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BUTLER, Mark, SAVIC, Michael, BEST, David <<http://orcid.org/0000-0002-6792-916X>>, MANNING, Victoria, MILLS, Katherine L. and LUBMAN, Dan I.

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Wellbeing and coping strategies of alcohol and other drug therapeutic community workers: a qualitative study

Butler, M¹., Savic, M^{1,2*}., Best, D³., Manning, V^{1,2}., Mills, K⁴., & Lubman, D.I^{1,2}

1. Eastern Health Clinical School, Monash University, Melbourne, Victoria, Australia
2. Turning Point, Eastern Health, Melbourne, Victoria, Australia
3. Department of Law and Criminology, Sheffield Hallam University, Sheffield, United Kingdom
4. National Drug and Alcohol Research Centre, University of New South Wales, Sydney, New South Wales, Australia; Centre of Research Excellence in Mental Health and Substance Use, University of New South Wales, Sydney, New South Wales, Australia.

* Corresponding author: Michael Savic, michaels@turningpoint.org.au

Abstract

Purpose

The purpose of this paper is to examine the strategies utilised to facilitate the wellbeing of workers of an alcohol and other drug (AOD) therapeutic community (TC).

Design/methodology/approach

This paper reports on the findings of a qualitative study that involved in-depth interviews with 11 workers from an AOD TC organisation in Australia that provides both a residential TC program and outreach programs. Interviews were analysed using thematic analysis.

Findings

Three main interconnected themes emerged through analysis of the data: 1) The challenges of working in an AOD TC organisation, including vicarious trauma, the isolation and safety for outreach workers, and a lack of connection between teams; 2) Individual strategies for coping and facilitating wellbeing, such as family, friend and partner support, and self-care practices; 3) Organisational facilitators of worker wellbeing, including staff supervision, employment conditions and the ability to communicate openly about stress. The analysis also revealed cross-cutting themes including the unique challenges and wellbeing support needs of outreach and lived experience workers.

Research limitations/implications

Rather than just preventing burnout, AOD TC organisations can also play a role in facilitating worker wellbeing.

Practical implications

This paper discusses a number of practical suggestions and suggests that additional strategies targeted at 'at risk' teams or groups of workers may be needed alongside organisation-wide strategies.

Originality/value

This paper provides a novel and in-depth analysis of strategies to facilitate TC worker wellbeing and has implications for TC staff, managers and researchers.

Keywords

Therapeutic communities, TC practice, staff wellbeing, burnout, qualitative research, Australia.

Introduction

Several studies have highlighted that alcohol and other drug (AOD) treatment workers are particularly vulnerable to work-related stress and burnout (Duraisingham et al., 2007; Reissner et al, 2008; Oyefeso et al, 2008; Best et al., 2016). Elevated levels of stress among AOD workers may be related to the complex client population they treat, the stigmatisation of AOD use and dependence resulting in negative community attitudes, rapidly changing work environments and challenging working conditions (Roche, 2002). Others have pointed to dissatisfaction with remuneration (Gethin, 2008) or with the job (Duraisingham et al., 2007; Best et al., 2016) and have noted that years of working with people who have experienced trauma is positively associated with vicarious traumatisation (Cosden et al., 2016) and secondary traumatic stress in up to 20% of workers (Ewer et al., 2015).

Compromised AOD worker wellbeing is associated with a range of potentially adverse impacts at an organisation level. For instance, along with low levels of job satisfaction, work stress and burnout has been found to be associated with high rates of absenteeism and turnover (Duraisingham et al., 2007; Van Gordon et al., 2014). High staff turnover is potentially detrimental to the development of ongoing therapeutic relationships with clients, which are important for AOD treatment outcomes (Meier et al., 2005).

While the challenging work of providing AOD care can negatively impact on worker wellbeing, poor worker wellbeing can, in turn, also impact on the quality of care provided. For instance, in a US study of mental health treatment, higher levels of worker exhaustion were associated with lower levels of client satisfaction with treatment (Garman et al., 2002). Best et al., (2016) have also suggested that one reason for this could be that workers experiencing high levels of stress may be less optimistic about client's treatment and recovery prospects and negatively affect therapeutic rapport. Similarly, the role of counter-transference, in which AOD workers transfer their negative emotional states to their clients (Imhof, 1991) and vice versa (Vyas et al., 2017) has been highlighted.

