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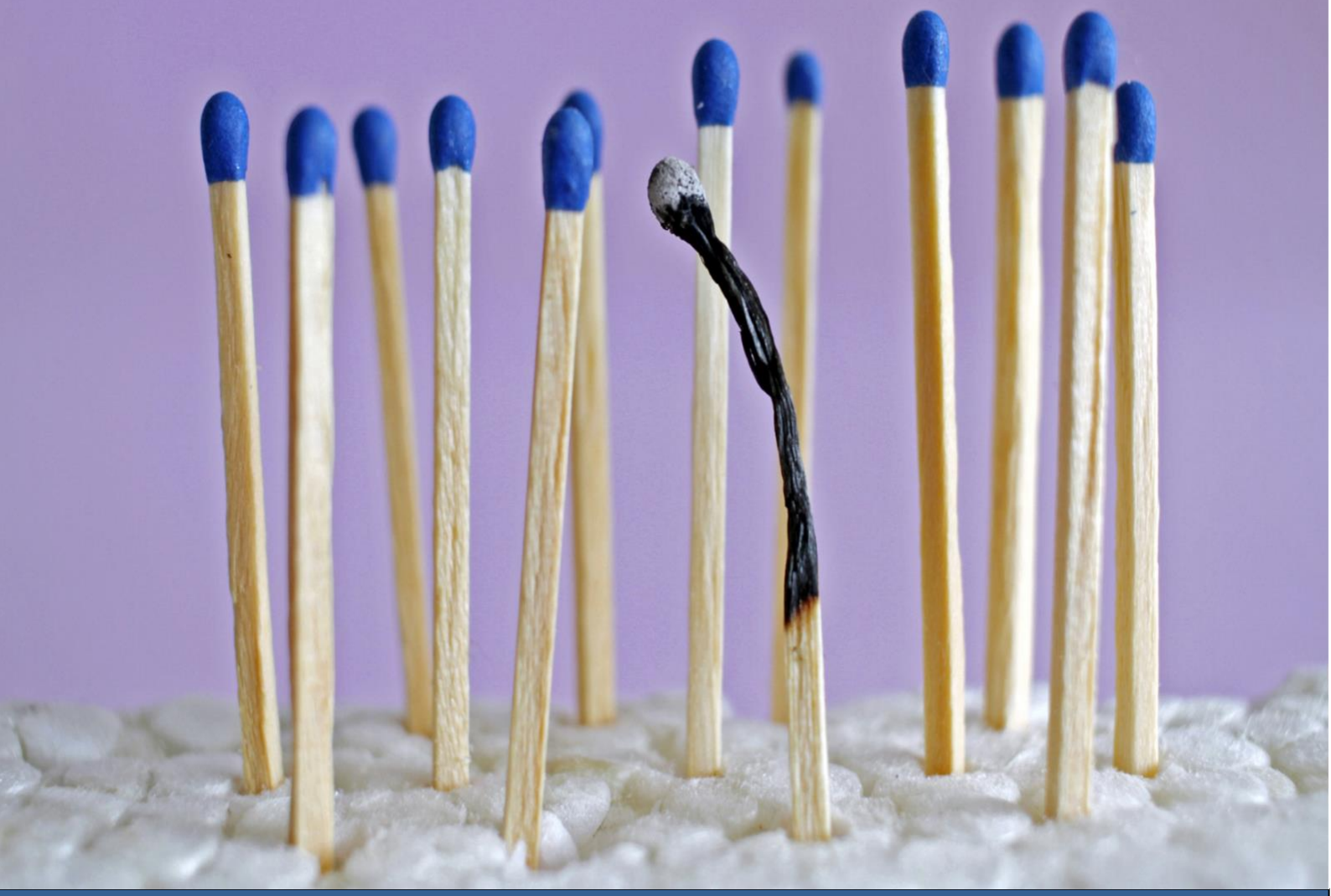
Scottish Drugs Forum



Identifying & preventing burnout in frontline services for people who use drugs & alcohol

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Report prepared for Dundee ADP by Scottish Drugs Forum

July 2022

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Acknowledgements

Thanks to Vered Hopkins, Lead Officer at Dundee Health & Social Care Partnership, and Dundee ADP for their support in conducting this project. Thanks also to the members of the project steering group who gave valuable input to development of materials. Thanks to the various SDF staff involved in the project especially Kate Lindsay for data collection. Finally, thanks to CORRA foundation for funding this work and a special thank you to all the participants who gave their time for surveys, interviews and focus groups.

1. Introduction

1.1 - Background

Through Scottish Drugs Forum's workforce development, Addiction Worker Training Programme and drug death prevention work, burnout amongst front line workers in drug and alcohol services has been highlighted as a key issue which can impact on staff wellbeing and on service delivery and quality. This includes factors such as poor health and wellbeing of staff, staff absence, staff turnover and negative staff attitudes and values towards clients. All of these factors impact on the ability of staff to offer high quality support which helps engage and retain people in treatment and support services. This ultimately risks being a contributory factor to Scotland's increasing drug related deaths.

Regular exposure to drug related deaths (DRDs), near fatal overdoses (NFOs) and the cumulative effect of supporting people with complex needs including trauma can mean that front line staff and volunteers are vulnerable to both direct and vicarious trauma through the nature of their work. In recent years, the workforce in this sector has increasingly included people with lived experience of problematic substance use and mental ill health. Whilst this has greatly enriched the workforce, it is also important to note that there may be particular vulnerabilities within the workforce to work related stress, vicarious trauma and lapse/relapse for staff who have lived experience and who may have a significant history of trauma and adversity themselves. Both these factors combined with other challenges within the sector of

seemingly ever-tightening budgets and limited resources, high caseloads and long waiting lists for onward referrals to more specialist help result in staff feeling overstretched and may lead to burnout.

According to the World Health Organisation (WHO) burnout is characterised by three dimensions (ref 1):

- Feelings of energy depletion or exhaustion
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job and
- Reduced professional efficacy.

They go on to say that 'burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life'.

These statements highlight the importance of both increasing understanding of burnout among front line staff in services for people who use drugs and alcohol and developing strategies to prevent burnout. This increased understanding can also aid the development of tools and policies to support people when burnout does occur.

Through SDF's mindfulness programmes for frontline staff, a need to address self-care as a primary goal was identified by most participants attending. Feedback from SDF's workforce development courses which includes exploration of self-care, has made clear the challenges that exist for the workforce in being able to identify, prevent and effectively respond to burnout. Most staff report having experienced burnout at some point in their career. The role of having personal lived experience of problematic substance use, mental ill health or trauma was suggested as an important factor to better understand within staff burnout. In reviewing participant feedback and enquiries to SDF's information line, it is clear there is a need for information on self-care and self-help for people approaching or in early stages of burnout.

Looking at the areas in Scotland most impacted by issues such as DRDs and NFOs, SDF worked with Dundee Alcohol and Drug Partnership to apply for CORRA foundation funding to conduct a pilot evaluation of staff experiences of burnout within the substance use sector.

It is hoped the findings will be relevant to other ADP areas in Scotland and can be used in the prevention, early identification and service response to staff burnout.

1.2 - Aims

The evaluation key aims were:

1. To investigate the understanding and level of staff burnout in front line services in Dundee for people who use drugs and alcohol.

2. Identify good practice of self-care and self-help as well as formal support and treatment for staff experiencing burnout.

2. Methodology

The project involved a mixed methods approach to data collection. Quantitative data was gathered via a staff survey. The survey consisted of:

1. Demographic information about the participant and their work role
2. The Areas of Worklife (AWS) Survey (Leiter & Christina Maslach, 2006)
3. The Maslach Burnout Inventory (MBI, Maslach and Jackson, 1981).
4. Additional questions about particular factors relating to drug and alcohol work e.g. drug related deaths and the effect of COVID-19 lockdown on their role. It also gave the opportunity to provide open-ended responses.

The AWS measures workplace factors that can contribute to potential burnout across six domains: workload, control, reward, community, fairness, and values. The MBI tool was used measure the levels and scope of burnout amongst front line staff. The MBI Tool is specifically designed to measure burnout rather than general well-being. There are several versions of the MBI, this evaluation used the MBI Human Services Survey (HSS). The MBI is a more direct measure of an individual's experience of burnout. Using a 7-point Likert Scale, the MBI asks participants to indicate how frequently they experienced feelings of burnout across three domains, these are: Emotional Exhaustion (EE), Depersonalisation (DP), and Personal Accomplishment (PA). Burnout is indicated by high scores for EE and DP, and low scores for PA.

The information gathered through the MBI and AWS quantified experiences of front-line staff and informed the themes explored through in-depth qualitative interviews and focus groups with frontline service staff and service leads.

2.1 Methods

2.1.1 Data collection

- **Survey:** Participants were recruited from a number of front-line alcohol and drug services in Dundee and were asked to complete the online survey using the Survey Monkey website.
- **Service Lead Interviews:** Semi-structured interviews were conducted with service leads by telephone or video call. The interviews were designed to explore manager's knowledge and experience of identifying burnout among their staff team. They were also asked to outline resources and strategies they use to support staff.
- **Staff interviews & focus groups:** In-depth interviews were carried out with participants who completed the MBI Tool. The interviews were informed by collated data and not individual experience of burnout. Themes to be covered emerged from initial analysis of the collated quantitative data from the survey and the MBI Tool.

2.1.2 Recruitment and sampling of participants

All participants were working in the Dundee City area and were in paid employment or working in a voluntary capacity.

Potential participants were identified in a number of ways:

- An information session was held with service leads to provide an overview of the project and ask them to identify staff members who may meet the criteria for inclusion in the project; Service Leads were also invited to opt into an interview. Although participants were referred by managers/supervisors, their details were kept anonymous, and any identifiable characteristics removed from reporting of results.
- The SDF Development Officer attended team meetings in relevant services, allowing staff members the opportunity to opt into the project if they wanted
- A poster was developed highlighting the project and giving details of how to get involved. This was displayed on locally focused websites and circulated across service networks and social media.

The project sample was not representative of all staff working on the front line in Dundee City but is designed to provide information on a range of experiences across the services for people who use drugs and alcohol.

Service managers were asked to support the project by allowing staff members space in their diaries to firstly complete the survey containing the MBI/AWS and secondly to take part in the in-depth interviews.

Potential participants for the staff survey were recruited via referral from service managers or via an open invitation disseminated across services providing details of how to get involved in the project. Once referrals were made or people self-referred, they were contacted by e-mail with the PIS, and Consent Record attached. A follow up telephone call was then arranged to discuss the project and arrange/carry out the interview.

2.2.3 Piloting the project tools

In order to fine tune and troubleshoot any issues with the questionnaire and topic guides, the materials were tested with the project steering group and necessary amendments made accordingly.

2.2.4 Consent Process

Informed consent was obtained prior to the participant undergoing any activities specifically for the purposes of the project. This included discussion between the potential participant and the SDF Development Officer about the nature and objectives of the project with opportunity for potential participants to ask questions and the provision of a Participant Information Sheet (PIS) which was emailed and included in the introduction to the survey. The voluntary nature of participation was clearly presented to potential participants during the consent process and in the PIS. Potential participants were made aware that they could choose to withdraw from the project at any point without penalty and without giving a reason for their withdrawal.

Due to the COVID 19 restrictions in place and the remote nature of the project, informed consent was recorded electronically as it was not possible to obtain signed consent forms.

2.2 Analysis

Analysis of survey data

Analysis was undertaken by the project team. Quantitative data from the AWS was analysed initially in excel to provide scoring for job stressors which may contribute to burnout, these subscales are 'Workload,' 'Control,' 'Reward,' 'Community,' 'Fairness,' and 'Values.' Quantitative data from the MBI was analysed initially in excel to provide frequency of feelings of burnout across three domains: Emotional Exhaustion (EE), Depersonalisation (DP), and Personal Accomplishment (PA). Burnout is indicated by high scores for EE and DP, and low scores for PA.

Absolute values were compared to the average scores in the normative sample in AWS and

MBI manuals, scores provided detail on how often aspects of burnout where experienced.

Data was then imported into statistical analysis software R Studio to allow tests for statistical significance and measurement of any difference between specific groups. The main comparison of interest was between participants in different work sectors: Third Sector, Community-Led, Health and Social Care, Local Authority, and NHS. Most participants were either Third Sector or NHS, so the most significant comparisons were between these two groups.

Free text comments from the survey were also analysed and thematically interpreted along with the qualitative findings.

Qualitative Analysis of Interviews and Focus Groups

Qualitative information from the service lead interviews and staff interviews were transcribed, and thematic analysis conducted for the purposes of identifying possible service developments and improvements. Interviews were transcribed and imported into NVIVO for thematic analysis by the evaluation team. A set of inductive codes were generated by the lead evaluator in an initial wave of coding. These codes were used by the rest of the research team to code the rest of the data. These were relatively high-level codes such as 'management style', 'causes of burnout', 'dealing with fatal and non-fatal overdose', 'protective factors', etc. The codes and themes were discussed in evaluation team meetings and organised into a general structure. The MBI survey was used as a structuring guide, and the various themes were organised under the three key headings of the MBI: Burnout, Depersonalisation, and Personal Accomplishment.

2.3 Ethical Considerations and Risk Assessment

Ethical Considerations

In working with a potentially vulnerable group of people it was important to consider that an informed and ongoing process of consent was discussed with those participating and suitable arrangements made for recording this consent.

The recruitment process was not coercive for this targeted group. Participation was entirely

voluntary, and participants could opt out at any time.

Data was stored on an encrypted PC, anonymised and access was limited to the project team. Contact details were stored separately from data and were destroyed at the end of the project.

Risk Assessment

Several potential risks were identified, and mitigating measures put in place.

Boundaries of confidentiality were made clear, and confidentiality of information established. This was particularly important as the work was in a relatively small sector within a tight geographical location. Local and national sources of support were also shared with participants in order to inform them of possible supports for burnout.

Dissemination of findings

Preliminary findings were promoted through a webinar available on SDF's YouTube channel. SDF will consult with Dundee ADP to develop a plan for dissemination of findings across Scotland.

3. Quantitative Findings

3.1 Demographic information

40 staff completed the online staff survey; 11 of these identified as "male", 28 as "female" and one did not answer.

The age ranges of participants were varied across the range 18-64, this is described in the table below.

Table 1.

Age	Number
18-24	2
25-34	9
35-44	10
45-54	11
55-64	8

Table 2 shows the roles and job status of participants.

Table 2.

