Compassion Fatigue

By Nathan Frost

Does a Career in Addiction Treatment Affect Practitioner Wellbeing?

DAPAANZ Registered Practitioner Lisa Phillips’ recently completed Master’s thesis measuring addiction practitioner wellbeing was motivated by personal experience of working in the sector. While employed as a Clinical Team Leader at a residential service in Wellington, Ms Phillips witnessed firsthand how the wellbeing being of her team of 14, as well as the wellbeing of her colleagues, was being impacted in relation to the work they did. This personal experience, coupled with seeing practitioner related stress impacting the lives of her colleagues, caused Ms Phillips to become invested in improving the wellbeing of the addiction practitioner workforce in Aotearoa New Zealand. Addiction Standard spoke with Ms Phillips recently about the research she undertook for her thesis, and what it has revealed about the current state of hauora within the addiction practitioner workforce.

Thanks for agreeing to be interviewed for Addiction Standard Lisa. Can I ask you where this idea for your Master’s Thesis originated from?

Its origins came from my conviction that Aotearoa New Zealand needs a strong and well supported addiction workforce to ensure that the people we love - who may experience substance use issues - get the best possible support when they access services. I noticed how often my team, my colleagues and myself as an individual were sharing about the impact of our roles on our own wellbeing. Conversations about our mood, our energy levels, and our relationships were common break-room banter. As I got to know my team better, we ventured in to the deeper challenges of the role. Questions like ‘should I still come to work if I’ve lapsed?’ and ‘what if I don’t want to tell my supervisor I’m attracted to that client?’ were being asked.

I understood the reservations that people had about talking to their supervisor about these honest, messy, complex human issues. So I started thinking, this has to be a much wider experience for practitioners than just this service. I started finding myself having conversations with friends who were working in day programmes, and who were hating addiction work. Hearing how the job was impacting on them lit a fire within me about this topic needing to be more public. Not the sanitised version of workplace wellbeing, the real version. The version you can only get when there will be no impact on your practice. The kind you can only get with complete anonymity.

I enrolled in a Master’s thesis program to allow my research findings a platform for further consideration. Often, research that isn’t backed by a learning institution doesn’t gather the momentum that it deserves. As a beginning researcher, I was aware that I needed the backing of my supervisors to gather the support to implement the research findings. I needed to see what was going on for the workforce across New Zealand to make this a legitimate piece of research, rather than just an opinion drawn from personal experience. My driving force was to give the workforce a chance to be heard, with the safety that can come from the korowai that anonymity can provide. So, I decided to commit. To commit meant enrolling in an academic program and decimating the voice of doubt that has been a constant friend of mine from childhood.

My thesis specifically explored how the wellbeing of addiction practitioners is affected by their professional practice. The research framework that I wanted to pin all the data to needed to be an Aotearoa model of health, because I looked at all these international scales for measuring health and none of them actually fit for Aotearoa. None of the international models recognise the karanga of our Māori whānau, which demands for health to be viewed with a much larger holistic lens. Applying a measurement tool to a person, without considering the beliefs and attitudes that sit behind that measurement tool, means New Zealanders are silenced in the many areas that contribute to our sense of hauora.

Reviewing literature from some revolutionary Māori thinkers in health revealed the Hua Oranga assessment. This tool was developed by Mason Durie and Te Kani Kingi in 1997, and what quickly became clear was the relevance of this way of considering health, when thinking of addiction practice in New Zealand. I had to opportunity to meet with Mason and asked his permission to apply the elements of Hua Oranga to my research. After some extensive questioning, permission was granted.

This research represents the first time that addiction practitioner wellbeing in New Zealand has been considered by application of a model of health specific to New Zealand, and where the application of a measurement tool for wellbeing has been supported by the designer of the tool. My research addresses a gap in addiction practitioner specific literature in New Zealand and internationally.

This research should be of interest to the entire sector because we actually all have a role to play in promoting wellness. We’re advocating for wellness in the lives of tangata whai ora, but what about workforce wellbeing? Registering bodies, advocacy agencies, the colleagues of addiction practitioners, and the practitioners themselves all have an ethical responsibility to support each other in relation to improving practitioner wellbeing.

So where did you go for your data pool?

The data pool I used was the DAPAANZ register, which is an online public register where you have the function to send a message to registered practitioners. So I got all the approval letters and info sheets, held my breath and sent them out.

There were 600 registered from various services across NZ at that stage. The response rate was only around ten percent so I think given that more people didn't respond, the biggest validation the research can get is to find a way to increase the sample size. In terms of the research methods employed, I gathered my data using a questionnaire with qualitative and quantitative components. The research took a pragmatic stance, working with a series of scales and multiple-choice questions, as well as opportunities to provide free form narrative. All questions related to how respondents were doing in terms of their own wellbeing, and specifically how they were doing since starting practice as an addictions practitioner. The questions covered things about respondents' physical, mental, social and spiritual wellbeing and as I looked through the data, it became evident that stages of practice had a lot to do with practitioner wellbeing.