While the existing literature on AOD worker wellbeing has made a useful contribution in highlighting the issues faced by workers, there are also some notable limitations. As articulated by Best et al. (2016) much of the literature on AOD worker wellbeing takes a deficit approach, focussing on quantifying stress and burnout and the negative impacts noted earlier. The focus on worker weakness has obscured the strengths, resources and strategies that AOD workers and their organisations employ to foster wellbeing and coping (Best et al., 2016).

Another limitation of the existing literature on AOD worker wellbeing has been its focus either on individual worker-level factors that influence wellbeing (such as age, gender or personal attitudes) or alternatively its focus on organisational factors (such as the level of organisational support, working conditions and job demands, organisational functioning etc.). While the former approach fails to encompass broader work and non-work related factors (Best et al., 2016), the latter approach does not sufficiently account for the diverse experiences of teams and groups that exist within AOD treatment organisations and the different treatment types that exist within AOD treatment systems.

The Therapeutic Community (TC) is one treatment type in which workers may have unique wellbeing needs. The TC is a well-established treatment, in which people who want to address their AOD problems reside and engage in the activities and rules of the community for an extended period of time (DeLeon, 2010). While there is considerable research exploring client experiences and wellbeing outcomes in relation to AOD TC treatment (see Magor-Blatch et al., 2014; Vanderplasschen et al.,

2013; Malivert et al., 2012), very little research has examined the wellbeing of TC workers (Vyas et al., 2017).

Many of the factors that are associated with compromised wellbeing in the general AOD treatment workforce may also apply to TC workers. Furthermore, one might imagine that the unique TC work environment and staffing profile might give rise to additional wellbeing challenges. For instance, TCs often employ workers with a lived experience of AOD problems and recovery. While these workers provide valuable care to clients, sometimes this can put their own recovery and wellbeing at risk (Gethin, 2008).

In addition, TC organisations have expanded in recent times to include a diverse array of program elements and teams, such as outreach teams, and aftercare programs, in addition to the traditional TC residential program (Dolan et al., 2007; Magor-Blatch, 2016). As the job demands faced by teams within a contemporary TC organisation may differ, there is a need to explore the diverse wellbeing needs and coping strategies employed across different teams, including administration and non-clinical teams. Not only do administration teams contribute to the successful operation of the TC but also research in a general health care context indicates that administration staff can experience high levels of stress as well (Denton et al., 2002). The predominant quantitative methods in AOD worker wellbeing research are not well equipped to examine particularities and different wellbeing needs at a team level.

In an attempt to overcome the gaps and limitations in the existing AOD worker wellbeing literature outlined, we conducted an exploratory qualitative study of the individual and organisational strategies employed to facilitate wellbeing in an AOD TC organisation in Australia. In particular, this study aimed to address the following research questions:

- What are the factors that potentially negatively affect the wellbeing of workers at an AOD TC organisation?
- What worker and organisational strategies are employed to enable workers to cope with work-related stress and facilitate worker wellbeing?

Methods

This study used a qualitative approach to collect detailed data from a diverse range of staff of an AOD TC organisation in Australia. The study was approved by the... (university human ethics research committee name and approval number omitted for purposes of peer review).

Recruitment and sampling

Workers were recruited from an AOD TC in Australia. The TC is a not-for-profit, non-government organisation, which contains a number of programs. The core program provided is a long-term residential TC program for people with AOD problems, in which residents participate in structured activities, group programs and community-related chores. In addition, the organisation provides a number of community outreach programs across a wide geographical area to facilitate access to the TC program and treatment for a diverse range of AOD, mental health and social issues. This organisation was approached because of their reputation in the AOD sector as a quality treatment provider, their delivery of many different outreach programs to their core TC program, and anecdotal observations that the organisation is particularly interested in worker wellbeing.

