offering higher salaries, designating two days per month exclusively for staff development, instituting flex-time and time off in lieu of overtime pay, and including the candidate's spouse in the recruitment process.

Despite the very real recruitment and retention problems widely experienced in rural areas, it is important to consider that Didow (1980) also discovered that over 50% of the rural workers surveyed indicated they were 'very satisfied' in their jobs. This apparent contradiction to reports of high burnout, turnover, and vacancy levels is a further indication of the great deal of variability in workers' perceptions and assessments of life and employment in rural areas, as discussed in my introduction to this review. It is my intention, through this present research, to give a voice to those employed in rural mental health throughout Northern Ontario and discover both the uniqueness and commonality of their rich experiences. It is my hope that increased understanding will go hand-in-hand with developing the know-how to retain the valuable people presently working in the North.

The Challenge of Northern Ontario

The context of this present study, Northern Ontario, constitutes over 80% of Ontario's land mass, yet holds less than 10% of its population. Five urban centres within the North house 75% of the region's total population, while 60% of its approximately 50 resource-dependent communities have less than 2500 residents (from Advisory Committee on Resource Dependent Communities in Northern Ontario, 1986). Thus, not all of the communities housing children's mental health centres in the North could be considered rural by population standards, but all are isolated and remote relative to their distance from major Southern Ontario or Manitoba cities.

The North is an ethnically and culturally diverse region with a large French-speaking population living near the Quebec border and a sizable Native population living both on and off reserves. Yet, "the dominant culture's (white, English-speaking) attitudes toward the North and its peoples" (Bennett, 1985, p. 57) pose problems for the human service delivery system in the North:

> Personnel are seldom invited to view the North as a homeland or native culture as having something to teach or give them. Instead, policies are introduced which create a psychology about the North as an isolated, harsh, cold, foreign environment needing to be conquered. (Bennett, 1985, p.57)

Thus, the North's desirability as a work locale is not necessarily enhanced by the very incentive programs designed to attract professionals to the region.

The vulnerability of the economy of the North, given that it is so tied to natural resources and heavily dependent on large corporations depleting and processing these resources, leaves its residents feeling they are flirting with disaster. Yet, in a study conducted by Neufeldt, Doherty, and Finkelstein (1983) of "boom" and "bust" communities in Northern Ontario, there was evidence of adaptive coping strategies, such as the mobilization of support networks, that were developed by the residents and community agencies to deal with the potentially stressful conditions.

Until very recently the provincial government has paid little heed to the peoples in the North, choosing instead to focus attention on the only resources the North was seen as having, that is, forests, minerals and game. This short-sightedness may be slowly changing, however, as evidenced by the establishment of the provincial Advisory Committee on Resource Dependent Communities in Northern Ontario in 1985, and of various human resource-focused programs such as the Ministry of Health's Northern Outreach Program in 1981 and the recent

Northern Initiatives program of the Ministry of Community and Social Services. The final report of the Advisory Committee on Resource Dependent Communities in Northern Ontario (1986) concluded that

> ...a band-aid approach will not significantly improve the plight of the residents of the North but rather a special commitment, both politically and by the residents of Ontario, is necessary, if the North is to share in a meaningful way in the quality of life present in this Province. (p. 70)

Emphasis within community psychology research is "placed on the identification and development of existing resources and strengths and the more effective distribution of human and material resources towards improving the ... well-being of individuals and communities" (Bennett, 1985, p. 58). This research will hopefully become part of a much larger commitment that will prove to be of benefit to those providing and receiving social services in this challenging yet invaluable region of our Province.

Research Questions

My aim in conducting this research has been to determine, from a variety of perspectives, what issues come into play in a rural or remote mental health worker's decision either to remain employed with a Northern Ontario children's mental health centre or to leave such employment. Specific questions to be answered through this study include:

1. Are retention and turnover a cause of concern to employers, employees, and/ or funders of children's mental health programs in Northern Ontario? Why?

2. What are the factors that influence an individual to initially agree to employment in a Northern Ontario children's mental health centre?

3. What are the factors that influence a children's mental health employee's positive assessment of living and working in Northern Ontario?

4. What are the factors that influence a children's mental health employee's negative assessment of living and working in Northern Ontario?

5. What are the factors that influence an individual to consider terminating employment with a Northern Ontario children's mental health centre?

6. What impact do gender differences have on employee retention within Northern Ontario children's mental health centres?

7. What changes need to take place to reduce the level of dysfunctional turnover and increase employee retention within Northern Ontario children's mental health centres?

Method

I have approached this study from several directions using a variety of information sources. For example, I have reviewed provincial government strategies relating to the retention of professionals located in Northern Ontario. As well, I have contacted university training programs across Canada to determine the extent of their training programs in rural mental health.

However, my primary approach to information gathering has consisted of on-site face-to-face interviews with front-line staff employed by children's mental health centres in Northern Ontario, their employers (agency administrators), and front-line supervisors. I have also used telephone interviews when a scheduled personal interview became impossible to conduct because of travel conflicts. In addition, I have mailed a questionnaire containing the same questions asked in the personal interviews to those clinicians and administrators who wished to participate but for whom I was unable to schedule interviews.

By using multiple approaches, I have hoped to not only extend the scope of my search for a better understanding of all the facets of retention, but also to communicate the message that this type of research is of value because of its context (Northern Ontario), its approach (participatory), and its outcome (development of a knowledge base regarding employee retention and enhanced quality of service).

The following brief discussion addresses the use of interviewing as a method for social science research, given the wide array of styles and approaches to interviewing, and the contrasting underlying assumptions of each. This will help to explain and clarify the methodological assumptions upon which I have based this research.

Interviewing as a Social Research Method

To discuss interviewing as a social research method is not to discuss a uni-dimensional type of methodology. Interviewing as a method spans all research paradigms, theoretical orientations, and fields of social science. It takes many forms within a wide variety of social contexts. The interview has been called a "mainstay of research within modern industrial societies" (Briggs, 1986, p. 1) and has been the subject of a great deal of methodological research itself. Doubts have been cast through the years as to the interview's viability in research due to concerns about bias and unreliability (Brenner, Brown, & Canter, 1985). Yet in recent years the interview has seen a resurgence in popularity, largely based on a growing appreciation of "individuals as heroes of their own drama, as valuable sources of particular information" (Brenner et al., p. 3).

Despite its variety of forms, the interview always implies human interaction and discourse between two or more people, at least one of whom is trying to learn something from the other. Agreement seems to end there, however, as to the relative value of what is asked, how it is asked, what is said, how it is said, where it is said, who asks and who answers, and what it all means. The interview situation itself, including the researcher's role, is seen by some (e.g., Briggs, 1986; Patton, 1980) as of equal importance to the actual content (verbal and non-verbal, spoken and un-spoken) of the interview.

The role of the researcher is of critical importance in the discussion of one of the main concerns in the use of interviewing as a research method, that is, interviewer-induced bias. The concern, as described by Briggs (1986), is that "the influence of one or more of a range of independent variables, such as age, gender, race, political views, personality, or interactional style of the researcher and/or interviewee, can bias responses to questions" (p. 21). Although Briggs agrees that "the researcher should attempt to ensure ... that none of these factors has any special effect on the data" (p. 21), he expresses concern that if a researcher believes that no source of bias is present or that it has been accounted for, "the researcher can treat these data

as if they were a direct reflection of the interviewee's thoughts" (p. 21). The importance of the context and the process of the interview may then be mistakenly forgotten.

The role of the researcher is critical with respect to another consideration in the use of interviewing as a social research method. According to Mishler (1986), "in the mainstream tradition the interviewee-interviewer relationship is marked by a striking asymmetry of power; this is the central structuring feature of interviews as research contexts" (p. 117). In support of a departure from social science research tradition, Mishler suggests that it is important for researchers to move away somewhat from concerns about problems such as reliability and validity and think more about "respondents' efforts to construct coherent and reasonable worlds of meaning and to make sense of their experiences" (p. 118). With the problem of power in the research relationship out in the open, the researcher must think carefully about how various types of interviews and the interview context might encourage or impede respondents' attempts to better understand their world. As a 'participatory researcher', her/his role is also to discover ways to empower her/his research participants in order to provide them more control of the research process, "to encourage them to find and speak in their own 'voices'" (Mishler, 1986, p. 118), and finally to promote the application of their new-found understanding to action in their own interests.

Mishler (1986) identified three alternative roles for interviewers and interviewees which allow a redistribution of power in the research interview, as informants and reporters, as research collaborators, and as learners/actors and advocates. As informants and as reporters of the informants' world, the players can decide such issues as confidentiality in order to allow respondents the control over the circumstances under which their personal views will become known. An even larger step toward reducing the power differential in an interview is to consider interviewees as collaborators. As such, the respondents become "full participants in the development of the study and in the analysis and interpretation of the data" (Mishler, 1986, p. 126). The final tandem of roles, as learners/actors and advocates, is the furthest departure from

the traditional power distribution. Use of research information to improve the living and/or working conditions of participants and the declaration of 'conscious partiality' in the research as a strategy in a political struggle are examples of approaches that dramatically point to significant changes in research roles. As summarized by Mishler,

> "the central question is whether and how different research practices and forms of interviewing may function to hinder or to facilitate respondents' efforts to construct meaning from their experiences, develop a fuller and more adequate understanding of their own interests, and act more effectively to achieve their purposes" (p. 135).

By purporting to offer a voice to those people in society who have been typically silent, it would be reasonable to conclude that participatory research is sensitive to all forms of oppression and exploitation in society. Yet this is not borne out in the majority of the participatory research literature, particularly with respect to women's voices and concerns which typically remain invisible or hidden within participatory studies (Maguire, 1987).

Feminist Participatory Research

The several examples of studies featuring non-traditional interview relationships, as cited by Mishler (1986), stem from feminist researchers who are conscious of the effects of exploitation and oppression. However, the acknowledgement of women as participants and as feminist researchers in alternative paradigm research has typically been absent in reviews of participatory studies (Maguire, 1987). Maguire argued that "to date, women and gender have not had a central place in participatory research theory and practice. This marginalization is noteworthy given participatory research's stated commitment to help people uncover and understand the central contradictions in society" (p. 49). Maguire unhappily concluded that "participatory research appears to be colluding...with the predominant male bias of the social

sciences (and) is in danger of becoming yet one more male monopoly in the knowledge industry" (p. 50).

The introduction of a new research paradigm offers an opportunity for changes that would make research theory and practice reflect the diversities of ***both*** female and male realities (Millman & Kanter, 1975). The feminist paradigm challenges the existing androcentric paradigm as another dimension of the alternative research structure which is designed to redefine and redistribute power. Yet feminist research recognizes the centrality to date of male power as a factor in the construction of 'knowledge' and therefore seeks to emancipate women (and men) from the totality of male bias and to create a just world for all (Maguire, 1987).

While Maguire asserted that the methodology of feminist research is not as highly developed as its theoretical underpinnings, she offered a valuable framework for feminist participatory research, stemming from her review of the participatory research literature and from her fieldwork with battered women in New Mexico. At the heart of the feminist research methodology remains the individual interview but with alterations which "allow for dialogue, mutual exchange of information, and the development of a trusting and personal relationship" (p. 102), so as to eliminate the traditional power differentials in interviews. The framework developed by Maguire is based on nine principles, including the careful critiquing of social science research for both positivist and androcentric bias, placing gender in the centre of the research issues, and giving attention to how women and men benefit from the project. She stated that she hoped the framework would be used as a tool to "help create participatory research projects more likely to recognize and meet women's emancipatory needs" (p. 105).

The process of discovering the issues related to the retention of mental health workers in Northern Ontario may not initially appear to be gender-related. However, as a woman and a researcher who has lived for the past 13 years in Northern Ontario, I see gender as a very real factor, given the realities of a research context that has been deemed 'a man's world' and a group of participants who represent a traditionally female-dominated profession (e.g., social

work). It has been my intention, then, to endeavour to remain cognizant of the principles suggested by Maguire in order to produce a piece of research which is of equal value to the women and men of Northern Ontario.

Research Setting

The context of the research itself is valuable information for the reader in trying to make sense of the many realities presented by the research participants. In this research, both the socio-geographic context (Northern Ontario) and the work context (human service agencies) are important aspects of the setting that must be taken into consideration when coming to some understanding of the interview results. I will discuss both contexts and will elaborate on the nature of human service organizations as both work settings and as settings for evaluation and research.

Socio-Geographic Setting

For the purposes of this research, I have defined the geographic region of Northern Ontario as that portion of the Province of Ontario that is incorporated into the North Region of the Ontario Ministry of Community and Social Services (M.C.S.S.). It is bounded by the District of Kenora on the west, the District of Nippissing on the east, the District of Parry Sound on the south, and by James Bay on the north. I have earlier characterized the North as a region of cultural and linguistic diversity housing five medium-sized urban centres, numerous small, single-industry communities, and a vast expanse of sparsely populated territory.

The Human Service Organization as a Work and Research Setting

The effectiveness and efficiency of human service organizations, such as children's mental health agencies, have increasingly become matters of concern as the escalating costs of service delivery and a diminished resource base become the reality for government funders and

agency administrators. The quality of service within what Cherniss (1980a) calls "people-changing organizations" must be of concern and come under close scrutiny as these programs come to play an increasingly important role in the lives of many families. As well, the impact of the work environment on employee turnover and retention has already been discussed.

Assessing the effectiveness of human service organizations must therefore become an accepted and ongoing process. I will briefly discuss two approaches that are designed specifically for the human service agency before describing the specific organizational context of my research.

Edwards, Faerman, and McGrath (1986) contended that human service administrators would do well to assess the performance of their organizations using the Competing Values Approach as part of a larger assessment strategy. This multidimensional approach helps assessors determine where an agency stands with respect to various criteria of effectiveness. These many criteria stem from four models of effectiveness: a goal-attainment model, and models which equate effectiveness with an organization's ability to adapt to environmental demands, with the morale and cohesiveness of the organization's employees, and with the health of the internal functions and processes of the organization. The proponents of this approach see it as a useful way to "articulate the explicit performance or effectiveness values held by internal organizational members and those of various other relevant constituencies" (Edwards et al., 1986, p. 12), such as clients, collateral agencies, and the general public.

A second approach to assessing organizational effectiveness was proposed by Cherniss (1980a). He argued that the design of a human service organization affects service delivery, program outcomes, and hence effectiveness, because the organizational design has such a strong impact on the motivation and satisfaction of its staff. Thus, he saw the main cause of ineffectiveness in human service programs as being the "lack of a coherent framework for diagnosing and treating organizational ills in these settings" (p. 126). His model is based on three assumptions: 1) the helpers themselves greatly influence the quality of service provided;

2) the helper's effectiveness is most strongly influenced by her/his motivation and zeal; and 3) the helpers are also employees and their motivation will be affected by the same factors that influence job performance in other work settings. The model goes on to describe how the three main aspects of the organization's design (roles, power, and normative structures) influence the helpers and thus the delivery of service. Ultimately, Cherniss intended the model to serve as a guide for those who want to assess and bring about change in their programs, particularly in the areas of increased staff satisfaction and program effectiveness.

The thirteen children's mental health centres within Northern Ontario receive 100% of their operating funds from the Ontario Ministry of Community and Social Services (MCSS). Yet each agency functions as an independent organization with a private, community-based board of directors. Staff in each centre are therefore not considered provincial employees or civil servants but are employees of the centre, responsible ultimately to their board of directors. Each centre develops its own personnel practices, including recruiting strategies, salaries, professional development planning, and termination policies. Centres submit annual budgets to MCSS and are limited operationally to the amount of funding the Ministry approves. Programs are designed with the aid of MCSS program supervisors. The mandates of most northern children's mental health services include the provision of counselling and assessment services to children up to age 18 and their families. To my knowledge, there are no formal, MCSS-mandated organizational assessment procedures that each agency must routinely undergo to determine program effectiveness. Thus, to this point, their use as sites for evaluative and community research has been very limited.

Research Relationship

I have worked in the field of children's mental health in Northern Ontario since 1977, coming to Northern Ontario from the United States via the University of Toronto. I have been

employed with Algoma Child and Youth Services (A.C.Y.S.) since 1980, spending five years in a satellite clinic in Wawa and the last four years in the head office in Sault Ste. Marie. Since September 1988 I have been on a two-year educational leave of absence and have received partial funding for my education both from MCSS through their Northern Bursary Program and directly from the agency.

I initially presented my idea for this research to two staff of the North Region office of MCSS in February, 1989. They told me at that time that the Ministry was soon to be embarking on a major research effort to address multi-disciplinary recruitment and retention concerns in the North, as part of the new Northern Initiatives program MCSS was sponsoring with the Ministry of Health and the Ministry of Education. The Ministry staff indicated that they might be interested in a small, exclusively mental health-focused study to complement the massive and necessarily cursory study already planned. They encouraged me to submit an outline of my project to them when I was ready to begin. They subsequently agreed to support the research in principle and to finance my travel, phone and mailing expenses over the period of data collection and feedback.

I next discussed my research interests with the Executive Director of A.C.Y.S. in the spring of 1989. He also expressed interest in the project and, upon receipt of an outline, agreed to contact, as a matter of protocol, the directors of the five northern children's mental health centres designated by MCSS to hire Northern Initiatives staff. These five agencies were initially suggested by MCSS because their involvement with Northern Initiatives afforded me the opportunity to interview a group of newly-recruited employees. However, in subsequent discussions I indicated that I did not wish to be restricted to this sample of children's mental health centres and would therefore contact each of the remaining eight directors myself.

In early August, 1989 the A.C.Y.S. Executive Director contacted the five directors, first by telephone and followed up with a letter introducing me as an employee of A.C.Y.S. and giving a brief description of the project. After receiving their indication of interest in

participating, he contacted me by mail and indicated I could proceed to contact each director personally to confirm his or her participation and to negotiate the next steps to be taken.

I then attempted to contact all thirteen directors by telephone, to introduce the research to those directors who had yet to be contacted and to confirm that each was interested in participating (I was unable to reach three of the directors by telephone). In the course of the conversation, I invited comments and ideas about the issues each believed were pertinent to this research, from an administrative perspective, and explained that staff's participation could include input into the research design as well as involvement in an interview or mail survey. I also informally ascertained the degree to which each director saw retention as a concern for her/his agency.

Finally, I explained that I would be unable to interview each employee face-to-face because of time and financial constraints, but that I hoped to conduct telephone interviews and/or a mail survey with those workers I could not meet with personally. I indicated that I wished to interview a range of employees who had recently joined the organization, had been on staff for several years, and had left the employ of the agency within the last year. I also indicated that I wished to formally interview each director and a small number of supervisory staff in order to gain administrative and management perspectives on the problem of retention.

I followed up my telephone calls with a letter of introduction to each director (see Appendix B), including those directors I had been unable to reach by telephone, and enclosed a copy of the project outline I had prepared for MCSS. I invited each director to contact me with any questions or concerns pertaining to the research. Ten of the 13 directors subsequently agreed to both personal and agency participation and one other gave his permission for me to contact his staff although he himself could not participate. Most complied with my request that they acknowledge in writing their consent to their agency's participation. I then offered each director two options in the process of soliciting workers' participation, recognizing there could be variations as to the amount of control each would want to exercise in the process. One

option was for the director to personally inform her/his employees about the research, to distribute information packages (including consent forms) I sent to the agency, to identify those who were interested in participating, and to either pass those names to me or ensure that consent forms were mailed to me. The second option was for the director to provide me with a full staff list and grant me permission to contact each employee to discuss the research and request her/his participation. By the time I had telephoned, several directors had already spoken to some of their employees about the project and agreed to speak to the remaining individuals prior to providing me with their names.

My relationship with the clinicians and other administrators (not directors) began with either my receiving their names from the director as being interested, my receiving their signed consent forms, or my receiving their names as a total staff group to whom I could then mail further information (see Procedure). Four additional administrative personnel consented to participate, as did a total of 57 clinicians.

I believe that several factors have contributed positively to the development of a mutually beneficial and respectful research relationship. The initial contact made with five children's mental health centres' directors by a peer hopefully served to stress the potential value of this research for their organizations and to 'pave the way' for each director to agree in principle to participate. My invitation to both the directors and the front-line workers to participate in the identification of the issues to be studied and the process to be followed indicated the value I placed on the input of the participants and my perception of them as collaborators in the research. Finally, I believe that my residence and employment in Northern Ontario over the last twelve years afforded me credibility as a researcher who has the interests of the mental health service providers and recipients at heart.

Research Participants

The participants in this study primarily included front-line children's mental health workers and supervisors, and agency directors and upper level administrators. From the sampling frame of agency employees that was determined by each director in the ways I just discussed, I decided upon a purposive sample of workers I would personally interview. Unfortunately, the sampling frame included only one individual who had left the employment of her/his agency. Thus, I was unable to include more than one participant who could be interviewed from the position of having terminated employment. Because I had very little demographic information to work with, for the most part I based my choices for the sample on gender, on the worker's present job description, on the location and size of the community in which s/he worked, and on the worker's availability for an interview. In weighing each of these factors I attempted to gain as much diversity in the sample as possible. Those participants who consented to participate but who were not included in the interview sample were subsequently contacted and asked to participate in the mail survey.

Measures

The interview schedules for both the front-line staff and the administrative/management staff (see Appendix A) consisted of open-ended questions designed to ascertain participants' views of rural mental health work and rural life in general, as well as from their specific vantage points as female or male workers. I formulated these questions with input from four northern children's mental health workers with whom I was acquainted. I contacted them by telephone, explained the nature of the research, and asked them to consider the subject areas they believed were important to cover. They provided me with their ideas during a follow-up telephone call one to two weeks later.

My use of open-ended questions was designed to provide each participant with maximum opportunity to provide insight into her or his unique situation and myself as

researcher with the best occasion to explore and understand that situation (Smith Fowler, 1988). Therefore, in addition to the standard questions, I identified a number of 'probes', based on my review of the literature and input from four participants, that I utilized to ensure that participants addressed the complete picture of life and work in rural and remote communities in Northern Ontario.

In the tradition of naturalistic inquiry (Lincoln & Guba, 1985), my organization of the questions and the sequence in which I asked them were somewhat flexible. The content of the questions also sometimes varied. The semi-structured interview provided the participant with the opportunity to provide both some of the question content as well as the answers. Thus the interview schedule evolved to some extent through the course of the study.

Procedure

After my initial contact with each of the prospective participants, either via telephone or an introductory letter, I provided detailed information about the study by mail, including an outline of the research proposal, prior to requesting the individual's participation. I did this in order to ensure that each person was fully informed of all aspects of the study before consenting to participate. This was in keeping with my objective of having each participant considered a true collaborator to the extent they wished to be. I then requested that those individuals who agreed to participate return to me a signed consent form (see Appendix C).

From the list of consenting participants, I determined a reasonably sized purposive sample of interviewees (see Research Participants section), given my time and financial constraints. The size of the interview sample reflected my intention to cover the entire expanse of Northern Ontario within approximately a two-month period. I also contacted by mail those individuals not included in the purposive sample for face-to-face or telephone interviews and requested their participation in a mail survey. In using this multi-method approach it was my

desire to allow each individual interested in participating the opportunity to contribute to the study and to receive feedback at its conclusion.

Anticipating that each interview would be unique, I wanted to ensure that the participant felt comfortable and relaxed in the situation and free to relate her/his own story. Knowing that my own level of comfort with the process was critical in creating a relaxed environment for the interview, I rehearsed the complete interview, with the help of a friend and a colleague, on two occasions. Also, the date, time and location for each face-to-face interview was negotiated with the participant with her/his comfort and convenience in mind and within the parameters of my scheduled visit to his/her community. As well, in my communications to each participant prior to the actual interview, I offered to send her/him a copy of the interview schedule I would be using so s/he could have full knowledge of the question content. Approximately half of the participants requested the questions in advance. All interviews took place between October and December 1989.

Prior to the interview, I requested that I be allowed to tape-record the interview, stressing that I would treat the interview information with complete confidentiality. Only one participant indicated her/his wish not to be recorded and so I took detailed notes during that interview. Mechanical failure of the recorder prohibited my taping one other interview, necessitating that I take notes. After each interview, I requested permission to re-contact the participant should I need to clarify any of the information s/he provided.

The telephone interviews also took place at pre-arranged times, convenient to the participants, and featured the same open-ended questionnaire used in the personal interviews. The telephone interviews also took place between October and December 1989. The mail survey questionnaires were identical in content to the other questionnaires and were distributed shortly after the face-to-face interviews were completed, primarily during December 1989. I asked that they be returned, via stamped, self-addressed envelope, by the end of January, 1990,

giving the participants ample time after the Christmas holidays to complete and return the surveys.

Once I completed the data analysis and writing, my next step was to contact several participants who had expressed interest in reviewing a draft of the results, confirm they were still willing to do this, and forward the first draft to them with a request for feedback. Upon receiving both their feedback and the feedback of my committee, I prepared both the final draft and the research summary which I mailed to each participant except the individual who requested and received feedback via the telephone.

Data Analysis

I analyzed the data from this study using several approaches, including standard content analysis. From the time I began collecting the data I attempted to discern the patterns, themes, and categories of analysis that came directly from the data (see Lincoln & Guba, 1985). This process was helped by writing "memos" to myself after an interview or upon re-hearing a recorded interview when an issue seemed particularly relevant or a theme or pattern seemed to be developing. To develop the categories, I used both indigenous typologies and those I constructed myself from the data. I used standard content analysis to assist with the assignment of data to categories and to aid with the quantification of the data. I also used the method of constant comparison to work back and forth between the data and the categories in order to verify the accuracy of the categories and the placement of data into the categories.

Upon completing all the face-to-face and telephone interviews, and sending out the survey questionnaires, I transcribed the interview protocols via computer. I decided that I would concentrate my analysis on the interview data at this stage and hold back analysis of the mail survey data so I could in turn use it to verify the usefulness of the categories and their defining characteristics. Once all the interviews were transcribed, I went back through each one individually, categorized all the data in each interview to correspond to the main research

questions, and appended the data into a separate data file for each research question, noting the participant's initials, gender, and site.

I then condensed the rough data files for each research question into key phrases, wherever possible maintaining the words of the participants themselves. These key phrases, each retaining the identification of its source and the site, were again appended into summary data files, one corresponding to each research question. The data in each summary file were then placed into categories. The limited analysis I began early-on helped me to organize this condensed version of the data on the basis of categories or labels used by the participants themselves, as well as those categories I also developed. Of necessity, I had to define the attributes or characteristics that distinguished one category from another. Thus, I brought together the individual information units that seemed to relate to the same content. I reviewed the provisional categories to determine if they were useful to me, and if they were internally homogeneous and externally heterogeneous. I did this by comparing each new incident (placed in a tentative category) with previous incidents (placed in the same and in different categories). The analysis became an ongoing process of working back and forth between the data and the categories, with the goal being to make each category explicit. I found several times that I needed to redefine a category or create a subcategory.

As the categories became more well-defined and saturated, I began to look for relationships between the categories and reviewed the entire set to see if I had overlooked anything. I then quantified the data by again examining each summary statement, assigning it to a category, and then counting how many respondents provided responses fitting into each category. I had determined from my literature review and from my preliminary analysis that I wanted to compare the data across four dimensions: gender, size of community, place of origin, and gender of administrator. My next step, therefore, was to assign each response in each category of each research question to the comparison groups - female or male, large community or small community, from outside the North or from the North, and from a female-

administered agency or from a male-administered agency. Once assigned, I counted how many participants within each group responded to each category.

I then designed a matrix for each research question, translated the raw number of participants responding to each category across the eight groups into percentages, and plotted the percentages. The matrices gave me useful, visual representations of the data and allowed me to see patterns of responses, contrasts and similarities, across the groups and across all research questions.

In addition to looking for patterns across groups, I also extracted several themes from the data that seemed to overlie responses to all research questions and helped to link or explain the data (Lord & Hearn, 1987). My formulation of these themes was an inductive process that began during data collection as I became aware of some common perceptions that seemed to repeatedly cross all groups and all questions.

Drawing and Verifying Conclusions

In drawing meanings from this qualitative data, I did not want to focus on linear assumptions of causality. Instead I strove for a holistic perspective that would describe the interdependence and relatedness of the phenomena I was studying, for example, quality of life, job satisfaction, gender, and human service organizations in a Northern Ontario context.

Validation and verification speak to the problem of deciding how much to trust my data, both by myself and by others wanting to verify and validate the findings of my analysis for themselves. In order to establish the trustworthiness (the equivalent to "rigor" in the conventional paradigm) of my data, I employed the following techniques, as recommended by Lincoln and Guba (1985), during the implementation of my study:

1) I endeavoured to build trust and rapport with the participants as safeguards toward limiting the distortions that are possible during the collection of data;

2) I triangulated my interview data with the mail survey data, as a means of validating each piece of information against another source and a second method;

3) During data collection and analysis I arranged for and carried out weekly debriefings with my thesis advisor, with whom I could honestly relate, via telephone (when I was travelling) and in person. I kept records of these sessions; and

4) I shared a draft of the research results with several of the participants and requested and received feedback.

By taking these four steps, by remaining constantly aware of my values and biases, and by following very structured analysis procedures, I feel confident that the results that follow accurately represent the perceptions of the research participants.

Results

In this section, I describe the results of the analysis of the data collected from various sources. The primary source of data and therefore the foundation of my discussion are the face-to-face interviews with 41 clinicians and 14 administrators from 11 Northern Ontario children's mental health centres. However, I also integrate data from several additional sources: mail surveys returned by another 16 clinicians, results of a country-wide survey of Canadian university schools of social work, the actual turnover statistics from six of the children's mental health centres I visited, and various other miscellaneous sources of information that pertain to retention of clinical staff in the North.

The interview data cover 11 main questions and numerous sub-questions, and will be organized as follows:

1. Profile of the agencies sampled.
2. Profile of the clinicians interviewed.
3. Factors in the decision to work in the North.
4. Life satisfaction factors.
5. Life dissatisfaction factors.
6. Job satisfaction factors.
7. Job dissatisfaction factors.
8. Introduction to gender differences.
9. Gender differences within agencies.
10. Gender differences for professionals within communities.
11. Recruitment concerns.
12. Turnover concerns.
13. Retention concerns.
14. Changes needed to encourage retention.

- individual level.
- community level.
- agency level.
- government level.

15. Use of the research results.
16. Feedback to the research participants.
17. Impressions of the interview process and content.
18. Group patterns.
19. Common themes.

I begin with a profile of the agencies I visited and the participants I interviewed. Although three of the seven research questions differed between the clinicians and administrators, participants from both groups often provided information that pertained to questions not asked of them but asked of the other group. I analyzed this information no differently than if it had been directly asked the participant, and when numbers were too small to warrant analysis as a separate group, the responses were combined with the responses from the target group. In several cases, there was enough information provided by the group not asked the question to allow a comparison between both groups.

The data from the interviews with clinicians were compared across 4 dimensions: gender, size of the community the participant worked in, the participant's place of origin (whether from the North originally or from outside), and the gender of the participant's executive director. When I initially designed the research, I had not anticipated analyzing the data for nor discovering any effects of employer gender difference. It is not my expectation that this research will shed a great deal of light on the very complex issue of gender differences in management, given that its focus is on a wide range of turnover and retention factors. There is a vast array of variables associated with leadership effectiveness, of which gender may be

only one. However, after listening to the views of workers in female-administered agencies compared to those administered by males, I decided a more in-depth comparison of responses from the two groups was justified. Differences appeared to emerge, especially in the dimensions of job satisfaction and dissatisfaction, as I initially analyzed the responses. Likewise, it was also my sense as I reviewed my data that a comparison across various age groups did not seem particularly relevant with this group of participants. Age does, however, come into play and will be discussed in relation to the concern about hiring new graduates as opposed to experienced professionals. Unmarried employees were another concern of administrators, and though being single is not necessarily related to one's age, age does seem to be a factor in administrators' concerns about employees' marital status.

I have quantified the interview data to some extent by breaking down the main questions into codes that emerged from the data, and by counting the responses of all participants for each particular code. The results appear as percentages of the total group or sub-group of participants. Next, I draw the reader's attention to some interesting differences (or similarities) between the comparison groups. Finally, I use quotes from the participants themselves to highlight directly the personal emphasis given to particular issues or concerns. It is by using the actual words of the participants themselves that their voices become most powerful.

Introductory Information

Profile of Agencies Sampled

Although I interviewed participants from 11 different agencies, I was unable to speak to the director of one of those agencies. Thus the profile of agencies represents only 10 of 11 children's mental health centres I visited.

The first agency opened for service in 1975 but the majority opened as children's mental health centres between 1979 and 1981. This represents the period of time during which

the Ministry of Community and Social Services first made funds available on a large scale for the development of children's mental health services across Northern Ontario. The latest incorporation of a children's mental health service in a community with no such previous service occurred in 1986. The newest agency was established in 1988, the result of an amalgamation of two independent agencies serving children in the same community.

The service delivery boundary of each agency tends to cover a geographic district of Northern Ontario, or a portion thereof, as in the case of the exceptionally large Districts of Kenora and Cochrane which are served by two agencies each. The two exceptions are the Thunder Bay centre which primarily serves just the municipality, and the two Sudbury children's mental health centres (English and French) which service the Regional Municipality of Sudbury. Under the same overall administration of the Sudbury Algoma Hospital, the Community Clinics Department covers the District of Sudbury-Manitoulin.

It is also important to note that different programs housed within the centres serve different catchment areas, some overlapping into the general service boundaries of other agencies. In this way, some of the larger centres act as additional resources to the smaller agencies. The most obvious example of this is the Sudbury Algoma Hospital which is mandated to provide child psychiatric treatment to the entire region of Northern Ontario.

To cover a typically vast geographic area, the majority of agencies use a multi-office service delivery model. Permanent staff are housed in some sites and itinerant staff are accommodated in others. The number of sites ranges from two in one agency to seven in another, with five agencies having three sites, one having five sites and one having six. Only two agencies have all their services based within a single community. The service delivery model has very important implications for the professional staff and the administration of an agency, especially in the areas of providing resources, supervising, travelling, and communicating across sites. Whichever model is chosen, an administrator is still faced with dilemmas of how best to serve children and families spread across a wide territory. The rights

of clients to accessible and relatively immediate service must be weighed with the needs of professionals for sufficient resources, supervision and collegial support, and with the need for agencies to operate within their given budgets.

The size of the professional staff groups in each agency ranges from 10-20 in the agencies housed in six smaller northern communities and from 25-90 in the agencies that are located in the five largest communities. In several of the smaller agencies, administrators participate directly in clinical services as well, often as clinical supervisors, and therefore are counted as part of the professional staff group.

Profile of the Clinicians Interviewed

Table 7 provides an overview of the clinicians involved in the face-to-face interviews. Nine categories of information are broken down across the eight comparison groups. Percentages shown represent the percentage within each group that corresponds to each category or sub-category. In this way, groups that vary in sample size can be compared (e.g., 27 women versus 14 men).