Role	Number
Nurse	10
Project worker	10
Support worker	12
Other	8
Job status	
Full time paid employment	36
Part time paid employment	3
Volunteer	1

The sample consisted of 17 staff from statutory sector and 23 from non-statutory services, this is described in table 3 below.

Table 3.

Sector	Number
NHS	14
Local Authority	3
Third sector	22
Grassroots/community led organisation	1

Staff were asked how long they had worked in their current services and in the sector, results are displayed in table 4 below.

Table 4.

Length of time with service	Number
Less than 1 year	9
1-3 years	9
3-5 years	4
More than 5 years	18
Length of time in sector	
Less than 1 year	5
1-3 years	7
3-5 years	9
More than 5 years	18

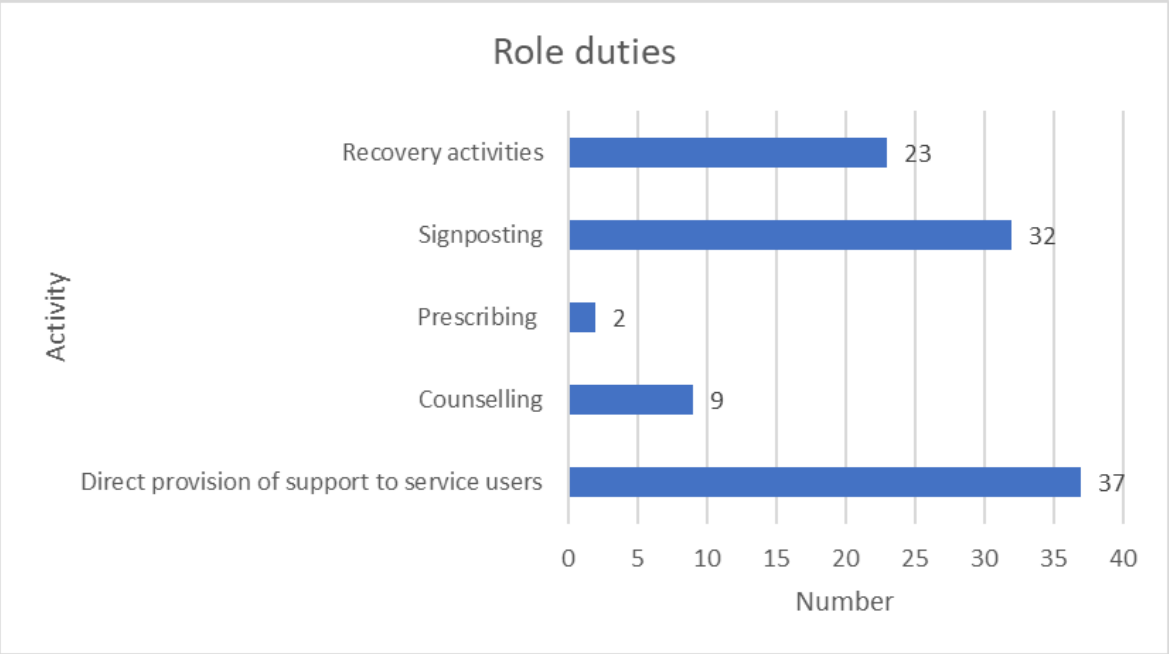
Staff were asked if they had any lived experience of substance use or poor mental health. More than half the sample had lived experience of either substance use or poor mental health with some participants having experience of both. This is broken down in table 5 below.

Table 5.

Lived Experience	Number (n=22)
Drug use	2
Alcohol use	7
Drug and alcohol use	3
Mental health	16

Staff were asked to select activities that were involved in their role. Figure 1 shows the responses

Fig. 1. – Role activities



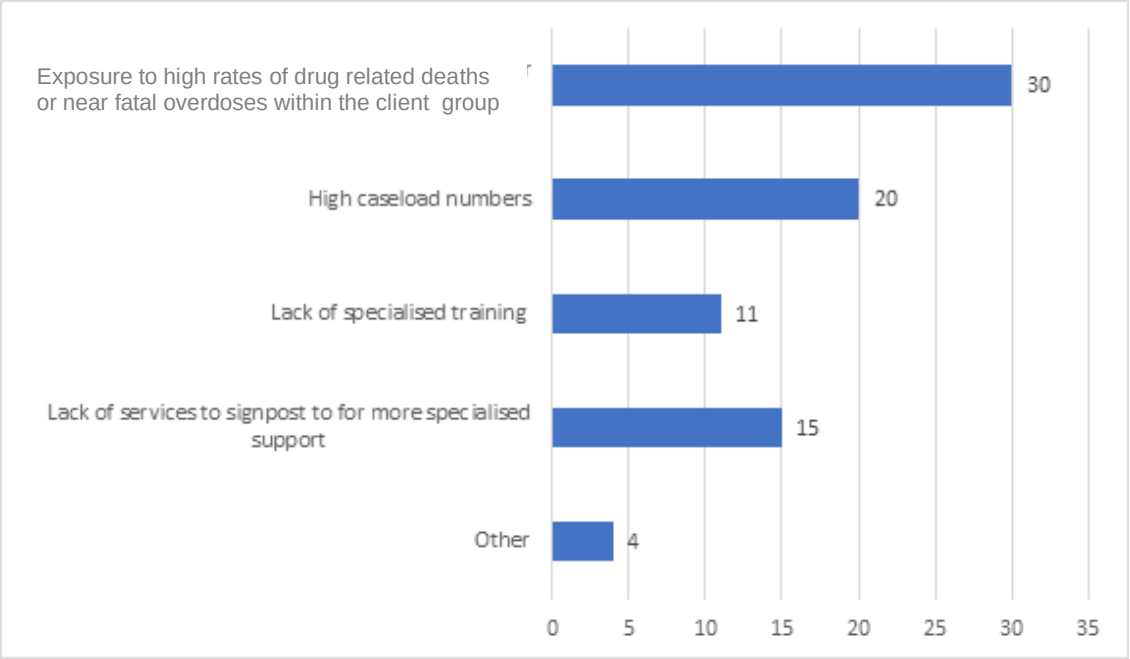
Other duties listed were:

- Carrying out assessments
- Creating care plans
- Management duties
- Involving volunteers in projects
- Administration of medication
- Motivational interviewing
- Responding to near fatal overdose

The most common role activities across the participants were direct support to service users; recovery activities; and signposting.

Staff were asked to select what they felt were specific challenges for the sector. Figure 2 shows the responses. Three quarters of respondents (75%, n=30) cited the exposure of high rates of DRDs and NFOs as one of the key challenges for the sector. Furthermore, half (50%, n=20) cited high caseloads and over a third (37.5%, n=15) identified lack of specialist services to signpost to.

Fig.2. – Challenges for the sector

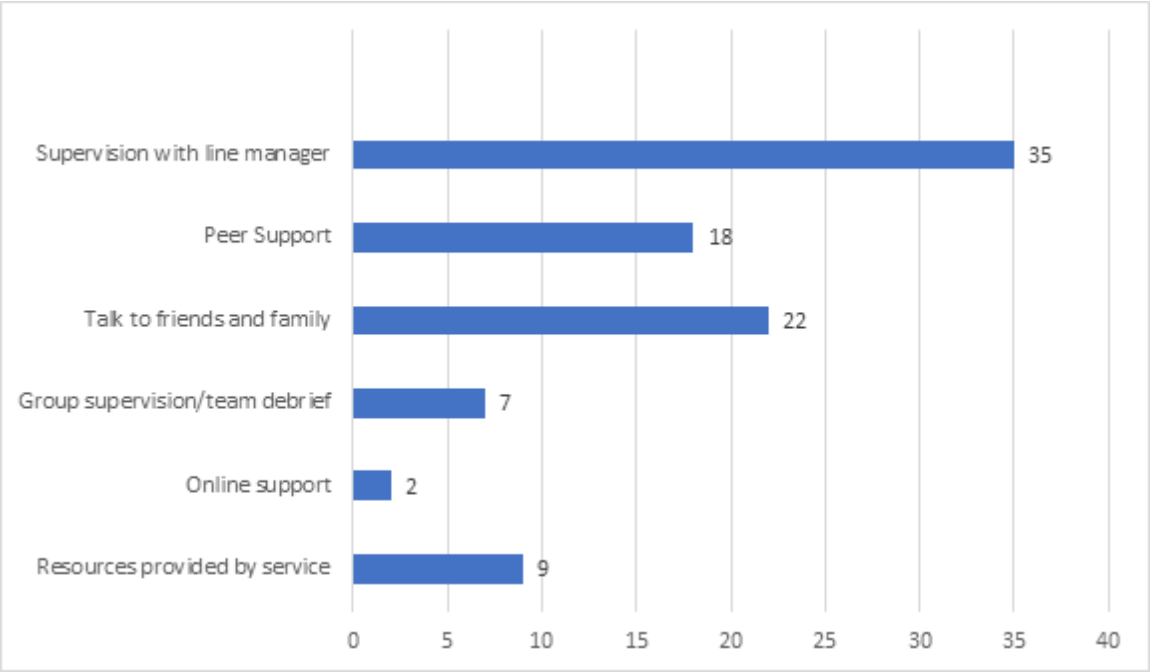


Other responses included:

- Lack of opportunities to refer service users for residential rehab
- A lack of services signposting their service users
- The pandemic

Staff selected which forms of support they had accessed at work to support their well-being. Figure 3 shows the responses. Supervision with line manager was the most common response (87.5%, n=35), over half (55%, n=22) talk to friends and family and 45% (n=18) engage in support from peers.

Fig.3. – Support accessed at work



COVID-19

To explore the impact of the Covid-19 pandemic on staff, they were first asked how their service was delivered before. Table 6 shows the responses. Appointment based support and phone support was the most common methods of delivery, (55%, n=22) with drop in and outreach also being common (42.5%, n=17).

Table 6.

Method of delivery	Number
By appointment	22
Online	3
By phone	22
Drop-in	17
Outreach	17
Assertive outreach	10
Other (“home visits”, “residential service”)	4

Staff were then asked what the main differences in service delivery had been since Covid-19. Table 7 shows responses, the most noticeable difference in service delivery seen by the majority (77.5%, n=31) was less face to face contact with service users.

Table 7– Main differences in service delivery since Covid-19

Service delivery change	N=	Percentage
I have less face-to-face contact with service users	31	82.5
I can only deliver telephone support	14	35.0
My working hours are longer	5	12.5
My working hours are shorter	4	10.0
My caseload has increased	5	15.0
My caseload has decreased	5	12.5
Other	7	17.5

Comments under other option received included:

- No change/not much difference
- Small differences like social distancing and masks
- More tasks that are not related to caseload
- Can only have face-to-face in emergencies
- We can offer support through social media

In further relation to Covid-19, staff were asked what impact the pandemic had had on teams/staffing levels. Table 8 shows responses. 40% (n=16) of the sample observed no changes to the team but over a third (37.5%, n=15) observed more staff absence or more staff having left since the pandemic.

Table 8 – Impact of Covid-19 on staff

Impact	Number
More staff absence	12
Less staff absence	2
More staff have left	3
No changes to team	16
Other	7

Comments under the other option included:

- Challenges with online team meetings/less communication with team.
- Impact on relationship with colleagues working from home.
- Staff having a reduced role/responsibilities due to COVID-19
- Staff leaving the service has led to increased workload

3.2 Areas of Worklife Survey (AWS)

The AWS measures workplace factors that can contribute to potential burnout across six domains: workload, control, reward, community, fairness, and values. The AWS responses showed some strong indications of workplace factors that could lead to burnout. It also showed some significant differences between workplace sectors (Third Sector and NHS) in these factors. Notably, NHS staff had consistently low AWS scores, indicating a mismatch between staff needs and expectations and what occurs in the workplace. Third Sector had consistently higher AWS scores, indicating a match between staff needs and expectations and what occurs in the workplace. The differences between the sectors were statistically significant in all the subscales. Table 6 shows the AWS scores between the third sector and the NHS for each subscale and the statistical significance, full results for all sectors are included in the appendices.

Table 9.

AWS subscales *SD = standard deviation	**Charity/Third Sector (n = 22)**	**NHS (n = 14)**	**ANOVA**	**P Value**
Mean AWS Workload (SD)	3.5 (0.8)	2.4 (0.8)	F = 4.3	0.007
Mean AWS Control (SD)	3.9 (0.6)	2.9 (0.8)	F = 5	0.003
Mean AWS Reward (SD)	4.0 (0.7)	2.7 (1.0)	F = 5.3	0.003
Mean AWS Community (SD)	4.1 (0.8)	3.1 (0.8)	F = 3.8	0.01
Mean AWS Fairness	3.6 (0.7)	2.9 (0.6)	F = 3.4	0.02
Mean AWS Values	3.9 (0.6)	3.1	F = 2.5	0.06

<u>AWS Workload</u>

The AWS Workload measure captured whether respondents had a manageable workload that provided the opportunity to do what they enjoyed, pursue career objectives, and develop professionally.

The difference between sectors for the average AWS workload scores were significant (p =

.007). Post hoc analyses for significance indicated that the average scores were significantly higher in the Third Sector (3.5) than in the NHS (2.4) (p = .003). There were no significant differences between any other groups. When compared to the percentile levels in the normative sample, the Third Sector score of 3.5 indicates a high match between the respondents and their workload. The NHS score of 2.4 indicates a high mismatch with what staff feel is manageable and their workload. This suggests NHS staff may be regularly working outside their limits and therefore may potentially contribute to burnout.

AWS Control

The AWS Control measure captured the ability of respondents to make choices and decisions, solve problems, and contribute to the fulfilment of responsibilities.

The difference between sectors for the average AWS control scores were significant (p = .003). Post hoc analyses for significance indicated that the average scores were significantly higher in the Third Sector (3.9) than in the NHS (2.9) (p = .001). There were no significant differences between any other groups. Compared to the percentile levels in the normative sample, the Third Sector score of 3.9 indicates a moderate match between the respondents needs and expectations and what occurs in their workplace. The NHS score of 2.9 indicates a moderate mismatch, potentially contributing to burnout.

AWS Reward

The AWS Reward measure captured whether respondents felt they received adequate financial and social recognition for their contributions on the job.

The difference between sectors for the average AWS reward scores were significant (p = .003). Post hoc analyses for significance indicated that the average scores were significantly higher in the Third Sector (4.0) than in the NHS (2.7) (p = .0008). There were no significant differences between any other groups. Compared to the percentile levels in the normative sample, the Third Sector score of 4.0 indicates a high match between respondents expectations and what occurs in their workplace. The NHS score of 2.7 indicates a moderate mismatch and potential contributor to burnout.