Workers were sent an email informing them of the study and inviting their participation in an interview. Interested workers then contacted the author, who further explained the project and screened for eligibility. Workers were eligible if they were over 18 and were employed by the organisation in any capacity, including administrative/managerial (head office), TC and outreach. Of the 40 workers in the organisation that were contacted by email, eleven workers made contact and showed interest in participating. All eleven agreed to be interviewed for the research project.

Key Informants

Ongoing comparison of interview content indicated that saturation (Glaser and Strauss, 1967) – the point at which no new themes emerged – was achieved with eleven interviews. This is in keeping with research that has indicated that saturation is typically reached within six to twelve interviews (Guest et al., 2006; Hennik et al., 2017). Six of the participants were female and five were male. The average age of the participants was 53 years, although ages ranged from 40 to 65 years. Three of the interviewees were with non-clinical administration workers based in head office, three were outreach workers employed by the organisation, and five were workers in the TC program. All participants had client contact although for administration workers this involved liaising with clients rather than providing direct clinical care. Most participants had tertiary level qualifications and the median term of employment was two years, although the duration varied from two years to 22 years. Similarly, the median duration of AOD treatment sector employment was five years, although one participant had been working in the sector for 22 years. Three of the participants declared that they had lived experience of AOD problems and were in long-term recovery. Even though the number of lived experience workers in the sample was relatively small, most key informants commented on the needs and the value of this group. Of the eleven participants, nine were in a committed intimate partner relationship, while two reported being single.

Data Collection

In-depth semi-structured qualitative interviews were predominantly conducted on the premises of the organisation during normal working hours. After obtaining informed consent and permission to audio-record interviews, the first author conducted interviews, which ran for between 45-60 minutes each. The interview schedule covered a range of topics, including the interviewee's work experience in the organisation and the wider AOD sector, and the challenges of working within a TC organisation. The interview also covered workplace-related stress, individual coping strategies and the perceived role of the organisation in supporting worker wellbeing. Finally, suggestions for improving the organisational support for worker wellbeing were also solicited.

Data Analysis

The interviews were transcribed verbatim and analysed using the Framework approach to thematic analysis (Ritchie and Spencer, 1994). The Framework approach is a well-established and systematic approach that was developed in the context of applied and policy relevant qualitative research (Ritchie and Spencer, 1994). This approach involved coding the data in NVivo and devising the thematic framework from themes that emerged from interviews as well as using research questions to determine key theme areas. Common themes as well as sub-themes were identified and relationships between the themes were explored. Coding and analysis occurred concurrently with interviews to ensure that the researchers could detect when no new codes and themes were being generated, and thus when the point of saturation had been reached (Glaser and Strauss, 1967). The first and second authors discussed the thematic framework and interpretations of the data as a form of analyst

validation to enhance rigour (Mays & Pope, 2000). Respondent validation – where the researcher's interpretations of the data are shared with participants to ensure accuracy (Mays and Pope, 2000) – was also employed to enhance rigour. This was done through summarising the conversation at the end of each interview process to ensure affirmation of the researcher's interpretation. Another strategy employed to enhance rigour was the incorporation of multiple viewpoints from staff employed by different teams of the TC organisation (Tracy, 2010). Paying attention to the experiences and views of different types of participants is particularly important given the aforementioned tendency of research on AOD worker wellbeing to ignore differences between teams. This is despite the fact that all teams contribute to the successful running of AOD treatment services and may have different wellbeing experiences.

Results

Three main themes were identified, with each theme containing several sub-themes as outlined in Table 1.