It is important to recognize that this group of participants was self-selected. Directors invited or allowed me to invite all their clinicians to participate and those who chose to participate signed consent forms. Therefore, the profile presented in Table 7 is not necessarily representative of Northern Ontario children's mental health professionals. According to the rough data from agency administrators, this group of 41 likely represents approximately 12% of the total population of northern children's mental health centre professionals. The group provides some interesting comparisons.

In comparisons based on gender, the women I interviewed were more likely to be younger, single and originally from the North than the men interviewed. The men were more likely to have moved north for their current job, to have had previous mental health experience,

Table 7

Profile of Clinicians Interviewed N = 41

	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=27	n=14	n=13	n=28	n=27	n=14	n=9	n=32
Age: (mean years)	35.4	34.7	31.7	37	36	33.7	37.7	34.5
Gender: (% of total)								
Female (66%)	- -	- -	57%	70%	71%	54%	55%	69%
Male (34%)	- -	- -	43%	30%	29%	46%	45%	31%
Marital Status:								
Single (40%)	46%	29%	46%	37%	50%	21%	44%	39%
Married/C.L. (60%)	54%	71%	54%	63%	50%	79%	56%	61%
Place of Origin:								
North (31%)	17%	14%	12%	19%	- -	- -	7%	24%
Other (69%)	83%	86%	88%	81%	- -	- -	93%	76%
Prior Residency:								
Yes (54%)	56%	50%	54%	54%	30%	100%	44%	56%
No (46%)	44%	50%	46%	46%	70%	- -	56%	44%
Training:								
Psychology (49%)								
M.A.	48%	36%	54%	39%	55%	21.5%	44.4%	44%
Ph.D.	0%	14%	8%	4%	4%	7%	0%	6%
Social Work (32%)								
B.S.W.	18.5%	7%	15%	14%	4%	36%	11.1%	16%
M.S.W.	15%	21.5%	23%	14%	15%	21.5%	33.3%	12%
Other (19%)	18.5%	21.5%	0%	29%	22%	14%	11.1%	22%
Previous M.H. Experience								
Yes (66%)	63%	71%	60%	69%	52%	93%	78%	63%
No (5%)	7%	0%	0%	8%	7%	0%	0%	6%
Internship only (29%)	30%	29%	40%	23%	41%	7%	22%	31%
# Yrs. in North (mean)	13.2	13.1	14.8	12.4	5.7	27.6	12.2	13.5
# Yrs. at Job (mean)	2.9	3.7	3.2	3.2	3.3	3.1	4.0	3.0

and to have worked at their present job longer. In comparisons based on the size of the community, the participants interviewed who were working in large communities were more likely to be younger, from outside Northern Ontario, and trained in psychology. Workers in small communities were more often older, female, married, trained in an area other than psychology or social work, and experienced in the mental health field, when compared to their large community counterparts. Respondents originally from the North were more likely to be younger, married, trained in social work and experienced in the mental health field. Employees coming from outside of the North were more typically female, had psychology training, came north for the job, and had less mental health experience.

The participants who completed the survey by mail present a profile similar to the interviewees in most areas. However, a higher proportion tended to be married rather than single, more were from the North originally, and their training was dominated by degrees in areas other than psychology or social work, as compared to the interviewees.

The most common job description of the professionals interviewed was that of family counsellor (n= 24). Individual counselling (n=18) and psychometry (n=10) were also common components of respondents' jobs. With few exceptions, the job descriptions were multi-dimensional, often involving five or six different areas of work. Administrative and management tasks were often coupled with direct service responsibilities as well.

Over 60% of the clinicians, almost all working in small communities, indicated that travel outside their home communities was a necessary requirement of their jobs.

Finally, although not directly asked, 11 of the participants volunteered that they moved to the North with a definite plan to stay only a limited number of years before returning to either Southern Ontario or the Montreal area. Several mentioned that since arriving in the North, their plans have changed. Two have decided to stay permanently but most have chosen to leave sooner than originally anticipated.

Research Results

It is important for the reader to keep several things in mind when reviewing the following results. First, because the questions used in this research were open-ended, the fact that a certain category of information was not mentioned by a participant could mean s/he felt it did not reflect her/his situation, or it could mean s/he simply forgot to mention it. Therefore, it is safe to say that, while the responses given may not represent all possible responses from all participants, they do represent those responses foremost on the clinicians' minds at the time of the interviews. Thus, they can be characterized as contextually significant but not necessarily generalizable over time or place. Second, the participants were not asked for hypothetical responses but were requested to respond in a way that reflected their own reality. My intent was to capture an accurate reflection of their present experience, not of how they perceived others around them to feel nor of their assumptions about what constitutes a concept such as job satisfaction. Third, because of the relatively small sample size, particularly within the comparison group of clinicians working for female directors, appropriate methodological caution should be exercised when drawing conclusions.

Factors in the Decision to Work in the North

The purpose of this question was to determine the basis on which the clinicians decided initially to move north to work, to return north after education or employment elsewhere, or to stay in the North permanently. Most focused on what attracted them to the North but a small percentage also mentioned factors that weighed against the decision to move. Table 8 provides an overview of the factors, pro and con, that were raised by the participants and includes the most noticeably varying percentages across comparison groups. In the table, the codes are presented in rank-order from the most commonly to the least commonly mentioned. Thus, it

Table 8

Attractors / Detractors to the North N = 41

Category (% of Total)	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=27	n=14	n=13	n=28	n=27	n=14	n=9	n=32
Attractors								
Job Description (61%)	69%	47%	50%	67%	69%	42%	78%	56%
Lifestyle (49%)	42%	60%	64%	41%	48%	50%	44%	50%
Community Qualities (49%)	50%	47%	57%	44%	41%	67%	33%	53%
Family/friends near (39%)	38%	40%	29%	44%	28%	67%	44%	38%
Beauty of Area (34%)	31%	40%	21%	41%	34%	33%	56%	28%
Adventure, Personal (34%)	31%	40%	36%	33%	48%	0%	22%	38%
Salaries/benefits (32%)	31%	33%	43%	26%	45%	0%	33%	31%
The Agency (27%)	31%	20%	43%	19%	38%	0%	33%	25%
Recruitment Process (24%)	23%	27%	29%	22%	31%	8%	33%	22%
Spouse Influence (24%)	19%	33%	14%	30%	21%	33%	22%	25%
Time-limited (12%)	12%	13%	14%	11%	17%	0%	0%	16%
Working Style of Agency (5%)								
Detractors								
Family/friends as Deterrents (17%)	15%	20%	36%	7%	21%	8%	0%	22%
Community Qualities (17%)	19%	13%	14%	19%	17%	17%	22%	16%

NOTE: Percentages are not provided for categories with less than 12% frequency.

can be seen that the **job description, the lifestyle, and the community's qualities** are mentioned by half or more of the respondents as the features that have attracted them to Northern Ontario.

The mail survey respondents identified the same codes, that is, **lifestyle, community qualities, job availability, and spouse's influence**, and ranked them as equally the most important factors that brought them north or convinced them to remain north.

As can be seen from the table, while women were more attracted to the North by the actual components of the job they were taking on, men were more attracted to the lifestyle offered by the North. A newly graduated psychometrist indicated why she considered the North:

> I was looking to find employment in an agency that was community-based to give me the opportunity to practice assessments and have contact with clients in other ways and also to get involved in the community. I didn't think I would get that opportunity working in Toronto. I was looking for a broader opportunity and this agency offered it. I think there's just more flexibility in the services in the North.

The strong attraction of a northern lifestyle is characterized by a male psychologist:

> There are no lakes or trees in the South; it's as simple as that. I like the outdoors and hate that cramped, hemmed-in feeling, the rush and the pollution. So my decision when I was still in Toronto was whether to live in the city five days a week and travel four hours to come north each weekend or just move up. I decided I'd rather have smaller bucks, less chance for credible advancement and be in the North so I could be near the lakes and the trees because that's where I function best.

The qualities of a northern community, while serving as a negative force in the decision of some respondents, also positively influenced close to half the participants to move north, particularly those clinicians originally from the North, those now working in large northern communities, and those employed by male administrators. Large northern communities seem to offer to some an appealing compromise in size to Southern Ontario cities. Said one clinician working in the third largest northern city, "The community seemed small enough to get away from big city hustle and bustle, the headaches of living in a congested place. It had a small town feeling and the people seemed pretty casual and relaxed." Another respondent described dramatically the immediate impact that a small northern community had on her decision:

> When I came up for the interview and crossed the bridge into town, I started to cry. I thought, 'this is the place I want to be' with its natural surroundings, its small size... to be out of the city, with no commuting, no noise or traffic.

Some respondents had very different first impressions of their prospective community:

> I didn't realize how far away the town was from everything... I didn't like the look of the town, with the mill, the old houses that looked so poor. It seemed like another planet, so initially I decided not to take it [the job]. But after the shock wore off, I decided I could stand it for one year.

A young woman from Quebec, who was anxious to find a job that could provide the clinical training she wanted to further her career, was nonetheless strongly discouraged from considering Northern Ontario by her family and friends: "They thought I was crazy. They associated the North with bears, cold and not much life." A sense of adventure and challenge, however, seemed to impel her and a number of other professionals from outside the region to

move to the North: "It was intriguing to me because it was like I was going to be a pioneer, but it was also ironic because the city was the largest place I've lived in in Canada." Another participant described the element of adventure in his decision:

> A friend from this area knew I was bored with my work in Toronto so he came to Toronto and talked me into moving north, though I'd never considered it before. We bought two 4-wheel drive trucks and drove north. We came ready for bears and lots of other challenges.

For Northerners themselves, the pull of personal ties and the familiarity and appeal of their home communities were the strongest factors in their decisions to return north after university:

> It wasn't automatic that I'd return north after university. There was a lot available in Southern Ontario that wasn't available here. But I was dating my husband then and he was from here... so was my family. Those were the calling cards. Plus the community is small enough to become involved in what's going on; I know what the whole community looks like, all the key players.

Salaries/benefits and job availability were of far more importance and attraction to job hunters from outside of the North, particularly those from Quebec. The agencies closest to the Quebec border tend to reap the benefits of a very tight job market in Quebec and low salaries compared to Ontario standards. As a clinician from Montreal with an M.A. in psychology explains:

> I had been looking for a job [in the Montreal area] ...but I couldn't find anything suitable. I was either over-qualified or under-qualified because I had no experience. The only reason I'm here is because the job market in Montreal is so tight - I didn't want to come to Ontario, didn't want something so isolated and small ... When I went to the interview, I liked the salary they were offering.. and the benefits seemed good, too. Now I know this agency pays really low [compared to other Ontario centres].

As is indicated by this last quote, sometimes the factors that initially attract a children's mental health professional to the North may actually turn out to be a source of dissatisfaction. However, as will be seen in the next section describing the factors that influence clinicians' satisfaction with their life in the North, there is more often some carry over from the features that initially attracted people to the North.

<u>Life Satisfaction Factors</u>

In response to my question, "What factors contribute to your satisfaction with your life in Northern Ontario?", 39 clinicians identified ten different categories of satisfaction. These categories are displayed in Table 9 in order of the frequency mentioned by participants. A definition of each of the categories is available to the reader in Appendix D.

Clearly, the categories **lifestyle** and **the human community** were the most frequently mentioned factors, across all groups, that contributed to clinicians' satisfaction with their lives in Northern Ontario. A satisfying **lifestyle** was characterized by the respondents in a variety of ways, including participation in leisure/recreational activities, solitary living close to nature, the slow pace of northern life, healthy living in a relatively unpolluted environment, and the

Table 9

Life Satisfaction Factors N = 39

Category (% of Total)	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=26	n=13	n=13	n=26	n=25	n=14	n=9	n=30
Lifestyle (77%)	73%	85%	92%	69%	80%	71%	56%	83%
Community as People (77%)	73%	85%	77%	77%	84%	65%	78%	77%
Community as Place (36%)	38%	31%	46%	31%	36%	36%	22%	40%
Beauty of Area (28%)	27%	31%	23%	31%	24%	36%	44%	23%
Opport's for Involvement (26%)	31%	8%	15%	27%	28%	14%	22%	23%
Access to People/Places (26%)	31%	38%	46%	27%	16%	64%	33%	33%
Easy Comm'ty Integration (15%)	15%	15%	15%	15%	24%	0%	22%	13%
Affordability (10%)	4%	23%	23%	4%	4%	21%	11%	10%
Climate (8%)	4%	15%	8%	8%	8%	7%	11%	7%

NOTE: "Opport's" has been used as a shortened form of "Opportunities".

"Comm'ty" has been used as a shortened form of "Community".

opportunity to develop new hobbies. Seventy-seven percent of the participants felt a northern lifestyle contributed to their life satisfaction. For clinicians working in the larger communities, those from the North and those from agencies with male administrators, lifestyle was the most frequently mentioned contributor to life satisfaction. A clinician from one of the larger northern cities offered a typical remark:

> My wife and I are very much into recreation, outdoors sorts of things and it's a great place for it. We do really like this city as a place for outdoor recreation. We do a lot of skiing...a lot of cycling, a lot of camping, a lot of canoeing. We can just take off for a weekend or even one day...we can go canoeing rapids all day and it's only a half hour away at the most... There's just a lot more flexibility that way and we enjoy it...So that's probably the biggest thing [I enjoy].

Another professional, who was born in a small northern community but who had lived in a city in the prairies for a number of years before returning, gave a convincing argument for the benefits of a northern lifestyle, especially after a stressful day of work:

> I live out in the bush...on a lake, and when I leave town and go out there, it's a complete change in atmosphere and lifestyle...It makes a big difference in just getting away from work. I'm not sure I would have stayed this long if I had to live in the town itself...Where we are we don't hear anything; there's a lot of room between you and your neighbour. After work you can go swimming...or head out in the boat...A lot of times I'll go get my mail by boat...just because it's nice to get out on the lake after work. That's the big difference for me ... the country living.

The category, **the human community**, was as frequently cited an aspect of northern life that participants found satisfying. The qualities of northern people, such as their caring, their honesty and their friendliness, the familiar and relaxed sense of the community, and the feeling of safety from knowing one's neighbours, doctors and teachers well, all contributed to the life satisfaction of over three quarters of the participants. One clinician told me,

> I really like to go outside in this community... to see faces I've seen before... to get a nod from people to acknowledge they know me. There's a special contact with people, a homey feeling...They stop and talk about the weather at great length...It's enjoyable, they're invested in the conversation, they make the time.

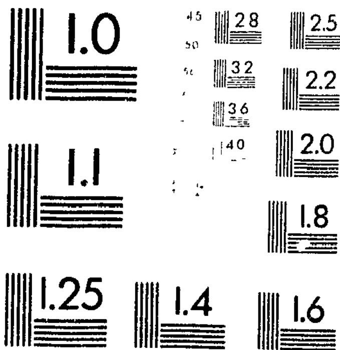
A woman from Eastern Canada, who with her husband had just happened upon a small Northern Ontario community while conducting research, was clear about her reasons for deciding to call it home:

> We came back because we had formed a lot of good friendships during the year we were here...that's what's keeping us here...a very strong group of friends...a real bond...lots of support... a really neat community.

Another respondent spoke of other qualities of Northerners she admired:

> I like the northern people, the toughness in them, their ability to survive on very little and their ability to be social. I know I will be accepted by them as long as I come without seeming rich or pushy or someone from the South...I have a lot of respect for these people.

2



Finally, a woman who moved to Northern Ontario from the States 16 years ago summarized her appreciation of both the northern lifestyle and the people in this way:

> I like...the rural living. I grew up on a farm in Michigan and don't like city living...I like the bush...the outdoor activities (and) the people in the North...Their slower pace of life...slows me down at times. I like (that) the people are more caring. It's more personalized...You know everyone, and as long as you don't mind living in a fishbowl, it's not too bad.

Differences across groups were noticeable in several expected areas. Northerners were more appreciative of the accessibility they had to family and friends, to their work site, and to larger urban centres than were those participants from outside the North. The ease of **community integration** was identified as a source of satisfaction to approximately one quarter of those participants from outside the North, whereas virtually no Northerners raised this factor in our discussion, possibly reflecting their already established social positions in their communities.

Compared to their female counterparts, more men were satisfied with the **affordability** of the North, as were more participants from large communities and more Northerners. For women on the other hand, the opportunities the North afforded them for related **professional/community involvement**, including private practice, were a more important source of satisfaction. One young woman from Quebec explained,

> Being in an isolated community where there are no other services or resources, there are many varied opportunities...I've been teaching courses for women here...I was on TV Ontario recently...I'm in community groups, doing research...have a small private practice...there are just so many things to choose from.

The mail survey respondents identified the same general categories of satisfaction, except in the category, **ease of community integration**, and also priorized them similarly. The northern **lifestyle** topped their list as the most commonly mentioned enjoyment factor. **The human community** ranked second behind lifestyle, and **affordability** and **accessibility** were close behind.

The strong consensus among the vast majority of participants as to the features of northern life they find satisfying, that is, the **lifestyle** and **the human community**, speaks to the importance of these factors in people's lives, regardless of their gender, their particular locale or their place of origin. As will be seen in the next section on life dissatisfaction, however, something as complex and multi-dimensional as a community defined by its people can also serve as a source of dissatisfaction to some of the same residents who derive satisfaction from some of its other qualities.

Life Dissatisfaction Factors

A total of 37 interviewees provided responses to my question concerning any feelings of dissatisfaction with their lives in Northern Ontario. Table 10, which summarizes and ranks the participants' responses, reveals that there was somewhat less consensus among the interviewees as to the causes of any dissatisfaction they might have experienced, compared to the life satisfaction factors they identified. Only one factor, **the physical community**, was mentioned by more than half of the participants.

Because the categories were generated from the participants' responses as opposed to being artificially imposed, several factors that were not mentioned in the context of the life satisfaction question emerged from the interviews (see Appendix D for the defining characteristics of each category). Concerns about one's **status as a single person** in a northern community and about a **lack of career opportunities** were new categories derived from the

Table 10

Life Dissatisfaction Factors N = 37

Category (% of Total)	Female n=26	Male n=11	Large n=11	Small n=26	Outside n=24	North n=13	F.Admin n=8	M.Admin n=29
Community as Place (68%)	62%	82%	82%	62%	67%	69%	75%	66%
Community as People (38%)	38%	36%	27%	42%	29%	54%	38%	38%
As a Single Person (30%)	31%	27%	27%	31%	42%	8%	38%	28%
Community Integration (27%)	31%	18%	18%	31%	42%	0%	25%	28%
'solation (22%)	9%	27%	23%	18%	25%	15%	0%	28%
Affordability (19%)	15%	27%	18%	19%	25%	8%	0%	24%
Lifestyle (13.5%)	15%	9%	18%	12%	17%	8%	13%	14%
Climate (13.5%)	15%	9%	9%	15%	13%	15%	13%	14%
Lack of Career Opp's (8%)	4%	18%	18%	4%	8%	8%	0%	10%
No Dissatisfaction (11%)	8%	18%	9%	12%	13%	8%	25%	7%

NOTE: "Opp's" has been used as a shortened form of "Opportunities".

interview data. **Isolation** as a life dissatisfaction category roughly corresponds to the **accessibility** category under life satisfaction, as its antithesis. The new categories, **status as a single person** and **lack of career opportunities**, surfaced in the mail survey responses as well. The mail survey respondents most frequently mentioned the **physical community** and **isolation** from urban centres, family/friends and professional peers as their primary sources of life dissatisfaction.

Participants' displeasure with the **physical community** largely stemmed from what their communities were unable to offer, e.g., culture and the arts, educational opportunities, library resources, specialized medical and social services, quality and affordable housing, good shopping, and convenient and affordable transportation out of the community to visit family, friends, and "civilization".

One respondent, having returned to the North after university to be closer to her family, described her ambivalence about leaving the South:

> There were a lot of things [in Southern Ontario] that aren't available here...the university and its library, community events, festivals...We have no access to the latest information...There I felt like I was on the edge of learning; it was growth-oriented. The North lacks cultural opportunities...It's predictable...boring.

A woman from Quebec who chose to come to Northern Ontario to purposely distance herself from relatives, nonetheless discovered she missed certain aspects of the city:

> There aren't a lot of cultural activities here...I'm really missing that. I don't go for the outdoors activities or going to bars, so there's not much else to do. Even if there was a cinema, that would be helpful...or a restaurant that serves something other than chips and gravy.

A young husband whose wife reluctantly agreed to let him seek adventure in the North, on a trial basis, was concerned about her growing disillusionment with the community:

> She's from Toronto and she likes cultural events, theatre, concerts...There's very little of that here. She can't find work as a librarian because there's only one library, so it hasn't been rewarding for her career either...She desperately needs orthodontic work...There's no specialist here...We haven't been able to afford to get it done because of the travel involved.

Finally, a recently arrived new graduate from Quebec aired some of her frustrations about the community:

> I'm still looking for things that are great. My apartment is very small and expensive...This may discourage me from staying long. And I am really unhappy with the transportation industries here...air flights in very small planes...lots of stops...very expensive. And now the trains are cut off...It's very frustrating...It takes so long to get anywhere.

The **human community**, a primary source of satisfaction to over three quarters of the people I interviewed, was also identified by over a third of the participants as a contributor to their dissatisfaction. Interestingly, it was the Northerners themselves, as well as the residents of the smaller communities who were more frequently dissatisfied with this aspect of their lives. A lack of privacy, a socially stifling atmosphere, and domination by conservative, male-oriented attitudes were the most commonly cited concerns about the **human communities** in the North. The following quotes typified these frustrations:

I was feeling a lot of stress...frustration at work...On weekends I would have liked to just go wild and be myself...to let loose, but I couldn't do that here...so I was stuck with it (the stress)...I was always running into clients...I just couldn't get away from the work environment";

The town is small...I feel like I have no privacy...It's a fishbowl effect. It's been hard for me moving from a big city...I'm always running into clients...There's lots of gossip...Everyone knows everything about you.

Another participant stated:

I don't like that [name of community] is a real red neck town, very blue collar...Attitudes are very traditional [and] there's not a lot of community awareness about...the oppression of people. [They have] traditional values: if you're poor it's your fault. On issues like sexual abuse, child abuse, people don't have much sensitivity towards those things at all.

As well, two clinicians who were indigenous to the North mentioned the unique problems they had to face when working as children's mental health professionals in their home communities. One explained:

There are lots of...problems in coming back to your own community because people expect me to...be the same farm boy from the country. Having to work so closely with friends and relatives in a small community...doesn't allow for socializing ...I end up having only a small, almost professional circle of friends because it's so risky with confidentiality. Because some of my friends...may

have had to get service from the clinic...they felt embarrassed...so they tend not to come around any more. And my kids have been picked on at school...It's typical of small rural communities.

Finally, the unique problems posed by being single while living in a northern community were articulated by 30% of the respondents, many of whom were originally from outside the region. They described their difficulties with trying to establish social networks, often because the communities were very couple-oriented, because they have no social anonymity and because of a lack of suitable partners, "slim pickings" as one male participant put it. A young woman who had broken up with her boyfriend shortly before moving to a small northern community said,

> It's very difficult being single here...It's so hard to meet people. There's a different mentality...attitude...People talk a lot in a small town so if they see you in a bar with a guy they start talking...there are no places to go to socialize.

Another women shared her feelings about her situation:

> This is a fairly conservative area, so being single and female has an extra...twist to it...My couple-friends don't know what to do with me when they're having a party...There just aren't a lot of eligible men who are appropriate partners. The men that come here are married...so it's not an easy place to live if you're interested in finding a partner.

Lastly, a woman who was born and raised in the same community where she is presently working, and was recently divorced, described the impact the situation was having on her:

> I'm really not satisfied with my social life...Being divorced I fit in like a whale in a bathtub here...That will be why I leave, not the job. But giving me the opportunity to move to a larger centre would be a way the agency could keep me.

A number of the comments highlighted in this section and in the previous section describing sources of life satisfaction also speak to the connection between an employee's personal life and their work life, and to how that connection may affect the retention of that employee. Descriptions of loving the lifestyle because it could so quickly remove one from the stresses of work, of liking one's job but needing to leave the community for personal reasons, of the impact of old friends having to use the services of the agency, or of the feeling of always running into clients in the community and so never really being able to leave the work environment, point to the constant meshing of the personal and the professional in rural and remote communities.

In the next two sections, I will present clinicians' perceptions of their work lives. That particular portion of each interview tended to dominate our time and evoke the greatest passion from the participants. It was clear that their identities as competent professionals, some just emerging, others already solidified, mattered a great deal in their lives and that they recognized the large responsibility they carried.

Job Satisfaction Factors

The responses from the 40 interviewees broke down into 22 categories describing sources of job satisfaction (see Appendix D for a detailed description of each category). These categories are displayed in Table 11 and again are ranked in order of frequency mentioned.

An interesting difference emerged based on the gender of the clinicians' executive director. Of the eight groups interviewed, seven of the groups most frequently mentioned job **flexibility and autonomy** as an important source of work satisfaction. The largest percentage of clinicians working for a female administrator, however, identified the feeling of being **supported and valued** by their agency, that is, by their director and managers, as their primary source of satisfaction. That same category is ranked only fifth overall and seventh by clinicians in male-administered agencies.

Second overall behind job **flexibility and autonomy** was the satisfaction derived from working with professional **colleagues**, due in part to their co-workers' competence, emotional support, eagerness to learn, and clinical orientation. Male clinicians identified this category more frequently than any other as a source of their job satisfaction. The quality and frequency of **professional development and internal training** opportunities were satisfying to over 40% of the respondents, although it was mentioned by only 30% of female clinicians as compared to 69% of the males.

The work itself and feeling **supported and valued** by the agency were also cited as sources of satisfaction by over a third of all the participants.

In contrast to their colleagues who were interviewed face-to-face, 75% of the mail-survey respondents indicated the **work itself** as a satisfying feature of their job, with job **flexibility and autonomy** a distant second at 31%. The categories of **community collaboration**, **level of supervision**, **opportunities for input**, **management/staff relations**, and **office accommodations** were not included in any of the mail survey responses.

Table 11

Job Satisfaction Factors N = 40

Category (% of Total)	Female n=27	Male n=13	Large n=13	Small n=27	Outside n=27	North n=13	F.Admin n=9	M.Admin n=31
Flexibility/Autonomy (57.5%)	56%	62%	62%	56%	59%	54%	67%	55%
Colleagues (47.5%)	37%	69%	46%	48%	48%	46%	67%	42%
Prof. Development/Training (42.5%)	30%	69%	54%	37%	48%	31%	67%	32%
The Work Itself (40%)	41%	38%	46%	37%	41%	38%	33%	42%
Feel Supported/Valued (37.5%)	33%	46%	15%	48%	41%	31%	78%	26%
Team Approach (30%)	30%	31%	23%	33%	30%	31%	44%	26%
Community Collaboration (27.5%)	26%	31%	54%	15%	22%	38%	11%	32%
Benefits (27.5%)	33%	15%	23%	30%	26%	31%	22%	29%
Level of Supervision (25%)	33%	8%	31%	22%	22%	31%	22%	26%
Opportunities for Input (25%)	22%	31%	31%	22%	19%	38%	33%	23%
Salaries (22.5%)	26%	15%	8%	30%	22%	23%	22%	23%
Seeing Positive Change (22.5%)	19%	31%	15%	26%	22%	23%	11%	26%
Resources Available (17.5%)	19%	15%	15%	19%	15%	23%	33%	13%
Man't/Staff Relations (17.5%)	15%	23%	23%	15%	22%	8%	22%	23%
Office Accommodations (15%)	22%	0%	0%	22%	15%	15%	11%	16%
Work Environment (Human) (15%)	19%	8%	0%	22%	15%	15%	33%	10%
Agency Philosophy/Vision (12.5%)								
Agency Policies/Procedures (12.5%)								
Agency Growth/Stability (12.5%)								
Management Style (7.5%)								
Career Mobility (7.5%)								
The Clientele (7.5%)								

NOTE: "Prof." has been used as a shortened form of "Professional".

"Man't" has been used as a shortened form of "Management".

Percentages are not provided for categories with less than 15% frequency.

Job flexibility and autonomy, as described by the interviewees, were attractive for a variety of reasons. A registered psychologist explained the appeal for him:

> The job has more potentiality than actuality. I can do anything...I can design my own job...I've had other job offers but then I think of having to fit into a team and do the same thing all day long...Here I'm sure that if I want to do something different I can...It's because we don't have teams and departments that are rigid...It's more like private practice.

A less experienced clinician working in a larger community appreciated the implied message that seemed to go along with the autonomy in her job:

> I still feel like I do what I want to do. I have a lot of freedom in my work. I have a lot of supervision if I want it, but I feel like they trust us. It's not something that's being said, it's something you feel all the time, like they're not on your back; they don't check things; they don't read everything you do. They really show a lot of confidence in what you do...That's probably the biggest thing that I like.

However, another clinician, a Northerner who returned from Southern Ontario in response to a more challenging job offer, explained that the flexibility and autonomy can be a mixed blessing:

> I really like the freedom in the North. I found it hard working in [a Southern Ontario city] because I felt like I was in a box professionally and if I dared to step out of it I was stepping on someone else's toes. In the North, because

> of the shortage of services and the expectations on you are so different, there are no toes to step on. But it can also add stress because you have to sort out on your own what you can...and...can't do because you don't have the training.

The positive impact of **colleagues** was mentioned by 19 of the 40 respondents as contributing to their satisfaction on the job. "The people I work with are wonderful," said one psychometrist. She continued,

> They are interesting, dynamic, thoughtful... good professionals who are good at their jobs and just good people. There's a sense of us being here because we want to be...not because we have to be. There's a real spirit to working with each other that makes it a very pleasant place to work.

Another psychometrist found his colleagues to be helpful in other ways: "We really work well together...get along personally and professionally. We're very supportive of each other and look out for each other." And a third described yet another benefit provided him by his co-workers:

> It's expected from my co-workers that my work performance is consistently very good...good or O.K. is not acceptable... I wanted to work with people who expected from me as much as I was expecting from me and I have that here. And I, too, expect very good from them and I get it...and the job satisfaction is A+, all the time.

As will be noted from the next section, the **professional development and internal training** opportunities offered by their agencies were sources of both satisfaction (42.5%) and dissatisfaction (50%) to the interviewees. Satisfaction seemed dependent on the extent and

nature of the opportunities available. The clinicians clearly relished any learning opportunities that enhanced their clinical skills and knowledge, exemplified by one worker's comments:

> There are lots of opportunities for growth here.. They bring in professionals and we get to go out to workshops... There is a real incentive to keep learning. For me it's a real motivation to stay with the agency if they give me opportunities to increase my skill level.

Some participants felt that internal training was preferable because it was less costly and thus allowed the limited monies available for professional development and training to go further. Others explained that it was beneficial to them to be able to travel out to conferences, workshops or training courses, not only educationally but because it served as a valued "mental health break" from the work place and the community. As one clinician said, "Being in this community, when I have a chance to go to a large centre in Canada or the States, there's not only the educational value but the novelty value in getting away from here."

Clinicians' descriptions of what they liked about the **work itself** emphasized variety and challenge. For example, a participant who worked alone in a remote community spoke of the rewards of her work: "I get excited when a case goes well. I like the wide range of people I work with...and there are all kinds of problems and situations I deal with that offer a lot of challenge." Another respondent mentioned the work being particularly satisfying because, "This is... where I grew up, I have a lot invested in it...It makes it more satisfying because I'm doing something for my own people and community." A third clinician, a local supervisor, enjoyed having to be a "jack (jill) of all trades, so I don't specialize in any one thing...I have to know a lot about a lot of things."

Finally, a clinician who was technically a half-time employee but was carrying a full-time caseload because of agency under-staffing explained why she still felt "contented": "I

really enjoy the work. I don't mind the overtime because this is where I want to be professionally...I just really like the challenge of it [the work]."

The last category I will describe highlights the clinicians' appreciation of the message from their agency that they are **supported and valued** as professionals. As mentioned earlier, although this category ranked fifth overall, it was the source of satisfaction mentioned most often by those professionals working for female administrators. It was the surfacing of this pattern during my preliminary data analysis that lead me to decide to compare all the results on the basis of male versus female administrators. The significance of this particular pattern relates to the literature that points to differences between the management styles of men and women managers. The first two quotes are from clinicians in female-administered agencies:

> My boss is a fine person, very reasonable and understanding. She makes you feel important, worthwhile, unique. It isn't necessarily your qualifications...She recognizes that each staff has certain things to offer... We're appreciated. Here your educational status isn't as important as what you can do and how you do it. The staff feel valued.

A second clinician described a philosophy of empowerment that extended not only to staff but to clients as well:

> There is an underlying philosophy here that speaks to being really valued in a concrete, operational way as a committed professional...and to a strong commitment to empowering families...That's what it's all about. We're well supported...with a commitment to seeing we have the physical resources we need...and to an empowering philosophy that makes this a very supportive, growth-enhancing, encouraging place to be.

The following woman worked for a male administrator and was actually drawn to her current position by her prior working knowledge of her boss and his approach:

> I feel people [here] value my skills and contributions. I really wonder if I'd have stayed on in this job if I hadn't had the same kind of positive input from my boss...if I wasn't being appreciated and valued...for the work I do.

In the next section, describing factors contributing to job dissatisfaction, several of the same categories mentioned in the context of job satisfaction are conversely defined as key sources of dissatisfaction. Most notable are the issues of **professional development and training, supervision,** and **feeling supported and valued.** There was a very clear sense among the interviewees that their professional growth and development, their own mental health and stress quotient, and their feelings of being supported and appreciated by agencies were paramount in importance to their being able to provide the best quality service possible.

Job Dissatisfaction Factors

The question about job dissatisfaction produced a total of 20 categories of responses from 40 participants. One third or more of the participants identified nine different categories contributing to their dissatisfaction on the job. Interestingly, this contrasted with the results around job satisfaction where one third or more of the respondents identified only five categories. This finding could be interpreted to mean that the levels of job dissatisfaction were somewhat higher than those of satisfaction, or at least that the dissatisfaction expressed by most interviewees was derived from multiple sources and thus more extensive. Table 12 provides the reader with an overview of the ranked categories and the percentages of response to each category, as a total group and as analyzed across groups.