AWS Community

The AWS Community measure captured whether respondents felt their organization had a high-quality social environment, characterized by support, collaboration, and positive feelings.

The difference between sectors for the average AWS community scores were significant (p = .001). Post hoc analyses for significance indicated that the average scores were significantly higher in the Third Sector (4.1) than in the NHS (3.1) (p = .01). There were no significant differences between any other groups. Compared to the percentile levels in the normative sample, the Third Sector scores of 4.1 indicates a high match of staff needs with occurs in their workplace. The NHS score 3.1 indicates a moderate mismatch and potential factor contributing to burnout among NHS staff.

AWS Fairness

The AWS Fairness measure captured whether respondents agreed that their organisation has consistent and equitable rules for everyone, particularly regarding consistent and transparent resource allocation.

The difference between sectors for the average AWS fairness scores were significant (p = .001). Post hoc analyses for significance indicated that the average scores were significantly higher in the Third Sector (3.6) than in the NHS (2.9) (p = .035). There were no significant differences between any other groups. Compared to the percentile levels in the normative sample, the Third Sector scores of 3.6 indicates a high match of staff expectations with what occurs in their workplace. The NHS score 2.9 indicates a moderate match.

AWS Values

The AWS Values measure captured the level of congruence between the values of respondents and the organisational values of their workplace.

The difference between sectors for the average AWS values scores were significant (p = .006). Post hoc analyses for significance indicated that the average scores were significantly

higher in the Third Sector (3.9) than in the NHS (3.1) ($p = .003$). There were no significant differences between any other groups. Compared to the percentile levels in the normative sample, the Third Sector scores of 3.9 indicates a high match of staff values with organisational values. The NHS score 3.1 indicates a moderate mismatch, potentially contributing to burnout.

Summary

Third Sector respondents had a high match for workload, reward, community, fairness and values, and a moderate match for control. NHS respondents had a high mismatch for workload and a moderate mismatch for control, reward, community, and values, but a moderate match for fairness. These interpretations are made in comparison to the percentile cut off scores in the normative sample, which is why a score of less than 3.0 can still indicate a match (e.g., the NHS fairness score of 2.9 interpreted as a moderate match). Overall, there is a clear pattern of a greater risk of burnout amongst NHS participants compared to the Third Sector. The greatest potential cause of burnout is workload. There were not enough participants in the other groups to make any significant comparisons.

3.3 Maslachs Burnout Inventory (MBI)

The MBI responses indicated experience of burnout amongst the respondents. Burnout is indicated by high scores for emotional exhaustion and depersonalisation, and low scores for personal achievement. MBI responses also showed some significant differences between workplace sectors (Third Sector and NHS) in these factors. Notably, NHS staff had higher MBI emotional exhaustion and depersonalisation scores, indicating experience of more frequent burnout. Third Sector had lower MBI emotional exhaustion and depersonalisation scores, they experienced burnout less frequently. The differences between the sectors were statistically significant in two of the three subscales (personal accomplishment had no significant difference). The most striking difference was for the measure of emotional exhaustion. Table 7 shows the MBI scores between the third and NHS sectors with statistical significance tests, a full breakdown of all the sectors is included in appendices.

Table 10.

MBI subscales *SD = standard deviation	**Charity/Third Sector (N = 22)**	**NHS (n = 14)**	**ANOVA**	**P Value**
Mean MBI Emotional Exhaustion (SD)	1.4 (1.1)	4.1 (1.3)	11.2	<.0001
Mean MBI Depersonalisation (SD)	0.6 (0.6)	1.7 (1.1)	4.2	0.007
Mean MBI Personal Accomplishment (SD)	5.0 (0.9)	4.3 (0.8)	1.2	0.3

MBI Emotional Exhaustion

The emotional exhaustion subscale measured feelings of being emotionally overextended and exhausted by one's work, with higher scores corresponding to greater levels of burnout.

The difference between sectors for the average MBI emotional exhaustion scores were significant (p = <.0001). Post hoc analyses for significance indicated that the average scores were significantly higher in the NHS (4.1) than in the Third Sector (1.4) (p = <.0001). There were no significant differences between any other groups. Taken as absolute values, the NHS score of 4.1 indicates that respondents felt emotional exhausted an average of once a week. The Third Sector score of 1.4 indicates respondents felt emotionally exhausted an average of a few times a year or less.

MBI Depersonalisation

The depersonalisation scale measures whether respondents have an unfeeling and impersonal response towards their clients or service users, with higher scores corresponding to higher levels of burnout.

The difference between sectors for the average MBI emotional exhaustion scores were significant (p = 0.007). Post hoc analyses for significance indicated that the average scores were significantly higher in the NHS (1.7) than in the Third Sector (0.6) (p = .002). There were no significant differences between any other groups. Taken as absolute values, the NHS score of 1.7 indicates that respondents felt depersonalisation an average of once a month or less. The Third Sector score of 1.4 indicates respondents felt depersonalisation an

average of a few times a year or less.

MBI Personal Accomplishment

The personal accomplishment scale assessed feelings of competence and successful achievement in one's work with people. Conversely to the previous two scales, lower scores indicate greater burnout, because burnout is associated with low personal accomplishment.

The difference between sectors for the average AWS workload scores were not significant ($p = .3$). No post hoc analysis was conducted for differences between individual sectors. As absolute values, personal accomplishment was high across all of the sectors, ranging from 4.3 for NHS (once a week) to 5.0 for Third Sector (a few times a week). This suggests that personal accomplishment is not contributing to burnout and may be a protective factor.

Summary

There were significant differences between NHS and Third Sector respondents for both emotional exhaustion and depersonalisation, but no difference in personal accomplishment. The most marked difference was the very frequent levels of emotional exhaustion for NHS staff compared with lower frequency for Third Sector. Depersonalisation was generally infrequent across all groups but occurred more in NHS staff and this difference was statistically significant. Personal accomplishment was experienced frequently and there was no statistical difference between groups. The high experience of personal achievement may act as a counterbalance to the regular emotional exhaustion and less regular depersonalisation experienced by alcohol and drug workers in this study. The qualitative themes relating to these findings will be presented in the next section.

4. Qualitative Findings

4.1 Frontline staff and service lead demographics

Sixteen frontline staff and seven service leads attended staff interviews or focus groups; the

breakdown of how participants described their gender and age is described in the tables below.

Table 11.

Gender	Frontline staff (n=)	Service leads (n=)
Female	11	4
Male	5	3
Age	**Frontline staff (n=)**	**Service leads (n=)**
23-33	5	
34-44	7	2
45-54	2	2
55-64	2	3

Staff were asked which sector/role they worked in which is described in the tables below. The majority worked in NHS or third sector.

Table 12.

Frontline staff (n=16)		Service leads (n=7)	
Job role	**Number**	**Job role**	**Number**
NHS	5	NHS team leader	2
Social worker	2	Third sector manager/project coordinator	6
Third sector project/support worker	8		
Peer worker	1		

Staff were also asked the length of time in their current role and in the sector which is described in the tables below.

Table 13.

Length of time with service	Frontline staff (n=)	Service leads (n=)
Did not answer	0	1
Less that 1 year	5	2
1-3 years	9	1
4-6 years	2	2
More than 6 years	0	1
Length of time in sector	**Frontline staff (n=)**	**Service leads (n=)**
Did not answer	2	1
Less that 1 year	2	0
1-3 years	3	0
4-6 years	3	0
6-10 years	3	1
More than 10 years	3	5

Staff were asked if they had any lived experience of substance use or poor mental health, whilst not directly asked, participants also shared their lived experience of substance use problems or mental health issues and one person their gambling dependency. More than half the frontline staff (n=10) had lived experience of some kind, six having had personal experience of problem substance use or poor mental health or both. More than half the service leads (n=4) had lived experience of problem substance use or poor mental health or both. This is further broken down in the tables below.

Table 14.

Lived experience	Frontline staff (n=)	Service leads (n=)
Total with lived experience	**10**	**4**
Drugs or alcohol	3	2
Mental health	5	4
Gambling only	1	0
Family history only	3	0

4.2 Staff experiences

Commons themes from the staff and service lead qualitative findings have been grouped in to the three domains from the MBI, burnout, depersonalisation and personal achievement.

4.2.1 Burnout

Staff interviews and focus groups explored burnout as an idea and experiences of this, as well as exploring what are typical causes and protective factors of it.

The common emerging themes were:

- There was an awareness of burnout in the sector across the staff and service leads and understanding centred around emotional or physical exhaustion. Some staff saw a need to improve awareness of burnout within the sector and training was viewed as an important part of raising awareness and having a better understanding of how to prevent, recognise, prevent and support staff experiencing burnout.

- Causes of burnout were varied and there were specific challenges related to working within the sector including:

    - High rates of DRDs and NFOs

- Limited follow up and lack of resources and specialist supports for staff affected by burnout
- High caseload sizes and workload
- Staff shortages and capacity issues, including: covering absence, staff retention and pressures of supporting new or less experienced staff
- Emotional impact of supporting clients who are marginalised and have complex and adverse life histories
- Stigma: both direct experiences of negative media coverage and criticism from other services and at organisational and government levels.
- Personal factors such as caring responsibilities

- Lived experience could be both an asset or a potential vulnerability to burnout as for some it offered a greater self-awareness and knowledge of coping skills to apply to stress yet for others, there were potential challenges around maintaining boundaries around self-care or vulnerabilities to relapse if exposed to high levels of stress. For people in early stages of recovery, mangers recognised there may be a need for a greater level of training or support as they may have been out of work for a significant period and as such may be quite unfamiliar with the demands of work and advancements in areas such as technology which could contribute to workplace stress.

- Management style could contribute to feelings of burnout, some participants suggested greater autonomy as often experienced in the third sector was protective compared to statutory sector which can feel less autonomous and left some feeling undervalued. Culture of the organisation and the workplace including being trauma informed and ensuring awareness and open dialogue about burnout was at the forefront of the workplace was viewed as an important part of prevention. Managers ensuring staff are able to take time off alongside flexible working policies, regular supervision, reflective practice sessions and possibility of external supervision were all other suggestions for prevention. Opportunity for informal communication and relationship building also contributed to greater resilience in staff teams.

- The impact of COVID-19 was varied, whilst for some it afforded some opportunities to have more effective and efficient engagement with clients and offered more freedom

in the role and new and more flexible working styles, it was generally highlighted as an additional source of burnout. This was due to isolation from collegial contact and support, challenges in separating home and work, having to adapt to new procedures and work under more challenging circumstances. Staff absence or staff shielding due to COVID-19 were further additional pressures on staff as face to face work could then fall to smaller staff teams creating team imbalance and increasing workload for some staff.

Themes are explored in further detail below, with example quotations included to illustrate these themes.

Awareness and understanding of burnout

Staff were all aware of the concept of burnout and all had either personal experience of it or had observed in colleagues at some point in their work. Staff offeried in-depth descriptions of their understanding of burnout and the majority described it in terms of some form of emotional and/or physical exhaustion.

"Burnout to me is someone who is reaching a point where they are emotionally and physically sort of drained and they're struggling to cope a little bit, it's also, yeah that's how I would say, it's mostly like being emotionally drained, or like physically drained, to the point that you're struggling to move forward or your just, just struggling."

Some interview participants highlighted that they felt understanding of burnout could be improved across the workforce:

"I think burnout's real; I don't think burnouts recognised as much as it should be that's why we welcome your study. I think it's really good. It's not only timely because of the extra pressure just now with Covid but I think burnout is something that we need to pay much more attention to within the sector and I don't think we have over the years and burnout to me, it's a combination of a few factors that will end up impacting on the individual".

No managers had received specific training on burnout but several gave examples of other

relevant training including management, supervision and mental wellbeing training. Training was seen as important by all managers within the sample both to better support staff but also in terms of self-care, specific training on burnout at induction stage was suggested by several as a key part of prevention:

"I think in terms of sort of training and induction, I think as a workforce we need to get much more honest about burnout. We know it needs to be in our very early training. What is it, you know what to look for, what does it feel like?"

Causes of burnout

High rates of drug related deaths and near fatal overdose

A particular issue raised as pertinent to burnout in the substance use sector were the high rates of DRDs and NFOs. Staff experiences of responding to overdose and death of their clients were wide ranging. Almost all staff gave examples of overdose, fatal and non-fatal which had impacts on burnout in themselves or others, many staff reported feelings of grief and loss:

"We're seeing a lot of fatal overdose, so you're losing people that you are close to",

The personal aspect to these losses as a result of empathetic engagement and building a relationship over time was evident. As one participant describes below direct loss for frontline staff is much more pervasive than staff in the sector without client contact who are exposed to DRDs mainly through statistics:

" I think what has the most impact on me is the area I work, being in addictions, is when you hear of a death, and you know them personally, they're no, and again I'm speaking personally, it's a figure for the Scottish Government, it's a figure for the health boards, but it's a person to me and engagement with them, I know them, maybe no as a friend, but I've nursed them and things like that, so especially the young ones, that's got a huge, I feel it's got a huge impact."

Limited follow up

Follow up from NFOs and DRDs for many was limited and this could contribute to feelings of burnout:

"Certainly I have never, ever been approached by management and offered support following a NFO, or a fatal overdose, never, not once since I started working here, and I think that has quite a big impact on you, because like I say, I mean all deaths affect you to a degree, but I think anyone who works in this service. There will always be patients that it has, for some reason, a slightly bigger impact, whether it just be how long you've worked with them, how close you've worked with them.."

Limited follow up and a general lack of resources and specialist supports for staff experiencing burnout was viewed to contribute to burnout. Staff raised that the cumulative aspects of burnout particularly surrounding aspects such as responding to NFOs and bereavement and loss with clients who had died. Many staff identified these aspects to the work required more specialist support or service responses such as compassionate leave available. These themes are explored more fully in the prevention and support section on page 65.

High caseload sizes and staff shortages

The majority of staff stated that workloads and caseloads were high and there was some level of staff shortages. Factors within staff shortages included sickness, staff leaving and holiday cover.

"I think we have so much to do, there's not enough time and there's not enough people"

Most staff who carried high caseloads or workloads, acknowledged the impact it had in terms of feeling overwhelmed by work or that it couldn't fit in to working hours. As one participant describes below, where staff had their own health issues, they were more vulnerable to burnout:

"I've got fibromyalgia, so the stress would get to me quite quickly, and pain, but I didn't, yeah, I did feel I was doing too much and I couldn't fit it all in one day, and I mean I was phoning 30 people, contacting 30 people every day, so that's a lot.."