So in your first year you're more likely to be impacted in certain ways than you will be in your second and third year and so on.

Hey that is really interesting, in what ways, can you give me some examples?

Yeah sure. In their first year of practice, (some practitioners dubbed it 'the honeymoon phase'), people believe that their clients are basically good, they believe that their work has meaning, they're making a difference and their mental health tends to improve; but they're consuming more caffeine, (laughs), so some funny little things like that. First year practitioners love telling people what they do for a living, they're proud of the job all of those sorts of things. This was certainly the case for me.

I felt like my role was some kind of opportunity to give back all I had taken during my messy years, and the contribution I was making helped rebuild my sense of identity. I was motivated by my work, and avoided the habits and routines that contributed to my own decline in hauora. I truly believed I was doing good work, and my lived experience was a key contributor to this.

The research reflected that in the second and third years of practice, there's a bit of a disturbing deterioration in what practitioners consider their mental wellbeing, so their beliefs about the inherent nature of people changes, their belief that their work makes a difference decreases, they spend less time with their loved ones, they're more likely to be using illicit substances or prescription medications to manage depression and anxiety, all sorts of quite heavy impacts are occurring in terms of the job impacting on their health and wellbeing.

And then after the third year of practice, the shit really hits the fan. So between the third and fifth year was the riskiest period for this sample of respondents in terms of deterioration in every single area of Hua Oranga.

And so what sort of percentage of the sample were these negative impacts affecting?

Practitioners within the sample at this stage of their practice were the most likely to be impacted in terms of their mental health.

Their rates of mental health deterioration become higher at this point of practice than at any other stage, with 83.3% of them reflecting on a deterioration between their fourth and fifth years of practice and this is likely to be occurring alongside deteriorations in physical, social and spiritual wellbeing.

Practitioners from this sample in their fourth and fifth years of practice were 39% more likely to develop a substance use issue while working in addiction services than those in their second and third years of practice, and 50% of respondents noticed an increase in their caffeine use, with an increase of 22.23% in the use of alcohol to manage stress related to the role. Also, 22.23% of respondents at this stage in their practice noted an increase in confidence to express their thoughts and feelings, alongside a 16.6% decrease in feeling their life made sense and a 15.5% decrease in believing that people are basically good.

Other decreases respondents noted included a loss of sense of personal identity, ability to prioritise spiritual wellbeing, and overall positivity. This stage of professional practice was reflected by the sample to be the most turbulent for practitioners across all dimensions of Hua Oranga. 66% of practitioners within the sample at this stage of practice were male, with females comprising 33% of the sample and 0% identifying as non-binary.

Survey respondent quotes published in the research included the following:

- I have less sleep, I feel worried about the job. I have less energy.
- Due to (an) unhealthy initial toxic work situation, my health deteriorated markedly. Since the work situation has changed my health has improved, but a lot of damage was done that has repercussions for the rest of my life.
- I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction.
- It can be quite isolating. Many people have strong views about addicts and it can get peoples heckles up.

- I am more careful about who I share with, as you quickly realize how small a town can be when working in addictions.
- Once I realised the sedentary nature of the work. I was able to adjust my diet to suit.
- The role is far more sedentary than my previous work. I think this is a key cause of the weight gain.
- I started using amphetamine in the weekends only. It gave me energy to get things done, because I was so tired from the working week. I don't think I have developed an addiction, I just feel it helps me get the most out of my week.

So is the data revealing a form of compassion fatigue?

Yeah, I think that's right, it's like an erosion or scar tissue growing over your ability to care. You're hearing the same story again and again, and the story stops being unique because you've heard it so many times. If a client has lost their children, or developed lung or heart issues, or survived abuse, or lost their home because they couldn't make rent; practitioners hear that story again and again and again.

It can get to the point where practitioners are at risk of becoming so calloused by the depressing regularity of these types of details coming up, that it stops being personal somehow, and all you hear are bits of information that fit somewhere in addiction assessment profiles. We can become detached, running straight for the functional analysis form when we 'discover' that a client has 'used', rather than respecting the value of sitting with the person for a while, and hearing them out when they choose to talk.

So does this process you're talking about have a really personal component for you? I guess what I'm asking is when you decided to become an addiction practitioner, what did you think you were going to achieve and did your expectations match up to the realities of the job several years in?

I felt as I reflected on who I was as a person, that my practice didn't match what I believed I went into the job for. So, I felt like when I did my training, I was going to nail it yeah. I was going to work wholeheartedly to impact motivation for change in someone's situation. But then when you get into the job, you realise how many restrictions you have, what's considered professional and unprofessional, how strange the criteria for 'over-disclosing' are.