Figure 1: Summary of themes

1. Challenges of working in an AOD TC	2. Individual strategies to cope and facilitate worker wellbeing	3. Organisational facilitators of worker wellbeing
1.1 Vicarious trauma	2.1 Family, friend and partner support	3.1 Formal staff supervision
1.2 Isolation and safety of outreach workers	2.2 Self-care practices	3.2 Employment conditions
1.3 Lack of connection between teams		3.3 Ability to communicate openly about stress

Key informants consistently highlighted the challenges of working in the AOD sector, individual strategies for coping with work-related stress and facilitating wellbeing, and the organisational strategies for facilitating worker wellbeing. Key informants also provided suggestions for improving organisational support, which are embedded in our discussion of themes. Throughout the interview data, the challenges and unique wellbeing support needs of outreach workers, the experiences of lived experience workers, as well as the important role of social support in facilitating wellbeing emerged as cross-cutting themes.

Main theme 1: Challenges of working in an AOD TC

Many participants reported positive experiences and aspects of working in an AOD TC, including the rewarding nature of the work, seeing people get better, and the TC philosophy and practices. However, they also relayed some challenges, which had the potential to negatively affect their wellbeing. These included vicarious trauma, isolation and safety of outreach workers, and lack of connection between teams within the organisation. Interestingly, key informants did not see burnout as an issue in their organisation, even though they felt burnout was an issue in the broader AOD sector. As will be discussed later, the reason burnout wasn't considered an issue in this AOD service

was partly because key informants felt that the supports offered by the workplace as well as their own coping strategies, produce a protective barrier to this issue

1.1 Vicarious trauma

Many key informants reported that a challenge in working in an AOD service provision environment is the effect of vicarious trauma. As is illustrated in the quote, vicarious traumatisation is where the traumatic history of the client can be internalised by the counsellor and negatively impact on the emotional wellbeing of the counsellor:

For example, we have some hectic and horrendous things that go on in peoples' lives and as much as you have boundaries, when you're in that moment you are taking stuff on board. There's no doubt about it. (Outreach worker)

This quote illustrates the kind of emotional labour that workers perform and the importance of, and sometimes difficulty in, maintaining boundaries. Another key informant alluded to this by saying:

The jobs that most people do here, jobs which can be full of angst at times dealing with people in crisis in their lives and some of that can be transferred. (TC worker)

Dealing with such transference was thought to be particularly challenging for lived experience workers, who may be trying to maintain their own recovery as well as their clients.

1.2 Isolation and safety of outreach workers

Another negative aspect highlighted by outreach workers in particular, was the issue of working with clients who have complex issues and presentations. Unlike in the TC where clients were abstinent and motivated to engage in treatment, outreach workers described the clients they worked with as being currently in "active addiction", potentially being aggressive or unstable, and potentially having a co-occurring mental health and AOD problems. Clients seen by outreach workers can attend their sessions while experiencing a psychotic episode or under the influence of illicit drugs. Partly as a result, outreach workers talked about being isolated and worried for their safety. For example, one outreach worker said:

The safety is one aspect we need to consider but also being able to unload is important. (Outreach worker)

This sense of isolation and lack of safety was compounded by the fact that most of the outreach workers were female while the clients were mostly male, and de-escalation can be difficult when male clients are potentially aggressive or unstable. However, funding constraints mean that it is not always feasible for more than one worker to be present at a time in an outreach encounter as key informants desired, and thus workers need to operate independently. Outreach workers suggested that one way of overcoming safety issues would be a greater level of risk management.

Another aspect of isolation noted by outreach workers was the inability to check in and consult with peers to determine whether the best treatment was being offered to the client. As one outreach worker commented "...particularly in (this organisation), everybody is isolated in the outreach programs". This was partly attributed to the fact that outreach workers often worked in various off-site locations, and thus could not access daily peer support in the same way that TC staff could.

1.3 Lack of connection between teams

As intimated, outreach workers reported feeling socially disconnected from the core TC part of the organisation. As one outreach worker stated:

There is a real distinction between head office, the TC staff and the outreach programs.

This has resulted from, and reinforced the development, of a situation where teams work autonomously and in isolation from the core TC facility and larger employee groups at head office. As the following quote illustrates, this has meant teams have little connection to other employees outside their team:

And I don't know anything really about the TC as there has always been the distance.
(Outreach worker)

Furthermore, when outreach workers are at head office they can be mistaken for residents or clients by other workers. However, the perceived lack of connection was not only limited to non-TC program staff. For instance, one TC worker commented that:

I just don't really know who's even working in the different teams anymore.