Table 12

Job Dissatisfaction Factors N = 40

Category (% of Total)	Female n=27	Male n=13	Large n=13	Small n=27	Outside n=27	North n=13	F.Admin n=9	M.Admin n=31
Lack of Supervision (55%)	52%	62%	23%	74%	48%	69%	56%	55%
Lack of Prof.Dev./Training (50%)	44%	62%	46%	52%	48%	54%	33%	55%
Burnout/Stress (47.5%)	56%	31%	46%	48%	44%	54%	22%	55%
Prof.Isol'n/Few Resources (47.5%)	56%	31%	38%	52%	48%	46%	22%	55%
Unsupported/Undervalued (47.5%)	56%	31%	54%	44%	37%	69%	11%	58%
Agency Instability (45%)	41%	54%	54%	41%	37%	62%	22%	52%
Excessive Work Demands (45%)	44%	46%	54%	41%	44%	46%	44%	45%
Salaries/Benefits (42.5%)	41%	46%	54%	37%	33%	62%	0%	55%
Management/Staff Relations (35%)	37%	31%	38%	33%	37%	31%	0%	45%
Colleagues (32.5%)	41%	15%	31%	33%	37%	23%	11%	39%
Agency Vision/Structures (30%)	30%	31%	31%	30%	22%	46%	11%	35%
Personnel Policies/Proc's (25%)	37%	0%	31%	22%	15%	46%	0%	32%
Quality of Service (25%)	22%	31%	31%	22%	26%	23%	0%	32%
Underfunding (20%)	22%	15%	31%	15%	19%	23%	0%	26%
Government Involvement (20%)	15%	31%	31%	15%	19%	23%	11%	23%
Office Accommodations (15%)								
Lack of Community Support (15%)								
Lack of Career Opportunities (12.5%)								
Travel Demands (10%)								
The Clientele (10%)								
The Work Itself (2.5%)								

NOTE: "Prof. Dev't" has been used as a shortened form of "Professional Development".

"Prof. Isol'n" has been used as a shortened form of "Professional Isolation".

"Proc's" has been used as a shortened form of "Procedures".

Percentages are not provided for categories with less than 20% frequency.

The inadequacy of the clinical **supervision** process was cited by 55% of all respondents as contributing to their dissatisfaction on the job. Two interesting comparisons emerged from the data. Sixty-nine percent of clinicians from Northern Ontario indicated a concern about lack of supervision, compared to only 48% of respondents originating outside of the North. The most dramatic difference between groups regarding their concern about **supervision** was the 74% response rate from workers in small communities compared to a 23% response rate from those working in large communities. This second comparison clearly indicates that the quality of clinical **supervision** and its accessibility are a major concern within the context of agency offices housed in small communities.

Half of all the clinicians I interviewed also saw the **lack of professional development and internal training opportunities** provided by their agency as a source of dissatisfaction. This result was quite consistent across all comparison groups, although men did mention it more often (62%) than women (44%). It is interesting, too, that 69% of the male participants also felt **professional development and internal training** contributed to their job satisfaction. These results may appear to be contradictory; however, as I explained earlier, it seemed as though respondents were indicating both their appreciation of having some learning opportunities but also their desire for much more in the way of training from their employers.

Three categories that would seem to be highly related (**burnout/stress**, **professional isolation/lack of resources**, and feeling **unsupported and undervalued** as professionals) garnered responses from 47.5% of the participants. These phenomena tend to go hand-in-hand in creating a potentially serious situation for the professionals themselves, their employers, and their clients, given the impact of **burnout/stress** as discussed in my review of the literature. Fifty-six percent of the women I interviewed expressed a great deal of concern about all three of these factors in their professional lives, as compared to only 31% of their male colleagues.

It is also interesting to note that these three concerns were raised by far fewer clinicians in female-headed agencies (11-22%) than in male-headed agencies (55-58%). This finding is

consistent with the results under the category **feeling supported/valued** from the previous question of job satisfaction. Another group that seemed to feel particularly **unsupported/undervalued** by agencies were those clinicians coming from the North. This feeling by northern clinicians may in part be a reflection of the over-arching sense of low esteem that northern citizens in general experience, according to the observations of the respondents themselves. This theme of undervaluing, of Northerners feeling like second class citizens, will be discussed in a later section of the results.

Agency instability, whether resulting from rapid growth, union strife, turnover, perceived management incompetence, or reorganization contributed to the dissatisfaction of 45% of the interviewees, as did **excessive work demands** from high caseloads and understaffing. **Agency instability** was highlighted in particular by northern clinicians and by significantly more professionals working under male administrators than under female administrators. Concerns about **excessive work demands** were reported consistently across all groups.

Salary levels and **benefit coverage** were cited as sources of job dissatisfaction by 17 of the 40 participants, and comparatively more so by professionals from large communities, from the North, and from male-headed agencies. **Management/staff relations**, indicated as a source of job dissatisfaction by 35% of all interviewees, was again mentioned more frequently (45%) in male-administered agencies and not at all in female-run agencies.

Those clinicians who participated in the research via the mail survey indicated most often that **salaries** were too low. As well, a **lack of professional development/training opportunities** and **professional isolation/lack of resources** were the next most frequently mentioned problems. There were no concerns about **supervision** cited by the mail respondents, in contrast to the interviewees.

The significance of some of these issues and the intensity with which they were discussed is revealed in the following brief sampling of the interviewees' own words. In describing his concerns about **supervision** in his agency, a clinician made these comments:

> We need to get back to the basics as far as accountability is concerned ... and on-site supervision. Right now I get my clinical support from my colleagues on the front line, not my supervisor...He doesn't have the capabilities...Our quality of supervision really needs improvement.

Another young professional spoke of his situation with a sense of desperation and frustration in his voice:

> [I feel dissatisfied] mostly because I'm not qualified to do what I'm doing and I'm actually the most qualified person here. I do family therapy and have absolutely no supervision. It's been true since I came...So I feel a lot of pressure...It's crazy...and I'm told it's O.K., just to do my best...that the situation is normal...just work hard and learn the hard way. They don't listen to my concerns [about the quality of service]...At the clients' level, they don't care...

Professional development and internal training opportunities were valued highly by the workers, whether they were new graduates or experienced clinicians, so barriers to those opportunities were troubling:

> I have been here for over a year and have applied for one workshop but I was refused because there was no funding. The agency has had workshops ... but

they're too elementary. There needs to be a system to have money allotted for experienced staff, too.

A local supervisor discussed how the lack of training affected her:

> Because we can't get qualified staff, I end up doing a lot of the training myself which takes away from doing other things that need to get done...I shouldn't have to be a training centre...I'm frustrated with the lack of training opportunities in the North...and it's very expensive to go south, so it's extremely difficult to get training for my staff or myself. Training is one of the biggest things [I'm dissatisfied with].

The lack of training opportunities in the North is a hindrance to the career development of some:

> I need more training for myself. There are steps in my professional development... that I haven't been able to achieve because there's no qualified [AAMFT] supervisor available to work with in this area... so I've had to put that on hold. In the long run it's doing a disservice to myself, the agency and the clients...I could be more effective with the clients if I had someone to consult with regularly.

Finally, a local supervisor and one of his workers who sought more training on her own while continuing to work because it was not available through the agency, discussed the realities of training in the North:

> If anyone here is going to take upgrading or specialize in something...we have to travel [200 miles] to do it...In small rural communities that's one of the major problems ...with everyone trying to move ahead, to retrain or just to keep up... We can't do it because of the distance. Several staff are travelling four hours into (the city) weekly to upgrade their training ... It's relevant to their jobs but they don't get mileage...So it hinges on the person's own initiative...There's not a lot of support.

Another clinician commented:

> Professional development should be mandatory...no one should ever be hired for a job and just allowed to stagnate. Everyone has to show professional responsibility...I take all the [training] opportunities I can get...You owe it to the people you're working with.

The concerns about **burnout** and high levels of **stress** were very real for front-line worker and supervisor alike. A local supervisor in a small rural clinic was very concerned about his staff's well-being: "They get people calling them in the middle of the night all the time. Ministries and employers need to realize that these staff live almost like being on call 24 hours a day...this can lead to burnout."

It was the experiences of the workers themselves, however, similar to textbook examples of **burnout** in the making, that were the most frightening to hear. A young M.A. graduate was losing her confidence after only two years on the job:

> My biggest worry is my caseload. It's way too big...It can't be handled by one person...so I get really discouraged ... It affects the way I feel about my

> work...like I'm doing a shitty job...because there's not enough time to prepare or to discuss cases with other staff or just to sit and think about a case...It's just one case after another...It's so frustrating because nothing is being done...so people will burn out because we feel very tired ... There's too much to do... so we can't provide top quality service and no one will listen.

Another recent graduate with a great deal of life experience behind her nonetheless was also struggling to stay afloat:

> The caseloads are far too high. I'm giving up my lunch hours; I'm working late...just trying to cope with the load... The paperwork...is like a black cloud hanging over me...There's no time for reports...or for reading up on clinical issues. I have no energy left...The men here don't recognize the value of the way I do things...There's no compensation...no recognition of the drain the job puts on you...It seems to be acceptable that I keep doing things this way and maybe burn out in the process...I get so stressed out that I just can't take on any more...I lose my motivation...It's a downward spiral ...Then I can't really use any time off because I feel like a zombie...If only we were allowed the consideration we give our clients...

As can be seen from these last two quotes, there is often a strong relationship between the various sources of dissatisfaction, for example, **burnout/stress, excessive work demands** and feeling **unsupported and undervalued**. The following comment comes from a worker who is the sole professional in her area of specialty within her district and describes her feelings of **professional isolation** and being **unsupported**:

> I feel very isolated...plus there's already a high risk of burnout especially in this type of work. I've always felt all alone here, even the other workers at times wouldn't support me or my program...I feel like I've never really fit in here...There was no support from other agencies...and no support from my bosses because they really didn't want the program to begin with.

Another woman, working in her first clinical job in a rapidly growing agency in a large northern community, explained her situation:

> At times there hasn't been the level of support and guidance I would have liked...maybe because the agency is growing so much in so many different directions that sometimes I've felt I was thrown to the lions and expected to do something rather than being brought along or supported. In part it has to do with it being a northern community with limited resources ... There's a real sense of your being on your own once you're up here.

The issue of **salaries** was also often taken to symbolize the undervaluing of rural clinical work and the professionals who carried out such work:

> I can make more money in Southern Ontario and the cost of living [there] is 20% less... There's no movement to address our salary concerns ... It's because of the general attitude that we're second class citizens...in second class services...that people come north because we're dedicated, like missionaries.

Another worker said she felt a lot of dissatisfaction around salary:

> I'm making half of what I could in nursing...a poor wage considering my years of work experience...It's because people in the helping professions often get stuck with lower paying jobs ... We need special people and our work has to be valued. Now, front-line work is considered lowly because of the salaries we're offered.

Finally, the category of **management and staff relations** incorporated clinicians' feelings of mistrust, alienation, and low morale, displeasure over an agency's authoritarian stance, descriptions of management's unresponsiveness to workers' concerns, the demonstration of favouritism towards certain employee groups, and the lack of a grievance process. As can be seen from Table 12, a dramatic contrast existed between the percentage of clinicians concerned about **management and staff relations** who were employed by male administrators (45%) and who were employed by female administrators (0%). Indeed, this matter was also of concern to at least one third of female clinicians, clinicians from both large and small communities, and clinicians originating from outside the North.

Gender Differences

The question I asked participants about their experience or observation of gender differences within their agencies and/or external to their agencies was clearly the most controversial and misunderstood aspect of this research. My decision to include this question in the research was derived both from the results of other research (authors who identified gender as a significant factor in the prediction of turnover and retention), as well as personal observations as a northern female professional. Several participants were quite indignant that this question was asked at all, while others expressed their doubts about its relevance to the research. However, several clinicians also indicated they were very pleased with the question and appreciative of the opportunity to speak to their concerns regarding gender differences.

Suffice it to say, a number of respondents, including those completing the mail survey, were very puzzled by the content and the intent of the question. Those I interviewed personally had the benefit of discussing the question's relevance while, unfortunately, those who participated by mail did not.

The question of gender difference offered interesting comparative data because it was the first question asked in common to both the clinicians and the administrators. The responses of many participants were mixed and included both neutral to positive observations, as well as some areas of concern. Because one goal of this research is to determine those areas of professionals' lives that influence their decisions whether or not to remain working in children's mental health in the North, I will place more emphasis on those comments that indicated the most concern to the participants and thus would be more likely to strongly influence their decisions to leave. It is, however, also very important to highlight those responses that spoke to agencies and communities operating in an atmosphere of gender equality and respect, for these are, ultimately, laudable goals to be achieved by all.

Gender differences within agencies.

A total of 46 participants (37 clinicians, 9 administrators) provided responses to my inquiry about the existence of gender differences in any aspects of their agency's operations, including the provision of clinical services. Sixty-three percent of the respondents included some positive observations about how gender was dealt with in their particular agency. These observations ranged from comments that gender did not enter into decisions around hiring, promotion, case assignments, and the determination of professional respect. Furthermore, respondents offered descriptions of the proactive steps some agencies have taken to become sensitized to and respectful of gender issues and to balance the traditional gender differentials in agencies' upper management. One program director spoke of his agency's efforts:

> Our central team has been exclusively male until last year and our front-line workers are slightly more female... This is something I've been trying to work at... We have been actively recruiting women for the team and have now hired three ... so it is slowly getting evened out.

A comment from a male participant was typical of those who felt that, in effect, gender did not affect their work environment:

> As a male worker, it's a non-issue for me. I don't feel disadvantaged as a male or embarrassed about being male because I don't feel my female colleagues are disadvantaged by being female. My boss is a female and it's not an issue. When sexist issues come up, they're usually presented in a jocular way...We all have some fun with it. I don't know of anyone who's terribly impassioned by the issue in a way that relates directly to this place...There are hard-core feminists here who remind us of what's going on in the world but no one here is bothered by our situation.

For other participants, positive personal changes have come about in part as the result of their working with female leaders and colleagues and becoming aware of different relational styles and management values. They were eager to share these experiences:

> In the last couple of years, I have been ... learning about the feminist perspective to working. It's been very valuable to me as a male worker to look at some of those issues...and it has made for some big changes in the way I work...and the things that I do... We very much operate here as more of a

collective than a bureaucracy ...Decisions are made much more collectively ... You certainly feel you always have a say in what you do.

A female clinician spoke of how the current female leadership in her agency has influenced her:

Men use power in the position of being one-up and I've experienced some women doing that, but not (here). I really appreciate that because the effect that has had on me personally is to empower me as a professional... It has allowed me to grow a lot...Power is not used to put professionals or clients down...It is worked out in a way so that everyone ends up winning.

Another male participant shared his experience of working with a female director:

Part of my satisfaction with this job is due to the director's sensitivity and abilities. I don't know if it's because she's a woman or because she's a skilled leader... I feel there's not the strong power struggle or the need to be in complete control ... It makes me feel very satisfied in terms of how the gender issues are respected and noticed here.

At the other end of the spectrum were the comments from 26 interviewees, or 57% of the total number of respondents to this question, that spelled out their concerns related to gender issues in their agencies. In order to protect confidentiality, I grouped clinicians and administrators together when analyzing the responses. I categorized the responses into six groupings and have included the quantitative findings in Table 13. The responses that did come from the six administrators who commented on the question were spread across all categories except **attitudes in the setting**. On average, two administrators responded to each category.

Table 13

Gender Concerns Within Agencies (All Groups) N = 46

Category (% of Total)	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=28	n=18	n=19	n=27	n=32	n=14	n=9	n=37
Management Style - (Structure, practices, effects) (26%)	36%	11%	21%	30%	22%	36%	22%	27%
Clinical Issues (26%)	29%	22%	21%	30%	19%	43%	33%	24%
Unequal Benefits, Opp's (24%)	29%	17%	16%	30%	19%	36%	11%	27%
Male Domination in Upper Man't, Administration (22%)	29%	11%	26%	19%	12.5%	43%	11%	24%
Gender-based Attitudes (22%)	29%	11%	16%	26%	12.5%	43%	22%	22%
Entrenchment vs. Change (7%)	7%	6%	6%	7%	3%	14%	0%	8%

NOTE: "Opp's" has been used as a shortened form of "Opportunities".

"Man't" has been used as a shortened form of "Management".

Responses from clinicians and administrators have been combined for the protection of confidentiality.

The **management style** category incorporated those responses that dealt with gender-related concerns about the structure and practices within an agency and their effects on the participants. The structures and practices highlighted by the participants included "a hierarchy of men", a "boys' club", a movement away from a participative model, no access for women to top-level decision-making, a circumvention of women's authority, and greater personal access for men to communication with senior management. The effects of these structures and practices, according to the participants, were that women came to feel unsupported, disempowered, threatened, treated like second class citizens, discouraged, and wanting to look elsewhere for work. Conversely, their perceptions were that these structures and practices allowed male management to be insensitive and disrespectful, and their male colleagues to be listened to more, to have more power with less scrutiny, and to have their opinions valued more than a woman's.

The category of **clinical issues** included those concerns related to the gender of the therapist versus the gender of the client in terms of comfort levels, power issues, mutual respect, and the presenting problem. As well, this category encompassed the following issues: men being under-represented in front line work where they are often needed, for example, to work with male adolescents and male abusers; women feeling particularly overworked on the front lines; the differences in working styles between the gender groups; the difficulties in supervising workers of the opposite sex; and conflict along gender lines over social/clinical issues such as violence against women.

Concerns about there being **unequal advantages and opportunities** along gender lines were shared by 24% of the participants who responded to the question. Examples cited included only male colleagues being encouraged to advance in the organization, men getting more promotions more quickly and having positions created for them, more male professionals leaving agencies because of low salaries, men earning more because they have higher status

and can "cut their own deals", and men with less work experience and less education earning salaries equal to women with more qualifications.

The category incorporating concerns about **male domination in upper management and administration** described participants' observations of agencies being "top heavy" with men and "bottom heavy" with women. Participants commented that men occupied most of the decision-making positions. The need for more women in upper management and more men in front-line positions was cited in part to influence the decisions and the level of support that women received compared to men in the agency, and to achieve an acceptable power and gender balance throughout the agency. Responses reflecting these concerns were offered by 22% of the participants.

Gender-based attitudes within the work setting were problematic, as well, for 10 of the 46 respondents. One man was concerned about an "anti-male bias" among feminists in his workplace. On the other hand, some female professionals spoke of the subtlety, others of the blatancy, of ingrained sexism in their agencies. Male qualities were said by participants of both sexes to be more highly valued, and that a "deep voice" commanded respect while women had to earn it. Several women were aware that men in power in their organization joked about women, and other men complained that it was difficult having to work with so many women. Finally, several colleagues spoke of the presence of very conservative, traditional values in their agency that denied the existence of social problems and family violence against women in the community.

The last category, which I have labelled **entrenchment versus change**, is represented by the comments of only three participants, two of whom were concerned that gender problems will be denied and thus not changed, and that female employees have come to accept these practices as "part of life" because they feel so powerless. The sole male respondent in this category admitted to both the evolution of a male infrastructure in the organization, and to his inability to understand how to change the situation.

Of the 10 mail survey respondents who answered the question, six indicated they saw no differences at all, two identified some concerns around **clinical issues** and one mentioned that the **attitudes** within the setting were troublesome.

Concerning gender-based access to power, several interviewees, representing both agencies in large and small communities, discussed their perceptions:

> Within this agency, males are put immediately into higher status positions...Positions have been created specifically when a man has started work...When a male does get hired he's automatically a good friend [of the director]. He gets to bypass a female supervisor and go directly to the director...He probably gets a higher salary, too...We know this but...we just accept it, which is really terrible...A male front line employee helped to undermine a clinical manager...and had more pull in program planning than she [the clinical manager] did... Decisions were made informally between him and the director.

Another stated:

> Internally, senior management is all men and middle management is mostly women. Very few (men) work here as counsellors. All the men collude...and tend to stick together. If I went to the director's office and asked if he could help me with something, he'd help me and that would be it. If a male colleague went there, they'd joke, laugh and have a good time...It's not something concrete that can be documented or measured but it's there...I've discussed it with other women here and they agree.

A third respondent commented:

> Management tends to be very male and always has been. A female in management has very little power...The one working here now...has secretarial duties...Local supervisors are all female except one, and most of the counsellors are female. So it's very top-heavy male and bottom-heavy female which isn't good. It tends to colour the way the agency makes decisions because decisions at upper management are very male, so it makes a difference in what kinds of things get done and how they get done ...There's a lot more stress than there needs to be simply because males are running the place and there's a lot more push because men push more than women.

The frustration of the situations in their agencies was evident in the comments of two other clinicians:

> [The sexism] has become so bloody blatant [here] that it's hard to avoid. Any men on top would be horrified to hear that...because they are so sure there's not a problem...It isn't out of evilness or nastiness but I think it's so ingrained...I've been wondering why men get all the jobs...I think it's their ability to sling the jargon around, the verbal sparring ... They would say it's because they're the best...but it boils down to a couple of characteristics they have that are valued by the other men. It's very disturbing and discouraging (for) the women in the agency...The subtlety gives it more power.

In another agency, this young clinician described the situation there:

There is discrimination [here] in certain ways but it's subtle...The director will sometimes push the male staff more in terms of offering them more opportunities or encouraging them to work to become managers, but none of the women have been offered anything or encouraged... The expectations are that men can move up and women stay on the front lines...The program for family violence was strongly resisted for a long time because it wasn't seen as necessary; it was believed that women who were battered wanted to be. Now ...it's supported but I'm not sure how deeply they're convinced.

As can be concluded from the range of comments in this section, there was a great deal of variability across northern children's mental health centres in terms of both the level of awareness within agencies regarding gender concerns, and how these issues were understood and respected within agencies. It was interesting to note the differing perceptions of some administrators and clinicians within the same agencies as to the existence of gender concerns. As well, some administrators seemed much more aware of gender differences experienced by their clinicians out in the community than any encountered by workers within their agencies.

Gender differences for professionals within communities.

The community context within which one operates as a mental health professional certainly has an impact over time on how a clinician views her/himself professionally and views the value of the services being offered, and ultimately, on whether the professional decides to remain with the agency. Messages from the professional community outside the agency and from the community at large, when critical, naturally filter back indirectly to a worker, or sometimes hit her/him head-on, in a way that can undermine self-confidence and the sense of purpose a worker must have to do the best possible job.

The purpose of this research question was to determine when and how those messages from the community related to the gender of the professional, and the kind of impact such messages actually had on workers. Of the seven mail survey respondents who answered this particular question, three stated they saw no problems related to gender in their communities, two had general concerns, and two had concerns related to professionals in the community. Forty-two of the interviewees (30 clinicians and 12 administrators) gave their opinions as to the existence of differences related to gender for professionals working within the community. The responses of 36% of the participants (32% female, 45% male; 37.5% clinicians, 40% administrators) indicated they either had no concerns or at least could identify some positive features in the community's dealings with gender. Several of the male participants commented that, "I feel females are respected and appreciated", and "I don't see the North as more macho (than the South)", and "I feel community acceptance is based on competence, not gender."

Some of the positive respondents, however, also identified some areas of concern relating to gender in the community. One woman said that she had not encountered discrimination in the community because of gender but later talked of how she must approach her work in the community:

> I am very conscious of approaching situations keeping gender in mind. There are situations that I go into with my 'court clothes' on in order to make it very clear that I am a professional and must be taken seriously, in a different way than when I don't think [gender] will be an issue...So I've probably altered my behaviour in some cases to take that into account.

It was also interesting that two participants from the same small community independently mentioned that they saw their community slowly moving away from male domination in its leadership positions, for example, recently electing a woman as reeve.

Concerns were voiced by 69% of the participants (84% female, 64% male; 72% clinicians, 60% administrators) and were divided between those that spoke to general differences, not specific to professionals alone, in how the sexes were viewed in their community, and those relating to the differences in the treatment of male and female professionals. Twenty-one statements of general concern and 15 statements of concern about the specific impact on professionals were verbalized during the interviews. Those comments reflecting a general concern described women in the community as having no voice, and feeling afraid, vulnerable, and isolated. Those women who challenged local attitudes were said to be criticized for speaking out about their concerns. Men were generally described as being listened to and respected more than women, being more readily hired for authority positions in the community, and as feeling threatened by feminists.

In general, those respondents who expressed concerns about how gender was handled in their communities saw the communities as being male-dominated and chauvinistic, having very conservative attitudes about gender roles, and being patriarchal in terms of employment opportunities and values. For example, one respondent remarked:

> To call yourself a feminist in this town is scary. I had a man leave one of my presentations when I said I was a feminist ...I sense a lot of anger about male/female roles from women in my university class.

In discussing family violence, she further noted:

> The community is pretty conservative about gender roles and I feel the fear that comes out from women in the community that as women they aren't well protected...and neither are their children. It's more dangerous for them in a small community because everyone wants to cover up and has a friend on the

police department or the fire department, so there's a friend somewhere to cover up and take care of the story of their situation.

A woman from a large community described her community this way:

> This is the kind of place where it's a lot easier to be a man, in terms of how people respond to you, how they listen to you...It's very patriarchal...and the company takes care of its own. What we get paid sums it up - a guy gets paid more at the mill sweeping the floor than I do...And it's very red neck in terms of what people like here - stock-car racing, hockey...and people drink a lot more.

According to 36% of the respondents, life in the community as mental health professionals was to some extent influenced by their gender. Male professionals were regarded as being more respected and valued, having more status, being perceived as the experts, and being more readily accommodated by other professionals in the community. Female professionals, on the other hand, were described as having to overcome more barriers, having to work and fight harder for respect, as feeling disadvantaged, discouraged, disrespected and excluded, and as more often being circumvented and confronted regarding her credentials. The impact of gender on a woman's status as a professional in the community is revealed in the following examples:

> The North seems to be very male chauvinistic...It seems to take awhile to establish who I am with males in other agencies or settings and then to get them to respect my abilities. This is especially true if you're young and female...you have a very hard time getting into the school system in particular

and I don't think this happens if you're a male. In [a community] a new female worker was told by the school principal she wasn't qualified to deal with a ... situation in his school.

Several other participants supported these concerns:

I have had to become extremely assertive to deal with male school principals. I just don't put up with their attitudes and now they know not to joke about women around me any more. I also resent the way I've been treated by the consulting [professional] and by male members of other agencies I have to deal with. Feminism is not alive and well in [the community]. Attitudes are very blatant. If you're female, you have to fight very hard to be heard and to be accepted as having something valid to say. I've had men from agencies in the town call a male colleague here about my clients because they wanted to deal with him. I've somewhat corrected the situation but it hasn't made me many friends ...It's an uphill fight.

A second commented:

Most of the collateral people I work with are ...females and their upper management tends to be male...The males in this field tend to command more respect and attention for their opinions from collateral agencies than women do...It's a gender-based attitude. I have seen a male psychologist... and a female psychologist do the same (work) and people pay more attention to what is said by the man...In meetings with collateral agencies, if I bring my male supervisor along, people tend to listen to him more, even if he said the same thing that

I said...a month ago, so I just sit there and bite my tongue... Men are supposed to know what they're doing and women are just wimpy and emotional creatures...trying to be warm and empathic...Equal opportunities and equal treatment of the sexes hasn't quite reached the North like it has other places.

Another woman discussed her perception of the plight of female professionals in the North:

If you're a male you automatically have more credibility...and a woman has to work twice as hard to build up her credibility in the community. If I had been a male walking into this job, it would have been very easy for me to get instant credibility. The challenges of being female in these communities is interesting...Almost all the time you're being confronted on your credentials...You have to prove what you know and that what you say is valid, especially if you're dealing with other agencies that are male-dominated. (This community) isn't unique in this.

A male participant agreed:

In the community there is a different way of dealing with male professionals and female professionals. There is a male macho image in this town...The words of a male professional are heeded much more than a female professional, even among reasonably educated people. I went to (a community) and was able to connect well with another school professional where the female team leader hadn't been able to make any inroads... and it had to do with my being a male.

Still another male observed:

> I've noticed that it's easier for a therapist to get what it's important to get from other professionals, schools, doctors if one is male. Females have to work harder... and must be somewhat male in their presentation of themselves to other professionals up here...I don't know why but I know I'm happy to be a male working here and that I'd have to work harder if I was woman.

These observations from clinicians were recognized and reinforced in the comments from three administrators:

> I think the women take a hell of a beating from the educational power structures that are male-dominated in the district, far more so than the males do. I don't think it has so much to do with position but with male/female, even if it's a female on the other end; *and*

> The principal in [a community] is very chauvinistic and is hard for the female team leader there to handle, but the men don't have any trouble with him.

A third administrator commented:

> It's also been my experience in the North, from watching the relations among the directors and the Ministry here, that it's a really tight old boys network and it's really run on the basis of male values, like competition, hierarchy, politics ... and that puts women at a disadvantage in that women don't value that and

hence don't develop those skills. So I see that as being a long term detriment to having professional women in the North because, unless you buy in to the relevancy of the bullshit, it's pretty discouraging.

It is evident, whether one is speaking from the vantage point of a clinician or an administrator sensitive to the social forces in her/his community, that one's gender can have a very powerful impact on personal and/or professional status in a community.

Recruitment Concerns

The subject of recruitment was not formally included in the research questionnaire because I had initially felt that much more research had already focused on recruitment rather than on retention, and I therefore wanted to limit my research to an examination of retention. However, once the interviews with administrators and clinicians began, it quickly became clear that recruitment could not so easily be ignored because, in fact, recruitment strategies and selection play a very major role in determining how successfully a setting can then be in retaining its staff.

Therefore, this section of the results highlights the realities and dilemmas of recruitment in the North, as well as the strategies that have already proven successful or the strategies that participants sense would prove useful in recruiting committed professionals to Northern Ontario. Because a question about recruitment was not formally posed to the participants, their remarks are taken from the context of their responses to the other research questions. Responses that could be coded as relating to recruitment were obtained from 14 clinicians and 12 administrators.

The clinicians identified 14 of what I have called "northern realities and dilemmas" related to the successful recruitment of professionals to the North. One clinician stated she did not feel recruitment was a uniquely northern concern. Others mentioned problems that in their

experience seemed to be more prevalent in the North than elsewhere. Difficulties they associated with recruitment in the North centred around the problems of recruiting in local communities (e.g., confidentiality concerns, costly training, difficulty in attracting applicants); the burden that the bilingual requirement places on recruiting; and the difficulty attracting experienced Master's level professionals. This last concern, one clinician felt, created a situation where agencies were forced to fill Master's level positions with less qualified and experienced workers, resulting in a reduction in clinical effectiveness and additional stress on the less experienced staff. Several interviewees also characterized the North as a place new graduates come to gain several years of clinical experience in order to better their chances of successfully re-entering the job market in Southern Ontario or Quebec. To recruit for the North, several respondents felt that special incentives were necessary, such as higher salary and comprehensive benefits, but they also voiced the concern that agencies should not be attracting those professionals who are only interested in earning more money. It was also mentioned by one respondent that recruitment was particularly difficult for small northern agencies in small communities, having to compete not only with Southern Ontario but with the larger, wealthier centres in the North that could typically offer more incentives and professional resources, as well as a more urban environment.

The administrators also cited a number of "northern realities and dilemmas" they felt interfered with their efforts to recruit competent professionals. Recruitment was deemed by one agency as the hardest task they faced, sometimes boiling down to luck. The recruitment issues that confronted agencies seemed to vary across disciplines, agencies, and community size. The employees that administrators felt were particularly difficult to attract to the North were bilingual staff, experienced professionals, Master's level clinicians, and particular disciplines (e.g., social workers, psychometrists, and psychiatrists). Two administrators also commented on the increased difficulty in recruiting professionals to come to small, remote communities as opposed to the urban areas in the North. Five of the administrators expressed concerns about

the problems presented by hiring new graduates. The inexperience and lack of confidence of new graduates were felt to impact negatively on the quality of service. New graduates were also seen as requiring a great deal of training on the part of the agency, which the agencies were willing to provide, but for which they felt betrayed when the new graduates commonly stayed only long enough to gain enough experience to be marketable in the South.

Recruitment in the North was commonly viewed as being very time-consuming and expensive, and thus it posed particular dilemmas to administrators. Three of the respondents explained that they were often faced with the decision of whether to wait for the right person, keep the position open and possibly cut back on services, or compromise on the qualities they ideally looked for in a candidate, such as commitment, qualifications, language skills, and work experience, in order to fill the vacancy more quickly. The other dilemma presented by several administrators was rooted in what they felt was the serious under-funding of their agencies. They therefore had to make the decision to either cut back on their recruiting costs and incentives and thus jeopardize the likelihood of successful recruitment, or to take dollars from their professional development and training budgets or other budget areas to continue to recruit, without any guarantee of success.

The administrators identified a key player in their recruitment quandary as the Ministry of Community and Social Services, the source of funding for all provincial children's mental health centres. They felt the extent of their concerns with recruitment and turnover was not understood, particularly in the area of cost. No allowances were made, they said, for the extremely high costs of recruiting. As well, the Ministry did not provide all agencies, particularly small ones, with an equitable and solid funding base, leaving those small agencies seriously disadvantaged in their attempts to recruit.

The other general aspect of recruitment that elicited a number of comments from clinicians and administrators was that of strategies, that is, what should be marketed and promoted about the North, how to advertise, and on what basis to select candidates. Clinicians

felt it was important to raise the profile of Northern Ontario in the South, particularly in universities. Several new graduates mentioned that they had no idea of any opportunities existing in the North until they learned of jobs quite by accident. They also felt it was important to promote the positive aspects of clinical work in the North, for example, having more control and autonomy on the job. Table 14 summarizes both the "attractors" and the "detractors" that were mentioned by clinicians and administrators as influencing agencies' success in recruiting workers for the North.

Recruiting locally through local papers and by word of mouth was mentioned most often as being a successful advertising strategy, though one participant had found it to be unsuccessful. The willingness and capability to provide training were perceived as a necessary adjunct to local recruitment. The offering of incentives and an aggressive approach were deemed as being necessary by several respondents. Ideas about the selection process centred on hiring locally because of an increased likelihood the worker will stay, and emphasizing fit more than qualifications. Qualities such as common sense, intelligence, ambition, stability, a commitment to the area, an interest in the predominant lifestyle in the community, life experience, and lastly, educational qualifications, were stressed as being the most important to consider when selecting.

The administrators I spoke to highlighted four factors they considered critical to promote when recruiting in the North, factors not unlike those identified by the clinicians. The administrators talked about the need to promote the North: its lifestyle, the beautiful outdoors, and the small-town atmosphere they felt existed in even some of the larger northern cities. Overcoming the negative stigma that seemed to be associated with the North was a big obstacle, they asserted. As well, the northern communities themselves could do more in the way of promoting what they have to offer to prospective candidates. An arrangement between one agency and the chamber of commerce in the community has been successful in linking

Table 14

Recruitment Attractors and Detractors

Clinicians	Administrators
Attractors	**Attractors**
- more salary	- more salary
- northern research opportunities	- well-resourced agency
- professional atmosphere	- links with professional resources
- good pension plan	- unique job opportunity
- involvement on clinical team	- good support
- internal stability	- training opportunities
- staff cohesion	- agency payment for interview
- training opportunities	- agency payment for spouse's involvement
- autonomy on the job	- collegial support
- agency working from ground up	- professional milieu
- agency respect for individual	- large professional group on staff
- agency respect for the profession	- involvement in service creation
- positive agency identity	- attractive lifestyle, community
- job opportunities for spouse	- personal/family satisfaction, QOL
- local Master's program	- lack of isolation
	- job availability

Table 14 (continued)

Clinicians	Administrators
Detractors	**Detractors**
- unfair treatment of local candidates	- low salaries
- discouraging job ads	- professional isolation
- low salaries	- lack of research opportunities
- no incentives, attractions to agency or community	- agency's internal chaos
- no collegial support	- smallness of community
- no professional development	- cold climate
- always on call	- personal isolation/distance from roots
- devalued as professional	- negative stigma of the North
- high cost of living	- the geography
- undesirability of community	- lack of other professional opportunities
- personal isolation	
- climate	
- lack of local housing	
- need for own transportation	

candidates to local businessmen and realtors in order to give them a better sense of the community.