Waiting lists for allocation were cited as high by many NHS staff:

"I suppose it's all the stress of trying to deal with, you know, not only your own caseload, but you've got something ridiculous like, I think it's 700 patients unallocated, so that means they don't have a nurse, and so if they're phoning with problems, you have to deal with it, and then obviously you've people off sick, you've got to deal with their stuff, people on holiday, so yeah, sometimes the stress of even trying to see your own caseload, now we're meant to see, or contact our own caseload every 4-6 weeks, I think it's 55 of them on my caseload"

The pressures of staff absence on top of already high caseloads was evident in the majority of staff, but this was especially apparent within NHS staff:

"Definitely you notice the staff shortage in work, at the moment whether it's sickness or I think we're interviewing just now, so we're going to be expecting some more nurses to join the team, which is definitely needed, as the majority of the time you've got your own duty to do, and your own assessments and then you're also covering other peoples when they're not here, so it is just more on your caseload"

There were a few instances of staff who were now in the third sector but had worked in the NHS previously and those staff generally commented that caseloads were better within the third sector:

"No, we don't really suffer with it. I have to say in my previous job, horrific caseloads of 80 odd, but not this one."

These kinds of pressures in the context of other service pressures resulting from the rates of drug related deaths was referenced by several staff. This involved pressures from the media, at local and national levels including the government.

"I would say at the moment, capacity within the service so at the moment we have quite a high volume of patients and staffing capacity is quite limited for various reasons, so the pressure then, you take on a lot of that work because it needs to be dealt with, you can't ignore it so you're taking on extra and also there's a lot of attention on our service just now from a national level and on a government level as well so there's a lot of focus because of drug related deaths, things like that really evaluate the service. So you're trying to protect staff, so you're taking a lot of that on board, some of the stuff that's coming through"

The need for higher staffing levels was mentioned by many staff, particularly in the NHS due to the workload pressures.

"I think the big thing is there just needs to be more people working in the field"

A major factor in staff capacity was issues with staff retention.

"I think the main, the main problem we're having is retention of staff, we get staff in, but what, I think in the 4 years that I've worked here, now out of what, there's meant to be about 13 qualified nurses, there is 6 left and that includes myself."

Whilst several staff mentioned recruitment occurring, this brought its own challenges with a constant flow of new workers and as staff continued to leave, new staff appointed to increase capacity, simply ended up replacing staff that had left. This resulted in capacity issues which were never really resolved.

"we've brough in all these new staff, and stuff like that, and I was, I'd actually sat there and wrote it down on a piece of paper, everybody that had left and everybody that had come in.. so the new people you think you've got in, haven't been brought in at all, they're just filling out the numbers"

The pressures of having new staff, with staff who had full workloads having to support and induct new workers which added additional pressures:

"I think one of the problems is, everybody's always asking for help, give a hand with this, give a hand doing that, how do you do this, and the problem you have is that more and

more staff with the more and more turnover, newer people and you're like, sometimes you've just had enough, you know what, give us peace.."

Some managers also recognised challenges with new workers who lacked experience in terms of managing boundaries and workload:

"maybe someone's new and, you know, experience is a great thing isn't it...I mean I know when I qualified I came into it and I was just like give me it all, I want to take everything on, I want to learn and I certainly had points where I totally stressed myself out, was completely stressed, because I was wanting to take it all in and was so enthusiastic and now I know I can set my boundaries, what I can and can't take on"

Staff retention within the third sector appeared to be less of an issue.:

"the staff that we recruited are still with us, and they love their job, and I've no absences at all.."

Emotional impact of supporting clients

Staff shared various experiences of the challenges and emotional impact of supporting clients with complex and adverse life events, for staff, this was a result of engaging empathically with clients. Adversities for clients included, poverty, deprivation, health inequalities and isolation but the most common theme was client's histories of trauma:

"I think working with people with very complex traumatic life experiences and I think listening to their story is sad, there's always some complex trauma or recent trauma or something they're really sad about in their life"

Another participant shared similar adversities of their clients including poor interpersonal relationships but saw their ability in building a therapeutic relationship and developing trust as a key motivating factor for the work:

"they suffer trauma, you know that they've usually no got any relationships, positive relationships and you might be unfortunately the only person that they trust, you know, in

life, so that's what keeps me going.."

In addition to the complexities and multiple disadvantages that service users faced, staff also highlighted the impact of marginalisation. As one staff member described this left them feeling their work was not valued:

"Completely devalued, people don't want to touch our client group with a bargepole and I'm being brutally honest there, the pandemic probably heightened that quite a lot because the priorities have been elsewhere so the focus is probably rightly so, about keeping them alive and safe so our client group kind of went to the bottom even more so of that pile.."

Some staff highlighted the challenges of retention in services for the client group and how this brought additional pressures to their work.

"You're phoning them and phoning them and phoning them and phoning them, and they're no answering, you know what I mean, so at what point do you then say to a person, sorry but you're no engaging…"

Stigma

Staff shared various experiences of stigma which ranged from direct experiences of negative media coverage, criticism from other services and at organisational and government levels.

Stigma from the community was referenced by majority of the sample, staff spoke about issues such as having to deal with stigma from within their own family about working in the field or stigma from the public from working in buildings associated with drug treatment. As one participant describes below, a lack of understanding from the public about the route causes of problem drug use was seen as a main factor:

"I don't think the people they understand the complexity, they just blame the individual or the service , I don't think that they understands fully the complexity of drugs and alcohol and the fact that the majority of those who experience this probably has a past trauma or a complex trauma or a really poor upbringing and life experience, there's not this understanding, it's a really judgemental thing and I think we need more education for the

community..”

The media was mentioned by many staff as a key driver of stigma. Staff reflected that both clients and services were stigmatised in the local press:

“we’ve had a lot of negative press, like literal press, for this place, like, like the local press here don’t, you know, seem to think this is a very favourable life, but not really ever understood what we actually do, yeah, I mean that, that’s a been a big thing, certainly for the guys we support as well, just like, you know, never speak to a reporter, like, just kind of typically the advice we give a lot of the time, just don’t, don’t, guys just don’t do it, you know, yeah.”

Most participants referred to print media as the main source of public stigma but social media was also referenced as described by one participant:

“I guess sometimes it’s draining and it does make you exhausted having to argue your point, but yes, the same as on social media, like on Facebook, things are getting shared about drug users, I just try my best to scroll past and avoid it, because I don’t think it’s worth it sometimes”

In addition to stigma from the media, several staff spoke about the impact of stigma from within the sector. A few participants spoke more directly about the impacts of local reviews and how the criticism received had had negative impacts on staff burnout.

“we’ve been working in a very busy service for a long time, long time – that I would say we’ve been neglected from the powers that be for a long, long time and then we’ve had people come up and review the service and the service has been going a long time, we’ve been trying our best for an awful long time and it feels like it’s coming at us from all angles, so we’ve got the pandemic, we’ve got the commissioned review and everything and that actually impacts on staff burnout because even though you’re doing your job to the best of your ability in the circumstances it feels like they’re being criticised as well..

Other experiences of stigma from within the sector are explore within the depersonalisation section on page 47.

Personal factors

Personal factors unrelated to work were also cited as contributory factors to workplace burnout such as impact of family responsibilities and caring issues:

"Things that can impact in a workplace, I think because life is so busy and we've all got so many things going on and all these different plates and you know, for example, you might help someone who's in a parenting role and grandparenting role and someone might have relatives that are unwell that they're looking after."

Role of management style

Team leaders/managers and other team members discussed the causal effect management style and approaches can have on burnout. The factors where management style could contribute to feelings of burnout, centred around a lack of autonomy, feeling undervalued and the whether the culture of the organisation was focused on staff wellbeing.

In one focus group, two staff members discussed management styles in third sector being preferrable due to greater autonomy:

"M1: I would never go back to work for the [public sector]… I quite like to just get left to do, to do things, you know what I mean, and that's what, what we have right, we're no being micromanaged, nobody is looking at our performances from on high…

M2: Aye, that's what I like about it, a good bit of, you can do things on a one to one and that, go on your own judgement, type thing, if you know what I mean"

This opinion was shared in staff interviews as another person describes below their experiences of NHS management approaches:

"it's just one of those things that it kind of gets to that point where you're not feeling valued, because management are just basically micromanaging everything that you do and it just, yeah, it becomes quite frustrating and you, you feel less valued for your contributions, because you can't actually make any"

Themes of being valued and organisational culture are further explored later in the report.

Lived experience

Staff discussed whether they felt their own or colleagues' lived experience of substance use and/or mental health affected burnout. As one person describes personal experience was a both a driver for working in the field but could bring vulnerabilities to burnout:

"If you've experienced trauma yourself, you know, and I think a lot of people within our industry have experienced life and perhaps experienced trauma of some sort, and that's kind of what drives a lot of us in to this world of work, you know, because we feel we can empathise, we can't relate to others, and we want to use some of that passion, and that care in helping others, it also perhaps makes us more susceptible to burnout as well."

This was a view shared by some managers, who discussed the need for additional support for staff with lived experience as described by one team leader:

"we need to recognise it comes with challenges as well and then you know, even from a managers perspective, you know … times you know, people will relapse, you know, we can all, we can all end up developing problems with drugs or alcohol, but if you've got a lived history you could be more vulnerable to, you know a full blown relapse, you know, and if you're working in high stress, and high risk level environments, then you know you, so there is … there are a lot of risks there, so I think supporting people with lived experience again is absolutely crucial, and having that trust, and having that honesty to be able to have honest conversations with people is really, really important"

One participant with family experience of problem substance use also noted the drive to work in the field but felt that this aspect was preventative for them experiencing burnout.

"I've got this thing with me that I didn't help my son, but I'll help somebody's son, so I've got a passion, maybe more than a lot, so it's not really affecting me."

One person discussed how strategies they used in their own recovery were transferable to coping with work-related stress/burnout:

"My problem was that whenever I was drinking, I was getting angry and I was lashing out at people every night, and what I did to, what I do is, I do walking, I do an intense amount of walking, I like to do walking, about 15 miles a day, so that's my release from doing that, that's how I, how, sorry, get that thought out of my mind, but sometimes you do still kind of do on that, and as, as I say, sometimes it can be frustrating when you feel that you're in your job and you're no getting support properly, you know"

However, another individual discussed the mismatch between their recovery experience and the reality of their job and how this caused frustration for them:

"I was a wee bit frustrated where I've ended up, you know what I mean, in like, like I'm more in harm reduction rather than in rehabilitation, you know what I mean, because I, my big idea was coming out the rehab, was going my 12 steps, carrying the message, getting people into rehabs, getting them through the doors of AA, you know what I mean, and I've ended up it's more about harm reduction, when, when you see what's going on, you know what I mean, harm reduction is the best line, and that's the first step, you know what I mean."

Another individual described lived experience potentially leading to staff taking on too much and the impact this may have on their recovery:

"I've just kind of experienced peer workers kind of being just expected to kind of get on whilst it needs more than that and I think you know and I've been part of that I've been part of peer recovery networking in Dundee for a long time and I've seen folk come in with so much potential and … but then maybe almost burn themselves out because they're wanting to do too much of a good job, and you know the boundaries go out the window so I definitely think there's something in there where that has to be more closely looked at to

make sure peer workers dinnae burn out or unravel quickly or you know… like I find that peer workers actually stop thinking about their own recovery, and because the job's more important and then things start going a bit pear shaped."

One participant spoke about the impact lived experience might have on external support available such as family supports available:

"Because something can happen and then later on that night you think, excuse my language, but you think aw fuck you know this affected me more than I thought, and it's OK to say, well they should have their own networks that they can speak to, but realistically, when you're in this field, the majority people who work with addictions or within social work or community education have had issues in the past and that's why they then want to help people because you know we have that connection and you have that empathy and so they don't have the family that they can go speak to, you know what we don't have that."

Impact of COVID-19

The effects of COVID-19 have had on burnout risks, due to changing working practices and experiences of staff was explored. Some staff expressed that there had been positive effects, such as more efficient processes:

"Before Covid, you took people to get assessed on a Monday and a Thursday, with a 3 hour window, and it was 9 to 12, and anybody in addiction, they're usually sleeping at that time, so yeah, so that was really difficult in the dropping in, and that's the only way they could get in, Covid allowed me to email referrals, and people were getting picked up like that (clicked fingers), so made people change the way they worked, and we're continuing to do that..."

Another individual explained that the team now felt more trusted to manage their own work and time, due to having to primarily operate from home:

"I think with Coronavirus that – I always felt like - I've experienced it myself, you know when I say I'm going to work from home tomorrow right I remember some admin staff going oh aye right, but I think that's gone now because we're all kind of doing that and I think I

speak to my team and they absolutely 100% trust the team and they use their time wisely and I can see how beneficial it is for them where they're not having to travel from Fife to Dundee to sit in an office to make a couple of phone calls."

However, more negative effects of COVID-19 were mentioned, all of which were seen as risk factors of burnout. Staff described difficulties with working from home meaning they could not separate themselves from work easily:

"that's your home environment, that's, that's your life, you know, you, you work to live, you don't live to work, you know and it's that home, not cutting off at 5 o'clock, I would say I've never had an hours break, lunch break, because I keep my phone on, because I'm in the house, and, and you just feel like you're on call all the time, so if you're sitting at the kitchen table, that's where you eat your, your dinner at night, you know, and it's trying to cut off from that, so if you've not experience that, I think it's probably difficult to understand that it's really no a good place to be."

Another staff member highlighted that being largely housebound for extended periods of time led to overall isolation and stress for staff:

"I definitely think that the kind of, the isolation, we're all missing that, you know before we would all be huddled in offices and traveling for hours to spend time together with people. That's all stopped. So, I think I think the lack of human contact. I think the that the isolation has definitely added to all of our stress levels..."

Similarly, someone discussed the loss of their usual support networks and normal activities outside of work and that this negatively affected their work life:

"And I guess a lot of us in the past we have used things like the gym or, I guess family, friends, and at some point we didn't have all that. I mean I lived on my own. I live on my own, and even though my son my daughter in law live close by, they're in a different tier from me, or they were different tier, she's a nurse and I'm a nurse so it was hard."

Changes to services that were necessary during the pandemic were described by one staff member as having created different dependencies for clients which they will have to

maintain beyond restrictions:

"actually what we've done over covid is we've actually created a dependency in certain things, so like food banks, there's like 25 and I'm one of them right, 25 different services in Dundee providing food, because that's all we could do, it was all we could do and, its like let's help as many people as we can right, great but actually what we've done is, we've created a dependency because you have people going from one food parcel, to another food parcel, another food parcel, another food parcel, so I know a woman that's got a car on finance because she's not had to pay for food. When this stops she's not going to be able to afford her car on finance you know I mean like so it's actually like, how is that going to affect people not having this food available?"