Some key informants suggested that there had historically been little effort made to connect employees who are unfamiliar with each other. However, the lack of connection between silos and teams has recently been well-recognised by management. Key informants reported that management have announced that there are several strategies in development to enable closer connections between teams and individuals, including inter-team meetings to share information, and an intranet site to allow team members to report on their activities. Including photographs of employees on the intranet was also suggested as another way of breaking down the perceived barriers to recognition.

Despite the potential for a lack of connection between teams, isolation and safety issues, and vicarious traumatisation, the self-care and organisational supports that were in place largely protected key informants from any negative effects.

Main Theme 2: Individual strategies to cope and facilitate employee wellbeing

We identified several individual coping and wellbeing strategies, including family, friend and partner support, and a range of self-care practices. These along with organisational support insulated workers against workplace stress.

2.1 Family, friend and partner support

Many participants discussed the importance of family and friends outside of work as a source of social and emotional support and coping strategy. The concept of a partner being a source of support had a double edge in that while it was helpful, the confidentiality of the clients/residents had to be respected and any specific discussion with a partner had to be contained. It was also felt that in some instances, partners would not fully understand or appreciate the intricacies of AOD problems and may not understand the secondary traumatic resonance experienced by workers. For example, one key informant said:

Sometimes I would say that I've had a shit of the day blah blah but I would never talk at length. One, because of the confidentiality issue and the other thing is because they don't understand. Unless you have worked here, people don't understand. (Head office worker).

Despite this, overall family, friend and partner support was deemed to be a significant asset:

I've got kids and they bring the joy into my life and that gives me lightness and a good balance from the heaviness of working here. (Outreach worker).

Family, friend and partner support may be particularly important for workers with a lived experience of recovery. For instance, one TC worker who had a lived experience of recovery discussed how he was used to talking with his partner, as well as other people in recovery, about his issues or challenges and that this was fundamental to his wellbeing.

2.2 Self-care practices

Key informants also discussed a range of other self-care practices they employed to maintain their wellbeing, and cope with work-related stress. Many mentioned “getting away” to nature and the beach was a high priority. It was explained that nature had soothing influences, with one participant referred to the beach in terms of a “higher power” reminder from 12-step fellowship meetings.

Others mentioned engaging in mindfulness meditation and exercise as a way of releasing work-related stress and maintaining wellbeing. As part of the holistic approach of the organisation, clients are expected to maintain a regime of daily exercise and meditation. As a way of “walking the talk” participants viewed engaging in self-care practices outside of work (as well as inside it) such as meditation and yoga as a necessary component of their daily routine as well. In fact, TC workers enjoy a 10-minute group meditation every morning as a precursor to beginning the day’s program. They reported this as a fundamental method of centering themselves and ensuring they are being present for the clients. However, this practice does not occur for administration staff and outreach workers, given their isolation and the fact that they begin work at staggered times and in different, separate locations.

Main Theme 3: Organisational facilitators of employee wellbeing

Key informants overwhelmingly reported a high level of organisational support and commitment to worker wellbeing. Organisational facilitators of employee wellbeing identified included formal staff supervision, employment conditions, and the ability to communicate openly about stress.

3.1 Formal staff supervision

Staff supervision occurred in various forms and was viewed as the most valuable strategy to facilitate worker wellbeing offered by the organisation. Group supervision is facilitated by an external supervisor (not a staff member of the organisation) and occurs on a regular basis (every three to four weeks). Another forum for discussion and support was team supervision, which was a team meeting with no external supervisor. Team supervision occurs more frequently in the TC, whereas the outreach teams conduct their own team supervision on a more ad-hoc basis given the isolation and infrequent opportunities to meet.

However, the supervision that was reported to be the most valued was one-on-one supervision, which occurs every six weeks. Some key informants described this as being akin to a personal therapy session where workers could discuss how they are functioning and what factors in their roles and lives are impacting on their functioning. Importantly, workers were free to choose their supervisor, which was deemed critical and more valuable than attending a session with a supervisor, who they were assigned.