Each agency, it was argued, could more skilfully and forcefully market and promote the variety of clinical experiences available to professionals, such as involvement in service creation as well as service delivery, that would allow clinicians to use all their skills. The majority of administrators also believed it was important to offer a variety of incentives, including very competitive salaries and relocation incentives. However, one administrator pointed to Ontario's Underserviced Area Program for physician specialists as an example of the questionable success gained from relying on only one approach to recruitment. This program of financial incentives was instituted by the provincial government in 1969 to attract doctors to areas in the North that have historically been underserviced by the medical profession.

As I knew very little about the Underserviced Area Program, I wrote to the program's headquarters in Toronto and requested a description of the program and any research that existed as to its effectiveness. In return, I received a very attractive brochure showing the tranquil scene of a Northern Ontario lake at sunset and the message on the outside reading, "If you care about the life you lead and the way you practise, you'll hang your shingle in Northern Ontario." Inside the brochure, the first two subtitles were "We Need You!" and "We'll Pay You!" The message appealed not only to a physician's interests in salary, but to "the chance to apply all of your skills and knowledge", a "warm welcome in a community where quality of life still matters", and a place "where your skills command ... respect... (and) where you can make a significant difference." The brochure described the tax-free grants of up to $40,000 over four years that are available in exchange for an agreement to practise in the North, part of which requires the physician to provide outreach consulting to a smaller community one day per month in exchange for all expenses being covered, a $300 per day honorarium, and either $436 per day or fee for service.

I also received two articles in the mailing, one written by a physician who has participated in the program, in which he essentially described the program and its components at length (see Copeman, 1987). The other article, by Anderson and Rosenberg (1990), described an evaluation of the program's success using "location quotients for Ontario's counties between 1956 and 1986 ... as indirect measures to assess the changing distribution of physicians in the province" (Anderson & Rosenberg, 1990, p. 35). The article cited other sources which regarded the program as a success but concluded that "while some change has been made, northern Ontario is as underserviced compared to the rest of the province as it was in 1956" (p.43). The program was criticized for being a "unidimensional solution" (p.43) when what was needed was "greater attention ... to quality of life factors such as work environment, social recreational facilities, opportunities for further training, and suitable housing" (p.43). Finally, the report also suggested that "more publicity needs to be given to the positive features of a northern practice, more importance placed on rural practice in medical schools, more support facilities made available" (p. 43), as well as more consideration to the doctor's family, the uniqueness of the communities' residents and alternative service delivery methods (Anderson & Rosenberg, 1990).

No such critique of hiring practices for children's mental health centre staff has yet been published; however, the administrators I interviewed gave accounts of what they had found to be successful and unsuccessful strategies in their efforts to recruit to their northern agencies. Table 15 summarizes these strategies for the reader. The respondents also provided a number of miscellaneous ideas and suggestions that they believed in principle would be important to consider in both the short- and the long-term. Administrators maintained that being able to use a variety of recruitment strategies was most effective.

They also commented on the need to develop long-range strategies for recruitment. Several agencies have recently adopted the plan of focusing on local high school students in order to increase their awareness and interest in the social services as a career option. Others

have decided to work more closely with universities to increase the relevance of the latters' service program curricula according to the needs of northern agencies and to establish university placements within the agencies.

The concept of working more in partnership with the Ministry, with local agencies, and with other northern children's mental health centres, to tackle their recruitment difficulties together was also endorsed by several administrators as a way to maximize resources. Another strategy that was considered important by several directors was the development of an attractive and comfortable hiring process which would include taking extra time with each candidate, involving the spouse, giving an accurate picture of the work setting and community life, and either compensating the candidate completely for the interview and relocation costs, sharing the costs, or offering a loan to cover the costs that would be forgivable if the candidate stayed for a period of time. An agency created its own foundation to make bursary money available to upgrade the education of local candidates and under-qualified staff, offering summer jobs to "try out" prospective employees. They were also beginning to use local community advisory committees to help recruit local candidates.

In conjunction with ongoing recruitment problems in the North, several administrators raised concerns about the Northern Bursary Program, supported by the Ministry of Community and Social Services and the Ministry of Northern Development and Mines to financially assist post-secondary students pursuing careers in specialized social services in the North. While several agencies had been somewhat successful in hiring and keeping Northern Bursary graduates, other administrators believed that the program was not targeting the right professions and positions (e.g., supervisory, upper management) for agencies and that it did not address the inequities in attractiveness across northern agencies in terms of size and location. Graduates could fulfil their obligations to the program by taking jobs in communities within two hours of Toronto or in the urban communities in the North, thus leaving the more remote

Table 15

Recruitment Strategies by Administrators

What Has Worked (for some)	What Has Not Worked (for some)
- hire a consultant that knows, fits with agency, has prof. connections	- develop creative advertising schemes
- use informal networks, personal contacts	- organize far-ranging advertising blitz
- use professionals on staff, their networks	- offer high salaries as incentives
- recruit in Quebec for bilinguals	- place ads in national, provincial newspapers
- recruit directly from universities	- promote honesty in work place
- give recruitment a higher priority	- promote lack of urban frustrations
- use a deliberate, step-by-step process	- promote local beauty
- use a personal approach with candidates	
- advertise locally	
- develop own staff	

communities with little benefit. A careful evaluation of the Northern Bursary Program was widely suggested.

A number of both administrators and clinicians also supported the large-scale project of developing more high quality and accessible university programs across the North, particularly at a graduate level. These programs could enable Northerners to more easily pursue relevant training in the social services, and provide a larger pool of qualified professionals committed to living and working in the North who would be available for recruitment. This notion will be discussed further in upcoming sections.

The questions of whom to select and how to select candidates were also addressed by the administrative respondents. The most commonly mentioned suggestion was to "be selective, only pick the best". What constituted "the best" candidate seemed to converge on the notion of selecting those who appreciated the North, fit best with the community and also with the agency's needs, and seemed committed to stay. However, it was also recognized that ideally a balance between those staff who are hired primarily because of their local commitment and those hired because of their qualifications and capability to immediately intervene clinically must be struck. Marital status was another factor that was raised by the administrators as an important consideration. Recruiting couples when employment opportunities were available for both seemed to be preferable to hiring single candidates, especially those with no local ties.

Turnover Concerns

The 14 administrators interviewed were queried as to their concern about turnover in their agencies and what they felt had contributed to turnover. At a later date, by mail, the agency directors were asked to submit any statistics they could easily compile about the extent of turnover within their agencies. Seven of the 11 agencies, or 64%, complied with my request and provided what statistics they had available. Few if any agencies had the capability at this

point in time to quickly call up this information via a computerized management information system.

In five (three small, two large) of the 11 agencies surveyed, turnover was characterized as a concern by management, while in four (two small, two large) agencies the directors indicated that they felt fortunate that, to date, turnover had yet to become a problem. One director did not state if turnover was a concern, and one director was unavailable for the interview. One director also indicated intentions to personally leave the agency within six months for Southern Ontario, largely because of disillusionment with agency politics. Administrators saw turnover as a concern in part because of the associated problems with recruitment. Thus, staff vacancies existed for long periods of time which in turn created long waiting lists for service and resulted in client complaints. High turnover was seen as expensive for agencies, again because of recruitment problems. Several directors expressed their frustration at seeing good staff from their agencies leaving to go to other local agencies, typically in the health or education sectors, that could pay higher salaries. No director mentioned concerns about the quality of service provided in the context of an agency experiencing high turnover.

Turnover statistics, as mentioned earlier, were provided at a later date by seven of the 11 agencies I visited. During the course of the interviews, several administrators also provided some turnover data that I will incorporate here as well. Two of the agencies, one large and one small, instead of providing actual rates, provided statistics about the average length of stay of their employees. The large agency calculated that the average length of employment for those staff who had since terminated employment was 1.9 years, with the men who have left staying an average of 1.65 years compared to 1.97 years for women. Of its current staff, however, the men have been there on average 2.8 years longer than the women. The small agency's statistics indicated that full-time staff who have left stayed an average of 2.19 years, and part-time staff stayed only .87 years. That agency lost 18 full-time and 11 part-time staff since 1982 and has a present staff size of 15. Table 16 shows the rates available by the size of the five agencies

and the gender of the administrator. Another agency, which is based in a large northern community but which employs a number of professionals in rural settings, calculated their turnover rate in the rural clinics as 42% five years ago but it was reduced to 13% by 1988 as the result of deliberate strategies designed to retain staff. A second small agency was unable to provide statistics but as one of its administrators said, "We've lost a lot of workers in recent years ... Last year alone we lost four at the centre and more at the residence. We have staff vacancies for long periods of time."

Table 16

Average Turnover Rates of 5 Northern C.M.H.C.'S

	Over x Years	Size		Gender of Administrator	
		Large	Small	Female	Male
Agency 1	4 yrs.		4.25%	4.25%	
Agency 2	10 yrs.	23.6%			23.6%
Agency 3	8 yrs.	11.6%			11.6%
Agency 4	15 yrs.		8.7%	8.7%	
Agency 5	10 yrs.		20.9%		20.9%

The causes of turnover in their agencies, as identified by the administrators, were divided along the lines of agency factors (37 responses), community factors (16 responses), and individual factors (16 responses). The factor most commonly mentioned (n = 5) was the **physical isolation** of the community, particularly in reference to the small communities. The next most frequently mentioned causes (n = 4) were **poor individual/community/agency fit, internal agency problems, lack of agency/peer support,** and **returning to school**. Three responses each related to the **lack of promotional opportunities**, the **lack of agency resources**, the **family or spouse leaving, low salaries,** and **high stress** on the job. Some miscellaneous reasons given as the causes of turnover included a return to full-time parenting, poor local medical services, few social opportunities for singles, recruiting those who do not intend to stay, poor supervision, no set policies and procedures, lack of training opportunities, lack of an agency vision/mission, unrealistic community expectations, feeling tired of work/needing a change, and having no opportunity for input in the agency.

Twenty of the clinicians who were interviewed offered some data concerning turnover despite not being directly asked a question on the topic. Seven of the participants, representing four agencies, indicated through the course of their interview that they were planning to leave their agency within six months. Seven others, also representing four agencies, said they felt turnover was a problem in their agency. Several of these participants mentioned their concerns about the impact of turnover on clients. With high turnover, one worker felt that clients hesitated to use the agency: "The community sees it as useless to go to the agency because they figure the staff will soon be gone ... They don't have much trust in the people here or in the agency".

A less direct, but nonetheless problematic effect, was that turnover either forced less experienced, less educated staff to fill in during staff vacancies, or it forced experienced staff to cover additional caseloads when other staff left, leaving them less able to handle their own

cases well. A respondent described her general impression of the effects of turnover on the staff:

> It's hard seeing people come and go ... When someone new comes in with certain training, making policies, doing training, they expect you to follow their format, and then they leave and someone else comes in. Turnover is quite high among professionals here ... It's difficult ... and it does affect the workers and the community a lot.

The twenty clinicians also indicated some of the factors that would cause them to leave their present job in a northern children's mental health centre. Most frequently mentioned (n = 7) was the feeling they did not fit in or feel comfortable in the community. Five respondents said that their low salary could cause them to leave, and four mentioned their disillusionment with their agency and the government bureaucracy as a serious consideration. The other factors mentioned were: stagnation and a lack of job challenge; their agency's internal problems; a lack of consideration and input for the workers; a lack of training opportunities; a lack of promotional opportunities; and high caseloads and heavy workloads that created a great deal of stress. Comparison of administrators' and clinicians' responses regarding the causes of turnover shows that the two groups agreed on most of the factors identified.

Retention Concerns

As part of the research questionnaire, I asked the administrators whether they were concerned about retention in their agency, what have been some of the reasons for their success in staff retention, and what have been some of the barriers to their success. Fourteen administrators from ten of the 11 agencies in the sample responded, and one director was

unavailable for the interview. Administrative representatives from seven of the ten agencies indicated that retention was a concern for them. This group included several agencies that had indicated that they had been successful so far in stemming turnover. Yet they still expressed some apprehension about their ability to retain staff in the near future, especially given the higher salaries available in other social service sectors around them. Comments such as, "It is a very strong concern for this agency", "It is high in importance to this agency's survival", "...We have staff voting with their feet", and "Seeing so much turnover around me emphasizes the need for us to keep striving for success" were indications of the seriousness of the issue for the majority of the northern agencies. Those agencies for whom it had yet to become a problem were characterized by comments such as, "Historically we had very little staff turnover, so retention by itself hasn't been that great a concern" and "I've never sat down and analyzed the turnover issue over the last 10 years... but I feel the agency has done well in retaining...staff but as we've grown larger it's a constant reality". Three agencies were also portrayed as having experienced a recent improvement in their ability to retain staff.

Factors that have contributed to the successful retention of staff were again divided across three groups: agency factors, community factors, and individual factors. Of the agency-related factors identified, the ability to **recruit** candidates who are most likely to stay was the most commonly mentioned (n = 12). Thus it is clear that, from the vantage point of administration and management, recruitment and retention go hand-in-hand. However, the policy of recruiting those who are most likely to stay, and thus allow for the most success with retention, often depends upon the availability of ongoing training and professional development opportunities, as locally-committed staff often come with fewer qualifications and less work experience. It is not surprising, therefore, that the administrators next cited the need for **opportunities for professional growth** (n = 11) as instrumental to their efforts to retain. Ten administrators felt that competitive **salaries** and a pleasant **work environment** were critical to successful retention. Six or more of the administrative respondents also mentioned quality

supervision and clinical support, a good **benefit package**, the **work itself**, the availability of **educational opportunities**, **peer support**, **opportunities for agency input**, and the **valuing of the professional** as important retention success factors related to the agency. A number of other categories were mentioned by five or fewer of the participants. Table 17 provides the reader with an overview of the responses generated by two or more of the administrators.

In comparing agencies in small versus large communities, and those with male versus female directors, there was some variability in the ranking of frequency of responses from the overall totals. Male-directed agencies, and those in both large and small communities conformed to the overall rankings of **recruitment** and **opportunities for professional growth** as the two most commonly mentioned factors. The agencies in large communities also cited the **work itself** equally as frequently as opportunities for professional growth, and agencies in small communities also included a **pleasant work environment**, **salaries**, and **supervision and clinical support** as ranking second behind recruitment and professional growth. Female-directed agencies, of which there were three, unanimously mentioned not only **opportunities for professional growth** but also **opportunities for agency input**, a **pleasant work environment**, and **supervision/clinical support** as necessary to their efforts to retain.

The community factors that were most often identified as having contributed to agencies' successful retention were an interesting social environment and the gaining of spousal approval and employment for the spouse, each category being mentioned by three respondents. Other community factors mentioned were living in a large northern community or having a large urban centre close by, having a variety of recreational and cultural activities in the community, and having quality, affordable housing available.

Only two individual factors were mentioned as contributing to successful retention: staff accepting the lifestyle, including liking the outdoors and the climate, and staff having local ties to family and friends. As reported earlier, 77% of all clinicians identified their lifestyle as a

Table 17

Retention Success Factors (Agency-Related) - Administrators N = 14

Category	(% of Total)
Recruitment	86%
Opportunities for Professional Growth	79%
Work Environment	71%
Salary	71%
Supervision/Clinical Support	64%
Benefits Package	57%
Work Itself	57%
Educational Opportunities	57%
Peer Support	50%
Agency Input	43%
Valuing the Professional	43%
Flexibility/Autonomy of Work	
Agency Growth/Change	
Intra-Agency Communications	
Individual Differences Respected	
Agency's Internal Resources	
Unity of Purpose	
Non-Monetary Perks	
"Rest and Relaxation" from Work/Community	
Utilization of the Northern Bursary Program	
Size of Agency	
Promotional Opportunities	
Priorizing Retention in Agency	
Unionization	

NOTE: Percentages not provided for categories with less than 43% frequency.

source of life satisfaction. As well, 64% of those professionals indigenous to the North maintained that having family and friends nearby contributed to their life satisfaction. Thus, both factors cited by administrators do indeed seem to be potentially influential for clinicians deciding whether to stay in the North.

Samples of comments from several of the administrators who believed their agencies to date had been somewhat successful in retention give the reader a flavour for the different "formulas for success":

> From the beginning, the original board and director had very clear ideas about the staff being the only resource that the program had, so they worked very hard to provide the support to the staff, to make it a good place for them to work. This [approach] has been consistent throughout the agency's existence, so it makes people more inclined to stay with the job. Some have stayed through periods of abominable pay because there has been enough other reward to keep them hanging in ... basic things like benefit packages, a lot of flexibility around mental health days off, a fairly significant commitment of resources to getting people out to conferences... The board and the staff work together around issues ... There's more of the idea that this is a group working together with shared goals and it's one thing we've maintained even as we got larger... There's not lots of 'us and them'.

Another director gave this explanation of his agency's success:

> We offer good professional development opportunities, a good work environment, excellent clinical support and supervision ... We do things well. People enjoy working here professionally and interpersonally. We keep very

aware of salary issues but we're not as competitive as I'd like to be ... Our benefits are more than fair... We try, as part of our professional development commitment to staff, to make sure all staff get at least one professional development opportunity outside of town yearly... Our job opportunities are unique compared to a Southern Ontario agency... You get a sense of strong commitment to them [staff] as people and professionals by the Board and management.

The director of a more recently established agency attributed successful retention to the following:

Our retention success has come from the setting. We have a statement of values...that appeal(s) to professionals, like an empowerment philosophy that extends to clinical work, and the management of staff to take more responsibility and to grow and develop in their roles. We realize we may be setting the stage for them to leave at some point because they all are potential managers in their own right. But I hope the organization can develop so there will be a place for them in it...We value participative decision making, so we work by consensus...in [deciding] any major program issues. [We] provide ways for people to...realize the goals they set...and strive to have one opportunity a year for staff to go outside the centre because it's also a mental health break for them."

Finally, an administrator from an agency which has recently seen dramatic improvement in retention in its community clinics describes some of the possible factors contributing to the turnaround:

We have tried to upgrade positions to a higher salary grid level...and (place) more of...an emphasis on hiring locally from within the community even if that meant providing more training...or a longer break-in period for someone...We have decentralized some of the decision-making and have made supervision a local issue... This has really helped people feel they belong...We are doing more training locally ... using additional resource staff from (the head office) and ... (providing) an intensive extern program... (Staff) were really pleased with the...effect of the training. It has given them a common language with which to relate to each other.

In terms of the barriers to successful retention, as experienced firsthand by the northern agencies, nine different categories were identified by a total of six administrators. No category was mentioned by more than three participants, however. The two categories that were brought forward by three different administrators were **government under-funding and under-support** and **lack of professional development/training. Community factors, recruitment problems, low salaries**, and **isolation** were cited by two respondents each as inhibiting their efforts to retain staff. Finally, **agency change, under-staffing**, and the **size of the setting** were mentioned by one participant each.

Three administrators, recognizing the importance of professional growth opportunities in retaining staff, felt they were seriously disadvantaged by the government because of under-funding for salaries and professional development, and because of the unwillingness to give retention concerns a higher priority. Thus, ironically, agencies found themselves in the position of having to cut back on professional development in times of restraint when they felt it was actually needed the most in order to boost morale. Others had to take funds for professional development from other budget areas. Another administrator discussed with concern the

agency's inability to provide enough training to satisfy staff as the result of the difficulty enticing a qualified trainer to the community.

A total of 20 clinicians also offered their opinions about what would influence them to stay with their present employers. The most commonly mentioned factors (n = 7) were the availability of **educational opportunities** (university level) and **higher salaries**. Their continuing interest in and challenge from the **work itself** was important to six of the participants. The quality and level of **peer support** and the availability of **professional development and training opportunities** through the agency were each raised by five participants. **Feeling valued as professionals** and having **local ties** were critical to four respondents' interest in staying at their agency and in the community. Another four clinicians said that they felt intelligent **recruiting** practices would also greatly assist agencies in retaining their staff. Other factors mentioned by three or fewer participants as contributing to successful retention included: having opportunities for research; having more agency resources; having the ability to get out of the community periodically; having professional autonomy and responsibility; being able to network/make connections with other professionals; being in a large community; having the agency make retention a priority; working in a pleasant environment; loving the lifestyle and the outdoors; having input into agency decisions; having promotional opportunities; making personal adjustments to the job and the community; receiving better benefits and more non-monetary incentives; and seeing evidence that the government was paying more attention to retention concerns.

With regards to her agency's long-term retention strategy, one female clinician in a small community commented:

> The board and the director are planning to keep people here longer and the way they think they can do it is by the salary increase...I really don't think it will make a difference. There are certain positions that are filled here by people

[from the community] who will stay despite the salary. It might be tempting to some but most of the staff who have come up from the South want to return. Only more training could keep them here longer...it would make an incredible difference. That's why I'll be leaving.

A male clinician from another small community noted:

Being in harmony with the job and with life in the community maybe isn't enough. It's not necessarily a good thing when working with people. You need to be flexible enough to keep learning more and to stay open-minded. Those that adapt to the community may fit well into a closed structure like this agency but it's questionable if that's the best way to judge competence, if it's the ideal to go after.

A comparison of the opinions generated from the two groups (administrators and clinicians) concerning retention success factors reflects a great deal of common ground. It does not seem surprising that more administrators would see recruitment as critical to their attempts to retain staff, yet this factor was also mentioned by four clinicians. Salaries and educational opportunities, though mentioned most frequently by the clinicians, were still only agreed on by 35% of that group. In contrast, the same two factors (salaries and educational opportunities) were cited as important by 71% and 57% of the administrators respectively. The wide variability in the clinicians' responses could well be due to the fact that they were not asked a question directly about retention during the course of their interviews. Thus, their comments are exclusively drawn from the text of their answers to other questions.

Changes Needed to Encourage Retention

The question, "What changes need to take place to keep children's mental health workers in Northern Ontario?", was asked of all groups of participants: administrators, clinicians, and mail survey respondents. In posing the question, I requested that the participants address a variety of levels, including individual change, community change, agency change, and governmental change.

From all groups, most of the interview content was directed toward suggestions for agency and governmental change. Only 21% of the administrators made any comments on changes at the community level and none responded with ideas about individual change. Ninety-three per cent suggested changes at the government level and 100% responded at an agency level. Among the clinicians, the lowest response rate was regarding community change (32%), and next were individual change at 56%, governmental change at 76%, and agency change at 100% participation. Of the 16 clinicians surveyed by mail, one suggested an individual change, two suggested community changes, four suggested governmental changes, and 14 offered suggestions for needed agency change.

Individual level.

A total of nine categories emerged from the interview data of the clinicians who responded. Table 18 summarizes this information. Although the numbers are small, a few comparisons can be made across groups. While more women than men felt that **creating positive relationships with other professionals in the community** and providing **support and showing respect for their colleagues** were valuable changes they could make, more male respondents mentioned the need to personally challenge the negative stereotypes about the North. Not surprisingly, clinicians from the North also identified this category more frequently compared to their peers from outside of the North.

Table 18

Changes - Individual Level - Clinicians N = 41

Category (% of Total)	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=27	n=14	n=13	n=28	n=27	n=14	n=9	n=32
Support, Respect Colleagues (24%)	26%	21%	8%	32%	22%	29%	22%	25%
Create Positive Community Professional Relationships (22%)	26%	14%	15%	25%	22%	21%	44%	16%
Challenge Negative Northern Stereotypes (17%)	11%	29%	15%	18%	7%	36%	22%	16%
Make Concerns Known (12%)								
Assess, Change Personal Working Style (7%)								
Adapt Better to Local Community, Lifestyle (7%)								
Be Less Greedy (2%)								
Take Better Advantage of Learning Opportunities (2%)								

NOTE: Percentages not provided for categories with less than 17% frequency.

Professionals working in small communities suggested the need to better support and respect their colleagues, as well as to establish good relationships in the professional community, far more frequently than those working in large communities. These opinions likely speak to the greater reality of professional isolation in the smaller northern communities and the desire to overcome it. A comparison of the responses from workers in agencies headed by women versus agencies headed by men shows that employees working under female administrators identified the establishment of positive relations among community professionals more frequently than their counterparts in male-administered agencies. It is also interesting to note that the suggestion of needing to **make concerns known,** while only being mentioned by five participants from four different agencies, was dominated by women from outside the North working in small communities under male administrators.

Only two mail respondents had any suggestions for individual change, and both identified the need to **create positive relationships with other professionals in the community**.

Community level.

From the interview data addressing change at the community level, I created eight categories. More administrators but fewer clinicians had suggestions regarding needed community change compared to individual change. Table 20 summarizes the findings for the clinicians' group. The three administrators who responded offered the same suggestion, which related more to recruitment concerns than to retention: that communities need to market themselves better to prospective professional candidates, in terms of housing availability and lifestyle.

With only 32% of the clinicians' group responding to this portion of the question, it is unnecessary to make comparisons across groups. Only one mail survey respondent offered

Table 19

Changes - Community Level - Clinicians N = 41

Category (% of Total)	Female	Male	Large	Small	Outside	North	F.Admin	M.Admin
	n=27	n=14	n=13	n=28	n=27	n=14	n=9	n=32
Increase Cultural Opportunities (17%)	19%	14%	23%	14%	22%	7%	22%	16%
Improve Image of Northern Communities (10%)	11%	7%	8%	11%	7%	14%	0%	12.5%
Offer More Singles-Oriented Activities (7%)								
Increase Availability of Quality, Affordable Housing (5%)								
Improve Library Resources (2%)								
Develop Better Recreation Facilities (2%)								
Develop Better Transportation Systems (2%)								
Move Toward Health Orientation, Promotion (2%)								

NOTE: Percentages not provided for categories with less than 10% frequency.

a suggestion for community change, that being the need to develop better transportation systems within and between communities.

Agency level.

One hundred per cent of the interview participants (administrators and clinicians) and 87.5% of the mail survey respondents spoke to the need for changes at the agency level in order to enhance the retention of northern children's mental health staff. The administrators identified 10 different categories of agency change, summarized in Table 20, while the clinicians identified 11 categories, summarized in Table 21.

A large degree of consensus was achieved by administrators across the first four categories. The need to **increase learning opportunities** for staff, including managers, was cited by all but one administrator as key to an effort to retain staff. Learning opportunities included professional development, internal training, educational upgrading, and clinical supervision and consultation. Two participants mentioned that learning opportunities could influence retention by boosting morale and developing the competence of local professionals.

Numerous strategies were also suggested to enhance learning opportunities within agencies. Identifying this issue as a priority for the agency, making an ongoing commitment to improve the number and regularity of the opportunities, and creating a work environment that supported professional growth were seen as important first steps. The respondents indicated that ideally they would like to have more government funding specifically designated for training. In lieu of increased government support, however, it was generally concluded that agencies would have to become more creative in their approaches to this problem. Pooling resources with other community agencies and with other northern children's mental health centres, offering staff exchanges across northern and southern children's mental health centres, and formally linking with Southern Ontario centres were some of the ideas mentioned. Several

Table 20

Changes - Agency Level - Administrators N = 14

Category (% of Total)	Large n=7	Small n=7	F.Admin n=3	M.Admin n=11
Increase Learning Opportunities for Staff (93%)	100%	86%	100%	91%
Improve Agency Communications - Internal and External (86%)	86%	86%	100%	82%
Give Higher Priority to Recruitment, Retention (86%)	86%	86%	100%	82%
Reduce Stress, Increase Staff Supports (71%)	71%	71%	67%	73%
Improve Agency Policies, Administration (57%)	86%	29%	0%	73%
Give Higher Salaries, More Benefits and Perks (57%)	71%	43%	33%	64%
Provide More Promotional Opp's (36%)				
Give More Recognition, Respect for Staffs' Achievements (21%)				
Develop More Programs Addressing Local Needs, not southern models (14%)				
Improve Physical Working Conditions (14%)				

NOTE: Percentages not provided for categories with less than 50% frequency.

administrators also offered the suggestion of agencies forming the core of a lobbying effort to promote the development of high quality, easily accessible university programs or "centres of excellence" in the North that were relevant to northern needs, and offered both appropriate training and research opportunities.

The vast majority of administrators also concluded that agencies needed to **give recruitment and retention concerns a higher priority**. The most frequently mentioned strategy (n = 7) was for agencies to recruit jointly with other local agencies and with other northern children's mental health centres. The establishment of placement opportunities for university students within agencies and the offering of more recruitment incentives by agencies were each mentioned by four administrators. In the opinion of three participants, agencies needed to become more aggressive and polished in their recruiting, including becoming more known to colleges and universities and doing a better job of publicizing job opportunities. Two other respondents spoke of agencies needing to more strongly voice their recruitment and retention concerns to government and to relevant provincial organizations. A greater emphasis on encouraging Northerners to become professionals was another suggestion made by an agency director.

The need for **improvement of agencies' communications** with government, provincial lobbying groups, other children's mental health centres, and internally with staff was also recognized by 86% of administrators. Joint planning with government and educating government about local needs were cited as ways to avoid wasting financial resources that could be better utilized by agencies to support their recruitment and retention efforts. One administrative participant voiced the need for agencies to learn to accurately hear and address staff concerns.

Seventy-one per cent of the administrators also agreed that, in order to improve retention, agencies would need to **reduce the levels of stress** felt by staff and concurrently increase the level of support available to staff. A wide range of ideas was offered as to how these complementary goals might be achieved. The most commonly mentioned strategy had

agencies making extra efforts to keep their staffs connected to outside professionals, to colleagues, and to resources available within the agency. Two directors believed that by eliminating staff shortages and filling staff vacancies, stress on present staff would be reduced. This strategy was obviously tied to an agency's ability to recruit competent staff, however. It was also asserted that children's mental health centres could go further toward promoting positive inter-agency relations, especially in small communities, as a means of reducing the stress on their staff. Ensuring realistic job expectations, promoting team work and job sharing, and allowing for more diversity in the job and the clientele were other changes identified as helpful in reducing stress. Agencies were also seen as having the responsibility to develop better managers who would be more sensitive to staffs' needs, and to work more closely with local communities to ensure that incoming staff become settled comfortably.

Another 57% of administrators felt that **salaries**, in particular, needed to be higher or at least more competitive with other government and social service sectors in order to both attract and retain staff. It is interesting to note that, according to recent data published by the Ontario Association of Children's Mental Health Centres (OACMHC) (undated), these administrators have a very legitimate concern. OACMHC statistics show that M.S.W. social workers employed by children's mental health centres lag behind all surveyed sectors in salaries from between 4.7% and 28.4%, and B.S.W.'s are paid 12% less on average than those employed in health-funded facilities. Ph.D. psychologists in children's mental health centres are paid between 6.5% and 17.5% less than in other sectors, while psychometrists fall behind in salaries anywhere from 3.1% to 28.7% compared to other sectors.

Fifty-seven per cent of the administrative participants also identified the need for agencies to **improve their policies and administrative practices** to encourage staff to stay. The suggestions in this category varied greatly, however. Some recommended changes would concentrate and institutionalize decision-making, such as from consolidating personnel policies and practices and centralizing programs. In contrast, other recommended changes reflected the

need to eliminate hierarchical management styles dominated by male values so that staff could be more involved in the planning and ownership of the programs.

The provision of more **career development and promotional opportunities** was another identified area of change for agencies. For example, respondents observed that agencies needed to provide more incentives for staff returning from university upgrading. Also, northern agencies were seen as having to provide opportunities competitive with those available in Southern Ontario centres. Greater **recognition of and respect for staff achievement**, including providing staff with opportunities to showcase their expertise and recognizing staff as important internal resources within agencies, were cited by three respondents. Finally, developing more creative **programming that is responsive to local needs** and **improving the physical working conditions** of staff were each identified by two administrative participants as changes needed to encourage retention.

Table 21 summarizes the responses of the 41 clinicians whom I personally interviewed. Unlike the group of administrators, the majority of clinicians agreed upon only two categories of agency change. Eight categories were common to both administrators and clinicians, and the clinicians identified three additional categories: **improvement in recruitment practices, increase in the agency's political power and positive image**, and **improvement in the quality of services, staff, and managers.**

Thirty-seven of 41 professionals indicated that to improve their ability to retain staff, northern children's mental health centres needed to increase the opportunities offered staff for **learning and growth**. In defining this category, I have included opportunities for internal training, professional development, university upgrading, and supervision. The participants discussed a number of important outcomes of increased learning opportunities, including the reduction of burnout and stress, keeping staff current in their profession, improving the quality

Table 21

Changes - Agency Level - Clinicians N = 41

Category (% of Total)	Female n=27	Male n=14	Large n=13	Small n=28	Outside n=27	North n=14	F.Admin n=9	M.Admin n=32
Increase in Learning, Growth Opportunities (90%)	96%	79%	92%	89%	93%	86%	78%	94%
Reduce Job Stresses, Increase Supports (80%)	78%	86%	85%	79%	78%	86%	78%	81%
Improve Recruitment (46%)	37%	64%	54%	43%	33%	71%	33%	50%
Improve Agency Policies, Admin. Practices (46%)	44%	50%	46%	46%	48%	43%	22%	53%
Increase Salaries (44%)	37%	57%	54%	39%	41%	50%	22%	50%
Increase Agency's Political Power, Positive Image (39%)	33%	50%	31%	43%	26%	64%	44%	37.5%
Review, Revise Programs, Treatment Models (37%)	30%	50%	38%	36%	30%	50%	44%	34%
Increase Recognition, Respect for Staff Achievement (34%)	37%	29%	31%	36%	30%	43%	22%	37.5%
Improve Quality of Services, Staff, Managers (29%)	22%	43%	31%	29%	22%	43%	0%	37.5%
Increase Promotional Opportunities (15%)								
Improve Physical Working Conditions (10%)								

NOTE: Percentages not provided for categories with less than 29% frequency.

of service, increasing staffs' credibility, and helping staff to feel clinically supported, stimulated, and motivated. They also did not restrict their comments exclusively to clinicians but also mentioned the need for training for supervisors and managers. Learning opportunities were mentioned as being especially important for less experienced staff and for the development of northern professionals, and it was felt the offerings must be relevant to both the clinician's needs and local needs.

A number of strategies for achieving an increase in learning opportunities were suggested by the professionals. It was recommended that agencies begin to show some leadership by making professional development, for example, a higher priority internally, and in so doing become more encouraging and supportive in terms of time and money made available to staff for this purpose. An improvement in agencies' educational and sabbatical leave policies, including greater financial assistance from bursaries or loans, was one critical factor mentioned by a number of participants. Workers identified their colleagues with families as being in a particularly difficult position when contemplating a decision to go back to university because of the inadequate financial assistance available.