One staff member described the stress caused by the need to adhere to restrictions and guidance:

"we were working with the social distancing, with the masks, with making sure we cleaned everything after each use, and that was quite stressful really because when people weren't wearing their masks, when people weren't going round the right one way system, that was a stressful time because it felt so unnatural, because there was only one person who was allowed to give people tea and coffee at the urn, just … we had to stack chairs, to get chairs out each day stack them away, take a different set of chairs the following day, because of the covid and everything. So there was a lot of stuff there that just made the whole thing quite tiring actually in a way that it just isn't when those restrictions aren't there, so yeah, there's been that as well obviously."

The need for some staff to shield and work only from home was mentioned by several staff and managers as this led to others doing more face-to-face work:

"we have had staff here who've been shielding and that brings its own challenge and people who haven't been able to see patients because of their pre-existing health conditions start feeling guilty about that and other staff are under pressure, the staff that are seeing people also then become quite sensitive because you're coming to them and saying, look, you know, we know that some staff can't see patients, I hope they don't think that we're judging them, and you know all these issues come into play..."

4.2.2 Depersonalisation

Staff interviews and focus groups explored the MBI component depersonalisation which in this context refers to a loss of empathy or emotional detachment which can lead to cynicism and negative views towards clients and others and for some a form of dehumanisation in interpersonal relations.

In this sample, there were two aspects to depersonalisation observed; firstly, this was observed with cynical attitudes towards service users. Secondly, this was demonstrated by a loss of connection or sometimes negative or cynical attitudes towards colleagues and other staff in the wider sector.

The key emerging themes were:

- Whilst regular exposure to high stress e.g.fatal and near fatal overdose of clients could lead to feelings of emotional exhaustion in some, displaying a high level of empathy, in others, it caused depersonalisation due to the high volumes and regularity of DRDs and NFOs, which had for some, meant they had become desensitised and numb to it, suggesting a possible reduction in empathy. In some staff this lead to avoidance or detachment from clients and colleagues or issues such as cynicism. It is important to note that many staff felt loss deeply and struggled with lack of supports for this.

- Relationships and links with other services could be a causal or protective factor for depersonalisation. Service staff reported many challenges of working with partner agencies and there was a tension between statutory and third sector observed from both sectors. Key themes pertaining to this tension was around stigmatisation of clients or lack of compassion by services, stigmatisation of services including unhelpful judgements and negative comments from service staff about other services, a feeling of some services not taking responsibility for areas which are their remit, undervaluing of service provision that is on offer, hierarchies between

services, poor partnership working or communication between services.

Desensitisation to fatal and near fatal overdose

The impact of DRDs and NFOs on some staff who had regular exposure and on occasion, continual exposure with the same clients could lead to depersonalisation in some staff. A few staff spoke about the workload such incidents could trigger:

"I've had somebody today, that's had 3 overdoses within the last 10 hours, that is going to take me the rest of this week, so all your other people are going to just need to wait, because this is, you know, it's prioritised"

Desensitisation could manifest within management support and follow up procedures surrounding overdose also, various staff described limited supports and as highlighted below, follow up could end up feeling more of a procedural exercise:

"I suppose from my perspective, when, when individuals have near fatal overdoses, we definitely do not get any support from kind of management or anything like that, it's very much, I don't know, its' quite, what's the way to kind of put it really, it just kind of feels quite like a tick box exercise a lot of the time, it's just like the same copied and pasted plan that gets put into documentation, by a consultant, do these 8 things with this patient at your earliest convenience, there's, there's just nothing really very patient centred about it all, it's, it's kind of all just this reactive, rehearsed, kind of stuff, that we have to do"

Several staff reflected a sense that some senior managers that were further removed from the frontline and perhaps expected a greater level of resilience or emotional detachment from the work than is possible when you are empathetically engaging:

"we're human beings, we're no robots"

The impact of repeated exposure to death on support that was offered was apparent

when exploring elements of follow up such as debriefing:

"You do have debriefs but to be fair, once you've had one, you've had them, all, there's no... It's not that helpful after you've experienced four or five deaths."

Length of time in the sector when dealing with emotionally challenging work such as bereavement and loss was highlighted by some managers:

It's a very challenging sector to work in for a long time and remain engaged, upbeat, positive, strong, effective. I think when you're working with the levels of trauma that this sector works in day after day, year after year, it can be very challenging and you know, you're working with trauma, you're working with loss, you're working with risk, you working with overdose, you're working with intravenous drug use."

Frustration towards the client group was one possible result of depersonalisation or cynicism cited by several staff. One participant describes below a lack of respect from clients as a key challenge:

"…another frustration with me, and definitely for the side of burnouts would be, I think the lack, the lack of, and this sounds bad, but the lack of respect from patients, you try and give them all the respect in the world, but the way sometimes, some of them treat you, is horrific, and the point that a lot of them don't take responsibility for their own actions"

Another participant identified challenges for them where a lack of honesty about substance use was perceived:

"People think your head zips up the back, that's another thing that I get frustrated, oh I've no used, no.."

Two participants discussed in a focus group difficulties experienced with clients around clients not acknowledging supports they have in place or taking responsibility for their issues:

"P1: we've got a lot of people who are just like, they sit and moan right, this is, this is, but I suppose this is a big frustration for me right, to the point where this does piss me off, they're sitting moaning that there's no help for them, so I sat with a couple, right, and honestly I sat and went through every, every agency that, everything they're working with, and they're still moaning that nobody is doing anything for them, and that, and I'm like, well what do you want…

P2: Selfish to the core … Selfishness comes with addiction, you know what I mean, everybody is to blame, drugs and alcohol's no to blame, if you weren't doing what you were doing and that situation wasn't the way it was and you just leave me alone to take my drugs and drink, I'd be alright, that's the way they see it, everybody would be alright, you know what I mean"

Coping strategies for aspects such as frustration and dealing with emotionally challenging work applied by staff included 'gallows humour' and was referred to as office banter. Individuals that engaged in this also reflected the difficult feelings that laid underneath such banter. Other staff spoke about the ability to contain frustration despite the challenges of client work:

"The guys are fantastic, even, I mean some of the clients that come through, it's almost like a revolving door, so we're seeing them maybe 2 or 3 times, or more and again they go out with the same compassion, the same commitment, so, but I told them it's okay to get frustrated, it's, as long as they get frustrated with me about that, no actually put it over to the client"

A possible impact of depersonalisation and cynicism was withdrawal from peers and the workplace:

"we have a tendency to sort of self-isolate and withdraw you know at times like that"

Relationships and links with other services

Within the whole qualitative sample, relationships with partner agencies were mainly described with challenges although there were a couple of staff who spoke about the need to work together. In particular, there was a tension described between statutory and third sector observed from both sectors. This tended to centre around both sectors having different expectations and understanding of the others remit and responsibilities and then experiencing frustration with either being left with complex cases or with services not accepting referrals.

Such issues left a feeling of siloed working and as one person describes below the best outcome for the service user was in working more effectively together:

"we've all got to take a part in reaching out, and saying actually I can't do this myself, you know, working in a silo, we've got to do it together, who's the best person to support that person at that time, and it's no always social work, you know, and that's, that's the way I feel, so I would say that in the past, yeah, we've never got a good press from other services, but I try and go out of my way to, to make that relationship, that we work together, because at the end of the day, it's about the person at the centre of that, it's no about people in different services no liking the service and no thinking the, the workers are good or whatever, you know, and the sooner we got over that, the better really."

Several staff described stigmatisation of clients or lack of compassion by services:

"there's other services kind of like GP surgeries, mental health services, that do hold very negative views of not just us as a service, but certainly our client group, and obviously that's going a little bit off-piste, but our client group is so widely stigmatised, from other health care professionals, GP surgeries, in-patient units, and it's just, it's unbelievable that specifically qualified people that gone to university to work with people, 9 times out of 10 in mental health services and things, that they could have those opinions on service users that use their services as much as ours, I just find it quite frankly a bit disgusting"

Various staff shared experiences of stigmatisation of services which included experiencing

unhelpful judgements and negative comments from service staff about other services:

"I feel quite stigmatised by other services as well, for example, I think it was approximately a month ago, there was a third sector service, in the same city, that was basically slandering our service on social media, and I had came across it, and I was absolutely fizzing like so unbelievably, I was just so disappointed that this service would kind of openly slander the service, we both, as services, both of us work very closely with this client group"

Many staff shared experiences of some services not taking responsibility for areas which are their remit or being passed work that was outside of their remit. These experiences were shared by both third sector and statutory sector staff about the opposite sectors.

One statutory staff member describes a feeling of third sector staff not understanding their remit:

"obviously there is the kind of standard where you have other services that, I just don't think truly having understanding of what we actually do here, and a lot of the time you know, they're passing stuff back to us, suppose somebody's being discharged from hospital, or something like that, and they're just like, oh yeah, back, back to key worker, back to key worker, key worker will do this, this, this and this, and a lot of if it is out of our remit and is not things that we actually undertake here in the service, and I don't know, I just find that I don't understand why it's so challenging to make other services aware of what we actually do here."

A third sector staff member highlights an alternative experience of similar situations, feeling that they are unsupported by the statutory sectors:

"My biggest thing is when I feel I'm not getting there with someone and I'm raising ASP issues, I'm raising substance misuse issues and I'm reaching out to the statutory body. I feel like it gets left to the third sector. I feel like we're not supported, like because I've not got a social work degree, who am I to say what's best for this person even though I've worked with them for 3 years. That's the biggest thing, it's the other services, there has to be … there's not a network of services working together, there's only a handful"

Another participant describes how their experience of making a child protection report to statutory services left them feeling disheartened:

"During the first lockdown, we were made aware that there was a possible child being trafficked [area]… and then I phoned social work to tell them that, right, and the woman was just like that, phew, and what do you want me to do, you know what I mean … she was as rude as possibly could be and basically told me that I had to phone the police and everything, it was my responsibility, no even a, no even a, a thanks for telling me that, we'll get on, could you phone the police, you know what I mean"

A particular challenge that was highlighted was the gap in statutory mental health services for people with substance use issues. As one participant described, this left staff without specialist training to 'pick up the pieces':

"Well the service users that I work with maybe don't … are not provided with the same amount of resources as somebody that maybe does not use drugs and alcohol. I feel if somebody has been taking drugs and they are in a mental health crisis, they are not being listened to and it's pass the buck, it's not a mental health issues, it's a drug issue, it's that so they can't help, so it's left to the third sector to pick the pieces back up and who aren't specifically trained in such aspects so I think what happens now puts a lot on the support workers plate, lots of issues, safeguarding issues and just having the ability to share that with other services would be beneficial and it's not so easy at the moment"

Another participant gave an example of statutory mental health services refusing supports to a patient who was using drugs, they suggested this was connected to the stigma of using drugs:

"The woman's like, I've been planning this, planning to kill myself for 2 weeks, and they still were like, oh no, she's volatile, she's been taking drugs or alcohol, and it was to the point, no, will you, you can't confirm if she's taken that, she's been in a low mood for the last 2, 3 weeks, and there's, the last time she was tested, there was no drugs in her system, but it's the way she's now stigmatised, soon as something happens, oh it's the drugs, it's the way of the drugs, they'll wear off, and so you're fighting a losing battle."

Challenges within accessing statutory sector supports generally left some third sector staff feeling like they were left to pick up support:

"when I'm trying to network with other agencies for somebody, that's when it does really get difficult for me because nobody'll support … they think housing support's in place, you could do that, you could do that, they don't need us too, or …. That is one of the biggest things. It winds me up and it burns me out, because I just feel it gets left to the minions basically.."

NHS staff also shared similar feelings towards the third sector. The participant below describes the pressure the NHS is under which they felt is often not understood:

"From an NHS point of view and this is biased but this is what I'm seeing, from an NHS point of view, for the most part we've been working really hard together, other organisations not so much, so they put a lot of pressure on us to do things that are not in our remit and are very very unrealistic. We're trying to deal with what we have capacity wise at the moment and some of it, it's not helpful. So where they're also asking other organisations to support us there's a lot of barriers there you know, you're having to go through their rereferral process and then it comes back and it's challenged and it just …. It's about the patient and I feel that gets lost"

Various staff mentioned poor partnership working or poor communication between services and for some this resulted in hierarchies between services.

One staff member describes the frustration that can result from poor communication and partnership working but noted improvements are being made:

"I think the main problem could be communication or lack of, where your repeating or duplicating or you're no getting support from other services, like going in the same direction, to get the best outcomes, that, that can be quite frustrating, because it's, unfortunately it is a thing that still happens, and you do tend to get a bit frustrated and anxious and angry and it does have an impact, so I would say that a lot of it is just lack of communications and also that impacting on your, your own self-esteem, when things do go wrong, which they do, and then the sort of, maybe no popular saying this, but the blame culture around it, so that's

something that I still find concerning, it's improving, it's getting better, but you've still got lack of communication."

Another participant gives an example of feeling they are not taken seriously by statutory services:

"Actually a working relationship with any of them would be really good, because to be honest, there's not much difference between us phoning them and asking them stuff, and the people we're working with, like to be honest, like it's, it's recruited exactly the same as them, we're just this complete level of indifference, and you know it's, it's sort of like, that would help massively, a massive amount"

Another participant in the third sector, described how negative experiences of partnership working with statutory services led them to believe the service provision that is on offer in their service was undervalued by statutory staff. They suggested the individual experience of the client could be lost with a focus on statistics:

"they don't even bother, they don't return your phone calls or anything, you know what I mean, it's like they're just, it's like because they're statutory services, they're working in siloes and that, and that, to me, that to me is frustrating and everything, and that to me is the, is the biggest thing, or the, they're more worried about outcomes and you know, they're more worried about, what does the stats say, rather than what, what's the individual experience is, you know what I mean, to me I'd rather have other people having good individual experiences, than oh well we can show, we can show that in our stats, you know what I mean, I'm no interested in stats, you know what I mean, I'm interested in, in the front line, I'm no, I don't care what the stats say, I want to know what the people that I'm speaking to, what's their experiences"

For some participants, these experiences could result in a feeling that statutory sectors did not care about clients:

"There has been a few that we have had in here, that have been absolutely brilliant, and good at what they do, and work with your clients, but there's others down there that just, no they won't and they don't actually care and it's horrible to think that, but they don't."

