Responding to the risks associated with the relapse of recovering staff members within addiction services

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Session Outline

- Historical Approaches
- Typical Scenarios
- Models of Monitoring
- Key Indicators for Well-being
- Institutional Response
- Further Investigation
- In Conclusion
Historical ways of dealing with substance impaired staff

The Ostrich Method

- Stick your head in the sand and hope the problem will go away
The Nelson Method

- Turn a blind eye (and hope the problem will go away)
The Santa Claus Model

- Be nice to everybody (and hope the problem will go away)
The Rip Van Winkle Approach

- Have a drink yourself
- Sleep for 20 years and when you wake up the problem will be gone and you can carry on as though nothing happened.
Draconian Model

The only punishment is death for all offences
Typical Scenarios – Common Features

• Long-term commitment to the field
• Assume positions of responsibility/influence in the service
• Two-way identification with clients
• Work is highly valued
• Relapse is always a possibility
This section examines the four options a service might adopt in monitoring the possibility of staff relapse:

- No monitoring
- Informal monitoring
- Consensual monitoring
- Independent monitoring
No Monitoring

- Is typically the default position of services
- Is based on the idea that recovery is a private zone and others have no right to scrutinize it
- The no monitoring option is a high-risk strategy
Informal Monitoring

- Acknowledges monitoring is a good idea
- Proactive systems are not put in place to enable concerns to translate into action
- Colleagues recognise the risks of relapse
- Opportunistic conversations occur
- Concerns are minimised
- It remains a high-risk strategy
Consensual Monitoring

• Requires the willing cooperation of the recovering nurse
• Is predicated on the individual recognising that relapse is a realistic and significant threat
• Requires an acknowledgement that choosing to professionally assist other addicts puts them in a position of trust, power & influence
Consensual Monitoring cont...

- Process begins at time of employment
- Understandings are specified clearly and in writing
- Internal monitor(s) are agreed
- Regular meetings monitor progress and identify potential threats
- Promotes active participation
- Risk of conflicting roles and alliances
Independent Monitoring

• Parallels with ‘advanced directives’ used in mental health and palliative care
• Completed when patients are ‘competent’, Advance directives have been hailed as a way of encouraging patients and treaters to discuss future contingencies and to negotiate mutually acceptable approaches to care
• More formal involving 3 parties:
  – The recovering person
  – Their immediate line manager
  – An independent monitor with experience in working with addictions
• Main disadvantage is cost to service
Key Indicators for Independent Monitoring

- Active self-care - such as regular attendance at groups or counselling sessions
- Accepting advice - willingness to hear the feedback of others and to explore how to incorporate suggested changes
- Reflective pride - examining the basis for perceptions of internal and external control
- Management of feelings - willingness to embrace major emotions and understand their source
Key Indicators for Independent Monitoring cont...

• Critical appraisal of thought processes - questioning motives, monitoring justifications

• Multiple life involvements - active in a variety of occupational and social arenas, most importantly that work has not come to dominate all aspects of time and thinking.

• Openness and honesty - openly declaring feelings with colleagues, particularly negative emotions involving anger and fear.
Summary

• These guidelines are useful in for us all in pursuing mentally healthy lifestyles, but they are particularly important in addressing the special needs of people in recovery.

• A set of identifiers such as these could be constructed in consultation with the recovering practitioner then used as a basis for discussion during the review.
Institutional Response

- I have worked to promote the model of ‘formal monitoring’ within health services.

- These efforts have been met with a flicker of interest by one group and fierce resistance by the majority.
Nursing Council Tribunal Findings

- **The Crime**
  - 12 assaults
  - 13 sexual assaults
  - 13 drug and alcohol misuse

- **The punishment**
  - 1 removal from the register
  - 5 removal from the register
  - 11 removed from the register
  - 2 deemed to be able to be rehabilitated
Theoretical analysis of an empirical problem

• Foucault’s articulation of the discourses on mental illness, criminality and sexuality over the last 2 centuries still dominate our lives today

• They are as much aimed at the regulation of conduct as the liberation of individuals from sickness, crime or sexual repression
Limits to this analysis

• Foucault’s analysis portrays individuals as regulated and subjectified by discursive practices.
• It is this view of power that is politically conservative, offering little hope of making positive change to social conditions.
• It is this view that Institutions take towards substance abusing staff.
Power is more than a concept

- Power is a relation between people and groups in which inequalities arise and are governed
- Are we eternally trapped in constantly spun webs of power and domination, from which there is no historical escape? (Burkitt, 1999).
A new explanatory paradigm?

- Is the work of Cornelius Castoriadis as a theoretical basis useful in exploring the determination of employers and registering bodies to personalise and individualise ‘addiction’ as a social construction of power between the bureaucratic institutions they represent and the ‘everyday’ world where interactions take place?
Revisiting Power

- Power is a relation between people and groups in which inequalities arise and are governed.
- Is there a possibility of influencing the relation between the ‘group’ (substance abusing health professionals) and the ‘institutions’ (employers and the nursing council)?
Social Institutions and Religion

- Modern capitalist society claims it is established at a distance from religion

- However, a quasi or pseudo-religious dimension of the institution still exists
Links to Addictions: The Moral Model

• The prevailing addiction archetype until the mid 20th.
• This views the addicted user as weak-willed and morally bankrupt; someone who should be punished or pitied.
• Outcome of the moral model was the Temperance Movement
• Today this model underpins the thinking of those who hold individuals entirely responsible for their drug use; assuming it to be an act of will
What to make of all this?
A personal theoretical exploration

- I can’t speculate on the motivations of institutions.
- If a ‘power’ analysis is applied then one might be tempted to conclude that nurses who ‘abuse’ patients (in whatever form) are extremely powerful and need to be ‘reined in’.
- Those who abuse drugs & alcohol are seen as ‘weak’ and unable to exert any power or control over their ‘will’.
- By association the organisation is seen as ‘weak’ and must demonstrate their ‘power’ by dealing harshly with the staff member who has transgressed.
In Conclusion

• There is little published literature on how relapsing colleagues should be managed in the workplace
• Addiction, relapse and recovery are complex and multi-dimensional
• There will always be facilitating and inhibiting factors in managing ‘recovering’ staff in the workplace
• These should not prevent us from tackling the problem and investing in organizational infrastructure to support recovering staff and manage the possibility of relapse
Reference

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