Easier access to university resources and libraries, possibly including the establishment of formal links with universities for resources, placements, research, and intellectual stimulation was also recommended. Bringing these kinds of resources north and housing them in a northern research and/or clinical training centre were the suggestion of two participants, one of whom has made the decision to leave the North because of the lack of research opportunities. Interviewees also suggested that agencies could better utilize the funds available to them now by hiring or training an internal trainer, better utilizing experienced clinicians already on staff as learning resources, and by linking and pooling resources with local agencies and/or other northern children's mental health centres.

The **reduction of the levels of stress** experienced by staff, and the concomitant **increase in clinical supports** were identified as very important steps that were absolutely

necessary for agencies to take if they hoped, not only to retain their staff but to keep them at their most clinically effective. The professionals indicated that adequate support was needed to prevent staff from experiencing all the burden of the job on themselves and thus to allow them to feel competent and satisfied with their work. Respondents recommended that agencies encourage the following practices:

1. **supporting** staff, financially and emotionally, with resources, policies, and benefits;
2. more **supervising and consulting** with staff, and providing resources, in the short-term, to share the burden of cases, and to provide reassurance, ideas and encouragement;
3. increasing opportunities for **training, learning and developing** of skills and expertise, to enhance competence and confidence over the long term;
4. **linking and establishing networks** with colleagues, other community professionals and collateral agencies, and other children's mental health centres, utilizing technology and also team-building, in order to reduce isolation;
5. **listening to and recognizing** staff grievances, the stress they feel, their needs and concerns, and the uniqueness of the communities in which they work;
6. **valuing and respecting** staff, their individual differences, their professions, and the work that they do;
7. staff **participating and sharing** in the decision making so as to share the burden and feel a part of the organization;
8. increasing **staffing** to help lower caseloads;
9. developing more **realistic job expectations**;
10. assisting staff with **adjusting and adapting** to their new community and their new job, in part by fostering contact with their outside support systems;
11. improving the **planning and managing** of agency change and striving for internal stabilization, as change can be stressful; and

12. **advocating and lobbying** with government on behalf of staff to address their concerns.

Slightly fewer than half of the clinical interviewees felt that agencies also needed to improve their **recruitment practices** and their **policies and administrative practices**. Finding, attracting and training northern professionals, and emphasizing the fit between the person and her/his work and community environment were the most commonly suggested changes in recruitment practice. One worker mentioned the importance of management changing its attitude that "imports are better than locals".

Some participants believed that agencies should provide a wider range of clinical services in order to attract more professionals, while others said that agencies should more strongly promote the northern quality of life, and should be more creative in their publicity by utilizing conferences, universities, staff exchanges and agency directories to promote job opportunities in the North and overcome the negative stereotyping of northern jobs. Incentives were also seen as crucial if agencies were to successfully recruit more experienced candidates who in turn could be further internal resources for supervision and support. Incentives, as described by the clinicians, included salaries, benefits, and regular learning opportunities.

Improvements in agency policies and administrative practices were characterized by the elimination of promotional and salary inequities between gender groups and across sites within an organization, and the introduction of personnel policies that were both socially progressive and beneficial toward reducing stress. Most importantly, staff asserted that agencies needed to listen better and become more proactive in addressing staffs' concerns and grievances. A number also recommended that administrative hierarchies needed to be reduced in size and flattened, and that structures that encourage the involvement of employees in decision-making should be promoted. The need for a clearly-stated agency mission or philosophy statement was

raised as an important component of any agency with vision and a sense of its future, qualities that staff find reassuring.

Salaries were only mentioned by 44% of the clinicians, compared to 57% of the administrators, as a factor they believed influenced retention. There was a mixed response as to whether salaries should be substantially higher in the North in order to attract and keep staff, or if they should simply be fair and competitive with salaries in the rest of the province, fearing that much higher salaries could attract professionals to the North who were primarily motivated by money. Two participants said directly that higher salaries would make no difference to them in their own decision-making process.

An increase in the **political power**, status and lobbying strength of northern agencies was primarily seen as a way to challenge the negative northern stereotypes surrounding the agencies, professionals, services, communities, and the people, and to make northern needs known to government. Participants suggested this could be accomplished in two ways: by agencies individually advertising, promoting and educating about their services, and showcasing theirs and staffs' accomplishments, and by agencies collectively showing cooperation, initiative and creativity in developing joint lobbying strategies.

In discussing the need to review and revise **clinical programs and treatment models**, interviewees generally agreed that agencies should re-instate their clinical services as a top priority, as some clinicians believed that their centres had become enamoured with technology and focused on administration. Acknowledgement of some of the unique service needs in the North and the development, with staff and community input, of treatment models that reflected northern, not southern, realities were also cited as important factors.

The need for more **recognition of and respect for the achievements** of agencies' own professionals was highlighted by 14 of the respondents. Concerns about the **quality of clinical services** and supervision, and the competency of management and clinical staff were raised by another 12 participants in discussing those areas needing improvement in order to keep staff.

It was recommended that agencies needed to priorize all concerns relating to service quality, and to be willing to routinely evaluate the effectiveness of programs and of personnel and make the necessary changes to ensure quality and competence.

The results of the mail survey were consistent with the data from the clinicians' interviews in all respects except that the mail survey respondents mentioned **salaries** ahead of agency policies and administrative practices.

Government level.

The changes needed at the government level that were suggested by the administrators fit into five categories. These are summarized in Table 22 for the reader. This group of participants again showed a great deal of uniformity in their perception of what changes government should make to retain Northern Ontario professionals.

Consistent with their view that **learning opportunities** needed to be increased through agency efforts, 12 of the 14 administrators suggested that government had some obligation to work with agencies toward the same goal. Administrators proposed that this could in part be accomplished by the government providing more funding specifically earmarked for professional development and training, particularly for those smaller agencies in smaller, more remote communities that had fewer local resources and poorer access to outside resources. The second primary strategy outlined by administrators was the need to either develop more education programs in the North that addressed the needs of northern agencies and professionals, particularly at the level of graduate studies, or at least, to improve the quality, relevance and accessibility of the existing university programs. Thirdly, these respondents indicated that the existing government bursary program needed to be reviewed and revised to provide greater benefit to the agencies in more remote communities, to students already living in the North, and to students with families to support.

Table 22

Changes - Government Level - Administrators N = 14

Category (% of Total)	Large n=7	Small n=7	F.Admin n=3	M.Admin n=11
Enhance Learning Opportunities, Universities in North (86%)	100%	71%	100%	82%
Increase Funding, Resources to Agencies (79%)	100%	57%	100%	73%
Seek Local Consultation, Collaborative Planning (71%)	86%	57%	100%	64%
Promote the North, Assist with Recruitment (43%)	43%	43%	68%	36%
Streamline Their Bureaucracy and Management (14%)	14%	14%	0%	18%

The next most frequently suggested change at the government level was a needed **increase in funding and resources** for those priorities identified in partnership with, not in isolation from, the agencies and local communities. Examples of some of the areas of need identified by these administrators were: professional development/training (n=7), salaries (n=5), recruiting (n=3), staffing (n=2), and staff relief travel (n=1). It was also widely recognized by the administrators that government was not a bottomless source of money. Hence, some were angry at the imposition of a number of extremely costly and unnecessary programs when the same money could be much more wisely and economically spent in ways that better addressed their real needs. Others felt unfairly restricted in how they could utilize their funds and suggested that by giving agencies more flexibility in spending, the money would be better used. Several others also suggested that the government must recognize differences and fund accordingly - differences between the costs incurred in northern agencies compared to southern agencies, and differences between the large northern children's mental health centres in the urban centres and the small northern agencies in the more remote communities.

The need for government to routinely **seek more local consultation and engage in collaborative planning** with agencies and communities was described by administrators, not only in the context of funding, but in all aspects of service delivery and development. Government decision makers, it was believed, needed a much greater understanding of northern issues and priorities in order to better address the real needs in the North. The respondents indicated that they wanted to be treated like partners in the short- and long-term planning process. They also maintained that they were deserving of the autonomy necessary to operate with more flexibility.

Six of the administrative participants suggested that the government could be more helpful to the northern agencies in the area of **recruitment**, by providing more funding, showing leadership in addressing recruitment problems and coordinating recruitment efforts, and redesigning its bursary program to make it a more useful recruitment tool.

A small number of administrators also cited their frustrations with the inconsistency of government policies and the poorly coordinated, highly hierarchical **government bureaucracy**, both of which they believed contributed to agency problems with service delivery and staffing.

Many of the administrators' comments in this portion of the interview reflected their seemingly incompatible desires for both increased agency autonomy and for increased partnerships with government in some aspects of their operation. Their task of finding a workable balance is certainly challenging.

Of the 41 clinicians interviewed, 76% offered suggestions for changes needed at a government level to assist with retention. Table 23 summarizes these results. Only one category was mentioned by more than 50% of the clinicians, that being the need to **enhance learning opportunities and universities in the North**. Again, as seen in the earlier comments about retention, clinicians identified pressing needs for greater financial support to agencies for professional development and training, and for upgrading the quality of the existing northern universities, which they perceived as having quite poor academic reputations. They recommended that the government should financially support a special effort to develop more northern professionals through upgrading their present qualifications and/or providing specialized training. The participants also identified the need to gain easier access to university resources such as library materials. They felt this could in part be accomplished by the government changing the locale of the Northern Outreach Program to one of the two major northern universities.

The Northern Outreach Program has provided resource materials, such as journal articles in specialized areas of health and social services, to northern professionals and is presently situated at the University of Western Ontario in London. In order for this move to be worthwhile, the Northern Outreach Program, together with the chosen university, would have

Table 23

Changes - Government Level - Clinicians N = 41

Category (% of Total)	Female n=27	Male n=14	Large n=13	Small n=28	Outside n=27	North n=14	F.Admin n=9	M.Admin n=32
Enhance Learning Opportunities, Universities in North (56%)	52%	64%	69%	50%	52%	64%	33%	62.5%
Increase Funding, Resources to North (37%)	44%	21%	38%	36%	41%	29%	11%	44%
Seek Local Consultation, Collaboration (34%)	33%	36%	15%	43%	30%	43%	44%	31%
Promote Positive Northern Image (27%)	22%	36%	38%	21%	22%	36%	22%	28%
Streamline Bureaucracy (22%)	19%	29%	23%	21%	15%	36%	33%	19%
Priorize Service Quality (15%)	0%	43%	23%	11%	11%	21%	0%	19%

to acquire all the needed information sources. In these ways, northern universities would be given the overall task of providing resources to northern service agencies and could also become the focal points for northern research and clinical training. One participant believed the idea of upgrading the northern universities was not feasible, and his suggestion was for the government to encourage more linkages between northern and southern universities for training and research.

Another important change identified by clinicians that related to learning opportunities for northern professionals was the need for all university training programs in disciplines such as psychology and social work to offer more training and theory in the area of rural practice. As this was an area of interest of my own as well, I conducted a survey in the summer of 1989 of the 23 accredited social work programs across Canada to determine to what extent their curricula contained any rural content. The response rate was 52%.

My findings indicated that three programs currently offered a course devoted to rural concerns. However, two of these programs only offered the course as an elective. Another program had offered a course in the past but gave no indication whether it was still being offered. Three other programs offered courses that had some rural content, while four programs had involvement in rural research. Four other programs replied that their curriculum had no rural content. Thus, the need expressed by clinicians for more a rural emphasis in counsellor training programs seems well-founded.

The clinicians also expressed concern about the amount of government funds that find their way to the North. Fifteen of them suggested that the North warranted **increased financial support** from the government, not only in the area of social services but for transportation systems and technology to overcome physical and professional isolation. However, the majority identified professional development and training as the area where they would most like to see funding increased. Salaries, library resources, new programs, bursaries, more staffing, better

work sites, research, and program evaluation were the other suggested areas for increased funding.

Like their administrative counterparts, fourteen clinicians also cited the immediate need for improved **local consultation and planning.** This approach was seen as far preferable to the current tendency of imposing programs on agencies and communities with little consultation.

Twenty-seven per cent of the clinicians believed that government also had a role in **promoting a positive image of the North** across the rest of the province and beyond. They saw this responsibility being achieved through the promotion of northern universities, rural social services, the northern quality of life, northern job opportunities, and northern professional expertise in various areas. Fostering more linkages in a variety of sectors between north and south was a means one participant suggested to give Southern Ontario a more accurate picture of what lay north of Barrie.

Streamlining its own bureaucracy and management was another suggested government change offered by 22% of the workers I interviewed. Constantly changing priorities and inefficient and ineffective bureaucratic systems were seen by participants as having a negative impact on agencies and workers, especially when major change within agencies was required. Helping agencies manage major change, such as occurs with amalgamation, was believed to be very important in relation to retention. One long-time northern professional concluded that a full review of the children's mental health system within the government was justified because the system was losing sight of its priority to provide services for children. Another suggested that more government officials in northern offices should themselves be from the region so they would better understand northern issues.

Finally, a small group of clinicians also saw a role for government to play in ensuring that **high quality** children's mental health services are provided across the North. By creating the expectation that agencies carefully and routinely evaluate their programs, their professional staff and their managers, the government can promote the notion of the accountability of

agencies for the quality of their services. Also, high turnover of skilled northern professionals should serve as a warning signal to government officials that quality service may be endangered.

Of the participants who responded via the mail survey, five supported the need for increased funding and resources to the North, four desired that government take more of a role in enhancing learning opportunities in the North, two suggested the need for government to streamline its own bureaucracy, and one each stated there was a role for government to play in promoting the North more positively, and ensuring the quality of northern children's mental health services.

Use of the Research Results

Because of the participatory nature of this research and because my intention in initiating the research was that the results be useful to all stakeholders of the children's mental health system within Northern Ontario, I asked the interview participants for their ideas about how they would like to see the results of the research used to best serve their interests. Twenty-eight of the 41 clinicians and all 14 of the administrators responded with their preferences as to how the research should be used.

Clinicians overwhelmingly stated that the results would best be shared with officials of the Ontario Ministry of Community and Social Services (MCSS), which is responsible for funding children's mental health services in the province, and with the directors and other decision-makers within the participating agencies. The next mostly commonly suggested use of the results was that they should be sent to both provincial and federal politicians who would be in positions of influence within their respective Cabinets and legislatures in order to lobby for the issues and concerns brought forward by Northerners in this research.

Publishing the research results in journals and in agency newsletters was another suggestion of several workers, while others recommended the research be shared with other

provincial government ministries, for example, the Ministries of Health, Education, and Colleges and Universities, with the universities themselves, and with professional associations within the province. Special interest lobby groups and the Ontario Association of Children's Mental Health Centres were also mentioned as suggested recipients of the results.

Administrators shared the opinion of the clinicians that MCSS and their own agencies should be the primary beneficiaries of the research results. Several also mentioned that a committee of MCSS officials and northern directors that was to be formed at some point should have the results available for their deliberations. Presenting the results at an upcoming conference on rural issues, and sharing them as well with provincial politicians, university officials, and even the media were other suggestions.

From both the clinicians and the administrators came the clear message that it was most important that the research results be both practical, that is, easily translatable into "cookbook" solutions or checklists that agencies and the government could easily refer to, and be written in a non-offensive or non-blaming manner in order to maximize their acceptability.

Feedback to the Research Participants

I gave my assurance to all stakeholders in this research project that they would receive feedback on its results. I asked each of them in what form this feedback would be most useful to them. Thirty-six clinicians and 11 administrators responded, with the majority (66%) of the entire group indicating that a written summary would suffice. Seven did not indicate a preference, six requested that I send them the complete thesis; one director indicated a preference that the results be communicated in person to the director and the staff, and one clinician said she preferred I share the results with her by phone rather than in writing. I assured the participants I would honour their requests to the best of my ability and as financial resources allowed.

Impressions of the Interview Process and Content

Each of the research interviews concluded with my request for immediate feedback from the participants as to their impressions of the interview process and content, and for their suggestions as to any improvements I could make in either area. Thirty-three clinicians and 12 administrators offered their comments and suggestions, for which I was most appreciative.

Eleven of the clinicians said they "liked the process", eight characterized it as "relaxing" or "comfortable", seven said they liked that they could "talk freely", six said it was "fine", two said it "went well", and one commented that she liked that there were "no surprises". As to the interview's content, eight of the respondents felt it was "relevant", another eight said that it seemed to "cover everything", five indicated they found it "easy to follow" and one said simply that "I liked the content".

As well, seven different professionals offered seven suggestions for improvement. The only suggestion made by more than one participant was that it would have been helpful for them to have the questions ahead of time. This option was given to all participants in my letter of introduction to each prior to the interviews taking place. However, in the future, I would automatically include the questions as part of the package of materials I send to participants when requesting their participation.

Other suggestions reflected some participants' feelings that I should have been more specific in my questioning, for example, that I should have asked about the "specific therapies offered at each centre" and the "worker's philosophy of working with clients", and asked the participants to priorize their responses (e.g., "what would be the most important thing to change to make you stay?"). One participant said it would have been helpful if I had provided more information, before the formal interview started, about myself and how I became interested in this area of research (we discussed this after the fact). The other comment was more of a question; the clinician wondered how I was going to tackle and prepare all the data.

The administrators, unlike the clinicians, commented more on content than they did on process, and they also offered more suggestions. Two administrators said they found the process "relaxing", two said they appreciated being able to "talk freely", and one each said "I liked the process", "I enjoyed it", and she or he thought that it was "organized well". In terms of content, three stated that it "covered everything", two said the questions were "relevant", two said they "liked the content", and one described the questions as "easy to follow".

Three of the administrators mentioned that I had neglected the subject of recruitment, which I subsequently corrected in later interviews, and two commented that it would have been helpful to have the questions in advance. Their other comments related to content areas that individual administrators said should have been covered, for example, "agencies growing their own staff", recruitment and retention concerns specific to professional disciplines, the importance to recruitment and retention of the variety of opportunities agencies could offer, identification of specific reasons for job dissatisfaction (I explained that this was covered in the questionnaire for the clinicians), and the need for actual turnover statistics from each of the agencies.

With regard to this last suggestion about turnover statistics, I had originally thought that obtaining the subjective opinion from administrators as to the extent of their concern about turnover and retention was valid enough for my purposes. I had rationalized that it was actually their subjective opinion that was more important because it influenced the way they priorized their concerns and developed strategies. However, after considering the comment from this administrator, I decided that the available statistics could lend more credibility to the argument that turnover and, conversely, retention were legitimate concerns in the North. Therefore, after the interviews were completed, I wrote each of the directors and requested whatever turnover statistics they were willing to provide to me. Their responses were reported earlier in this section.

I appreciated all the feedback I received and incorporated what I believed would add to the research while keeping its focus. I will utilize other suggestions in future research endeavours.

Group Patterns

In qualitative research, it is both interesting and informative to look at the very large volume of interview data in a number of ways. I have already reported on the responses to each of the research questions by each of the eight groups into which I have assigned the clinicians who participated. I formed these eight groups to serve as a basis of comparison across gender (of participant and executive director), size of community, and place of origin. I have noted what I have concluded to be some interesting comparisons across groups on a particular question.

By exploring patterns of response across all questions but within individual groups, it is sometimes possible to gain a clearer picture of what really matters to a particular group and of the overall differences across groups. As in all qualitative data analysis, defining patterns is to some extent an interpretive exercise. However, the quantification of the responses helps to make the determination of patterns a little easier.

Women

As a group, the female clinicians I spoke to were most often attracted to their jobs in the North by the nature of the job itself and the opportunities it afforded them, by particular qualities of the community itself (e.g., homey, personable), and by the features of a northern lifestyle (e.g., outdoor activities, peaceful). Both the lifestyle and the human component of the community were also the major contributors to women's feelings of satisfaction with their lives, as they commented on how much they appreciated the availability of leisure activities and

living close to nature, as well as the friendliness and honesty of the people. Yet, women identified fewer sources of satisfaction than six other groups.

Many women expressed a number of specific concerns about their communities, including the lack of urban conveniences such as cultural activities, municipal services, and library resources. Many also found their communities embracing very traditional and conservative attitudes towards women while affording them little privacy and opportunities for networking. Women who were single found their integration into the community particularly difficult, given the above-mentioned factors as well as the lack of prospective partners and the orientation of communities toward couples, not singles.

Women expressed more job dissatisfaction than six other groups of participants. Only female clinicians mentioned burnout and high levels of stress most frequently in citing sources of work-related dissatisfaction. With the same frequency, they also raised related concerns about feeling professionally isolated and having access to so few resources, and about feeling unsupported and undervalued as clinicians and employees. A lack of clinical supervision, professional development and training, coupled with excessive work demands, were also frequently mentioned by women, likely exacerbated by the stress and isolation many felt.

Somewhat ironically, it was from the flexibility of their job and the autonomy with which they were allowed to work that most women derived job satisfaction. Working in small communities, some at a great distance from agency headquarters, in agencies that are sometimes understaffed with workers and supervisors, does indeed allow for a great deal of autonomy and flexibility on the job. Yet, without the necessary physical, clinical, and emotional supports, such scenarios can also be a recipe for burnout. Several women, in my judgment, were, unfortunately, very close to that point.

In addition to the flexibility and autonomy on the job, women also found satisfaction from the work itself and from the support and respect of their colleagues. It was the nature of the work that attracted many women north to begin with and it appears that many continued

to find it appealing. Collegial support was also cherished, especially in light of the fact that many women felt unsupported by their agency management and structure. Their concern about a lack of support at the agency level coincided with their level of concern about gender issues in the work-place. Again, women were the second most vocal group in raising gender concerns within agencies. Only Northerners themselves raised more concerns. However, unlike Northerners, women pinpointed the management style of the agency, that is, its structure and its practices, and the effects of both as the primary source of their concerns.

As a group, women most frequently identified the need for more collegial support and respect, and the creation of positive professional relationships in the community as changes that individuals could make that would promote retention. Both are positive ways of enhancing the supports women felt they were lacking in other areas. Women also talked about community change more than all groups except those clinicians from large communities.

At the level of agency change, women, more than any other group, expressed the need for an increase in the learning opportunities available to clinicians. The majority of women also indicated that this same issue, including enhancing northern universities, needed to be a government priority for change as well. Secondly, women clearly expressed the need for agencies to reduce the stresses for workers on the job and increase supports. Both of these targets for change coincide with the primary sources of work dissatisfaction for women. At the government level, a third or more of the women also stated that funding and resources to northern agencies needed to be increased, and that government must become more proficient at seeking community consultation and engaging in collaborative planning with local services.

Men

Collectively, the male clinicians identified more factors contributing to their life satisfaction than did any other group. They also provided more responses describing what attracted them to the North, what dissatisfied them about their communities, and what they

found satisfying about their work than most other groups. In contrast, they also cited fewer sources of job dissatisfaction than most other groups. Thus, the men I interviewed, excluding administrators, were predominantly very attracted by and pleased with the lifestyle that northern communities offered and with the social community, but found more displeasure than most groups in some of the physical aspects of their communities such as the small size, poor shopping, and lack of university resources. They were also generally more pleased with their jobs than most other groups.

In terms of their assessment of their jobs, job flexibility and autonomy were mentioned by six of ten male clinicians as contributing to their satisfaction. However, male clinicians cited, more than any other groups, the support and respect of their colleagues and the professional development and training available to them as their sources of satisfaction on the job. Yet they also, more than any other group, cited professional development and training, as well as the lack of clinical supervision, as sources of dissatisfaction. Factors such as the inaccessibility of such opportunities, the time lost, and the lack of agency support for these opportunities were commonly mentioned. Clearly, the male clinicians highly valued professional development and training, appreciated the opportunities offered, but felt negatively about the priority such opportunities were given by agencies and government, and about certain aspects of the activities themselves. Their concern about the lack of clinical supervision was equally strong, thus reflecting an overall sentiment that learning opportunities, in any form, were of paramount importance to themselves and, indirectly, to their clientele. Male professionals were also concerned about the instability of their agencies and the impact this instability had on staff retention.

In terms of gender differences, male clinicians most often expressed concern about the clinical impact of gender, for example, the effect on supervision of the supervisor and supervisee being of the opposite sex, and the difficulty for a male therapist working with female victims of abuse.

The most frequently mentioned individual change proposed by male clinicians involved individuals challenging the negative portrayal of the North, its services and its professionals. Fewer males identified change needed at a community level than any other group. However, at an agency level, only Northemers themselves offered more ideas for change. Along with Northerners, the male clinicians cited the need for agencies to reduce job stresses and increase supports, including clinical supervision, to its workers more than any other groups. Also, in keeping with the concems they expressed about professional development, training, and supervision, male professionals were adamant about the need for reform, at both the agency and the government level, in this area. In particular, they cited the need to increase the opportunities available, including those for graduate level studies in northern universities.

Clinicians in Large Communities

Those clinicians whose primary work setting is within one of the five largest northern communities, i.e., Timmins, North Bay, Sault Ste. Marie, Sudbury, and Thunder Bay, formed this group of participants. This group, in general, offered more responses about attraction to the North and about life satisfaction than most other groups. They also cited fewer sources of job satisfaction than most other groups.

Like the male clinicians, this group of participants was most attracted to the North by its lifestyle and particular qualities of its communities. Larger communities offered more of a variety of activities, several offered access to a university, and in general these clinicians felt their community was an attractive compromise to urban centres elsewhere. The satisfaction that these workers derived from their communities again was related to the lifestyle, for example, recreational opportunities nearby, and to the human component of the community, the people they found to be interesting, accepting and also informal. Their primary complaint with their communities had to do with the lack of cultural and artistic opportunities and with poor municipal services, such as snow removal or road repair.

Clinicians working in large northern communities raised fewer factors they liked about their jobs than most other groups. They most often mentioned liking the amount of flexibility and autonomy they had on the job. The opportunity to collaborate with other community professionals was mentioned more often by this group than any other, and by quite a large margin. They seemed appreciative of the fact that larger communities naturally have a larger professional community and thus derived satisfaction from collaborative exchanges. However, within their own agencies, they were particularly concerned with their agencies' instability, the excessive work demands and pressures, the low salaries, and the lack of support and recognition they received. Also internally, most of their gender concerns related to the domination by men of their agencies' upper management and administrative positions.

This group of clinicians offered the highest proportion of responses concerning community change and the lowest proportion concerning individual change of any group. Their main interest with regards to community change was seeing an increase in the number of cultural events and activities offered in their communities. It may be that they expect more from a larger community, namely that it provide opportunities similar to those of comparably-sized communities in Southern Ontario. At an agency level, their priorities were similar to most other groups: increase their learning opportunities, increase other supports, and reduce the level of job stress, which in their case came primarily from under-staffing, long waiting lists, and heavy caseloads.

At the level of government change, this group offered fewer total responses than most other groups. However, they more frequently expressed the need for government to play a role in increasing learning opportunities and enhancing universities in the North than did any other group. This is interesting in that it is the large communities which house the North's universities. Thus, these clinicians would presumably be most familiar with the nature and quality of the universities' programs.

Clinicians in Small Communities

This group of clinicians seemed, more than any other, to represent the norm in terms of their level of response to each of the research questions. They did not respond more than other groups to a particular question, nor did they respond less. Thus, their responses, both in frequency and in content, seemed representative of the majority of participants.

It is interesting, however, that clinicians in small communities expressed more concern about the issue of clinical supervision than did any other group, even though it was the most frequently mentioned concern of most. While almost three quarters of the respondents from small communities expressed a strong concern about the availability and quality of supervision, in marked contrast less than one quarter of their colleagues from large communities voiced that same concern. The participants I spoke to who worked in smaller, more remote communities were frustrated, and some admittedly frightened, about the implications for them and for their clients of the serious lack of quality supervision available to them. It was not acceptable for them to simply try to "do their best" under the circumstances and wait until things improved. In relation to this specific concern, several did state that they would be leaving their jobs within months unless the situation changed immediately.

Nine out of ten of these respondents believed that an increase in learning and growth opportunities, including clinical supervision, must come about at the level of agency change. In light of their expressed concern about supervision, it is also interesting to note that this group cited more than other groups the need for individual clinicians to provide support and show respect for each other, possibly, in part, to help fill the supervisory void.

At the level of government change, in addition to identifying the need for more learning opportunities and more funding, this group, more than most others, cited the need for government to consult and collaborate more with local communities and service providers. They did not want their smaller communities to go unheard.

Clinicians Originating from Outside the North

This group of participants was made up of those clinicians, now working in the North, who originally came from a location outside the region. The profile of this group was one of clinicians who were initially attracted to the North by more factors than any other group, including their sense of adventure and challenge. However, this group, in turn, expressed the highest degree of dissatisfaction with their lives compared to all other groups. This dissatisfaction was largely centred on the physical aspects of their community, on their status in the community as single persons, and on their difficulty integrating into the community. Some described their communities as too small, or too culturally deficient. Others said they feared their community's economic instability, and several expressed concerns about the inadequacy of the transportation systems to allow them access to their original homes and friends.

In terms of community integration, this group of clinicians felt the process took too long and that their community was too closed socially. Others described a feeling of culture shock when they initially arrived and said it has required a great deal of personal energy to adjust.

Despite their concerns about life dissatisfaction, this group identified fewer sources of work dissatisfaction than most. They also had less concern about gender differences in the work place, particularly in relation to clinical issues, than did most other groups.

With regards to needed changes, this group of professionals identified the need to increase cultural activities at a community level, and, like all other groups, believed that agencies and the government must give higher priority to increasing the learning opportunities. They also agreed that agencies needed to better support their staff and help reduce job stresses, and that government should assist in this process by increasing funding and resources to agencies.

Clinicians Originally from the North

Workers who are indigenous to the North made up approximately one third of all clinical participants. This group provided some distinctive responses to the research questions, reflecting their unique position as the group most familiar with the North and likely the most settled in their communities. It is not surprising, then, that Northerners gave the fewest number of responses to the question about life dissatisfaction. It is interesting, in contrast, that Northerners expressed more concerns about both job dissatisfaction and gender differences within agencies than any other group. They also offered the fewest number of ideas for change at the community level but, in keeping with their level of job dissatisfaction, provided the highest number of suggestions for change at the agency level.

In contrast to other groups, Northerners stated they were most attracted to the North by the qualities of northern communities and by the fact that many of their family and friends were close by. They ranked their accessibility to people and places far higher in relation to life satisfaction than did any other group, again reflecting the reality that many of these participants had family in the area, had long-established friendship networks, and had developed ways to cope with or overcome the physical isolation of remote communities. Like other groups, they mentioned most often the satisfaction derived from the northern lifestyle and from the community of people with whom they lived.

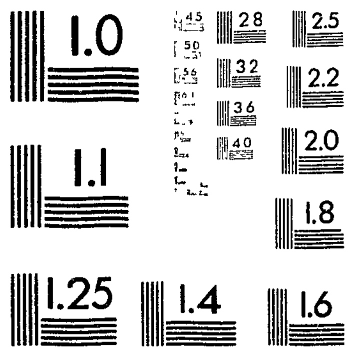
In citing fewer sources of life dissatisfaction overall than any other group, Northerners did express more concerns about the human community than any other group. Thus, while identifying the local people as a source of satisfaction, they experienced some discomfort with their neighbours as well. A number of these participants talked about the unique problems that were posed by their being raised in the local community, in terms of professional expectations, confidentiality, and their acceptability as professionals in the eyes of long-time acquaintances and friends.

In the area of job satisfaction, Northerners' responses largely coincided with the rest of the groups. They were somewhat more satisfied than other groups, however, with the level of input they were allowed within their agencies. Yet, in terms of job dissatisfaction, Northerners, with much greater frequency than other groups, cited a number of concerns. While agreeing with other participants that the lack of clinical supervision was a concern, Northerners expressed an equal level of concern about workers being unsupported and undervalued in their agencies. As well, six out of ten of them cited their agencies' instability and low salaries as sources of dissatisfaction, and this ratio was higher than in any other groups. Northerners were also more concerned about their agencies' lack of vision and a movement away from a predominant clinical orientation, as well as agencies' unfair or misguided personnel policies and procedures, than were other groups.

Far more than any other group, Northerners identified gender-related concerns within their agencies, particularly with respect to clinical issues, male domination in upper management and administration, and the prevalence of gender-based attitudes. They were more critical than most with respect to how the North in general deals with gender issues, typically using terms such as "macho" and red-necked" to describe attitudes at large.

In terms of change, Northerners had the least to say about change at the community level and the most to say about change at the agency level. More than other groups, they identified the need for more individuals to challenge certain unfair negative stereotypes about the North. Similar to other groups, they cited the need to increase learning opportunities and supports and reduce job stresses.

Yet Northerners also spoke more frequently about the need for agencies to both improve their recruitment practices (many suggesting the need to recruit and train more Northerners) and to collectively enhance their political power and prestige in order to be able to lobby more effectively for northern issues.



Over 60% of clinicians indigenous to the North believed that the provincial government had a responsibility to improve learning opportunities in the North. Some were graduates of northern universities and had mixed reviews about the quality and relevance of the education they received. Others who had been forced to uproot themselves to return to university outside the region said that accessibility must be improved if professionals are going to stay in the North. Northerners, more than most other groups, also recommended that the government should consult more locally, do more to promote the North, and improve the efficiency of their own bureaucracy.

This group as a whole, possibly because they felt the most comfortable and secure being on their home turf, seemed to be the most outspoken and did not hedge their words when they were displeased and wanted rectification.

Clinicians Working for Female Administrators

As I have mentioned earlier, I arrived at the decision to compare participants on the basis of the gender of their executive directors only after a preliminary analysis of the interview data seemed to indicate some differences. The group of clinicians working for female administrators was the smallest in number (n = 9), representing approximately one quarter of all clinicians interviewed. Therefore, it is appropriate to suggest some methodological caution to the reader when drawing conclusions from this small sample.

This group, in addition to being attracted to the North by the job itself, also found the beauty of the area to be equally important to them in their decision. Like other groups, more have found the northern lifestyle and the human community to be satisfying in their lives than other factors, and like other groups, the primary source of life dissatisfaction has been the physical aspects of their communities. This group indicated more frequently than other groups, however, that they felt no dissatisfaction at all with their lives.

Clinicians working for a female administrator also cited far more sources of work satisfaction and far fewer sources of work dissatisfaction than any other group. The most frequently mentioned source of satisfaction on the job was their feeling of being supported and valued by their agency. Two thirds also expressed pleasure with the flexibility and autonomy they were given, with the quality of their colleagues, and with the level of professional development and training they were offered. Also cited more often than in other groups was the opportunity to use a team approach in their work and their satisfaction with the work environment.

This groups' percentage of responses relating to job dissatisfaction was half the size of the next lowest group. They ranked far below the norm in all categories but two, the lack of clinical supervision and excessive work demands. This group also identified the fewest number of concerns relating to gender differences within their agencies, and of those mentioned, concerns about clinical issues predominated.