Whilst hierarchies were often described between the third and statutory sectors, NHS staff also shared experiences of this with other statutory agencies. Disparity in pay was an aspect:

"I mean the top of the nurses' band you've got to be, once you're in the job 5 years, it's something like £32,000, start on that, and you've got to be there 5 years, starting wage for a social worker is £38,000 and that's from day one."

4.2.3 Personal achievement

Staff interviews and focus groups explored the MBI component personal achievement. As described in the MBI manual where there is a reduction of personal achievement, individual staff may assess themselves negatively and may experience demotivating effects from situations which are challenging and may have negative outcomes despite their efforts. This can lead to feelings of self-doubt about their own skills or abilities to make a difference.

The key emerging themes were:

- Crisis driven work and a general feeling of firefighting could impact on feelings of personal achievement for some. Some staff identified that when focusing on crisis and engaging with high-risk clients, the subsequent necessary focus on risk management impeded on opportunities for more meaningful engagement around recovery. Crisis work appeared to have a cyclical effect on other aspects of burnout. Feelings of firefighting were linked with triggering absence or staff turnover which in turn could place greater pressure on existing workforce and led to greater staff capacity issues which in turn often caused feelings of firefighting.

- The costs and rewards of caring work were key factors in feelings of personal achievement. For many staff, doing meaningful work where staff experienced feelings of being able to help clients, see progress and contribute to their recovery, created feelings of personal achievement and acted as a buffer for burnout. Feelings

of reduced personal achievement were highly linked with the demands and complexity of the client work. The experience of supporting a client group with often entrenched issues and high rates of trauma which can make progress within recovery more challenging, impacted on staff's feelings of personal achievement.

- Both crisis driven work and the complexity of client work within the substance use field could lead to negative impacts on staff wellbeing and resilience and could leave them feeling less able to respond to the demands of their caseload or more complex clients. For several staff, this lead to questioning the impact of their work and whether it made a difference.

Crisis Driven work

Staff identified various challenges with providing crisis work. Many staff spoke about the focus on crisis and risk management and how this impacted on their sense of achievement:

"I suppose as well, for me, it's lowered sense of accomplishment, we're dealing with crisis all the time it seems to be, now I've come from support worker, to social worker recently, but even as a support worker, we used to do some really sort of good work with people around their triggers, about you know, how they were doing, go out and about with them, but it looks like we're just getting the real high risk cases in, so we're getting all the ASP's from the, you know, from the police, that we've got to deal with, having risk management meetings, you know, formulation meetings, and it just feels a bit like the persons getting lost in that, because you're dealing with the risks, so that could make you, instead of having that sense of achievement, and support someone, you kind of feel like we're just fighting fire all the time, that's certainly the way I've felt in the last year or so, especially with Covid, because people have got mental health crisis, things are coming to the forefront, and yeah, it's difficult"

The cumulative effect of continual crisis work was acknowledged as a factor by several staff.

"when you're dealing with crisis every day, and it's just people coming in and like, oh this is

happening, this is happening, and they're sort of screaming and shouting at you, wanting help and it's kind of like take a second, we'll go talk, and it's like they're just screaming at you, it can be, I find myself I get emotionally drained more than anything, and that's when it's like wow, like just, just take a breath, and you try to recuperate, but when you're dealing with it every day, it can sort of, in the long term it builds up..."

This often led to staff feeling like they were firefighting:

"you're constantly firefighting kind of thing, you put one fire out, and think yes, we're getting somewhere, there's another fire, another fire…"

Crisis work left some staff feeling they had less time for more recovery focused work such as care planning.

"I think working with people with very complex traumatic life experiences and I think listening to their story is sad, there's always some complex trauma or recent trauma or something they're really, really sad about in their life … constantly coping with crisis, with a lot of our clients, we are responding to crisis more than working on a care plan … crisis and adult protection, there's domestic violence and all of these can be a lot. "

Some staff recognised challenges of providing abstinence-based recovery supports in clients with active substance dependence, as described by one participant this brought its own pressures when working with escalating drug deaths:

"Aye and we're crisis, we're really crisis managers, right, you know what I mean, we're crisis, we're crisis intervention really, you know, we're no, there's no, we're no, we're no recovery as such, because for all intense and purposes recovery doesn't exist for a large portion of people, but, but then when the drug deaths come out, everybody starts going, what are you going to do about it, and it's like, what it, what it, we can't, and I say this, at the end of the day right, this is the standard time for everything, we cannot force people to, to no take, we can't lock them in this room and go right, you're going to do the rattle and everything, we can help them, we can facilitate it, we can take people to AA, we can take people to NA…you know, but at the end of the day, we can't make people…"

Managers also recognised recovery work and seeing progress with clients had a mitigating effect on burnout from crisis work.

"In Dundee, we see a lot of fatal overdoses, for example, that has an impact on burnout and even if we weren't seeing anyone fatally overdosing and loads of really good recovery stuff, and people getting, you know, getting into really positive stuff, doing well, moving on in their recovery, that, that's going to help on burnout"

Costs and rewards of caring work

Staff identified both costs and rewards of working in support roles. The rewards centred around feeling of being able to help and make a difference:

"I think they value us helping them more than they would going to their drug worker, they, I think they value having that one person that they've told their story to, and not having to repeat it again and that you know everything about them, and that they could just come to you and unload and be like, well this is what's happened now, like what do I do, and trying to find them, try and help them find like, right well we need to go and speak to this person, you need to go and see this person, and help them get it sorted, and most of the time they do get it sorted, and they're like, I've been sitting panicking for days, wondering what to do, and it's like just come in here, and it's been sorted within half an hour."

Staff seeing rewards in their work through progress and change was something that was identified as an important part of feelings of personal achievement by both staff and managers:

"Also the frustration is, with many of our service users you don't progress, you work hard but due to their complexity you don't see any change and you see them die, for one or another reason, often because of their health or overdose or unexplained and that all together can be a lot"

Several staff recognised the drive to see progress and for many the measures of progress centred around behaviour change such as stopping substance use.

"I think a lot of people want people with addictions to succeed, right so much that they maybe forget the cycle of change and then maybe forget that, you know, just because all that support is there, just because all the services are there, doesn't actually mean the person will change. You know it doesn't actually mean that they will stop and it's not necessarily because there isn't enough services or they don't have enough support, it's just that the person is not ready you know and I think a lot of people put pressures on themselves."

Small numbers of managers suggested that staff perceptions of progress could be impacted by the, often gradual, recovery process. As one manager described the organisational and national focus on abstinence may contribute to staff perceptions of progress:

"A lot of people get burned out because they are so trapped in this society where it's all about figures, it's all about numbers, it's all about, how many people have you stopped taking drugs?"

The same participant goes on to say:

"which causes staff to be so focused on the end result that they don't see the small bits that actually assist the person and it's a shame"

Small numbers of staff spoke about the positives of death prevention work. As one participant describes, being part of a lifesaving intervention gave them rewarding feelings:

"but do you know what, after it, the fact that I saved the life, she died in the ambulance, and was brought back, she died in the hospital and was brought back, but they said it was touch and go, they didn't think she was going to make it, so the fact that I was able to do that, what an amazing feeling.."

Costs tended to be in relation to the challenges of working with the client group, for some this was connected to clients being demanding:

"Sometimes I fixate on things, you know what I mean, it might be, it's no usually, sometimes it be with the clients, because you thinking, excuse my language, but what the fuck more do you think you want me to do, and they stand there going, oh well you know, you should have done this and that and everything, and well look, we've done as much as we can for you"

As one participant described demands from clients could feel challenging to achieve:

P: "They can also be quite demanding, on like they want help, but they want it 3 days ago, there's no kind of, they can be quite abrupt about it sometimes, unintentionally meaning it.

I: Yeah, and do you think like they have kind of expectations, that you can't meet, is that an issue, or is it just?

P: Em, like I say, they want everything done 3 days ago, they don't, they don't want the, they want to engage that day, so you have to be able to do everything, and change the world from that day."

Responding to clients in crisis was one of the key challenges in client work identified.

So sometimes you can, maybe your clients don't attend, and you need to go on a wee manhunt for them and chase them around, so that can become a bit exhausting sometimes, or the length of appointments sometimes, I mean I've seen one of my women having a crisis and been sitting there till 7, 8 o'clock on a Friday night"

Small numbers of staff raised particular challenges with clients such as dealing with abusive behaviour:

"I've got a lot of who are notorious ones, and it can be quite a handful, and abusive and offensive"

Consequences of crisis and complex work

Many staff reported challenges of bringing client work home:

"We're a distress hub, so we can have people come in that are suicidal, or so then we would take them into a room like, you'll speak them through and private stuff, follow up from there, so yeah, that can be really, really difficult listening to that, and not think about it when you go home kind of thing, do you know what I mean."

Staff discussed the impacts of dealing with crisis work on service users and quality of service provision.

"I: So does feeling that..Impact on relationships with service users?

P: It can sometimes definitely because you've neither got the energy nor the patience that you'd normally have and so something that you could maybe deal with on a normal day, like, yeah let's do this, when you're feeling so burned out, it's such a big ask to do a little task and that's unfortunate on the service user as well.."

Some staff recognised a reduced ability particularly when dealing with more demanding clients:

"A lot shorter tempered with them, stupid things like, if they were coming to me in distress, then that's completely different, but it's like, you know, when you walk about, you've got to have a mask on, but they just please themselves, doesn't want to do that, so you're always shouting, wear a mask, wear a mask, tidy you after yourself, you know, like stupid things that I just feel as though I was snapping at them, like why are you doing that, and they probably know it as well, because a couple of them have said, oh you're a bit, you know, grumpy today, and I say, do as you're asked to do, you're not a child."

The impact of staff absence due to burnout put further pressure on staff capacity for many staff:

"We've got a few members of staff that are off long-term sick, due to burnout, you know, and so a bit like the others said, you know, about picking up caseloads and picking up all the crisis, you know, so we are understaffed, you know, and I understand the reasons why that is, however it just puts more pressure onto you personally"

The participant goes on to describes this also could have an impact on continuity of care and offering trauma informed care:

"you know, you don't know these cases, you know, our whole thing is building up relationships, and then you're going out to see somebody and needing to look back say 2 years case notes, because of the crisis that's gone on and right, okay, what's happened for that person, and getting a chronology of what's going on, so that you don't actually make things worse and then I suppose that's my thing, you know, once you get a case from staff, you build that relationship, they open up, you know what their triggers are, you know what's going on, you're coming from a trauma informed practice anyway, but when it's somebody that's no known to you, and they're already wary, because you're their second or third or whatever worker, you know, it, it's really challenging, and it's no good for, it's no person centred, you know, but it's restricted because there's no much else you could do, because staff are off, you know"

The additional workload of covering for other staff on top of existing caseload took work over manageable thresholds for several staff, one participant describes the challenges of feeling able to say no:

"when people are off sick, or they've kind of like left the service, stop working for the service and things need covered, like you feel quite, when a kind of more senior member of staff approaches you asking you to cover stuff, you feel like you can't really say no, because yeah, you feel quite obligated to cover everything when you're asked to, because you know that every other one of you colleagues is just as busy as you are, so you try to support your other colleagues by being like, oh I don't want to overload them, so I'll just take it on myself, and I think that like, it just makes it very easy for the kind of higher staff to delegate things, because I think they have that recognition, that whoever they ask will likely just say yes and cancel whatever they've got planned for the day, and that obviously just then has even more of a detrimental effect on kind of your workload and stuff as well"

Managers also acknowledged the effect of unplanned work on top of core workload:

"you still have your day-to-day running to make sure that your team's operational, that you're supporting that, that you've got your basic HR sort of thing, so you have staff absence, you've got different rotas that need to be completed, you've got your main priority tasks, then on top of that, as I say you've got your day-to-day things that come in that blow it out of the water"

For some staff seeing a lack of progress as described earlier led to questioning the impact of their work and what difference they made as described by one participant below:

"..you start to feel what, what's the point like in what I'm doing, what am I actually doing to help here"

Consequences for these types of challenge included staff feeling pessimistic about the future:

"it is just getting worse and worse and worse, and it's hard to feel like there's a future in it, in working in this, feeling like this, unless things drastically change".

For some this led to thoughts about leaving the sector:

"there is a point now that I am looking at leaving, because you just can't, I don't want to do it anymore, and sometimes it sort of beats you down to a certain point."

Acknowledgement and feeling valued from others were linked to feeling of personal achievement for some. Several participants described low levels of feeling valued:

"out of every 5 working days, I'd probably feel valued for half a day, I don't know, I think it's, it's a mixture between how you're treated within your own service, and also some other services, and their kind of perspective of the job that you do over their version of the jobs you don't do, within the service"

Feelings of value often occurred through positive feedback from managers or through positive relationships with clients or colleagues. As described by one participant below, recognition through pay would be another welcome method:

"P: but I think it's very rare to get a well done, we've maybe had 1 or 2 managers that do say well done now and again, but thank you, here's, here's 10% off of JD Sports, and a 3% pay rise, yes.

I: That'll do.

P: Yeah, be like that, no, how about a 10% pay rise…"

4.2.4 Prevention and support for burnout

Staff interviews and focus groups explored what aspects were important in terms of prevention of burnout and also what supports were available to frontline staff for staff who did experience burnout.

The key emerging themes were:

- Prevention of burnout had an organisational/managerial level and an individual level.

- Organisationally, the organisational culture and level of managerial supports were important factors in prevention of burnout. Effective aspects to this were mainly regular supervision, opportunities for reflective practice, clinical or external supervision opportunities, time off where needed and chances for more informal team communications and team building. A key part of a positive organisational culture was good communication within staff teams, feeling listened to and being valued.

- Experiences of debrief support for crisis and emotionally challenging work such as

responding to NFOs and DRDs was varied in the sample. Some staff described limited follow up for NFOs or DRDs whilst others gave examples of follow up through ad-hoc support or their planned supervision.

- Stigma was a perceived consequence of asking for help which impacted on participants in this sample accessing support for burnout.

- On an individual level, prevention mainly centred around self-care strategies including exercise, relaxation activities, socialising and mindfulness.

- For staff that had experiences of accessing support, this was mainly around workplace counselling through occupational health or employee assistance programmes. Experiences of workplace counselling supports were generally positive and people were generally seen quickly, however limitations were noted e.g. support was time limited. More specialist support such as psychology or counselling outside of work appeared to be more difficult to access with issues such as long waiting lists.

Organisational culture and management support

The culture of the organisation and the workplace was viewed as an important part of prevention, this included being trauma informed for staff as well as clients and ensuring awareness and open dialogue about burnout was at the forefront of the workplace. Managers ensuring staff were able to take time off alongside flexible working policies, regular supervision, reflective practice sessions and possibility of external supervision were all other suggestions made for prevention. Opportunity for informal communication and relationship building also contributed to greater resilience in staff teams.