All these terms that don't exist in a normal human relationship, exist at work, and you start wondering how much of the job is you, and how much of the job is in fact organisational policy. Surely who you are as a person contributes to your effectiveness as a practitioner, but often it's not allowed to.

So I started to become that wanker who is speaking with a client, and the client is telling me the precious and tapu details of their life, and I'm sitting there guessing exactly what happened next because I've heard and lived this story before, which is a horrible place to be.

So you felt you became cynical?

I think so. A lot of practitioners aren't completely vanilla, as in they have their own lived experience of mental health and addiction, so that sort of egotistical 'I'm on to you' attitude comes in too you know, and it's a yuk way to think of another person. When I began working as an addiction practitioner, I bought with me many elements of my own lived experience. I believed these would be tools for my practice, but I was naive about how little of my own experience would be welcome as shared knowledge within my practice. When you've lived through something, there's a certain way of being that only people who have lived through that thing truly understand.

When you have lived experience as a sex worker, you notice things that many other people don't. There are automatic thoughts that go through your mind because of that lived experience. You will always notice where other people choose to sit in a room. You will always feel more comfortable in a seat where you can see every other person in the room, as well as every exit. You will always ask yourself why a person is talking to you. You will always automatically asses every person in a room and decide what you might need to do to each person to get out of a room. You are always aware of a person's tone, their proximity to you, and what this might mean for your safety. When tangata whai ora come in to a service, and you can see them going through the same thought process before every group or 1-1 session, you naturally want to reach out to them and tell them 'it's OK, I've been there too, here's what you can do to interrupt the fight or flight and let your mind rest'. But you can't,

unless you're employed in a role which specifically allows that conversation to happen, such as a peer role.

You would imagine that bringing lived experience to work would allow you to contribute to bringing policy to life and ensuring that the service you work for reflects the needs of the people it serves. Staff members with lived experience serve as a valuable filter to ensure polices make practical sense. Despite this, many practitioners feel like the sharing of their own experiences is discouraged. So yes, it might be safe to say that I did become cynical!

So to me you've just touched on stuff practitioners may face on a personal level but what about the impact of the organisational structure and polices of the services practitioners work for?

If you can't be the complete version of yourself, heart, head and human at work, clients may as well be reading recovery websites or reading a recovery book. Recovery is messy and does not lend itself to sections in an assessment or wellbeing plan. Human to human, mess to mess and heart to heart – these are the components of effective practice that employees are nervous to navigate. We still have subconscious beliefs regarding who is fixed, and who is broken in the practitioner/client relationship. When we read our organizational policies and procedures, and our codes of practice do we see the subtle expectation that the practitioner is 'fixed', and tangata whai ora are 'broken'?

My biggest driver now is reframing professional practice, and the concept of professionalism in the mental health and addiction workforce. Looking at our codes of ethics, and our codes of practice, are we able to see any person being able to measure up to these? Are we able to see any humanity in these documents at all? I think, if we read our roles from these codes and frameworks, professionalism and clinical practice can become so cold and dehumanised that it removes the effectiveness of face to face recovery.

I really do believe that professionalism is about something much broader than the words you choose to use, or the way you choose to dress. It is more than knowing when to shut your mouth, and it is more than some letters after your name. Professionalism involves having the courage to challenge policies and practices that don't make sense, and organisational hypocrisy is one part of this. One aspect of addiction practice that many find confusing is the emphasis that services place on 'lived experience' being reflected in the workforce. This emphasis looks good on paper, but then when a staff member with lived experience begins to struggle, their struggle may be perceived as an inability to fulfil the tasks of their role.

This comes across as hypocrisy by the services who state that addiction is a 'chronic, relapsing condition', while at the same time expecting their staff to carry out their duties without symptom presentation. I know that it's about reframing professional practice, but I'm wondering; who is responsible for doing this, and how do we do it? Is it client led, is it practitioner led, is it DAPAANZ led, I don't know. I just know it needs to happen.

What about some of the structural issues around internal supervision, did your research delve into that at all?

Yes, it did. Most of the practitioners in this research don't like internal supervision. Clinical supervision and EAP aren't working for many but talking to somebody employed at the same level at a different service is seen as useful. It needs to be somebody not directly involved with their service, somebody who doesn't have an influence on a practitioner's ability to progress in their career.

Most respondents stated they fear transparency with somebody who works within the same service as them, due to the possible impact honesty may have on their career paths. I can totally relate to this sentiment. I would wonder what might end up being passed on about me and how that might stunt my career. I absolutely believe there's a role in redesigning what supervision looks like and what purpose it serves.

And, how much of supervision is for the staff member and how much is it for the client? Because currently, it seems to be so client heavy that we forget the wellbeing of the person who's providing the support, which is a risky thing on its own.