Interestingly, this group also identified the most changes needed at an individual level and the least number needed at an agency or a government level. This result may reflect an attitude of willingness to take more personal responsibility for change, especially in the area of creating positive relationships with other community professionals, which promotes collaboration. At a community level, the only change they mentioned was the need for more cultural opportunities.

At any agency level, this groups' main priorities were the same as other groups, that is, increased learning opportunities and supports, and a reduction in job stresses. In other areas, such as agency policies and practices, salaries, and the need to increase recognition for staff, they voiced less need for change than did other groups. At the government level, although citing fewer changes overall, this group did mention slightly more often than others the importance of government using a more consultative and collaborative approach to planning.

The value they placed in participative decision-making seemed to recur throughout their discussions on job satisfaction and change.

In summary, this group seemed the most satisfied overall.

Clinicians Working for Male Administrators

This group was represented by the largest number of participants, approximately three quarters of the clinicians interviewed. Their responses describing what attracted them to the North and the sources of their life satisfaction held to the norm of all participants. They identified more sources of life dissatisfaction than most other groups but no one factor stood out as divergent from other groups.

These clinicians cited fewer sources of job satisfaction than did any other group. With regard to feeling supported and valued by their agency, this group offered 50% fewer responses than their colleagues. In terms of job dissatisfaction, only one other group, clinicians from the North, expressed more concerns. Yet, their responses did not outnumber other groups in any category except their concern about management/staff relations. The issue they raised most often was feeling unsupported and undervalued by their agency, yet five other categories ranked close behind. The number of concerns they expressed about gender differences within their agencies interestingly did not stand out as higher or lower than most groups. A possible explanation for this finding is that, given the low levels of job satisfaction and the extent of dissatisfaction with various aspects of their work, gender-related concerns may have played a less prominent role in this group's overall assessment of the quality of their working lives. One front-line supervisor commented to me that, because there were so many other issues of concern in her agency, she did not have time to think about gender issues.

With regards to change, they, like most groups, repeatedly cited the need within agencies for more learning opportunities and supports, and for a reduction of job stresses. They mentioned slightly more often the need to improve their agencies' personnel policies and

administrative practices. In terms of change at the government level, this group offered far more suggestions than any other group, but the changes they proposed were priorized similarly to all groups as a whole.

Common Themes

The majority of the results I have reported so far reflect the identification of categories of information emerging from responses to the research questions, and also the frequency with which these categories were mentioned by all respondents. Qualitative analysis also involves the identification of common themes that emerge repeatedly from the data regardless of the question being discussed or who is responding at the time. Such themes may represent the over-arching contexts within which many participants have developed and framed their remarks.

I have identified and will discuss two themes that I believe were particularly dominant in the interviewees' remarks. The theme of "valuing" arose in many discussions and in relation to many issues or concerns, as did the theme of "isolation versus a sense of community". Three other less dominant yet still important themes also emerged across many interviews: "fit", "vision", and "growth and learning". These three secondary themes will also be discussed briefly.

Valuing

Very early on in the process of conducting interviews across the North, it became evident to me that participants, in their roles as employees, professionals, administrators, and local citizens were expressing some similar perceptions and concerns. The importance of being valued by others and of feeling valued within oneself was a theme that was shared by all groups of interviewees in all aspects of their lives as they were described to me.

As a resident of Northern Ontario for 13 years, I had previously been aware of sentiment in the region that the North was always forgotten, overlooked, or at best

misunderstood in the context of provincial politics and legislation, and that realistically all the power resided in the southern portion of the province. This view was again expressed by administrators and clinicians alike in their displeasure with the lack of local consultation and collaborative planning, and with the tendency of government to impose programs rather than serve as partners in the planning process. Clinicians talked of the impact on their personal lives of unfair taxation policies in the North and of their perception that the taxes collected in the North went toward bolstering Southern Ontario interests. They mentioned their concerns about the natural resources of the North being exploited and depleted, and the North receiving little in return. Others expressed anger about their roads not being maintained in winter and generally allowed to decay, and particularly about transportation systems, such as the railroads and air routes, being eliminated altogether. As citizens and as suppliers of an important service, they did not feel they were valued as Northerners.

The perception that fellow Northerners as a group felt like "second class citizens" or the "poor dumb cousins" of the province, and that they collectively possessed "low self-esteem", was expressed by a number of participants indigenous to the North as well as several from outside. It was suggested that the people in general felt inferior, their service organizations and their universities were seen as inferior, and that the North had become not only a "training ground" for new graduates but also a "dumping ground" for professionals who could not find work anywhere else. Thus, some clinicians believed that, just because they worked in the North, they and their skills were viewed as inferior by Southern Ontario standards.

Clinicians also described other distinctions that were made by communities, by local citizens, and by employers that provided them with the clear message that one attribute or characteristic was favoured or valued more than another. Several clinicians who had lived all their lives in the North, had completed graduate degrees, and were now employed in northern centres commented on how disheartening it was for them to realize that, just because they were Northerners, they were held in low esteem locally compared to professionals with equivalent

credentials coming from Southern Ontario. Conversely, several clinicians from outside Northern Ontario who came to a northern community to work said they experienced the resentment of some colleagues and clients because it was expected they would not stay long and so were seen as being of little value to the agency and the community.

As has already been discussed, a number of clinicians and administrators also expressed the view that in the North, women generally and women as professionals specifically, were not as valued and respected in northern communities as their male counterparts. The expressions by women of their fear and vulnerability in their homes and communities, and the effects experienced by participants of blatantly sexist attitudes in the community and the workplace contributed to my sense that many women in the North clearly felt de-valued.

Another concern raised by clinicians that related to their perceived value was the sensitive area of language and how their ability or inability to speak both of Canada's official languages affected their worth in the eyes of others. One professional stated clearly that he knew for a fact that because he could not speak French, he would not be considered for any internal promotions and would likely be unable to move to any higher level positions anywhere in his community. He felt that as a unilingual clinician, he had limited value in his home community. Other clinicians who were primarily French-speaking talked about the negative remarks directed toward them in their new communities when it became known they were francophones. Clearly, the value placed on and the respect shown for professionals based on their language capabilities is an issue relevant to the lives of northern clinicians.

The value of a worker's educational credentials versus her/his clinical skills and work experience was raised as an issue by several administrators and clinicians. Opinions varied as to the relative importance of each, but it was evident that some clinicians felt they were unfairly disadvantaged within their organizations because they had more of one qualification than the other.

Across agencies, there was evidence from the interview data that some small agencies were disadvantaged by their size and location which, some felt, translated into lack of power and voice when they raised concerns or requested resources. Some respondents, therefore, were of the opinion that government placed more or less value on an agency's appeal for resources based on the agency's size and consequent prestige rather than on the merits of its request. These concerns were expressed by participants representing both large and small centres.

The value placed on the entire children's mental health system by government was also questioned by several participants. They expressed frustration that government no longer treated children's mental health as a priority, that it was getting lost in a bureaucracy that paid increasingly more attention to the adult side of social services, based on funding cutbacks and the lack of response to northern needs in children's services.

All of the perceptions I have presented, whether the perceptions accurately describe the truth or not, do reflect a disturbing mood across the North, a mood expressed through the voices of this particular group of people. There were also, however, some expressions of pleasure, contentment, and appreciation by a small number of individuals. These responses were typically the result of participants feeling valued and respected by their colleagues, their employers and/or their clients. Participants described this kind of valuing as being expressed to them in various ways. Being given responsibility and autonomy on the job, being asked for input into planning and decision-making within the agency, and being recognized as a skilled clinician and a resource to both the agency and the community were all ways in which their value and worth had been communicated to these respondents. These same employees were, for the most part, employed by those agencies that articulated and/or practised a philosophy of empowerment extending to clients and staff alike.

Feeling valued, therefore, would seem to be a critical component of any discussion about retention of employees, given its likely effects on how satisfied one feels with life in the community and on the job.

Isolation versus Sense of Community

Another prevalent theme that emerged from my analysis of the data incorporates two contrasting experiences, the experience of isolation as opposed to the experience of a psychological sense of community. The latter was first defined by Sarason (1974) as including the supportive links among citizens that reduce their sense of isolation and alienation. Isolation was mentioned by a number of participants but in varying contexts. Personal isolation was discussed by newcomers to the North who were unfamiliar with the language, the culture, the peoples, and the geographic territory in which they suddenly found themselves. All had left behind their home community, and for some this meant a large urban setting offering numerous opportunities and activities, and for others it meant the town where they had been raised. Some had left behind family and friends who were very skeptical about this new venture and tried to discourage the move. Respondents commented about their difficulty adjusting to the new situation and some about feeling very alone in the process. Others indicated that they felt very fortunate that their employer and new colleagues had "taken them under their wing" and helped them find housing, included them in social events, introduced them to community leaders and professionals, and, in effect, helped them begin to build a sense of community within the agency and the town.

An expression of personal isolation was also forthcoming from participants who were single. Their concern was also shared by a number of administrators who perceived the status of being single as a particularly difficult one for northern professionals. Respondents commented on the difficulty of finding suitable mates and also on the dominance of couple-oriented activities in northern communities, leaving single people isolated or feeling they fit in "like a whale in a bathtub". Several respondents discussed the dilemma they were left with as a single person in the North, that is, whether to keep to themselves, forego a social life and thus remain isolated or to develop a social life in the community at the risk of becoming the subject of gossip and even jeopardizing one's professional reputation in the community. Thus,

ironically, the personal isolation of a single person could often be overcome only at the expense of personal privacy.

Personal isolation was also a reality for many women in the North, according to participants who described the high incidence of family violence and the lack of tolerance for feminist beliefs as consequences. Isolation was also mentioned in relation to women as professionals, particularly those working within and around male-dominated structures. Several women described feeling cut off from decision makers and thus denied the opportunity for input or to have concerns addressed.

The feeling of being professionally isolated certainly extended beyond female clinicians and was expressed by numerous clinicians for a variety of reasons. Some clinicians commented on feeling physically and/or philosophically isolated from colleagues, feeling removed from members of their particular profession, and missing out on professional expertise in the form of consultants and specialists. Two clinicians working in different northern communities each described having to rely on calling experts in other parts of Canada and in the United States for consultation. Others talked about not having access to clinical resource materials to keep them updated on clinical developments and to assist them with case planning. However, the majority of the references to professional isolation highlighted the lack of clinical supervision, few opportunities for ongoing training or outside professional development, and the inaccessibility of university upgrading as the main reasons for the concern. One clinician mentioned how she personally had to conduct a search over several months across Southern Ontario for a supervisor who had the necessary clinical expertise and who was located within a half day's drive so she could at least meet with him monthly.

Conversely, there were a number of clinicians and several administrators who talked about how much they appreciated working in close proximity to skilled, knowledgeable and supportive colleagues, about the motivation they felt when given opportunities for agency input, and about the advantages of team work and of sharing the burden of cases and other aspects

of their work load. A clinician who was quoted earlier described how he was able to trust and rely on his colleagues and his bosses to let him know when his work was top quality and when it was lacking. That sense of community among colleagues and with management goes a long distance toward reducing professional isolation and likely toward enhancing the quality of services that are being provided.

Finally, the theme of isolation was discussed in the context of the physical geography of the North. This reality often encompasses and makes even more real the experiences of personal and professional isolation which have already been described. The fact that communities are often many miles apart and are often located great distances from urban centres or from clinicians' home communities makes networking and communicating and travelling much more difficult for many northern professionals and administrators in their work context and in their personal lives. Those participants who have been able to overcome these geographic barriers seem to attribute much of their satisfaction to the development of strong friendship networks in their communities and to the development of strong bonds among small or large groups of colleagues within the work place.

Secondary Themes

In addition to the themes already discussed, three other themes became evident as I analyzed the interview data. The significance of the concept of **"person/environment fit"** was commented on by a cross section of participants, including those who had the responsibility of hiring and those who had been hired in part on the basis of meeting this requirement. "Person/environment fit" is an ecological concept "which emphasizes the relationship between people and their environment rather than examining the characteristics of either in isolation" (Heller, et al., 1984, p. 118). In the context of this research, the concept particularly pertains to the process of recruitment and hiring, and to the judgments that must be made during that process. "Fit" was most often discussed by participants in the context of either the relationship

between an individual and a community, or the relationship between an employee and her/his work place. It was seen as a critical factor in the determination of which candidates had the potential to stay the longest on the job and in the community, thus explaining its relevance to retention. However, it was also a factor that could not be precisely defined and seemed to embody different elements for different participants. Thus, the determination of whether a person would "fit" or not was highly subjective, and certainly not an exact science.

In relation to her/his community, respondents perceived an individual as "fitting in" if s/he could either embrace the lifestyle, overlook the limitations, and/or find a niche in order to comfortably blend in with both the human and the physical community. Ideally, once this transition had taken place, the individual would develop a sense of commitment to the community and its people, and thus would be willing to devote a number of years of service to both. Participants seemed to agree that the likelihood of a "good fit" was greatly advanced if the individual was either from the community or at least from the North, as s/he would have the benefit of familiarity or at least some identification with the North. Otherwise, the judgment seemed to become much more difficult and again highly subjective.

The determination of the potential "fit" between an employee and an agency should begin, according to administrators, with the clear identification of the agency's present and future clinical needs and the articulation of a working philosophy embraced by the agency. With its needs and philosophy in mind, the agency can then begin the process of trying to find an acceptable match, starting with the decision of where and how to carry out its advertising and concluding with the selection of a candidate. An employee who "fit" with an agency was not only seen as more likely to stay on the job longer, but it was felt that he or she could be counted on to support the agency within the community.

"Vision" was a somewhat vague theme that nevertheless surfaced regularly, mostly in the larger system contexts of agencies, the government, and the North as a region. Children's

mental health agencies in the North, individually and collectively, were seen as needing to develop a vision for services in their communities and the region based on identified needs. Administrators in particular were of the opinion that they must then be allowed opportunities to share their visions with government decision-makers and together plan for the future of services in the North. All too often, according to administrators, what is articulated to them as the government's vision and direction for northern children's mental health services seems to come from the political sphere rather than from a process of local consultation and planning. The consequence is that agencies find themselves in a position of having to carry out a government vision and its component directives that they believe do not best serve their communities. The incongruence (or "lack of fit") can create resentments and cause undue stresses, directly or indirectly, on agency personnel.

"Vision" is best shared in common with all elements of a system that is responsible for the delivery of a service. On an agency level, this process must include and involve the staff who directly provide the service. A number of participants discussed the concept of vision in their work setting. Some maintained that no long-range view existed at all in their agency and several were concerned that the vision articulated was that solely of the management and thus at odds with many staff. Others considered their agency's outlook on the future to reflect their own, either because they had had a role in its development or because it was clearly articulated before they were hired. For this latter group, a shared vision and sense of direction seemed to translate into a greater investment of creative energy and self initiative, trusting that their efforts would be recognized and valued.

The final theme I will discuss is that of the **motivation for learning and growth,** which seemed to be widely held by the clinicians' group and also acknowledged by the majority of the administrators, as my quantification of the data indicated. Clinicians spoke repeatedly and emotionally of their desire for more learning opportunities in order to enhance

their knowledge and skills, to better serve their clients, to remain current in their professional field, to feel stimulated and challenged, and to upgrade their educational qualifications and possibly their marketability. The barriers to learning and growth among northern professionals seemed to stem from geographic and professional isolation, from the lack of funding available to agencies and individuals for this purpose, and from, to some extent, the northern universities.

Participants' suggestions for a training centre, a research centre, and a "centre of excellence" in the North, their concerns about the quality, relevance and accessibility of northern university programs, and their frustrations with government initiatives such as the Northern Outreach Program and the Northern Bursary Program that were not meeting their needs were all indications to me of the importance of this theme to clinicians in general and specifically in relation to their retention. Clinicians indicated to me they would be leaving their northern jobs because without research opportunities they no longer felt challenged or because they had no opportunities for clinical training. Others talked about leaving because they could no longer stand the stress and the responsibility of doing therapy without supervision or because they wanted to pursue a graduate degree and were thus forced to leave the North.

The value placed on learning and growth affected the lives of participants as some made sacrifices to enhance opportunities for their children, for example, to participate in French immersion offered only in another community; for their spouse, for example, to pursue a graduate degree on a full-time basis; and also for themselves. Participants told me of the circumstances they had to endure in order to obtain a university degree while working in the North, of travelling four hours return to their university class, of staying overnight in another community each week, and of working a full 40-hour week on top of class time and assignments or having their pay cut back accordingly. The pursuit of learning and growth as a professional in the North is at best challenging and at worst exhausting and discouraging, as described to me by several participants who had given up in their efforts.

Discussion

In this final section, I begin by outlining the parameters within which I carried out this study. I relate my findings to the research I reviewed earlier in this paper and discuss the value of and my experience using a qualitative, participatory methodology. I provide specific guidelines for change and recommend a more large-scale initiative applicable to all children's mental health organizations. I conclude by reflecting on a more personal side of this research process.

This study is the compilation of the opinions and perceptions of a self-selected group of mental health clinicians and administrators employed in children's mental health centres located in Northern Ontario, a region that is considered isolated relative to the rest of the province. The results of this inquiry, therefore, have primary relevance to those readers who work within or are knowledgeable of the context within which the research was conducted. It is to this audience that I address my findings, discussion, and recommendations.

Within a naturalistic paradigm, which I have attempted to apply to this study, the concept of the generalizability of qualitative research is rejected (Lincoln & Guba, 1985). Instead, the naturalistic paradigm assumes that, at best, only a working hypothesis can be abstracted from the findings. The transferability of such a hypothesis then depends on the degree of sameness between the original investigative context and the "receiving" context. Lincoln and Guba concluded that "if there is to be transferability, the burden of proof lies less with the original investigator than with the person seeking to make an application elsewhere...; the responsibility of the original investigator ends in providing sufficient data to make such similarity judgments possible" (p. 298). Thus, the results of this inquiry are certainly not intended to be universally applicable or even necessarily applicable to other rural or remote regions of Canada.

As is true in most qualitative research, I did not undertake this project with a specific theory or hypothesis to test. My intent, instead, was to allow the experiences and perceptions of the participants, once inductively analyzed, to evolve into "grounded theory", that is, theory that follows from the data instead of precedes them. The rationale for my taking this approach is aptly described by Lincoln and Guba (1985): "No a priori theory could anticipate the many realities that the inquirer will inevitably encounter in the field, nor encompass the many factors that make a difference at the micro (local) level" (p. 205).

Discussion of the Findings

It was true that I did indeed discover realities through the course of this research that I had not anticipated. I discovered during my travels across the North that the region was more culturally diverse than I had expected, including, unfortunately, a higher level of English/French antagonism in some communities. I was surprised by the availability of cultural and artistic opportunities in some larger locales, even though many participants felt there were not enough of such opportunities.

I was particularly struck by the variability across communities of all sizes in their perceptions of their own isolation. Communities that I had assumed (because they were furthest from Southern Ontario) would feel the most isolated, such as Kenora, were actually only two hours from a major urban centre and appreciated relatively easy access to urban advantages. Finally, even though I had certainly been aware of the phenomenon of regional "low self esteem" in the North, I did not appreciate the extent of this feeling until I had travelled across the region and listened to the participants.

Despite my having to undo some of my stereotypes about Northern Ontario, the characteristics of rural Canada summarized in Table 2 held true for the most part across the North, and not only in the smaller, more "rural" communities. Without exception, each of *the people* and *the community* characteristics of rural Canada identified by other authors were

mentioned during the course of the research interviews. I had begun this project with the perception that northern working contexts were primarily "rural", despite having lived and worked in a northern community of 80,000 for several years. By definition, most of the communities I visited were considered "urban" on the basis of the size of their population. Yet, possibly because of their geographic context, that is, their remoteness in distance from the "hub" of the province, communities large and small were characterized by participants as having a rural or small town atmosphere.

I discovered through my travels the perception of the existence of a two-tiered children's mental health network, both across the North and within the province at large. Northern children's mental health centres primarily saw themselves as being "have nots" in comparison to Southern Ontario agencies. In relation to each other, however, there were also distinctions made between those agencies that seemed to be thriving financially and those that were barely surviving. Feelings of distrust, resentment, and competitiveness among the agencies were alluded to in some of my conversations and seemed to stem from perceived power and influence differentials.

I also encountered an almost unanimous condemnation of a new government initiative designed to implant significantly more professional resources into northern agencies that have been chronically under-resourced and under-funded. I questioned at first why agencies would balk at a plan for the provision of badly-needed resources. However, my discussions with administrators and clinicians revealed that they were angered by the government's lack of consideration for process and the absence of local consultation. Resources were seen by these participants as far too valuable to squander via a service delivery model that had proven ineffective elsewhere.

In most respects, the characteristics of service delivery and practice in the North that I uncovered corresponded to those identified by other authors writing about both the American and Canadian rural mental health contexts. My two findings within the northern children's

mental health system exemplified the concerns expressed to me about barriers to resource allocation and service delivery, urban versus rural prejudices, inappropriate government policies, and the real value of only those resources, programs, and service delivery models that accurately reflect the carefully assessed needs of each unique community.

The clinicians I spoke with described many of the opportunities and drawbacks of work in rural or remote communities that are commonly cited in the literature, as can be surmised from comparing the characteristics in Tables 3 and 4 with the job satisfaction and dissatisfaction categories defined in Appendix D. It was interesting to note, however, that very few participants commented on the socio-economic condition of their communities as influencing their provision of services. Given the increasingly precarious state of the economies of northern communities, for example, the closures of several major mines and mills, this is a curious oversight. The fact that no specific research question was designed to ascertain how such local realities affected mental health practice may be a limitation of this study from an ecological perspective.

Individually, many participants exemplified the qualities and skills identified by others (in Tables 5 and 6) as being necessary to successfully live and work in rural or remote communities. Most had multi-faceted job descriptions and thus were in the position to work more as generalists than specialists (see Webster & Campbell, 1977). Most felt that flexibility and autonomy on the job and their interaction with colleagues, qualities identified by Campbell and Findlay (1980) as important for rural practitioners, contributed to their satisfaction on the job. As well, three out of four of these respondents enjoyed the lifestyle and the social milieu of their communities, qualities which Campbell and Findlay (1980) again deemed necessary for workers in the rural Canadian context.

The results of this study also relate somewhat to the findings of Zapf (1989), that is, that rural practitioners, especially those new to the geographic region, commonly experience culture shock, followed within a year by recovery. In terms of participants' expressions of stress

and frustration related to their lives and work, clinicians from outside Northern Ontario expressed more dissatisfaction with their lives than Northerners, while clinicians from the North were more dissatisfied with the work context. Thus, dissatisfaction was not confined to those workers recruited from outside the region. While the term "culture shock" was seldom used by clinicians, many did comment on their levels of stress. The participants most notably experiencing stress indicated that pressures seemed to mount with passing time, not subside, as in the period of recovery described by Zapf. Similar to Zapf's findings, women, more frequently than men, reported prolonged frustration and stress associated with their work.

My research indicates that, in general terms, workers and their agencies across Northern Ontario compared favourably to characteristics described throughout the rural mental health literature. However, cursory comparisons of particular qualities or characteristics matter little compared to actual realities lived out daily by professionals working in the North. The individual stories of the workers and the frustrations and dilemmas of their administrators make the reality of burnout particularly troubling.

The fact that the phenomenon of burnout is attributed by researchers (see Pines & Aronson, 1988; Streepy, 1981; Beck, 1987; Hargrove, 1982b) to many of the same characteristics of **workers**, of **jobs**, and of **agencies** that have emerged from these research results should be of utmost concern to those in decision-making positions in northern agencies and to their funders. Many of the **workers** I spoke to were new on the job and most were women. Some described their overinvolvement with clients or their loneliness. They described their **jobs** as having high visibility, and themselves as having to deal with professional isolation and barriers to service delivery. Some felt their **agencies** were demonstrating an authoritarian administrative style and exerting unrealistic work pressures. Others saw their agencies as not providing sufficient support, supervision, and positive feedback to their workers.

Burnout may possibly exist in all other rural mental health contexts in Canada, but as this research demonstrates, it is indeed a reality in Northern Ontario. Close to half of the

clinicians I interviewed, and more women than men, identified burnout and stress, professional isolation, and a lack of support as contributing to their feelings of job dissatisfaction. In particular, I heard the stories of three women in three northern communities that powerfully described their feelings of desperation, and of feeling completely overwhelmed and exhausted but with no place to turn. All the women were new to their communities. For each it was also her first job in the field and so wanted to do well. Two of the women felt they had no support or understanding from the male administration. The third was of the opinion that while her director was sympathetic, he was unable to be helpful because he too was overworked. One of these women has since left her job and the community. These powerful stories may indeed be more common across the North than stakeholders in the children's mental health system would care to admit.

The administrators I spoke with did not discuss burnout per se in the context of either turnover causation or the impact on quality of service. Some did identify as problematic several of the environmental antecedents mentioned in the burnout literature, such as physical isolation, lack of agency and peer support, stressful jobs, and internal agency problems. The concept of poor person-environment fit, while not linked specifically to burnout by the administrators, was seen by several as a cause of turnover.

It was more reassuring to hear over 70% of the administrators acknowledge that a reduction in work stresses and a concomitant increase in staff supports were changes that needed to take place at an organizational level if retention in their agencies was to be enhanced. It was not so surprising, but equally as convincing, that 80% of the clinicians saw these as needed changes. Thus, while administrators seemed to have some awareness of the possibility of burnout emerging from a dysfunctional organizational context and of the need to correct some of the contributing factors if staff were to be retained, the existence of burnout within their settings seemed to be outside their awareness.

While the reality of burnout was very evident for the clinicians, unless its presence is made real for administrators as well, it is likely that burnout will remain only a theoretical concern and thus draw far less attention. The actual impact of burnout on both the individual worker and the quality of service offered to consumers hence would likely not be dealt with. This disturbing situation speaks to the need for more encouragement of and increased opportunities for the voices of the workers to be heard and taken seriously (Spencer, 1986).

The quality of life in northern communities clearly entered into participants' decisions both to come to the North as well as to leave it. The prevalent lifestyle of the area, particular qualities of the physical community and its people, and the isolation from or accessibility to family and friends were repeatedly mentioned by clinicians and administrators alike as sometimes working for, sometimes against agencies' efforts to recruit and retain professionals. Of the two models described by Zautra and Goodhart (1979) for assessing quality of life, participants seemed to rely solely on the concept of "person-environment fit" to explain how and why they experienced either satisfaction or dissatisfaction with their lives. Comments such as, "I decided I'd rather have smaller bucks, less chance for credible advancement and be in the North so I could be near the lakes and the trees because that's where I function best" and "I'm really not satisfied with my social life...Being divorced I fit in like a whale in a bathtub here...That will be why I leave, not the job" exemplified individuals' sense of fit or not and the impact this perception had on their employment decisions.

On the basis of their responses to questions about life satisfaction and dissatisfaction, participants seemed to subjectively express more satisfaction than dissatisfaction with their lives. In specifying the factors contributing to their quality of life, the participants cited primarily subjective measures (see Korte, 1983) that reflected the aspects of their lifestyles and of the human side of their communities that were most satisfying for them.

It is curious, given that quality of life seemed to play such a prominent role in the decisions of clinicians both to come to the area and to stay or leave, that neither clinicians nor

administrators paid much heed to the possibility of change at a community level contributing to retention. Only 21% of administrators and 32% of clinicians gave any responses at all regarding community change. The administrators' responses pertained more to recruitment concerns while a small number of clinicians suggested the need for more cultural opportunities, singles-oriented activities, better housing and transportation, and more library and recreation facilities. Community economic development, so vital to the survival of fragile, single-industry towns, was not mentioned as a necessary process in the long-range restructuring of more health-oriented communities. One worker admitted that while there were a lot of things she did not like about her community, she felt there was nothing that could be done about it.

This worker's perception, likely reflected in the overall lack of response to the question of change at the community level, could be as the result of several phenomena. Mental health practitioners have typically not been trained to look beyond individual or small system (e.g., family) causation or intervention in their efforts at diagnosis and remediation. Thus, to consider intervention in such a large and complex system as an entire community may seem foreign. Also, communities do not typically make available many mechanisms through which citizens can conveniently voice their displeasure and work for change. Thus, dissatisfied citizens often vote with their feet by deciding to leave instead. Finally, I have referred previously to the feeling of low self-esteem across the North, which could also be described as a feeling of disempowerment that seemed to pervade the comments of the participants. Feelings of powerlessness on a regional and community level would certainly inhibit any thoughts of the possibility of change on such a scale.

There was no specific reference made by any of the research participants to the concept of "quality of working life", nor was there evidence of formal agency-wide QWL programs operating in the agencies I visited. However, I must qualify these observations, given that I did not ask specifically about the concept, nor was I able to spend any additional observational time in the agencies other than to conduct interviews. Nadler and Lawler (1983), however,

defined QWL as more than specific projects within organizations. They saw QWL as a way of thinking about employees, their jobs, and the work setting that demonstrated concern about the impact of a job on the employee, concern about the setting's effectiveness, and thus encouraged employee participation in problem-solving and decision-making. It is in this respect that I did see some evidence of the belief in QWL and its principles.

While I did not formally explore the impact of age on clinicians' perceptions of job satisfaction and dissatisfaction, I did analyze differences between the sexes. My results supported the findings of Jayaratne and Chess (1982-83) that gender differences exist in factors reported as influencing satisfaction and dissatisfaction on the job. However, the differences I uncovered did not entirely correspond to those identified by Jayaratne and Chess. Concerns about salary levels and promotional opportunities did not vary remarkably between men and women, as they had with Jayaratne and Chess' participants. Yet, the female clinicians did express substantially more dissatisfaction relating to their levels of burnout and stress than did the men, in part a reflection of their concern about workload, a gender-related issue discussed by Jayaratne and Chess. Thus, the sample of clinicians I interviewed, while demonstrating clear differences between the sexes, seemed less influenced by monetary and advancement goals and more by factors that aided or interfered with their performing their jobs.

Although not the primary determinant of job satisfaction, the elements of leadership style established within agencies seemed to play an important role in workers' perceptions of satisfaction or dissatisfaction on the job. As identified by the clinicians, factors such as being valued by their agency, utilizing a team approach, having the opportunity for input, experiencing positive management/staff relations, working in an amicable office environment, and sharing an agency vision speak to the presence of leadership attributes defined variously by Hellriegel et al. (1989), Conger (1989), Block (1987), Weiner (1987), Gowdy (1987), and Helmer and McKnight (1989).

One of the most interesting and surprising findings of this research for me was the contrast between agencies administered by women and those administered by men. Whether coincidental or not, clinicians working in agencies directed by women cited far more categories of job satisfaction and far fewer of job dissatisfaction and gender concerns within their agencies than did their counterparts working in male-administered agencies. Also, the limited data on actual turnover rates show female-administered agencies to have the lower rates. As I have mentioned earlier, this was not a comparison I anticipated nor one I originally designed the research to explore. The contrast emerged from the content of the responses of both clinicians and administrators. Using appropriate methodological caution, I cannot conclude, from such a small sample of participants and from data that were not provided in response to a specific question about the effect of gender on management style, that gender is indeed at issue at all in this respect. It is possible that the women directing Northern Ontario children's mental health agencies are, by coincidence only, quite non-traditional in their approach to management. As reported earlier, research addressing the relationship between gender and management style has been inconclusive. Yet my findings seem consistent with the research by Vinnicombe (1987) which determined that women more often managed as visionaries and catalysts, that is, by being creative and progressive, and by communicating care and enthusiasm. Also, given the high frequency with which clinicians working for women mentioned feeling valued and supported, the terms "relationality" (Wine, 1982) and "appreciative management" (Smircich, 1985) do not seem out of place when describing the predominant leadership style within these three female-directed agencies.

Of critical interest to me, however, is not necessarily that women are managing those employees who seem most satisfied, but what these female directors seem to be doing differently from the others. From the interview data of clinicians working for female directors, it is clear these workers felt far more supported and valued by their agency, they utilized more of a team approach, they experienced less stress, burnout, and professional isolation, and none

expressed any dissatisfaction with management/staff relations. Gender issues within their agencies were of far less concern to these clinicians who overall cited fewer changes needing to take place in their agencies than other groups. These results support the findings of researchers such as Near et al. (1987) and Field and Dubey (1987) that a holistic concern for employees and the utilization of a democratic leadership style contribute significantly to job satisfaction.

The clinicians from female-administered agencies and two of the three female administrators spoke specifically about an empowerment philosophy existing within their settings and a belief in the value of staff input and participation in problem-solving and decision-making. This philosophy of management went beyond rhetoric in these agencies and, according to the clinicians, established a positive climate for the day-to-day operations. Although other yet unidentified factors could be contributing to the satisfaction felt by these workers, it was clear how good they felt about being valued, about being made to feel a part of their organization, and about not getting caught in internal power struggles.

Empowerment as a concept implies the feeling of mastery over one's life in a variety of contexts. As a process, empowerment is viewed as the mechanism by which mastery can be enhanced, not only for individuals, but for organizations and communities (Rappaport, Swift, & Hess, 1984). "Empowerment is not only an individual psychological construct, it is also organizational, political, sociological, economic, and spiritual" (Rappaport, 1987, p. 130). Thus, Rappaport (1987) sees empowerment taking on different appearances and manifestations, depending on its context:

> To understand the meaning of empowerment one must know something about more than individuals; one must know what, or who, one has authority over. There is built into the term a quality of the *relationship* between a person and his or her community, environment, or something outside one's self. Part of our

task then must be to specify what these relationships are like for people, organizations, and communities (p. 130).

This study has uncovered some of the ways in which empowerment or conversely, the feeling of powerlessness, may impact on the quality of the relationships a worker has with her/his work context and community context. And it is often the quality of these relationships that helps to determine whether an individual remains in a particular context or leaves, either voluntarily or because s/he is no longer deemed effective (e.g., are burned out). Feelings of being unsupported or undervalued in their agencies were reported by close to half of all clinicians. Powerlessness was reflected in the comments of female clinicians describing the male domination in their agencies' power structures, being circumvented by male colleagues, and their lack of access to upper management. In their communities, women described the lack of respect they received as professionals, as well as the vulnerability and fear they sensed from other women in the community. Administrators also alluded to the helplessness they sometimes felt in the face of government initiatives they had little or no input into but which affected their organizations tremendously.

Overall, it seems clear that the perception, or in many cases the reality of powerlessness, although varying in context, was an overriding feeling among many of the participants and arguably, throughout the region of Northern Ontario. It is my contention that the process of empowerment, while not being the only answer, can make a significant contribution to individual employees, to northern children's mental health centres, and to northern communities in the areas of service effectiveness and quality, employee retention, and needed social change. I see the agencies themselves as the necessary focal points from which the process of empowerment must evolve, as long as the sincere belief in and commitment to such a philosophy exists within the organization.