The need for trauma informed practice to include staff was highlighted by a few staff and managers. As one participant describes, without this inclusion of staff, this can leave a feeling that staff are left to deal with vicarious trauma:

"we place an emphasis on trauma informed practice, I mean what about the workers, what about their trauma that they're experiencing, where's the support, are we inhuman, are we supposed just to get on with it"

One manager discussed the importance of adapting to staff needs in order to support them and help prevent burnout:

"I would say being a bit more flexible, if it's, you know if they're not sleeping, so I allow them to come in a bit later, be more flexible with hours. Short notice holidays, that sort of thing."

Time off where it was needed was an important factor in support for responding to staff burnout highlighted by both staff and managers. As one staff member describes, getting time off was helpful and made them feel supported:

" I have felt well supported as I was off for 4 months with my own mental health and I felt I could speak and I was really helped"

Another mentioned that, while flexibility is important, providing staff with consistent supervision also helps, especially when this includes opportunities to explore well-being:

"we were having a regular support and supervision as well and part of the supervision, you know, we focus on, you know, when you have a meeting you kind of start off with that informal kind of how you are doing what you been up to kind of thing but within the support and supervision we've got, you know, a section where we talk about health and well-being..."

Peer support from colleagues and supportive team relationships were mentioned by many staff.

"..we're all really supportive with each other, and phone each other or Zoom, we used to check in once a week on Zoom and things like that, just to check in and make sure we were still okay and handling everything okay, so yeah the support within team is very good."

All managers discussed the need for good communication with their teams:

"I do promote a really kind of honest communication within the team. So if someone is not feeling OK or someone's a bit concerned about something, that we speak about it, and that can be difficult as we know because when the person is feeling … when you're feeling that pressure, when you're feeling under a lot of strain, and sometimes people do shut down in terms of communication, speaking to others about that, you know people can start to give themselves a hard time, that can be a feature within this."

One manager below suggested that getting to know each other as individuals and in informal contexts can help significantly:

"we chat every day and even when it was like we're all working from home, we all caught up every day over Teams just to have a coffee and a moan, because just to actually speak to somebody that you know and feel comfortable with, it's good, and I would have, I would set time for it individually as well as groups because I think sometimes people don't want to talk about something maybe in front of somebody else, so it's just giving staff time. Just giving them time. Speaking to them."

Informal supports were also mentioned by staff such as team lunches or socialising opportunities:

"..even to go to something daft, cinema or bingo, bingo seems to be a huge one, I've never been in my life, but gets all the, all the women always talk about the bingo, we should all go to the bingo, but yeah be something as interesting as that, or something that would actually gel the teams together.."

An external element to such activities was described as important by a few staff as this provided opportunity for team building and socialising but also provided a mental break from the workplace as is described by one participant about the introduction of regular staff lunches:

"..I definitely think they need to introduce something like that, like away from this building"

Staff identified a key part of good workplace communication was feeling listened to by managers. Positive experiences of this, led to staff feeling valued:

"The very first thing [manager] will say, how are you? How's your mental health, how's your caseload? He always just, it's not straight in about the work, it's about us, and that makes it, for me certainly, that makes me feel valued and important."

Debriefing and follow up support

Experiences of debrief support for NFOs and DRDs was mixed, some staff described limited follow up whilst others gave examples of follow up through ad-hoc supports or through their planned supervision. Others noted needs beyond standard follow up procedures, such as the person below who described the need for time off:

"When a death occurs I always take the rest of that week off because I feel..whether my senior says it's boundary issue or not I always feel I'm a person that's got feelings if I've worked closely with someone so intensively it's going to affect me when they pass, I feel that, I know the police get counselling and aren't allowed to go back on shift and if we're on a shift and a death occurs we're meant to see that shift out depending on staffing levels whether there's somebody there to take over to allow you to go or not..."

More regular and structured support was also mentioned as important, one participant suggested mandatory support:

" I think we need to think of something deeper to be honest, group support, regular support rather than just when someone dies, someone passed away yesterday. It can happen at any time..workers are..we should be asked to attend regular bereavement support as a group or an individual regularly every few month rather than say oh we lose people, move on, move on, but it remains with you so I feel you should be forced to take part in bereavement support every few months, I've never heard of someone going to counselling for bereavement."

Stigma around asking for help

Stigma around asking for help with burnout was mentioned by several participants. Fear of repercussions from disclosing burnout was one aspect:

"...I always felt if I went to my boss, that my boss would think I was uncapable of doing my job, or that maybe, maybe I shouldn't be doing this job anymore. If you, you're struggling and I always had that thought in the back, like always eats at me, thinking if I asked for help, I'm going to be seen as like that's a weakness in that maybe I can't do my job anymore or I can't do this and it's not the case. I can do my job, it's just, I need a little bit of help and I'm struggling."

As one participant below describes, for some there can be particular pressures on staff in helping roles to identify their own support needs:

"...there is a lot of, you know, sort of stigma and fear of, kind of repercussions you know, 'I'm going be … I'm going to be demoted, I'm going lose hours' or you know, it will be a lot of different barriers and I think you know, we're quite a proud workforce and sometimes asking for help can be really difficult, particularly when you're in the caring role, you know, you're the one that should be strong because that's what you do, and sometimes it's really difficult to be open and honest about your own vulnerabilities and your own health and your own, you know, wellbeing as well."

Prevention activities and support available

Staff shared a variety of prevention strategies and support options open to staff. Prevention often centred around self-care strategies including exercise, relaxation activities, socialising and mindfulness:

"I'm very active in walking and running, I like my runs, so I just plug my earphones in and listen to a podcast or some music and go for a run, that really helps, helps my mind, so if I'm having a tough day, I genuinely just come home and get straight into the running stuff

and go out, or I'm very mindfulness, I like doing all the mindfulness stuff, so I do like gratitude lists in, I like my Netflix series as well, so just if I'm needing something to overtake my mind and it's not so serious, I'll plug in Friends or I'll put in a new series that's on, that'll just take over my mind, so yeah, quite a few things, or just go out and socialise with friends, I'll phone a friend and say can we meet up for a coffee, or something a bit stronger sometimes"

Beyond self-care, knowledge of self-help resources was limited in the sample. A few staff mentioned awareness of local self-help and web based resources via staff intranets although one participant describes the limited usefulness of web based resources:

"P: There's a wellbeing page on staffnet.

I: Right, tell me about that.

P: It's a page on the intranet for us, that's about it.

I: And have you never accessed it?

P: I've accessed it, but I know it's a load of rubbish… It doesn't give much at all."

The same participant went on to describe that self-help was not a replacement for need for organisational change.

"You can do all the mental health things and do the controlled breathing and stuff like that, but that'll no change it, it's… it's.. that's okay for me, but it's not going to help the service change as a whole, that's where I am at with it."

A few staff spoke about getting support from family however as described by one participant, offloading to loved ones could trigger feelings of guilt:

"I think in terms of when I'm at home, I try my best not to vent too much to my partner, because it's just, it's probably mot very fun for him, to just hear me moaning and complaining about work every day."

More formal supports involved occupational health or employee assistance programmes which included counselling support where needed:

"P: You call Occ Health and they decide of course if you need the counselling or anything like that

I: So how long does it take to get to speak to someone at Occ Health?

P: Not too long, they give the option of four meetings actually and then a review with your manager if you need more … I took the opportunity when I was off with stress and I found it very very helpful. I think that it's something that should be there more regularly before you are in crisis to be honest. I mean I know people who have had a mental health experience but as I say perhaps [inaudible] could have a , you know many people although they are professional care professionals, it's a form of prejudice, we need to go for counselling before it's got so bad you know, it's actually very helpful"

Timely supports such as counselling could avoid staff absence in some cases:

" I was at the point of burnout, to the point I thought I was going to hand in my sick line and want to go off, because the stress was just too much, there was just too much pressure, and now with certain thing being put in, put in place in work, and counselling, a lot of that stuff has eased off now, and it's getting a bit easier, yeah."

One manager reflected their role in picking up counselling type supports:

"I guess when I'm doing managerial supervision, there is a counselling role, especially depending on what's going on for staff, whether that be sometimes with performance management, or whether that's there's things affecting them. So obviously I'm there to support and to look at what other supports are there for them, and there's been in the past..I've put in occupational health referrals for ongoing support for staff as well."

For staff that did access counselling through occupational health or employee assistance programmes, the majority suggested they were seen quickly, limitations were also noted

however such as the number of sessions offered:

"So it's only, you only get 8 sessions, it's only for a small period of time, I think it's like 8 weeks, so a session a week, and I think we only had to wait like 2 weeks, by the time we were put in, yeah, to it, it wasn't long at all, before our sessions started, yeah"

Long waiting lists for support in the community was also mentioned by one participant:

"there's counsellors, if you're feeling, go to your doctor, well I'll wait nearly 2 years to see a counsellor"

Staff identified more specialist mental health supports as being difficult to access:

"P: We also have psychology that we can access if need be but to be fair that can be quite difficult at times.

I: Difficult to access do you mean?

P: Yeah"

Small numbers of staff shared example of workplace prevention and support activities such as wellbeing days including things such as massage therapies or having input from psychology colleagues around maintaining wellbeing. Where these occurred the feedback about engaging in such wellbeing days was positive.

5. Discussions

Consequences of staff burnout were wide ranging, having direct impacts on staff wellbeing and health as well as having impacts on service delivery, quality of service provision and as a consequence of these, client engagement and retention in treatment. These consequences mirror findings in other research (Oser, 2013). In this sample, staff spoke of mainly of emotional exhaustion and the mental health impacts, but also of physical health

consequences, both of which impacted on absence and emotional wellbeing and resilience. The MBI manual outlines “the defining feature of occupational stress is an imbalance of occupational demands with available coping resources”. The findings in this sample are clear that staff within the sector are often overstretched in terms of caseload size, complexity of workload and are also regularly engaged with emotionally draining work such as NFOs/DRDs. Other research in areas such as nursing, highlight that these kind of factors are significant contributors to staff burnout and that the consequences for both staff themselves and their patients can be severe (Dall’Ora et al., 2020).

There was a marked difference between the third sector and NHS staff levels of burnout. NHS staff had higher (statistically significant) MBI emotional exhaustion and depersonalisation scores, indicating experience of more frequent burnout. The most striking difference was for the measure of emotional exhaustion which was experienced on average once a week by NHS staff. Depersonalisation was experienced an average of once a month or less. Third Sector staff had lower MBI emotional exhaustion and depersonalisation scores, they experienced burnout less frequently, an average of a few times a year or less. Personal accomplishment was experienced frequently in the quantitative data, ranging from once a week for NHS to a few times a week for Third Sector staff, although qualitative data presented more complexity and at times a different picture. The higher levels of personal achievement appeared to act as a counterbalance to the degrees of emotional exhaustion and depersonalisation experienced by alcohol and drug workers in this evaluation.

Whilst caseload sizes, workload and staffing issues, happened throughout the sector, these issues appeared to be particularly an issue within the NHS sample. Notably, NHS staff had consistently low AWS scores, indicating a mismatch between staff needs and expectations and what occurs in the workplace. Third Sector had consistently higher AWS scores, indicating a match between staff needs and expectations and what occurs in the workplace. A mismatch between people and their work environment in these areas reduces capacity for energy, involvement, and a sense of effectiveness. Matches in these areas enhance engagement. From the AWS results, there is a clear pattern of a greater risk of burnout amongst NHS participants compared to the Third Sector. The greatest potential cause of burnout is workload.

The recent Dundee Drug Commission report highlighted similar challenges within nursing

nationally as well as locally and outlines staff recruitment as a key part of service efforts in Dundee to respond to capacity issues.(DDC, 2022). Whist recruitment is an important part of responding to the issue, this evaluation suggests retention of staff needs to be equally prioritised as many staff shared challenges of having a lot of new staff in terms of limited experience or putting additional pressures on them inducting and supporting new or less experienced staff.

Part of differences in experience of burnout within the third sector and NHS was connected to aspects such as organisational culture and management supports. Greater autonomy, flexible working, regular and supportive supervision and opportunities for debriefing, team building and peer support within the workplace were all key in terms of buffering the high stress and emotionally demanding work. For some staff, the available coping resources open to them are limited; where staff do have good access to resources and supports, levels of burnout are significantly lower. Therefore, consistent access to a range of resources and supports and offering greater autonomy and flexibility within the workplace are important factors for preventing burnout.

A level of emotional detachment is a well-documented strategy in emergency service staff such as ambulance staff or police in responding to repeated exposure to crisis situations. (Lawn et al, 2020). Equally recent research on compassion fatigue within nurses suggests nurses may feel they are too compassionate (Hoffmeyer et al., 2019) and therefore may be more likely to become more detached or less compassionate. Coping strategies such as ‘gallows humour’ can be observed in such professionals to deal with high stress situations. (Alexander and Klein, 2001). Humour styles within gallows humour are important factors to consider when exploring the potential impact of its use as a coping mechanism. An aggressive style e.g. put down humour towards others or a self-defeating style e.g. put down humour towards self, suggest more negative effects (Dyck and Holtzman, 2013). Possible aspects of cynicism can be observed within more negative examples of gallows humour or ways of describing clients in this sample as they involved aspects such as sarcasm towards clients, self-deprecation by workers or negativity towards personal attributes of clients. These examples could be related to coping strategies for dealing with emotionally challenging work such as NFOs and loss of clients.

Where staff do not have adequate supports around debriefing and follow up supports, they

are not provided with ample opportunity to process the emotional impact of the work. At the same time, in order to form effective therapeutic alliances with clients, staff are required to possess a high level of ability to engage empathically with the people they support, yet, the risk of high empathetic engagement is being vulnerable to becoming emotionally drained. This presents a complex balance required of workers to possess a high level of empathy yet not to over empathise and be resilient to the emotional demands of the work. To respond to this complex balance will require a mixture of high quality staff training and best practice in supervision. This could include ensuring regularity of supervision, offering opportunities for external supervision such as is offered in roles that require clinical supervision and ensuring there is opportunity for ad-hoc supports such as debriefing as required.

The role of stigma in burnout was multi-layered in this evaluation, various staff reflected the contagion of stigma which ranged from observing stigma towards their service users and indeed experiencing themselves as staff within services. This is in line with other research on burnout amongst substance use practitioners which found that the social stigma around problem substance use tainted both clients and people involved in treatment (Oser, 2013).