Key informants also valued the level and diversity of supervision formats, as one TC worker commented:

I think having a number of forums where you get to discuss what's happening at multiple levels, means the multiple levels of accountability is really good within the therapeutic field where boundaries and safety are paramount.

3.2 Employment conditions

Key informants reported that the favourable employment conditions facilitated wellbeing. One condition that was consistently discussed as being beneficial to wellbeing was the four-day working week. In recognition of the potentially stressful and emotionally taxing work that employees perform, all workers operate within a 35-hour week. Although it was occasionally problematic in terms of scheduling/attending group meeting or training sessions, the ability to either work two days at a time, or have a three-day weekend every weekend to rest and recover was seen as invaluable. As one key informant stated:

No matter how hard the days are, I know that I am going to have a day off within the next 48 hours. (TC worker)

In addition to the four-day working week, another strategy that was largely embraced and valued was the six-week annual vacation allowance. It is important to note that this level of leave is accommodated by the fact that the eight public holidays currently available in Australia are not treated as such by the organisation. The extra ten days leave in lieu of the public holidays is valued as it can be taken with longer annual leave as a block allowing for deeper rejuvenation from workplace stress and strain. Further illustrating the wellbeing potential of the workplace, one key informant referred to his eagerness to return to work following any protracted absence, such as a holiday, by feeling the need to "return to the sanity of the rehab" (TC worker). This key informant went on to explain that, as a lived experience worker, he found comfort in the structure, stability and support of the workplace, both as someone in recovery and as an employee.

The one area where key informants thought there was room for improvement in relation to employment conditions was around job security. The organisation depends to a large extent on competitively tendered government funding, and thus jobs were not always secure. While key informants recognised that there was little that managers could do too to circumvent funding and broader system issues, it was felt that greater communication from head office would help in alleviating the anxiety around job security at these times.

3.3 Ability to communicate openly about stress

Safety in reporting personal and mental health issues was a key feature in interviews. The safety and ability to communicate openly about any stress experienced in this organisation was considered measurably higher than any previous workplace experience by all key informants. For example, one TC worker said:

The values and how it's actually practised in the therapeutic community where safety is one of the key institutions. How you develop safety in the community and our organisation is the ability to be able to speak up and feel and experience whatever it is. I would say that's definitely the case here.

Key informants commonly commented that workers need to be able to express and share in the same manner as the clients/residents in order to mirror the values of the organisation and TC philosophy.

This is considered to be congruent with the workplace supervision strategy where openness leads to a safer and clearer connection and relationship with others:

There is a level of safety here where you can be vulnerable and still be safe here, but this is a therapeutic environment and everybody has your best interest at heart which is totally different to a corporate environment. (TC worker)

For those ‘lived experience’ workers the ability to declare their recovery reflected different viewpoints as to the value of openness and the opportunity to share. Some considered identifying as being in recovery as a way of “walking the talk” and thus it was seen as valuable to clients, while other respondents stated that it often led to workers “not taking themselves out of the recovery system and getting caught on the treadmill”. While some found being open about their own recovery empowering, others felt that it can be difficult for lived experience workers to move forward with their recovery when immersed in the early recovery of others. However, the accommodation of lived experience workers and their decisions to disclose their recovery status as desired reiterated the level of support in the workplace environment and lack of stigma.

Discussion and conclusion

This study provides insights into worker wellbeing in one AOD TC organisation. While some of the challenges AOD TC workers reported have been highlighted in other studies of AOD worker burnout and wellbeing (Roche, 2002; Duraisingham et al., 2007; Best et al., 2016), the current analysis highlights that particular teams and groups of workers may face unique challenges and have particular wellbeing needs. For instance, tailored and targeted wellbeing and risk-management strategies may be needed for outreach workers, who in this case, appeared to be the most isolated, experienced difficult working conditions, and were not able to fully avail themselves of the broader organisational support provided.