The costliness of turnover was indeed confirmed by the administrators in this study. They identified the necessity of having to recruit staff so frequently as a particularly critical and costly concern for northern agencies, given their distance from major universities and from the bulk of the population centres in the province. Successful recruitment was also seen as the key ingredient to an agency's ability to retain its staff, which most felt hinged on hiring those candidates most likely to stay. Thus, administrators seemed to equate recruitment success and the increased potential for retention with their ability to hire those individuals who best fit their organizational needs and who seemed to blend well into the community. Specific selection criteria for staff were not identified (see Carr, 1982), but administrators seemed to generally believe that developing their own core of staff from local talent was at least part of the answer, given their proven adaptability to the community (see Elkin & Boyer, 1987). However, they also expressed the dilemma addressed by Thompson and Barr (1984) that, while it was important to recruit those who would stay, it was also important not to compromise agency standards. Thompson and Barr argued that rural clinicians should actually be better qualified than their urban counterparts.

To be successful in such a development process and thus not compromise standards, administrators recognized that their agencies and communities, with government assistance, must provide ongoing, comprehensive learning and professional growth opportunities. Most (93%) also agreed that similar opportunities must also be extended to all staff if retention is to be enhanced. Clinicians agreed, with over 90% citing the need for increased learning opportunities, including better quality and more frequent supervision, if they are to be expected to stay on the job. These findings correspond to those of Thompson and Barr (1984) and Didow (1980) in rural Alberta who determined that workers in rural or remote communities may indeed need more supervision and staff development than urban clinicians and thus recommended that administrators must make the provision of such opportunities a priority.

Of the nine factors identified by Thompson and Barr (1984) as having a negative impact on retention in rural Alberta, all were cited by some portion of the participants as being factors for them and for their agencies in Northern Ontario. However, in the North, expressions of the need for more and better supervision, professional development, and upgrading opportunities far exceeded the extent of concern in Thompson and Barr's rural Alberta study. The pursuit of learning and growth as a professional in the North is at best challenging and at worst exhausting and discouraging, as described to me by several participants who had given up in their efforts. Clinicians, agencies and government must work together to rectify the situation. The North cannot afford such defeats.

Discussion of the Methods

In characterizing this research as participatory, I have utiliz:.d the defining principles offered by Mishler (1986), in particular, that the researcher provide participants with more control of the research process, encourage them to speak in tieir own words, and promote action to serve their interests. To these ends, I have made every attempt within the limits of distance and time, to involve the respond , not just as informants, but as collaborators. Participants shared in designing and testing the questions, evaluating the interview content and process, determining how the findings can best be used, and judging how accurately my analysis reflected their realities.

As an example of feminist research, this inquiry has rightfully placed gender in a place of prominence (Maguire, 1987), given that women and men traditionally hold such disparate positions in the management and delivery of mental health services. Bou male and female realities have been represented (Millman & Kanter, 1975) by means of a research process which promoted dialogue and the mutual development of trust (Maguire, 1987), critical principles in a framework for feminist participatory research. Of significance within this framework as well, this study was undertaken in the hopes that both men and women, clinician and administrator,

would derive benefit. Finally, as a feminist researcher, I believe it is also important to take the reader beyond the "hard data" of the research and share my personal experiences and reflections during the investigative process, as they are integral components of the research context.

I also believe the use of a participatory methodology in this research contributed greatly to the value of the research in several ways. Involving several of the participants in the design of the open-ended questionnaire insured that the necessary content areas were covered and that the questions would encourage the participants to speak in their own voices. By my offering the survey questions ahead of time, participants had an opportunity to review the content, clarify any uncertainty before beginning the interview, and thus could provide more well-thought-out responses. I sensed from the participants that the amount of information I supplied to them in advance and my assurances of strict confidentiality gave them the message that I was not covering anything up and thus greatly improved the quality of the research relationship we were able to develop. Indeed, their responses to my question concerning how they felt about the interview content and process were overwhelmingly positive, leading me to feel confident that the participatory approach was a comfortable, even empowering one.

As the result of seeking immediate feedback from the participants about the interview process and content, I was also able to make some minor adjustments along the way. For example, by changing the order of the questions and asking participants about their dissatisfactions first, I hoped to avoid leaving them in a negative frame of mind after the interview. Unfortunately, the participant who made the suggestion at the end of her interview had to leave the interview feeling the impact of a very emotional discussion about her work situation. I contacted her the next day to ensure that she did not regret our conversation and was still willing to let me use her interview.

Also, in keeping with the methodology's view of the participant as collaborator, I asked for and received very useful information concerning how this research could best be used by and disseminated to stakeholders, including the participants themselves. These ideas will assist

me in providing the kind of feedback that participants will find most useful to them. Their responses will also assist me in planning effective strategies around the overall use of the results.

Living such a distance from the research sites during the time I was analyzing the data had me concerned that I would be unable to involve any participants in the analysis and writing of the results. However, a friend who had lived and worked in the North for many years and who cares a great deal about its welfare agreed to read a rough draft of the results. Her feedback was very helpful and has been incorporated into the document.

In addition, one male and one female participant agreed to read the document and comment once the entire first draft was completed. Thus, in the spirit of feminist participatory research, I have sought the perspectives of both gender groups to better ensure that the project is of equal benefit to both men and women. Also, by incorporating what I believe to be a very relevant question about gender differences, my bias about the importance of gender in the context of this research was "on the table" for discussion by participants and gave them permission to voice their concerns in this area.

When such a project is close to being completed, it seems easier to look back and question different aspects of it. I have some concern about how participants were selected to participate in this research, mainly because I had little control over the process in some agencies. Because of time and distance constraints, I had to rely on some administrators to distribute the research information and consent forms to their staff group. Therefore I do not know if all employees were given an equal opportunity to participate. I also realize my ties with a northern agency, given the smallness of the "community" of northern centres, were initially problematic for some and that trust building with these participants was more difficult. Conversely, I am convinced that my position as a northern agency employee and thus as a true stakeholder in both the mental health field and the region of Northern Ontario was a great

advantage in most cases by according me credibility as a sincere researcher of northern concerns.

I also experienced a methodological dilemma common to qualitative researchers: should I conduct more interviews in order to get a wider variety of perspectives or should I interview fewer participants but in a more in-depth fashion? I chose to do more interviews than is typical in many qualitative studies in part because of the number of northern children's mental health settings. Also, because of the diversity of each agency and community and because I wanted to compare the results across several variables, I decided it was more important to obtain a wider variety of viewpoints.

I was not entirely satisfied with the quality of the mail survey results and put the blame squarely on my design of the questionnaire. At the very least I should have provided lines for respondents to write on and should have immediately followed up the survey mailings with a phone call to review the questions. I do believe, however, that the mail survey is an important component to this research in that it has allowed all the workers who wanted to participate the opportunity to do so. The results of the mail survey also served as an important reliability check for the content of my data categories.

I have also considered whether I should have asked participants to priorize their responses to each question, for example, what was **the most important** contributing factor to their job satisfaction? I possibly should have included a specific question about the place of recruitment in the process of retention. Fortunately, however, participants seemed to inherently understand the connection and thus provided me with data addressing it.

The use of a tape recorder proved to be invaluable during the interviews. Although it malfunctioned once and one participant requested me not to use it (I saw this as the product of the agency chaos around her/him), the recorder gave me the opportunity to relax during the interviews, to keep them conversational, and to be assured that the richness of the participants' own words would not be lost.

Because it involved so much travel in a short period of time, I found the data collection process tiring. On one Friday afternoon, I got caught in a blizzard in a remote community, so instead of simply boarding the small Twin Otter airplane for my home in Sault Ste. Marie, I found myself on an ancient Ontario Northlands bus trekking down a narrow highway for 13 uncomfortable hours. I regret that I had no time to observe the agencies more closely. I was typically able to spend only one day in each setting, a day that was taken up mostly by interviewing. Had I been able to take the time to have coffee in a staff room or spend a half day with a clinician going through her/his paces, I would likely have developed more of a sense of the organizational culture of the setting.

However, I can honestly say that I found the interviews themselves to be exciting and immensely interesting, as well as challenging. After I recovered from some first-interview jitters, I felt relaxed and able to fully concentrate on what was being said. I did not always like what I heard. I found the stories that were filled with the despair of not knowing how to obtain relief from tremendous stress left me feeling helpless. At times I felt angered by attitudes that were expressed, by flippancy over what I believed were important issues, and by stories of unfairness, discrimination and political games. On the other hand, I felt particularly exhilarated after listening to participants who were unconditionally enthusiastic about their work and their workplace. In short, there were many emotional ups and downs during the course of the two months. But I was always excited to anticipate what lay ahead in the communities I would next be visiting.

Recommended Action

Prior to outlining the action plan for change that I see as appropriate, I want to state my value assumptions and the rationale for the change I propose. Coming from the perspective of community psychology, I am concerned with the interface between the individual and the organization's processes and structures. A central question is, what are the implications of

organizational practices for the enhancement of the quality of individual lives, including both service consumers and service providers (Keys & Frank, 1987)? I do not subscribe to the belief in "generalized, causal, linear laws of human behaviour that apply in any place at any time to any individual" (Keys & Frank, 1987, p. 242), as they ignore the reality and importance of change in contexts, across history, and within the individual. Therefore, I do not believe in the legitimacy of my providing a set prescription of specific actions for all agencies to follow in order to curb the turnover behaviour of their employees.

I recommend, instead, a two-tiered approach to change. First, I offer some guidelines that reflect those areas of change which have emanated from the participants' own suggestions and which I have expanded upon from the perspective of an empowerment model, as articulated by Block (1987). My caution again in offering this first approach is that, while the guidelines provided here will give individuals, agencies, and government some ideas as to areas of concern to be rectified, they may not collectively represent the needs of any one agency. I have observed differences in the research results depending on both the organizational context (size of the community in which the agency is located; gender of the administrator) and on individual differences (gender; place of origin).

I also do not believe that limiting change to this first list of recommendations goes far enough toward ensuring the long-term, meaningful, all-encompassing changes that arguably need to take place at all levels of the children's mental health system. Thus, my recommendation for a plan of action also includes a more global perspective, precisely because I believe in the need for the major stakeholders in the system to take more responsibility and be more exact in identifying and resolving their own needs.

Guidelines for Change

There are no easy solutions to the reduction of turnover and the enhancement of retention in the North. However, the following suggestions have been offered by participants

and serve as guidelines for change. As well, I encourage the use of the following guiding principles in efforts to implement the changes suggested to me by workers and administrators:

- seek to foster autonomy, not dependency, helplessness, or vulnerability;
- have courage, do not opt for maintenance;
- have a "vision of greatness" to guide the choices, and encourage others to develop one also;
- seek collaboration and sharing, not control or competition;
- share the responsibility for change with all sectors, including within the individual;
- seek quality in solutions, not quantity;
- recognize all stakeholders as valuable resources, encourage their self-expression, use their ideas, involve them in the processes, for they all want what is best for their organization (Block, 1987).

The recommended changes are as follows:

1) **Increase the quality and number of learning and growth opportunities available to employees at all levels of the organization:** The clinical supervision needs of agencies and staff must become the top priority of both the agencies and MCSS because of the immediate and very serious implications for clients in terms of quality of service and for staff in terms of stress levels. This concern must be closely examined and addressed immediately in a joint process involving the workers, administration, and MCSS.

Employees at all levels of the organization must take the responsibility of identifying and conveying their learning needs to the organization, and taking advantage of opportunities that meet these needs. The agency has the responsibility to work with staff and together develop individual and collective plans for supervision, training, professional development, and educational upgrading.

Internal training opportunities must be geared to both workers' needs and their skill levels.

External professional development opportunities offer the added benefits of increasing professional networking opportunities and serving as a mental health break for staff.

MCSS needs to more seriously consider the professional growth of all children's mental health employees as a long-term investment toward the improvement of the quality of mental health services in the North and toward the reduction of turnover expenses. To that end, MCSS needs to address the following:

a) their level of expenditures to agencies for training and development, considering the unique needs and context of each agency;

b) the evaluation of the Northern Bursary Program, particularly in how it serves bursary candidates who must support families, bursary candidates already working in the North, and agencies in more remote communities in the North;

c) the evaluation of the Northern Outreach Program and the feasibility of moving it to a northern university for better accessibility to northern workers and to enhance the material resources in the North; and

d) the levels of concern expressed generally about the quality of northern university programs, their relevance to rural mental health concerns, their capacities to meet the upgrading needs of northern professionals, and their feasibility as northern research centres in the human services.

Finally, an appreciation of the critical significance for the North of an ecological perspective, whereby the concepts of mental health assessment and intervention are expanded to include community- and region-wide social and economic development, must be embraced by university training programs and imparted to all trainees.

2) **Reduce the job stresses experienced by front line and supervisory staff, and increase the level of professional supports available to them:** Each agency, with all its stakeholders, must assess its own unique situation. Are job descriptions realistic? Can clients be effectively served in other, less taxing ways? Do staff have mechanisms through which they can safely voice concerns? Can paperwork be minimized? Have ways been identified by which internal staff could provide more support to their colleagues? Is job sharing feasible and desirable? Are any agency policies or procedures unnecessarily contributing to staffs' stress? Have agencies attempted to identify at a community level what professional resources are needed, what resources are available locally, and how resources could be shared? Have agencies attempted to identify at a regional level how professional resources could be pooled and shared? Are current MCSS initiatives meeting local needs and staffs' needs for resources? What collective strategies can be developed that address the oversights?

Agencies must use the knowledge of their staff group and collaborate with them in devising solutions and investing in a commitment for change. Staff under stress must feel they have a voice and that their concerns are understood and accepted as real. Too often I heard workers say that no one would listen to them, or that their concerns were minimized, or that they were afraid to say anything for fear of criticism, or that their supervisor felt powerless to make any changes. These kinds of situations must change and it is everyone's responsibility to see that they do. Individuals can make choices about being more supportive to colleagues, or about persisting in making their concerns heard, or about seeking out support in unorthodox ways (e.g., one clinician called an expert in California for clinical advice). Agencies have the responsibility to seek out information from staff about their stress levels and to then collaborate on solutions. They also have the responsibility to either individually or collectively communicate their concerns to MCSS and ask to work collaboratively with them toward a long-term solution. MCSS has the responsibility to not minimize the concerns of the agencies (and

thus the concerns of the workers) and to work together toward change. Workers are the most valuable resources that agencies and MCSS have.

3) **Improve recruitment practices:** I refer readers to tables 15 and 16 and to the category descriptions in Appendix D for more details of participants' many suggestions in this area. Recruitment is one of the most difficult concerns facing northern administrators. They are inherently at a disadvantage compared to southern agencies because of their location and because of the stigma attached to the North as a place of last resort. A number of agencies believed their most realistic, long-term strategy was to recruit and train local citizens. This strategy then is dependent on training resources, including relevant university programs, being readily available to the agency and the trainees. Local supervisors expressed concerns that the burden of training often falls on them to the exclusion of their other responsibilities. Other staff expressed concerns that work pressures sometimes force new recruits into positions of clinical service they are not yet trained to handle and that harm could possibly come to clients as a result. Another clinician was concerned that by focusing on hiring only locals, the agency would become a closed system. However, this strategy seemed to best serve the expressed need for a suitable "fit" between individual, agency, and community and thus would presumably enhance retention.

The other alternative seemed to be to raise the stakes (e.g., offer more financial incentives) and recruit workers with more formal education, but not typically more work experience, from outside the region. This strategy has had mixed results. One agency (in a large community) found it to be effective for the most part, while an agency in one of the more remote communities in the North found it exasperating, extremely expensive, and effectively creating a revolving door of employees coming and going. Several factors might be considered in comparing these two situations and thus the feasibility of this strategy: the desirability of the community, the internal resources of the agency for training and caseload

coverage during training, and the organizational culture that develops as the result of relative stability versus regular (and thus expected) turnover.

Administrators commonly believed that recruitment could not be successfully accomplished through a single strategy and I agree. Two agencies, operating in very different contexts, have developed comprehensive, long-term strategies for recruitment. Again I return to the need to know the unique dynamics of the agency and the community in order to begin structuring a recruitment plan. I also reiterate the need for agencies to use their current staff to help devise the plan, for they have lived through the experience and have many ideas about do's and don'ts.

While it may be accurate to say that MCSS has been of little help to agencies around recruitment, it is not enough to only look to them for solutions. It is necessary, however, for agencies to clearly and emphatically make their point to MCSS that northern recruitment is particularly difficult and thus needs some uniquely creative solutions. Sharing recruitment costs such as advertising, university recruitment tours, and bringing candidates north for an all-important site visit may be one possibility. Negotiating block placements with university graduate programs could allow students the opportunity to become engaged with an agency prior to graduation, after which they would hopefully wish to return. Two agencies discussed beginning their recruitment with high school-aged students who express an interest in careers in the social services. Two other agencies shared the opinion that agencies needed the flexibility to establish their own private foundations to help fund recruitment efforts, among other things.

4) **Improve agencies' policies and procedures**: While guidelines for policies and procedures that cover all labour and human rights codes could be secured from human resource specialists (e.g., the Personnel Association of Ontario), the specifics must be tailored to each agency's needs. Again, a process of collaboration is a must in order to design a package that can be supported by all sectors in the agency. It is very important to assess the value of each

policy and procedure to the organization and its stakeholders. Does it provide too much structure and external control of staff? Does it therefore foster dependence and vulnerability or does it allow for flexibility and individual differences? Is there a built-in process for review by all parties affected?

5) **Review salary levels:** I have used the verb "review" rather than "increase" because there was mixed response from participants as to how the question of salaries should be handled. Some definitely saw salaries as important incentives for both recruitment and retention and thus as needing to be higher than in other health and social service sectors and other regions. Others disagreed with the need for higher salaries and described "competitive" and "fair" as the benchmarks they would strive for. Still others believed that higher salary levels were not important, would not keep them in their jobs, and would only attract those looking for money. One participant felt s/he was being "bought off" by her/his employer and, besides saying it would not work, expressed resentment at the attempt.

My position is that it is very important for northern agencies to work for parity with other health and social service sectors in order to have a chance of competing at the recruitment stage and throughout all stages of an employee's career. Northern children's mental health workers do indeed deserve a fair and equitable salary, giving consideration as well to the high cost of living in northern communities, including high food and transportation costs. However, I also believe it is dangerous for agencies to place too high a priority on salaries at the expense of other factors.

It is my contention that workers who derive meaning from their work, who feel valued and supported by their agencies, who are encouraged and supported to grow professionally, and who have ongoing opportunities to be involved in the organization's problem-solving and decision-making processes, place less emphasis on salary. My data show, for example, that those clinicians working under the female administrators, who seemed to encourage more

participatory involvement, expressed no dissatisfaction regarding their salaries. Of the remaining clinicians, 55% did express salary concerns. With regard to changes needed, only 22% of workers employed in female-run agencies mentioned salaries, while 50% of their counterparts in male-headed agencies believed change was needed in the salary area.

Salary cannot be the sole, nor should it be even a primary measure of an employee's worth to an organization. I fear that workers who place a great deal of emphasis on their level of pay are discouraged about their work and the contribution they are allowed to make to the organization. As Block (1987) puts it, "We say that if we can't do meaningful work and we can't be part of an organization that we truly believe in, then we want to be paid a lot for the sacrifice we are making" (p. 43).

Again I emphasize that it is important to work for parity in local communities across the North and across the province, making use of collective strategies among the northern agencies and of provincial lobbying groups such as the Ontario Association of Children's Mental Health Centres. However, I do not believe, and neither do more than 44% of clinicians and 57% of administrators, that it is a critical change toward resolving retention problems.

6) **Recognize the achievements and contributions of employees**: This is a very important step in the process of creating a more empowering work environment, as long as it is done honestly and sincerely. Expressions of appreciation and praise must not be made with a manipulative intent, as this practice in turn fosters workers' dependence on the approval of management. Such expressions must also not emanate from an artificial climate but from an atmosphere that continually encourages self-expression. Finally, I believe that this kind of recognition and the expression of it should come into play for all levels of the organization, that is, front-line staff should have the opportunity to acknowledge a particularly helpful supervisor or consultant or secretary, and a director might recognize the special contribution

of a custodian or psychiatrist or bookkeeper. It is the atmosphere in which such appreciation and respect is communicated that is most important.

7) **Improve agency communications, both internal and external:** This is another key element to a positive, growth-enhancing work place. Information sharing, in an authentic, non-manipulative manner, is absolutely necessary when a leader believes that everyone is a partner, that is, that everyone in her/his organization is responsible for the success of that organization. This belief extends beyond the walls of the organization into the community and the region at large, when one believes that other community services and citizens, other northern children's mental health centres, and government offices are partners in the provision of the best quality mental health care possible.

Within agencies, information sharing can mean groups and/or individuals are given financial information, and information detailing possible changes in the direction or structure of the agency, and that they then become part of that restructuring process. In order for this to be achieved, Block (1987) believes that leaders and in fact, any employee of the agency, must become models for how the whole agency should operate with regard to communications, using language that is authentic, accurate, and inclusionary.

8) **Increase the agency's political power and positive image:** Although this change was most commonly mentioned by clinicians and in the context of the agency, several also mentioned the need for individuals, communities, and government to work toward improving the image of the northern professional and the North at large. I concur that change must be initiated at all levels. It is not only the responsibility of an organization's leaders but of each worker to take ownership of how s/he wants the organization to be and to model that behaviour and attitude. It is too safe and not very empowering to remain dependent on the agency to do

all the changing without the benefit of knowing and experiencing each employee's vision of what the agency should be.

In the same way, each agency must have its own vision, derived from internal collaboration, of all it can and wants to be. The organization must take responsibility for bringing about change in accordance with this vision and not only look externally, for example, to MCSS for funding, direction, and their blessing. It is important to work collaboratively, internally and externally, to assess the elements of a common vision and to develop strategies to achieve it.

9) **Address gender concerns both within agencies and within communities:** This recommendation did not specifically arise from the results to the question about needed changes. However, after hearing the remarks of a number of women and several men describing the levels of discouragement, helplessness, frustration, and sometimes fear that were related to gender issues in their own work places and communities, I believe it is critical that agencies not minimize these concerns and instead recognize them as real and pervasive in all contexts in our society. Agencies need to make a commitment to assess and understand these matters, and in so doing, must be extremely careful not to fall into the trap of blaming the victim. Employees raising such concerns must not be reproached or made to feel they are the creators of their own misfortune. Instead, a "gender concerns" committee, involving employees of both sexes from all levels of the organization, can be established as a vehicle through which exploration and change can evolve, both internally and in response to community attitudes.

<u>The Larger Picture</u>

On a larger, more comprehensive scale, I believe that the process of **organization development**, a change strategy that integrates human needs and organizational goals, is the most appropriate method for each of the organizations I have surveyed to come to a more

holistic understanding of its unique contexts (e.g., historical, geographical, social), human processes (e.g., relationships, communications, empowerment) and structures (hierarchies, job descriptions, personnel policies). Organization development is a method of evaluation and planned change involving humanistic and democratic values that has as its goal the overall effectiveness of an organization (Heller et al., 1984).

I have previously introduced four different models of assessment and change that would be considered components of an overall organization development approach. I recommend that agencies consider these models carefully in order to maximize the benefits that planned change can bring to the organization:

1) **Quality of work life** (QWL) initiatives assess and improve upon certain working conditions, such as job security, participation in decisions, opportunities for individual choice, and control over work time and place, that affect how an employee experiences the organization (Hellriegel et al., 1989). Zautra et al. (1986) have offered suggestions on how to plan and carry out a quality of work life intervention in an organization. They stress the critical importance of careful assessment and planning, citing the example of the relationship between stressful job events and interesting job tasks. Agencies identifying a concern with high levels of job stress and burnout, for example, need to carefully consider "whether planned reductions in stress negatively affect the number of challenging job tasks, and, conversely, whether job enrichment programs increase employee stress" (Zautra et al., 1986, p. 391). Through a careful assessment and intervention process, these agencies could better protect their workers from unnecessary job stress and also promote their goals for career and personal growth.

2) Edwards et al. (1986) have discussed the **competing values model** as a framework for assessing an organization's internal functioning and effectiveness. They have constructed a questionnaire that assesses the eight performance criteria (adaptability, readiness, growth, resource acquisition, cohesion, morale, human resource development, training) they have deemed as determining organizational effectiveness. From the results of such an assessment,

administrators can consider the steps they need to take to change their agency's performance with respect to specific criteria (Edwards et al. 1986).

3) The model of organization development described by Cherniss (1980a) focuses on the **human service organization's design**, which he believes "affects service delivery through its impact on staff motivation" (p. 125). He has identified a number of design dimensions (role structure, power structure, normative structure, job design, role strain, motivation, job satisfaction, attitudes toward clients). Cherniss offers an example of the application of his model in a residential treatment program for teens using a survey and feedback approach. For the survey portion of the assessment he has used a modified version of Taylor and Bowers' (1972) survey of organizations, as well as informal interviews and observations. Cherniss (1980a) states that use of an outside consultant is not necessary, that "administrators, supervisors, staff, and even board members in human service programs can ... use the model as a basis for assessment and change in their programs" (p. 146). Participation by these various stakeholder groups, to which I would add consumers of the service, in such an important organizational project could well prove to be an empowering opportunity.

4) The positive impact of a philosophy of **empowerment in an organizational context** is discussed by Block (1987) and Conger (1989). By agency leaders providing positive emotional support, rewarding and encouraging staff in visible and personal ways, expressing confidence in workers' abilities, and fostering initiative and decentralizing responsibilities, Conger argues that staff come to believe in their own effectiveness which can translate into the organization becoming more effective. Simultaneously, the empowerment of employees also means the identification and, wherever possible, the elimination of organizational characteristics that foster a sense of powerlessness among staff (Conger, 1989). Thus, Conger offers a framework for the organizational assessment of "context factors" that can potentially lead to a state of powerlessness for staff. The components include organizational conditions (e.g., significant organizational transitions, poor communications), supervisory style (e.g., authoritarian,

negativistic), reward systems (e.g., low incentive value, not competence based), and job design (e.g., lack of training and support, limited participation, limited contact with senior management).

Once the organization is assessed on this basis, Conger (1989) advocates that administrators utilize various managerial practices (described earlier) to bring about a sense of empowerment among staff. However, Conger strongly cautions that such a process demands time, confidence, and creativity. He also believes empowerment is not a "pill" nor just simply a technique. "To be truly effective it requires an understanding of subordinates and one's organizational context" (p. 23). As well, he believes that only those administrators or managers who feel secure enough in themselves will be able to see the empowerment of workers as a gain, not a loss.

It is my belief that the setting where mental health professionals work each day should ideally serve as both a supportive refuge and a place for rejuvenation and growth in the face of very heavy emotional and intellectual demands. It should represent the same systemic model of cooperation, fairness, respect and openness that clinicians strive to impart to dysfunctional families. It is difficult to rationalize how clinicians can be expected to empower families when they themselves are subjected to less than empowering behaviours and attitudes from those colleagues and leaders who make up their work "family".

While I see each northern children's mental health centre as the target for the organization development process, I do not see a centre's role in the change process stopping there. Given that individual and environmental enhancement are so intertwined, I believe that **each agency could become the focal point for needs assessments and interventions on the level of community change**. Some of the possible areas of intervention that I envision, taken from both the participants themselves and the community psychology literature, include:

- facilitating positive inter-agency relations;

- facilitating citizen participation and community organization to create an empowered citizenry;
- working with citizens to design and implement community prevention programs that would reduce environmental stressors, increase citizens' competencies, and create a "sense of community"; and
- facilitating community efforts to organize and pressure government for change.

In these ways, agencies could assist northern communities to enhance their quality of life and become the kinds of settings in which clinicians as citizens could thrive.

As mentioned in my presentation of the guidelines for change, I also believe that responsibility lies with each agency employee to create her/his own vision for all the organization can be and to model those behaviours, attitudes, and values that embody that vision. This is a critical part of the empowerment process, a process that must ultimately come from within.

Finally, I concur wholeheartedly with those participants who expressed the need for government, specifically MCSS, to work more in partnership with agencies and communities in meeting their mutual goal of competently and effectively serving the mental health needs of northern children and families. Such a partnership would be imperative in the undertaking of organization development as I have proposed. Northern communities need to be better understood by government if they are to become more valuable as resources to their citizens. I believe MCSS needs to seriously assess its own organizational values and its vision for the North. Are there ways it may be fostering a sense of dependency, helplessness or vulnerability among some, if not all, northern agencies? Is this the kind of atmosphere under which these agencies, their workers, and ultimately their services are likely to thrive? Why do there seem to be some agencies that are "have's" and others that are "have not's"?

It is my hope that the children's mental health centres in Northern Ontario and their funder, the Ministry of Community and Social Services, will view this study as a preliminary work in a much-needed assessment and change process. In the tradition of an ecological approach to intervention, this process would encompass not only each individual agency, but the community, regional and government contexts as well, in order to effectively and efficiently use all available resources.

Recommendations for Future Research

I see this research as contributing to the literature in several important ways. The rural and remote context of the study makes it unique with respect to the discussion of issues such as burnout, job satisfaction and dissatisfaction, gender-related concerns, and the organizational context. The community psychology principles and values that underlie my inquiry, such as empowerment, the psychological sense of community, and the ecological model, while providing a less than conventional backdrop for the study of employee retention, allow for a more comprehensive and realistic perspective.

In many respects, this study has served to support the findings of a number of researchers but has done so from within a non-traditional investigative context. From urban American perspectives, Pines and Aronson (1988) related burnout to gender, while Eisenstat and Felner (1983) and Greenburg and Valletutti (1980) saw burnout as attributable to job design and the work environment. Streepy (1981) and Beck (1987) concluded that burnout was associated with barriers to service delivery, the degree of work pressure, and lack of support. This research has helped to confirm these linkages in the context of rural and remote settings in Canada and has also identified the reduction of burnout and high levels of job stress as a factor in enhancing retention. However, because burnout *per se* was not the primary focus of this inquiry and because there has been virtually no research directed toward burnout in rural areas, I consider this an area of investigation that must be pursued.

Job satisfaction and dissatisfaction are other research areas in which very little has been written concerning the rural workplace. The research of Jayaratne and Chess (1982-83; 1986) did not specify geographic context, while Field and Dubey (1987) conducted their studies in urban centres but did not address this fact in their conclusions. Near et al. (1987) conducted the only inquiry that considered rurality in their research design. Although the study was carried out in an urban setting, they considered whether the participant grew up or currently lived in a rural or suburban environment, in attempting to determine the relationship between job satisfaction and life satisfaction. However, their results were inconclusive.

I believe this research project, again in part because of its rural/remote context, contributes to the understanding of job satisfaction and dissatisfaction in a way others have not. The importance of leadership style to job satisfaction (also see Field & Dubey, 1987) and its possible link to gender, and the impact of gender differences within organizations and communities are questions few researchers have explored, particularly in rural areas, commonly thought of as men's turf. I see the need for further research to address these questions at large and, more specifically, within rural human service settings typically staffed by female frontline workers and men in upper management positions.

Another unique contribution of this research is its focus on the rural human service organization and on the organizational factors that have an impact on satisfaction on the job and ultimately on retention. Fenell et al. (1987) identified necessary characteristics of rural administrators, including leadership skills, effective program planning, implementation and evaluation, and budget and fiscal management skills. However, they did not explore the relationship between the rural administrator's characteristics and successful retention, nor did they address any additional organizational qualities.

Finally, I believe that the qualitative methodology I used brought together a number of voices of people who may have not otherwise been heard. It is an empowering approach for

both participant and researcher and one that I believe must be considered more readily in research undertakings in all contexts.

A Personal Note Regarding this Project

Over the course of the last year, this project has become a very personal journey for me. It has been my first experience into the world of research and thus has generated some doubts and anxieties. Since my ultimate goal is for the research to be practical and usable, I have recognized that the results must be presented in a way that does not offend or lay blame but also does not compromise the intensity with which feelings and concerns were expressed to me by the participants. This is a very difficult balance to achieve. It is further complicated by the reality that I will be returning to work in a northern children's mental health centre upon completion of my degree and that my professional standing in the small "community" of northern agencies, professionals, and government officials could be at stake. However, I have made every attempt to analyze, present and discuss the results of this inquiry in a way that most accurately and fairly represents the views of each and every participant.

This journey has come to represent my own politicization as a woman and as a worker. The personal reflections woven throughout this document may seem unimportant or unnecessary to express. After reading an early draft of this thesis, a research participant cautioned me that such disclosures may be interpreted as indications of weakness or victimization, and that by personalizing the research process and reporting style I may generate more questons about the credibility of the findings. However, I stand by the values of non-traditional, non-positivist feminist research and assert that, as a researcher, I am not an objective observer. I am a participant in the process and therefore share my experiences as part of the data. I also firmly believe that the interview data I have presented speak for themselves in terms of the content, the quantitative strength, and the conviction that change, through participation and empowerment, must come about if clinicians are to willingly stay in the North.

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Appendix A

Interview Questions - Clinical Staff

Introductory Questions:

- Where are you from originally?
- How long have you lived in Northern Ontario?
- How long have you been employed by this agency?
- How long have you worked in the mental health field?
- Current job description; geographic area you work in?
- Type and location of professional training ?
- Age (optional)
- Marital status (optional)

Research Questions:

1. Were you a resident of your present community or another community in Northern Ontario prior to becoming employed with your present employer?

   If not, what factors did you consider in your decision about whether to take employment and move to Northern Ontario?

   (PROBES: family background, extent and location of training, years of experience, familiarity with area, incentives, expectations)

2. What factors might contribute to your satisfaction with your life in Northern Ontario? with your job in Northern Ontario?

   (PROBES: job tasks, work atmosphere, perks, non-work factors)

3. What factors might contribute to your dissatisfaction with your life in Northern Ontario?
   with your job in Northern Ontario?
   (PROBES: job tasks, work atmosphere, non-work factors)

4. In your opinion, what changes need to take place to keep children's mental health workers in Northern Ontario?
   (PROBES: individual level, agency level, government level, training level, community level)

5. What differences (if any) have you experienced as a female or a male worker compared to your colleagues of the opposite sex?

6. How would you like to see the results of this research used?
   How would you like to receive feedback of the results?

7. How did you feel about this interview?
   the content?
   the process?
   What improvements can you suggest?

Interview Questions - Administrative/Management Staff

Introductory Questions:

- How long has this agency been in existence?
- How many professional staff do you employ?
- What children's mental health services do you provide?
- What geographic area does the agency serve?
- How are services delivered to outlying areas?

Research Questions

1. To what extent is the retention of your clinical staff a concern for your agency?

   Are there other personnel-related issues which are of greater concern to you as an administrator/manager?

2. What factors have contributed to your agency's ability to retain your staff?

   What are your agency's current strategies in an effort to retain staff?

   What have you tried in the past?

   What would you like to be able to try?

   What do you think will work the best?

3. What factors have contributed to staff turnover in your agency?

   What is your agency currently doing to try to prevent staff turnover?