So are you saying the core role of what supervision should exist for - that you can turn up and basically be completely transparent and honest with someone - isn't being met?

Well, I never was completely honest with my supervisor, never. I came to mandatory supervision with great little examples of my practice and things I could talk about. Supervisors weren't asking 'how are you really doing Lisa?', and if they had asked that, I'd say 'great' and it would not have been true. This was no reflection on the competency of my supervisor. This was a reflection on the impact of fear on the supervision relationship.

I mean how many of us would be OK with telling our supervisor that we are doubling our Citalopram because we're not coping? Would we share that the pot we smoke to help us sleep is getting in the way of the three nights a week we work as a call girl to cover the costs of the facial surgery we had to have to rebuild our noses after our ex booted us out of a 2nd storey window?

Do we share that it's hard to sit up straight because our ribs hurt so much, after they were broken, and went through a lung, which had to be removed, and now we're always short of breath? Would we say that the tramadol and codeine really help with our pain, but we're nervous about driving the work van while we're under the influence of opiates? How much truth are we comfortable telling? How much truth are we allowed to tell before we are 'unsafe' for practice? How close can we skate to the line before someone decides we're not OK?

These are the questions that need an answer. Our practitioner workforce need more than EAP. They need the assurance that their lived experience, and all the fluctuations this may entail, will be treated as an asset, with the full support required to maintain excellent standards of service with tangata whai ora.

Until this happens, many practitioners will continue to show up to supervision with sweet little snippets of their practice that provide a pleasant distraction from the issues they are tacking in their own life. Meanwhile, the supervisor drives home believing they have built a genuine therapeutic alliance and pats themselves on the back for facilitating such a robust session.

And it was because of those concerns around your career that you weren't completely transparent?

Yeah, one hundred percent. I have heard the generalisations people make about tangata whai ora. I have been in the position of tangata whai ora. Having been in both camps, I was acutely aware of what topics to avoid with my superiors in terms of protecting my own career.

So I imagine one area people would be loath to talk about in their private lives would be admitting any drug use. What percentage of the sample admitted as much?

It was really high. 25 percent. And, the highest illicit drug use within the registered practitioner workforce happened within the turbulent time frame of 3-5 years. So if you've been practicing for over 15 years, the majority of that sample weren't using any substances whatsoever. It wasn't clear if that's a general aging trend, or if that's unique to practitioners. I do think the high rates of illicit substance use are unique because I haven't been able to find other literature that talks about that in related professions like nursing etc. So I'd love to compare it but there's nothing to compare it to, because we don't ask it.

And was this just illicit and did you break it down further for example 'I'm smoking pot' or 'I'm smoking methamphetamine'?

There was quite a bit of amphetamine use related to fatigue, and a lot of prescription substances that weren't being used as prescribed but just substance use in general be that alcohol, smoking, the whole range.

We don't seem to like ourselves, or the system we work in, very much in this workforce. There's something that needs to change so that our hauora workforce aren't feeling the pull to use illicit substances, and so that the journey alongside whai ora is sustainable and life giving.

If we take what we have, which is a committed, knowledgeable, resilient and genuine workforce, and we breathe life on the way we support them, we could have revolution in the way we practice working with recovery. We already have the skill, the means and the motivation within this workforce, so let's get it done.

We have a responsibility to support each other through this, and this is reflected in our own registering bodies values. My hope would be that the addiction workforce could access any supports they may need, without fear of reprimand or discrimination. Addiction is a health issue and needs to be treated as such.

The findings of Ms Phillips research should be of interest to every invested party within the sector that has a critical role to play in improving addiction practitioner wellbeing. Addiction practitioners in Aotearoa and those who train, monitor and support them, are capable of building on the findings of this research to improve the health and wellbeing of the workforce.

Ms Phillips believes that the addiction workforce needs to be encouraged to be bold when sharing their own backgrounds with addiction, which would serve to normalise these issues, as well as reflecting that addiction does not discriminate. We can be employed, hold down a full-time job with a family, and still have issues with addiction. According to Ms Phillips, the key is that we talk about these challenges, and the more we do, the less those of us who are in recovery, or working towards recovery, will feel isolated and unable to connect.

Ms Phillips' Doctoral research (commencing 2019) will also be dedicated to the addiction sector. This research will progress the findings of her master's research, by designing and developing a nationally recognised suite of addiction workforce support tools and recommendations. These resources will be designed with key stakeholders in the Aotearoa New Zealand addiction space and will be informed by the needs of the workforce.

Ms Phillips believes the addiction workforce requires the same levels of tenacious, relentless support available to tangata whai ora. She would love to hear from anyone, especially workforce groups and peak bodies, who would be interested in informing the design and scope of her Doctoral work. She can be contacted at **lisajordanphillips@gmail.com**