Many of the explored themes concerned social connection, such as peer support, supervision, family and friend support, and speaks to the value of the promotion of social support and connection within organisations (Best et al., 2016). People like outreach workers, need to feel connected not only to their team but also to the broader organisation (Cojuharenco, et al., 2016; Gillet et al., 2016) as this enables them to access greater support beyond their team or silo. The more individuals feel connected to others, the more they believe their actions have a substantial impact on the common good (Cojuharenco et al., 2016). Best et al. (2016) refer to the value of a greater social support network in the employee’s own life in terms of enabling them to facilitate share and discuss things, but in this study, this cohort of key informants tended to not share details of work challenges with family and friends due to client confidentiality issues. Despite this they still retained the support of their families, which again reiterates the value of supportive social networks. Given that TCs tend to be located in rural and regional area where staff may not have existing connections or families, the TC staff community may provide a useful source of community and connection for workers.

Another group identified in our study as potentially having unique work-related challenges and experiences were lived experience TC workers. It is understood that a proportion of the AOD sector workforce is in recovery (Gethin, 2008) and the means available to develop healthy and sustainable coping strategies is paramount for this cohort. Gethin (2008) discusses a range of issues identified in research pertaining to AOD workers in recovery such as; over-identifying with clients, poorly maintained professional boundaries, a singular view of treatment (what worked for me, should work for you), and unclear guidelines about managing a relapse. While vicarious trauma was flagged as a

potential issue for lived experience workers, key informants who participated in the research study conveyed generally positive attitudes toward lived experience workers and their ability to cope, which may reflect the particular organisations' value and recovery focus. Given the small number of lived experience workers interviewed in this study, further research on the experiences wellbeing and stigma of lived experience AOD workers in a range of different service settings would be valuable.

The present study highlights the role of individual self-care strategies and organisational supports as not only mechanisms through which workers cope with challenges or prevent burnout, but also ways in which broader worker wellbeing is facilitated. Echoing the calls of Best et al. (2016), this necessitates a shift in thinking from the AOD workplace as a singularly risky and stressful environment, to one that is potentially wellbeing-promoting. With several organisational strategies in place to facilitate worker wellbeing, the organisation described in this research is a good example of a supportive workplace. It not only promoted organisational strategies to facilitate wellbeing, but it also contained an ethos that promoted self-care and wellbeing, which may be different from more corporate AOD treatment organisations. Other organisations could learn from the various strategies employed to enhance worker wellbeing. While it may not be easy for AOD TC organisations to change their employment conditions so that they promote wellbeing, our analysis indicates that there are several relatively low-cost measures that could be taken. These could include the provision of multiple forms of staff supervision, and particularly independent external supervision, the encouragement of self-care practices, and widening the net of potential support available to staff by facilitating connection between (as well as within) teams.

It is important to note that this study was conducted with a relatively small number of workers in one AOD TC organisation – one that is particularly invested in the wellbeing of its workers – so the results may not be generalisable beyond this context. However, as an exploratory study in an under-researched area, it does provide an indication of possible factors that influence worker wellbeing and coping in a TC setting, which other studies could build upon. As not all staff in the organisation were interviewed, our sample may not be representative of all workers at the organisation. Staff that did not self-select to participate may have been more likely to experience stress, poor wellbeing and absenteeism. Similarly, the mean age of the participants in this study of 53 years of age is older than might be seen in other AOD TC organisations. However, the AOD workforce in places like Australia is ageing, with national workforce surveys highlighting that the majority of AOD workers are aged over 45 (Roche and Pidd, 2010). Having said this, the self-care strategies employed by key informants in this study might be reflection of their stage in life and perhaps a greater emphasis on health and wellbeing as people age and approach retirement. The self-care strategies employed, and wellbeing needs may differ for a younger or newer worker cohort. Despite these limitations, this study highlights an array of potential individual strategies and organisational supports that promote wellbeing among AOD TC workers. It also reiterates the potential need to shift toward a worker wellbeing focus, and the value of bolstering organisation-wide strategies to facilitate wellbeing by implementing additional strategies that are targeted at “at-risk” teams or groups within an organisation.

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