   What have you tried in the past?

   What would you like to be able to try?

   What do you think will work best?

4. In your opinion, what changes need to take place to keep children's mental health workers in Northern Ontario?

   (PROBES: individual level, agency level, government level, training level, community level)

5. What differences (if any) have you observed there to be in the experience of a female worker compared to a male worker living and working in a northern and/or rural environment?

6. How would you like to see the results of this research used?

   How would you like to receive feedback of the results?

7. How did you feel about this interview?

   the content?

   the process?

   What improvements can you suggest?

Appendix B

Letter to the Executive Directors

Dear Executive Director:

Re: Retention research

My name is Syd Parlour. I have been an employee of Algoma Child and Youth Services since 1980, both in a counselling capacity and as a clinical supervisor. While with A.C.Y.S. I have lived and worked in Wawa for five years and in Sault Ste. Marie for four years.

Presently I am on an Education Leave for two years and am enroled in the Master's program in Social-Community Psychology at Wilfrid Laurier University. The research for my Master's thesis, under the supervision of Dr. Richard Walsh, will focus on the issues related to the retention of children's mental health workers by Northern Ontario Children's Mental Health Centres.

I understand that Ron Rodgers, Executive Director of A.C.Y.S., has been in contact with you concerning your participation in this research. I would appreciate receiving from you a **written confirmation** of your willingness to participate and your willingness to allow me to contact your counselling and managerial employees to individually request their participation.

Once I establish a list of potential participants, I will select a sample of participants whom I will interview in person, as well as a sample whom I will interview by phone or contact by mail survey. I am interested in speaking with employees who are newly-hired, those who have been on staff for several years, and, if possible, a small number of former employees who have left the agency within the last year. I am particularly, though not exclusively, interested in interviewing employees living and working in more remote communities.

I would appreciate receiving from you a list of employees, with addresses and phone numbers, whom I may contact to request their participation. I hope to start the interviewing

process in late September and conclude before Christmas. I anticipate that each interview will take roughly ninety minutes, though this may vary. All information I receive from participants is strictly confidential. Once all the results are analyzed, my plan is to provide feedback to all participants, likely in the spring of 1990.

If you would like further information about any aspect of this research, please feel free to contact me at any time. Thank you very much for your cooperation. I look forward to hearing from you in the near future.

Sincerely,

Ms. Syd Parlour

Appendix C

Consent Form

I have fully agreed to participate in research conducted by Sydney Jean Parlour, knowing that it concerns issues pertinent to the retention of children's mental health workers who are or have been employed in children's mental health agencies in Northern Ontario.

My rights as a participant have been explained to me, particularly my right to refuse to answer any questions about which I feel uncomfortable, and to withdraw from the research at any time.

I understand that the information I give will be kept completely confidential and that my participation will remain anonymous.

____________________ ______________________________

Date Participant's signature

____

Participant's address

____

____

Participant's phone number

Appendix D

Definitions of the Categories Emerging from the Data

Attractors / Detractors to the North.

1. Job Description, Opportunities: heard of job through a friend, a professor; job was available; agency did not require experience; wanted work experience; was desperate for a job; agency promised supervision, training; job fit into career plans; liked the variety of work experience; wanted to work with a team; clientele sounded interesting; liked working with colleagues; could not find job elsewhere.

2. Lifestyle: was familiar; liked outdoor activities, sports; wanted to leave the city; liked privacy, space, quiet.

3. Community Qualities: small; nice people; personable; slow pace; variety of community professional opportunities; good real estate investment; rural atmosphere; was close to city; housing was available; met cultural and material needs; proximity of a university; accessible cultural opportunities; attractive community; good place to raise family.

4. Family/Friends Near: are nearby; community is accessible to them; support the move; is home community.

5. Beauty of Area: the natural surroundings; the trees and lakes; geographical setting is beautiful; listening to loons; likes the bush.

6. Adventure, Personal Reasons: came for adventure; liked the challenge; felt like a pioneer; wanted to get away from relatives; wanted a change.

7. Salaries/benefits: liked the salary, benefit package; salaries higher than elsewhere;

8. The Agency: new agency; liked the setting; agency is growing; liked agency philosophy, orientation.

9. Recruitment Process: impressed with way that agency recruited, interviewed; agency was first to respond; agency showed interest, was helpful; was impressed that agency was willing to wait.

10. Spouse Influence: spouse was attracted to the area; moved for spouse's health and retirement; moved for spouse's job; spouse was discouraging.

11. Time-limited: took job because knew they could leave shortly; had a plan to only stay for few years.

12. Working Style of Agency: informal, flexible, autonomous, personal nature of work.

13. Family/Friends Discourage: they discouraged the move; long distance from them.

14. Community Qualities (Negative): too small; unstimulating; too isolated; unattractive; no learning resources; boring culturally; too predictable and conservative.

Life Satisfaction Factors.

1. Lifestyle: develop new hobbies; leisure activities; slow pace; solitary living; living close to nature; healthy, unpolluted.

2. Human Community: people are helpful, interesting, caring, open, honest, friendly, accepting; familiarity of people; homey, cozy; family-oriented; clients are courteous, comfortable; is a safe place, know neighbours, teachers, doctors; small town atmosphere; informality; church ties; relaxed; less materialistic; community spirit.

3. Physical Community: clean, lack of pollution; lack of traffic; have recycling; cultural opportunities; nice housing; good shopping; education facilities.

4. Beauty of Area: natural surroundings; geography.

5. Opportunities for Involvement: private practice; variety of opportunities; can specialize.

6. Accessibility to People, Places: to urban centres; to the work site (short commute); to family.

7. Ease of Community Integration: feel at home; have integrated; have established roots; is in own niche.

8. Affordability: housing; lower cost of living.

9. Climate: likes the winters; is not a problem.

Life Dissatisfaction Factors.

1. Physical Community: economic instability; too small; lack of shopping; lack of culture, arts; lack of municipal/rural services; poor transportation systems; lack of educational facilities; lack of collateral health, social services; lack of libraries; polluted, congested.

2. Human Community: problems when raised in community; no privacy; conservative, male-oriented attitudes; socially stifling, closed; language, cultural intolerance; people devalue social services.

3. Status as Single Person: hard to develop social networks; lack of partners; community not singles-oriented; no anonymity; loneliness.

4. Community Integration: takes too long; too closed; hard to develop social networks; culture shock; need self-initiative; not much to do at first; considered an outsider.

5. Isolation: from urban centres; from friends, sources of support; from professional peers; causes stress.

6. Affordability: expensive gas, property, shopping, food, transportation; high taxes.

7. Lifestyle: unfulfilling; too limiting in orientation; do not like outdoor activities, sports.

8. Climate: do not like winter driving; winter is boring; too cold, snowy.

9. Lack of Career Opportunities: because town too small; because of language; for spouse.

10. No Dissatisfaction:

Job Satisfaction Factors.

1. Flexibility/Autonomy of Job: allowed flexibility in work; likes the autonomy; given autonomy on job about case decisions; can work flexible hours; given added responsibility, authority; allowed to be innovative.

2. Colleagues: likes colleagues; colleagues are competent, give support, consultation; support, closeness of colleagues; likes working with variety of disciplines; get peer support, respect; are helpful clinically; work team is competent.

3. Professional Development/Training: opportunity for training, upgrading; have in-house training; valuable learning experience; positive opportunities; strong commitment to professional development and training; flexible use of professional development money; enjoys providing training.

4. The Work Itself: loves the work; likes the challenge of the work; varied caseload; variety of clinical approaches; diversity of situations; broad range of experiences; work is tied to professional training; varied roles; job description; feels good about work done.

5. Supported/Valued by Agency: get support for upgrading; get support for decreasing workload; feels supported; feels valued, respected as professional; feels liked as person; get a quick response from management; feels needed; supported for travel decisions; respect from boss allows opportunity to take on varied tasks; likes high expectations of management, co-workers.

6. Team Approach: staff collaboration; access to team consultation; opportunity for co-therapy; interdisciplinary team; team is supportive.

7. Community Collaboration: like agency's community orientation; working in own community is satisfying; like opportunity for community work, collaboration; like working with community groups, schools; like working with community professionals; feel needed, appreciated in community.

8. Benefits: benefits are good; holidays are good; get a work vehicle

9. Level of Supervision: is appropriate; amount and quality is good; has improved; is adequate; good clinical support; available when requested.

10. Opportunities for Input: on case assignments; into her clinical role, decisions; into choosing nice physical setting; into developmental goals; into program planning, development; into agency changes.

11. Salaries: competitive; good; recently improved; are O.K.

12. Seeing Positive Change: in clients; in own skills; in agency; in community; results of work.

13. Resources Available: can purchase books; improved agency library; ample physical resources; professional resources; access to Southern Ontario resources.

14. Management/Staff Relations: likes boss; satisfied with management; administration is responsive to staff; good relationship with management; treated well by management.

15. Office Accommodations: new physical setting is important; nice new office; have improved; pleasant.

16. Work Environment (Human): likes work environment; professional atmosphere; open environment; staff want to be there; is caring, person-oriented, supportive, understanding.

17. Agency Philosophy/Vision: respectful toward clients; growth-enhancing; family-oriented; shared philosophy on staff.

18. Agency Policies/Procedures: education leave; compensation time for overtime; flex-time.

19. Agency Growth/Stability: appreciates agency stability; agency growth, change is exciting; growth allows unique development opportunities.

20. Management Style: appreciates supportive participatory management style; responsive to clients, staff.

21. Career Mobility: promotional opportunities; can change jobs; not a dead-end job.

22. The Clientele: likes them.

Job Dissatisfaction Factors.

1. Clinical Supervision: inconvenience; cannot recruit supervisor; is very inadequate; lack of supervision affects services; not accessible; lack of structure; supervisory conflict; inexperienced supervisor; lack of feedback; conflicting style with supervisor.

2. Professional Development/Training: inaccessible; lose time from work; funding is too low; few opportunities; not supported by agency; was refused opportunity; too elementary; unfair allotment; lack of opportunities deters recruitment.

3. Burnout/Stress: burnout is close; feel too isolated; too many pressures; feel overwhelmed; stress from paperwork; work is very stressful; at risk for burnout because I work alone; from the community being so critical; stress because staff inexperienced; staff have own mental health concerns; stress from shortage of other services; always being on call causes stress.

4. Professional Isolation/Few Resources: few professionals with similar interests; no professional stimulation; lack of qualified consultants; lack of community resources for clients; forced to seek out own resources.

5. Unsupported/Undervalued: agency doesn't acknowledge staff credentials; judgment not trusted; staff made to feel incompetent; staff treated like second class; undervalued as social worker, because of having a degree; undervalued for working style.

6. Agency Instability: staff incompetence; management incompetence; too much growth and change; high turnover; always reorganizing; staff dissension; problems with amalgamation.

7. Excessive Work Demands/Understaffing: have to work overtime; too much paperwork; caseloads are too high; too long a waiting list; create too many pressures; demands too heavy on supervisor; heavy demands from community.

8. Salaries/Benefits: not competitive; not an incentive; inadequate; too low to attract or retain; used to keep staff where agency wants them; need review; unfairness causes tensions.

9. Management/Staff Relations: felt mistrusted by agency; managers do not apologize; management unresponsive; no grievance system, need one; too authoritarian; union may help; no employee rights; feel alienated by management.

10. Colleagues: tensions between co-workers; too inexperienced; not supportive; too many cliques; too unmotivated; too critical; incompetent.

11. Agency Vision/Structures: no clinical direction; no philosophy, mission statement; ambiguous job roles; too male dominated; too technology oriented; too administration oriented; poor recruitment because agency doesn't know needs.

12. Personnel Policies/Procedures: unfair; poor mileage rates; no grievance process; not enough vacation time; unfair internal promotions; no education leave policy; no compensation for isolation.

13. Quality of Service: too low a priority; affected by instability, turnover; dissatisfied with quality; affected by supervisory conflict; affected by lack of resources; affected by finding experienced, qualified staff; services dangerous because of lack of supervision; management lacks concern for clients, quality; lack of government concern.

14. Underfunding: leads to understaffing; leads to lack of training, professional development; leads to low salaries; prevents program evaluation.

15. Government Involvement: interferes with service delivery; causes underfunding; incompetent, ineffective bureaucracy; do not take agency, community concerns seriously; unfair funding practices; only listen to large communities; frustrating to deal with; show no leadership.

16. Office Accommodations: too small; inadequate; cramped; no ventilation; lack of space restricts staff growth; cold in winter, hot in summer.

17. Lack of Community Support: unrealistic expectations cause conflict; lack of cooperation; undervalue agency's work.

18. Lack of Career Opportunities: refused promotions; agency blocks promotion and transfer; due to being unilingual.

19. Travel Demands: dangerous; tiring; time-consuming.

20. The Clientele: hostile; needy; do not respect personal boundaries; see too often in public; unmotivated.

21. The Work Itself: job description did not fit with training, interests.

Gender Concerns Within Agencies.

1. Management Style (Structure, Practices): hierarchy of men; boys club; authoritarian; women have no access to top; movement away from participatory model; circumvent women; men collude, stick together; men have personal access to top; women pushed out of upper management; get more men to counter women's power move; use power to be 1-up, force issues, not diplomatic; (Effects): women feel unsupported, disempowered, treated like second class, threatened, have no input; male management insensitive, disrespectful; women have no channels for grievances, have to emulate men to get ahead, feel powerless, are discouraged, will look elsewhere for work; is unequal treatment; men listened to more, opinions are more valued, have more power, under less scrutiny.

2. Clinical Issues: sex of therapist versus sex of client affects comfort level, power, respect; harder for male clinicians to deal with sexual abuse, family violence victims; women overworked, burning out due to working style; need more men in front line positions; differences in working styles; hard to supervise staff of opposite sex because they think differently, power issues; female-male conflict over clinical issues like violence against women.

3. Unequal Benefits, Opportunities: women have lower job qualifications; only male staff encouraged to advance; male turnover higher because of low salaries; men get more promotions, more quickly, have positions created for them; men earn more, can cut deals, have higher status; woman not considered for job because wanted man; men with less education, experience earn same as women with more.

4. Male Domination in Upper Management, Administration: top heavy with males, bottom heavy with females; males in most decision-making roles; need women in upper management; have to hire more men in front line to get balance; because women dominate social work, men must dominate administration; having so few female managers affects decisions, support male versus female workers get.

5. Gender-based Attitudes: males do not understand, respect female clinician's style; feel anti-male bias from feminists; male director threatened by female staff in women's action group; male director doesn't believe social, violence problems exist for women; male director makes sexist comments; sexism in agency is subtle, powerful; sexism in agency is blatant; sexism in agency is ingrained; male qualities are more highly valued; men in power joke about women; a "deep voice" commands respect, women have to earn it; offensive that men complain that it is hard to work with so many women; when disagree, men quick to call women anti-male; women have to fight for credibility with colleagues.

6. Entrenchment versus Change: men at top will deny any problems; men at top not willing to change; as a male, does not understand, know what, how to change to eliminate male infrastructure, hire more women; female employees accept practices as part of life, feel powerless; considering union.

Retention Success Factors - Clinicians.

1. Educational Opportunities: opportunities for further education; accessible university education in the North; northern training programs in universities; better access to Ph.D. programs; the means to pursue a doctorate.

2. Salaries: pay $10,000 more than other places to counter the cost of living; more incentives; competitive salaries; need to pay more; will not help; must compensate for stress.

3. The Work Itself: need to do the work you want; job itself; range of work options; more job responsibility; to include research.

4. Professional Development/Training: have to offer more; only better training would keep me; must be available and accessible; need to feel current.

5. Peer Support: liking colleagues is important; need colleagues to be supportive; network with other professionals; have professional support group; need team building.

6. Effective Recruitment: good fit between person, agency and community; hire locals; do not hire undesirables.

7. Having Local Ties: being married with kids in school in the community keeps her there; locals will stay despite salary; met wife, married, so stayed; need to have family, roots to stay.

8. Agency Valuing Staff, Their Skills: agency values people's skills, not just paper credentials; need sense of pride in rural social work so feel good about work; is treated well; need to feel appreciated, valued.

9. Connections, Networking: use phone to contact outside experts for information, support; must network with other professionals; need to feel a part of something, connected.

10. The Community: likes it; am affected by local economy; likes the people.

11. Individual Factors: to meet own personal goals; learning to pace herself; social opportunities.

12. Research Opportunities: want collaborative research institute, research opportunities; need more research money.

13. Professional Autonomy, Responsibility: have the freedom to develop own program with large budget.

14. Work Climate, Conditions: need internal agency improvements; agency has family atmosphere.

15. Love Lifestyle, Outdoors: have to love the outdoors, winters; like the lifestyle.

16. Career Advancement: need to offer advancement opportunities.

Retention Success Factors - Administrators.

1. Recruitment: jobs should go to Northerners who will stay; aided by recruiting locals; helps to recruit those who like local activities, have local ties; recruit those known to current staff; grow your own staff; be creative, proactive; recruit carefully; recruit those who fit with organization; success from hiring, training locals; have gone away from hiring for degrees only; must have deliberate, step-by-step process;

2. Opportunities for Professional Growth: staff training is a must to develop skills so staff will value themselves; agency is committed to professional development, give generous money; must invest more in professional development, training; need it for support for staff; staff want opportunities for growth; need to develop staff so they feel growth; training is a must; encourage specialized training in outer offices to meet local needs; opportunities for growth and challenge; need growth and development orientation, commitment; place high value on training; have good internal training; intensify internal training as it gives staff a common language; attached research component to training; intensive training energizes, supports, teaches new skills; need good size budget; encourage staff to use all opportunities.

3. Work Environment: develop positive, fun attitude in work setting; agency must feel like good place to work; try to create nice work atmosphere; need good working conditions; fun place to work, good staff group; working conditions reasonable; develop supportive, encouraging work environment; nice place to work, good atmosphere, lots to offer; people enjoy agency personally, professionally; no agency politics.

4. Salary: higher so staff can afford to get out for rejuvenation; hoping increases will retain staff; need good salaries; must pay staff well; need competitive salaries as incentive; must be upgraded.

5. Supervision/Clinical Support: must provide staff with support; need good supervision for inexperienced staff; train, free-up local supervisors to be first level of support to front line staff; bring specialty services regularly to outer offices or have it accessible; use peer review

for support; offer regular, intense supervision, focused more on new staff; have good clinical support, supervision; key is providing good supervision; have localized supervision so it is regular, immediate; give regular support, supervision to front line supervisor; give more supports to clinics to reduce isolation, burnout; stabilize, structure supervision, support.

6. Benefits Package: staff stay because benefits are good; very good benefit package; good benefits are incentives; are considering a 4 over 5 plan; have fair benefits; offer unpaid leave of absence; make available affordable housing.

7. Work Itself: offer challenges in the job; have developed good programs, are meaningful, measurable so staff feel accomplishment; provide staff with variety of opportunities so don't burn out, can be successful; need variety in cases, job description; have a clear service model; is enjoyable work; have good professional opportunities, challenging, range of skills to develop; respect the difficulty of the job; clearly define roles; offer challenge to be creative.

8. Educational Opportunities: establish links with universities to give support, research opportunities, status, back-up, reduce isolation; agency's invested money in upgrading of senior employees as investment; must tolerate difficulty of staff getting degrees; pay for upgrading for committed staff; need quality local education programs to grow own staff; need greater access, acceptance of U.S. university programs in Canada; university programs need to be relevant to northern needs; high quality local university programs could impact on growing, keeping professionals in North; helps having local M.S.W. program; if can train and educate in the North, staff will likely stay; must give staff opportunities to return to school.

9. Peer Support: need to develop support groups for foreign professionals; male professionals look after each other; must provide collegial support; need to develop strong core of professionals for support; a larger local staff group gives more internal support, team approach.

10. Agency Input: everyone is consulted on major decisions; have staff training and development committee made up of staff; need staff participation; need to get staff involved

in defining policies and procedures; must give more control to staff in some areas; have staff involvement in program issues; offer participative decision making; not losing values to hierarchy; include staff in decisions, have some influence; give staff choices, input so they feel part of agency; too much hierarchy causes problems; have decentralized decision making; staff feel part of team, have input.

11. Valuing the Professional: staff stay because they feel valued; senior employees seen as good investment; need to better market, showcase skills of staff; empowerment philosophy for staff; commitment to staff as people and professionals; staff need to feel respected professionally.

12. Flexibility/Autonomy of Job: offer flexibility for mental health days off, in use of professional development money; flexibility, self-regulation in scheduling; flexibility in rules, overtime.

13. Agency Growth/Change: have undergone major reorganization to address problem areas; growth gives opportunities to keep staff interested; have to adjust to large staff increases, growth.

14. Intra-Agency Communications: must keep staff connected; need regular staff meeting to explore new ideas; must fund travel to and from outer clinics; use technology as communication link.

15. Individual Differences Respected: should have concern with staff's adjustment; must tolerate different lifestyles, needs, demands; help staff meet personal goals, be responsive to staff's needs.

16. Agency's Internal Resources: staff need adequate resources; develop internal library, A/V resources; need large core of services that outer offices can use, benefit from; must share resources within; need greater variety of professionals on staff; have increased professional, expert resources to clinics.

17. Unity of Purpose: staff, management, board work together for same goals; need all agency people pulling together; need to have clearly stated, appealing values that all support; identify, maintain purpose, clear philosophy.

18. Non-Monetary Perks: staff need rewards other than salary;

19. Get Breaks from Work/Community: must give opportunities to leave the community yearly for rejuvenation; encourage outside workshops because they serve as a break.

20. Utilize the Northern Bursary: bursary program has worked for agency; gets people north to work.

21. Size of Agency: determines amount of political clout, visibility.

22. Promotional Opportunities: wants agency to develop so is room for career growth opportunities; consider current staff first for new positions; more opportunities for job change.

23. Priorizing Retention in Agency: need to pay attention to what agency needs to do to keep staff satisfied; need variety of strategies because staff are different.

24. Unionization: having a union has some advantages; union helps with salaries, benefits, job security.

Changes Needed - Individual Level - Clinicians.

1. Support, Respect Colleagues: northern professionals must promote themselves; need to get along with colleagues; need support from colleagues; new staff need more support.

2. Create Positive Community Professional Relationships: need to get along with community professionals; need support of community professionals; need strong local professional network; need more inter-agency collaboration for support; need expanded professional connections; for information sharing; to reduce stagnation.

3. Challenge Negative Northern Stereotypes: relating to isolation, clinicians' lack of education, services second rate, lack of professionalism, that outsiders better than Northerners;

demystify North; promote Northerners as professionals; northern professionals could be on forefront of clinical movements.

4. Make Concerns Known: need to have more voice; need way to bring concerns to management.

5. Assess, Change Personal Working Style: develop maturity to recognize own limits; personal style can lead to burnout; need to separate work time from personal time.

6. Adapt Better to Local Community, Lifestyle: make the best of supposed rugged lifestyle; need to learn to adapt; create organization to help newcomers to adapt.

7. Be Less Greedy.

8. Take Better Advantage of Learning Opportunities.

Changes Needed - Community Level - Clinicians.

1. Increase Cultural Opportunities: need more; need more of a variety; more cultural events; would help adaptation; more commitment to sponsoring cultural events.

2. Improve Image of Northern Communities: should emphasize ecological factors, quality of life; give more support to locals who want to return to work; communities need to believe Northerners are as good as outsiders.

3. Offer More Singles-Oriented Activities.

4. Quality, Affordable Housing.

5. Improve Library Resources.

6. Develop Better Recreation Facilities.

7. Develop Better Transportation Systems.

8. Move Toward Health Orientation, Promotion.

Changes Needed - Community Level - Administrators.

1. Communities Need to Market Themselves Better: regarding their housing market; regarding their lifestyle qualities.

Changes Needed - Agency Level - Clinicians.

1. Increase Learning, Growth Opportunities: training; professional development; upgrading; supervision; to reduce burnout; to keep current; to increase credibility; to gain equal footing with South; to train supervisors; to train managers; to develop northern professionals; to feel clinically supported, competent, stimulated, challenged; to improve quality of service; must be built in; must give more time for; must make a higher priority; improve education leave policies; by linking, pooling local resources; offer more bursaries, training grants; take more leadership; hire, train internal trainers; establish links with universities; give paid sabbaticals, leave; help establish research, training centre.

2. Reduce Job Stresses, Increase Supports: encourage networking, connections; use technology; reduce isolation; promote team building; give more support against burnout; give more holiday time; make realistic work expectations; respect different working styles; give more compensation, recognition for work stress; make allowances for employee differences; give more consideration, nurturing; respect individuals, disciplines; need more staff to reduce pressures; actively assist new staff with fitting in; need more professional development to reduce isolation, link with other professionals; allow more input, participation; value staff for their work; need good supervision for support so do not feel burden alone; colleagues need to share, discuss stresses, to be listened to, need channel for grievances; reduce caseloads; agency needs to be strong staff advocate; recognize, acknowledge different pressures on rural staff; agency needs to stabilize internally; agency needs to better manage change.

3. Improve Recruitment: find, attract, train northern professionals; emphasize the fit between person and environment; better publicize the North through universities, conferences, staff exchanges to overcome negative stereotypes of northern jobs; provide wider range of

services to attract more professionals; promote northern uniqueness, lifestyle, quality of life; salaries must be competitive; must be funds for incentives, including salaries, professional development; need to find ways to attract experienced clinicians for supervisors; focus on high school students to raise their interests in social services as career; select for commitment, fit, common sense, motivation, trainability; need less emphasis on experience, qualifications; agencies need to change attitudes that imports are better than locals; need definition, selectivity, caring in recruitment process; need incentives to encourage Northerners to return from upgrading.

4. Improve Agency Policies, Administrative Practices: need to address staff concerns, grievances; improved policies could reduce stress; eliminate gender inequality from salaries, promotional opportunities; rectify salary imbalances across professions; promote a ground up operation; policies could promote growth, learning; need more progressive attitudes, policies on social issues; management structure needs flexibility; promote organizational development; need more women in upper management; reduce, flatten administrative hierarchies; need agency stability; need agency philosophy, vision; agency should be run like a business.

5. Increase Salaries, Benefits: need to be very competitive or higher; need to be higher as incentive to come, stay; need to be competitive with South; need to be fair; are a top priority, need to be higher; need to be equitable across locations for same job; travel allowances must be higher; need salary equity between men and women; higher to attract better clinicians; higher salaries probably would not retain people longer; higher as a reward; do not want people who come only for salary;

6. Increase Agency's Political Power, Positive Image: challenge negative stereotypes of northern agencies, professionals, services, people; increase stature of northern agencies through advertising, promoting, educating, showcasing accomplishments; collectively develop effective lobbying strategies by educating communities and government, removing barriers between agencies, educating provincial organizations; collectively show initiative, creativity in

developing joint strategies, as is more power in numbers; need to eliminate competitive atmosphere among agencies.

7. Review, Revise Programs, Treatment Models: expand programs, more variety to attract more staff; acknowledge unique service needs in North; need more localized, personalized services in North; do not endorse southern models; need more creative programs; need full backing of management for programs to work; need staff input on programming needs; clinical services need to become agency priority; work with communities to promote health orientation; more emphasis on community development, mental health awareness; need strong clinical programs to attract interns; need to consider native services; need program, treatment evaluation; should utilize research to determine program needs.

8. Increase Recognition, Respect for Staff Achievement: agencies need to show respect for individual staff, professions; need to feel you fit in, feel important, that you can grow; clinicians should be more valued, their input heard; need recognition as local experts on community needs; need to recognize colleagues' accomplishments; work and worker needs to be valued more highly; profession needs higher status; need to promote northern professionals' accomplishments; need to recognize worker's skills, experience when assigning a job; need to recognize, respect different styles.

9. Improve Quality of Services, Staff, Managers: quality affected by burnout; need to reduce staff incompetence; managers need training in administration, not clinically; quality needs higher priority; need more competent managers to bring out best in staff; quality affected by lack of educational opportunities; need more competent supervisors; good clinicians get sucked into management, agency loses their clinical skills; managers need better skills at assessing staff's competence; need quality assurance program to ensure accountability, competence; need more accountability in agency; promotions by competence, not nepotism; quality is expensive; need to upgrade professionally at all levels; need to evaluate program effectiveness.

10. Increase Promotional Opportunities: need opportunities for career advancement, better job opportunities; should not be limited by language; for women in management; to recognize staff's value and encourage them to stay.

11. Improve Physical Working Conditions: need to be upgraded, made more comfortable, multi-purpose; are a disgrace because they think we will put up with it.

Changes Needed - Agency Level - Administrators.

1. Increase Learning Opportunities for Staff: through staff development; training; upgrading; supervision; need to attract experienced trainers; is difficult to coordinate, costly; to boost morale, confidence; to increase local competence; need regularity; need management development; so can develop local professionals; must be higher priority; need more funding; consult with universities so their curriculums are more relevant; need ongoing commitment; must improve Northern Bursary program, is inadequate; agencies should pool money for group training; need more funds for small agencies; must improve northern universities; make links with Southern Ontario agencies; need adequate space, facilities for training; cost-share with other agencies, with employees; use creativity; need joint strategies with other agencies; need to establish "centres of excellence" in North for training, research; need easy access to quality programs; must create work environment that allows for professional growth, development.

2. Improve Agency Communications - Internal and External: to plan jointly; to educate others, including government as to local needs; to avoid financial waste; to seek out additional resources; to hear, address staff concerns.

3. Give Higher Priority to Recruitment, Retention: should recruit jointly with other agencies; need to establish university placement opportunities in agencies; need to consider more recruitment incentives, like housing; agencies need stronger voice for recruitment/retention concerns; have to market the communities better; need to be aggressive in recruiting; must become more known to colleges, universities; must better publicize job opportunities; getting

more qualified staff will attract more qualified staff; need to be selective, make good initial match; need positive, polished campaign; need to review, revise recruitment practices and policies; need to paint realistic picture to candidates; need to emphasize growing, developing northern professionals.

4. Reduce Stress, Increase Staff Supports: need to make extra efforts to keep staff connected to outside resources, professionals, colleagues; eliminate staff shortages which cause stress; develop positive inter-agency relations to prevent stress; staff need stronger support system; need diversity in their jobs, clientele to prevent burnout; need to work with local communities to support newcomers; need realistic job expectations; need staffing flexibility, numbers for coverage sharing; need to promote team building; workers need sufficient resources to do their jobs; develop better managers who can be sensitive to staff needs; administrators need own support group to relieve stress.

5. Improve Agency Policies, Administration: need good management, emphasizing positive, healthy internal structures; institute creative policies as incentives; agencies need to centralize, are too disjointed; need to tighten up personnel policies, orientation practices; need to eliminate hierarchical management because it is alienating; managers need to be competent, skilled; alter domination of male values in upper management, is exclusionist; need to approach agency management differently; need to effectively manage change; need to involve staff in planning, take ownership in programs.

6. Give Higher Salaries, More Benefits and Perks: need to be higher to attract, to compensate for isolation, working conditions; especially higher for small agencies; address salary inequities between satellites and head office; need salary parity across all social service sectors.

7. Provide More Promotional Opportunities: have to give staff who have upgraded the reasons, opportunities to return; offer staff exchanges with other agencies to pursue special

interests; need opportunities comparable to South; women are disadvantaged because male skills are valued; need more opportunities available.

8. Give More Recognition, Respect for Staffs' Achievements: agencies have to build on internal resources, use what they have; need to provide opportunities for workers to showcase their expertise.

9. Develop More Programs Addressing Local Needs: should eliminate expensive programs that do not meet local needs; be more creative, culturally appropriate, not emulating southern models, to increase effectiveness, job satisfaction.

10. Improve Physical Working Conditions: office space is big problem, needs correcting; sites need to be centralized to promote team building.

Changes Needed - Government Level - Clinicians.

1. Enhance Learning Opportunities, Universities in North: give agencies more money for professional development, for upgrading and training Northerners; upgrade quality of northern universities; upgrading northern universities is not feasible; ensure university programs reflect rural practice; create easier access to university resources; reduce negative stereotypes of northern universities; give northern universities the task of resourcing northern agencies; encourage linkages between northern and southern universities; upgrade the degrees offered by northern universities; fund a northern clinical training centre; fund a northern research centre.

2. Increase Funding, Resources: for professional development; to overcome isolation; for salaries; for library resources; for programs; for bursaries; for staffing; for improved work sites; for more technology; for more resources; for research; for program evaluation; in general.

3. Seek Local Consultation, Collaboration: acknowledge unique needs, differences in northern agencies, communities; stabilize their priorities in consultation with stakeholders; recognize local issues of concern; do not impose programs on agencies, communities; seek community consultation; allow more agency autonomy.

4. Promote Positive Northern Image: promote northern universities; promote rural social services; promote northern quality of life; promote northern job opportunities; promote linkages between the North and South; promote northern expertise.

5. Streamline own Bureaucracy: stabilize priorities; inefficiency, ineffectiveness of government bureaucracy, management has negative impact on workers; delegate more power to agencies; eliminate waste; need to review entire children's mental health system; government staff need to be more home-grown; need to clarify expectations, mandates, definitions; need to help agencies carefully manage change.

6. Priorize Quality of Service: need to ensure staff, management competence; need to ensure high quality of service; need to promote organizational development in agencies; children's mental health needs higher stature, priority in government; need to investigate high turnover of quality staff; need to ensure evaluation of programs, treatment models.

Changes Needed - Government Level - Administrators.

1. Enhance Learning Opportunities, Universities in North: professional development needs to be higher government priority; bursary programs need to be altered to benefit northern, remote agencies; need more education programs in North; need to improve quality of northern university programs, need to reflect northern needs; small agencies need more professional development funding; should create budget specifically for northern training; professional development needs to be available equitably across all northern agencies; learning needs to be accessible.

2. Increase Funding, Resources to Agencies: for professional development; for salaries; for recruiting; for necessary agency changes; agencies need more flexibility in use of funds; eliminate costly, ineffective programs; for staffing; for staff relief travel; funding needs to be more equitable across agencies; northern agencies should get proportionately higher funding

compared to southern agencies because of higher costs; need to acknowledge differences between large and small agencies, fund small agencies more to compensate.

3. Seek Local Consultation, Collaborative Planning: need better understanding of northern issues; must consult regarding local priorities; must allow agencies more flexibility; consult on use of service dollars; stop imposing programs; consult to avoid financial waste; should focus on long-term planning; need more planning at district, area levels with agencies; plan with agencies as partners.

4. Promote the North, Assist with Recruitment: provide more funds for recruitment; show leadership in addressing recruitment problems; play coordinating role with northern agencies in recruitment; need better understanding of recruitment problems in North; must redesign Northern Bursary so will be better recruitment tool.

5. Streamline the Bureaucracy and Management: be more consistent with policies; government needs more competent staff; should become more centralized, better coordinated; need to flatten bureaucracy; need better management practices, to be run like business; need to be more consistent in management, less reactionary; centralization equals financial efficiency equals quality service.