Stigma occurred both from wider society, the media and sometimes from other services. The effects of this contagion of stigma contributed to causal elements of burnout around emotional exhaustion and depersonalisation and could reduce feelings of personal achievement which acted as a buffer of burnout.

The first Dundee Drug Commission Report highlighted the impact of stigma in responding to drug use and outlined a recommendation to “Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner” (DDC, 2019). Findings in this sample suggested this remains a challenge locally and chime with literature on stigma which describes the layered aspects of stigma as described in the PCS model (Thompson, 2006); personal level: our core values, attitudes and personal beliefs, cultural level: organisational values, service policies and procedures, structural: Societal values, attitudes and beliefs. As stigma is experienced on a personal, cultural and structural level, challenging stigma therefore needs to occur at all three levels, covering individual practice, workplace cultures and norms, service policies and protocols and raising awareness of

stigma within the wider community including the media.

From the findings, it appears there is a need to tackle organisational stigma locally poor communication in order to improve partnership working and build better relationships between the third and statutory sectors. This will not only likely improve staff experience of working in partnership but ultimately will improve the quality of service provision for service users. Poor relationships could result in issues with partnership and working and impact on navigating referral pathways between third and statutory sectors, this was particularly apparent within mental health. The local developments with the 'whole system of care' test of change provides an opportunity to build better relationships and improve service users access to appropriate mental health support (DDC, 2022).

Maslach and Leiter (2005) propose that the disparity between the treatment and support staff wish to provide and the support they are actually able to provide is a key contributory factor in staff burnout. Staff and managers shared many limitations in treatment and support of clients when looking at the complexity of their circumstances and multiple disadvantages including history of trauma , poverty, deprivation, health inequalities and stigma. In this context, when working with clients who have more intrenched substance use dependencies, staff often reported work being crisis driven and centred on risk management which this sample suggested could impede on opportunities for meaningful engagement around recovery.

Amongst the sample, it was clear that perceptions about crisis work affected feelings of personal achievement. It could be argued that within drugs work, crisis work which includes drug death prevention and maintenance is amongst the most important work conducted as ultimately it keeps people alive so that they *can* recover. If we consider crisis work for substance use in the same light as emergency services such as paramedics, it presents a different picture of the importance of delivering lifesaving crisis support. There was some evidence within this sample that performing the lifesaving aspect of their roles, could contribute to, rather than mitigate the effects of burnout. This appeared to centre around the cumulative aspects of regularly responding to crisis such as NFOs. Research on the concept of empathic distress fatigue, sometimes described as compassion fatigue, suggest staff can experience the distress of others as their own (Klimecki & Singer, 2012). Given the volume of distress observed within clients in the context of the substance use field where

people are subject to inequalities, multiple disadvantages and stigma, it is easy to see how experiencing these stresses as their own could have an impact on feelings of efficacy and subsequently how staff view their personal achievements. These challenges for clients, can lead to staff holding perceptions that clients “are difficult to treat” which in turn can impact on staff views of their effectiveness within client support (Oser, 2013). Lack of confidence in therapeutic success is noted as a factor in burnout in counsellors working in substance use services and self-efficacy of staff is identified as a protective factor which ensures continuity of care for clients. (Baldwin-White, 2014). There was some evidence of staff questioning the effectiveness of their work within this sample and many staff shared feelings that people they supported could be difficult to treat due to the complexity of their life circumstances and the nature of substance use dependency. On occasions in the sample this led to some staff questioning leaving the sector. This suggests a need for focus on staff perceptions of therapeutic success and strategies which build self-efficacy in order to help retain staff within the sector.

Emerging within the understanding of burnout and risk of compassion fatigue within helping roles is the concept of compassion satisfaction. Compassion satisfaction is a positive consequence of helping which occurs from finding meaning and fulfilment in your work and can help to protect against compassion fatigue (Stamm, 2010). Given the protective elements of compassion satisfaction, it is important to recognise the drives and motivators of working within caring roles and within the substance use sector. This includes having lived experience which was high within this sample and is a key factor in compassion satisfaction (Stamm, 2012). Seeing progress was a motivator in this sample and helped to buffer some of the more challenging aspects of crisis work. The drive of seeing progress and the consequences Recovery researcher and author William White suggests repeated exposure to relapses with clients without equal exposure to recovery alongside, can impact on burnout (White, 2012), therefore strategies to mitigate staff’s negative experiences of crisis work could include reviewing the balance within staff caseloads.

The challenges that arise for services are where the main remit of their work is crisis support and therefore it is important to ensure staff in those services have the level of support needed in place to work through the challenges in their work and more work is done to communicate the value and necessity of their role in the delivery of The National

Drugs Mission To Reduce Drug-Related Deaths, both organisationally and societally. This work should include celebration of retaining vulnerable people in treatment, a key protective factor in preventing DRDs and should be regular features of initial induction, ongoing training and support and supervision. The role of stigma in burnout was clear in this evaluation, it is therefore worth considering whether stigma also had a role to play in workers perceptions of what is meaningful work and feelings of compassion satisfaction. Equally where staff were afforded opportunities for good quality management support and positive and affirming feedback on their work, staff were more likely to see meaning in more crisis support roles.

The rates of lived experience was high within the sample, more than half the quantitative sample and slightly under half in the qualitative sample had lived experience of either substance use or poor mental health with some participants having experience of both. Family experience of substance use or mental health problems was also mentioned by several people who did not have direct personal lived experience. Having lived experience could be both an asset or a potential vulnerability to burnout as for some it offered a greater self-awareness and knowledge of coping skills to apply to stress, yet for others, there were potential challenges around maintaining boundaries connected to self-care or vulnerabilities to relapse if exposed to high levels of stress. Various studies have found that exposure to stress, especially repeated stressors in people with problem substance use histories can trigger relapse (Al'Absi, 2007; Carter and Hall, 2012).

The stress vulnerability model (Zubin and Spring, 1977) puts forward that people with a high vulnerability to stress, may only require a small amount of exposure to stress in order to experience poor mental wellbeing. The cumulative aspects of responding to stressors within the substance use sector combined with possible ongoing challenges for individuals with lived experience due to their own individual trauma histories are likely to key factors in increasing vulnerability and may therefore reduce the threshold for capacity to manage stress in some individuals with lived experience. In contrast, in terms of self-care, self-management and factors that increase resilience to stress such as having supportive networks, a lot can be learned from recovery communities to build resilience within the drug and alcohol workforce. It is therefore important to embed such learning and practices within workplace cultures in the sector but also ensure adequate supports are there for people who may have potential vulnerabilities to stress. For people in early stages of recovery, mangers recognised there

may be a need for a greater level of training or support as they may have been out of work for a significant period and as such may be quite unfamiliar with the demands of work and advancements in areas such as technology which could contribute to workplace stress.

COVID-19 impact on the issue of burnout was mixed, some staff noted more staff absence and turnover with others noting no significant change. The majority noted changes to service delivery, especially in terms of greatly reduced face to face contact. In the qualitative data, whilst for some it afforded some opportunities to have more effective and efficient engagement with clients and offered more freedom in the role and new and more flexible working styles, it was generally highlighted as an additional source of burnout. This was mainly due to isolation from collegial contact and support, challenges in separating home and work, having to adapt to new procedures and work under more challenging circumstances. Staff absence or staff shielding due to COVID-19 were further additional pressures on staff as face-to-face work could then fall to smaller staff teams creating team imbalance and increasing workload for some staff. Such themes have been found in other recent literature in Scotland (Carver et al., 2022) and of particular note to consider is the argument that the additional pressures of COVID-19 may have more of an impact on staff who have previously had no experience of having to manage their mental health and may therefore have less coping strategies in place. (Highland TSI, 2020).

Some staff saw a need to improve awareness of burnout within the sector and training was viewed as an important part of raising awareness and having a better understanding of how to prevent, recognise, prevent and support staff experiencing burnout. As there was an acknowledgment that there was a need to better identify and prevent burnout in this sample and that burnout when left unaddressed could have significant consequences for both individuals, service delivery and service quality, exploration of early identification techniques may be useful to consider. Tools such as the Professional Quality of Life (proQOL) Health, help health care workers to monitor the impact of caring on their wellbeing (Stamm, 2010) and can be applied on an individual level or used as an organisational tool. Such tools may be useful to consider as part of burnout prevention.

Prevention of burnout had an organisational/managerial level and an individual level. Organisationally, the organisational culture and level of managerial supports were important factors in prevention of burnout. Effective aspects to this were mainly regular supervision,

opportunities for reflective practice, clinical or external supervision opportunities, paid time off where needed and chances for more informal team communications and team building. Another key part of a positive organisational culture was good communication within staff teams, feeling listened to and being valued. On an individual level, prevention mainly centred around self-care strategies including exercise, relaxation activities, socialising and mindfulness. These findings mirror other research in staff working in substance use counselling or nursing (Best et al., 2016; Beitel et al., 2018; De' Oliveria et al., 2018) and suggest a range of both formal and informal supports and strategies are required in preventing burnout. Equally a combination of self-initiated and systems supported strategies were important. Recent literature emerging from work in America surrounding the opioid crisis, suggests the need for collective care and puts forward that only through collective care can we achieve sustainability in our work and prevent burnout (Reynolds, 2019). Whilst self-care activities are a clear aspect of prevention in this sample, it is essential that prevention of burnout is not seen as mostly the responsibility of the individual and crucial that organisations and managers create the environments and cultures which maintain morale and enable staff to practice self-care. This is a particular challenge within the sector due to factors such as high caseloads, staff absence and turnover and emotionally demanding work. Equally, collective care places responsibility for staff wellbeing beyond the individual but as something that is achieved by collective contribution to wellbeing by all members within the system of care. It also acknowledges the relationship between self-care and collective care in that it is not possible to adequately achieve one without the other.

The main supports used for issues relating to burnout were supervision and more informal supports such as support from family and friends or peer support. Clinical professions such as psychology or counselling have minimum requirements for clinical supervision as part of accreditation and such supervision is concentrated on processing the work with clients. Such arrangements allow protected time for debriefing and ensure client confidentiality is maintained by minimising the occurrences of staff debriefing with family and friends. Whilst supervision was cited as an important part of support that occurred for people in the sample, as highlighted earlier, many participants discussed limited opportunities to debrief from the emotional impact of client work and responding to crisis such as DRDs and NFOs. Given that workplace supervision for the drug and alcohol workforce often includes a range of areas and is not generally solely focused on purely therapeutic work with service users, it

may be useful for services to explore offering a regular clinical supervision offering for nurses, support workers and other staff. This would ensure there is protected time for staff to debrief adequately and offering this separately to line management structures would help staff to feel emotionally safe to explore the impact of their work without fear of repercussions.

The managerial and organisational response to worker distress is an important part of avoiding mental health issues occurring from burnout, this includes acknowledgement, levels of empathy expressed and appropriate care (Lawn, et al., 2020). Both staff and managers, outlined management and organisational responses that were supportive and offered regular supervision opportunities or tailored supports such as flexible working were helpful in responding to burnout. For staff that had experiences of accessing support, this was mainly around workplace counselling through occupational health or employee assistance programmes. Experiences of workplace counselling supports were generally positive and people were generally seen quickly, however limitations were noted, the main issue being support was often time limited. More specialist support such as psychology or counselling outside of work appeared to be more difficult to access with issues such as long waiting lists.

Stigma was a perceived consequence of asking for help which impacted on participants in this sample accessing support for burnout. Staff shared concerns of consequences such as being seen as unfit for work and some suggested that seeking help when in a helping role is especially difficult. There is extensive literature that outlines work which involves regular exposure to trauma commonly results in issues such as vicarious trauma (Killian, 2008). There is an element of risk to this acknowledgement in that it risks becoming normalised and being seen as a perhaps unavoidable part of crisis work which may in turn lead staff to less helpful coping strategies such as depersonalisation or reinforce a belief that staff should have a higher level of resilience and self-management. The concepts of vicarious resistance and post traumatic growth, namely the positive impacts and growth that can occur as a result of exposure to trauma, can be applied to the workforce and are achieved by actions such as collective care described earlier. (Reynolds, 2021).

Collective care within the workplace involves factors such as systems, policies and

protocols which prevent burnout, strong leadership and management, regular supervision with opportunities for more informal peer supports and team building. Whilst there are strong examples in the findings of this occurring at individual service level, it was not consistent across the sample. What the findings make clear is that areas of the workforce are clearly overstretched due to issues such as staff shortages, absence and turnover and need urgent attention to enable the sector to fully develop a collective care culture. Whilst a challenge for the sector in the current environment, it is one crucial to address if we are to maintain a consistent, competent and healthy workforce that can adequately respond to the ongoing public health emergency of drug related deaths and harms.

6. Conclusions

The findings suggest there is an urgent need to address staff capacity issues, caseloads and workload which are key contributors to burnout in this sample. Given the high rates of lived experience within the sample either through personal experience or family members, it is important to harness the assets of lived experience but equally ensure we protect against possible vulnerabilities to stress which may impact on individuals negatively.

It was evident that stigma has a pervasive effect within the sector and contributes to feelings of burnout among staff. Stigma within this sample was experienced on multiple levels and was directed at people who use services, staff working in services and also to services and the work they do. It is therefore essential that challenging stigma occurs on personal, cultural and structural/societal levels. Stigma also occurred between services and sectors and there was an evident need for work to be done to develop a shared understanding of remits and create better partnership working and communication between services which will help to reduce some pressures on staff which can lead to burnout.

It was clear that due to the demands of drug death prevention activity such as maintenance and crisis work needs to balance with ample opportunities for seeing progress in clients. The cumulative nature of responding to crises such as NFOs and exposure to high levels of DRDs can creates challenges such as empathetic distress fatigue which can lead to aspects of burnout such as cynicism. More effective communication of the national drugs mission may

aid in reframing of drug death prevention work and boost compassion satisfaction by providing an opportunity for staff to re-engage with the value of the crisis and maintenance work they deliver, which ultimately keeps people alive.

The findings suggest prevention and support for burnout needs to occur at individual and organisational level. There is a clear need for training and resources for both staff and managers on how to recognise, identify and prevent burnout. Positive organisational cultures and management support such as access to regular and high quality supervision buffer staff experiences of burnout. Equally informal, ad-hoc and peer supports such as opportunities for reflective practice or team building which approach more of a collective care model were important parts of prevention. On an individual level, prevention mainly centred around self-care strategies including exercise, relaxation activities, socialising and mindfulness. Effective organisational strategies for manging burnout when it does occur included regular supervision, adequate access to tailored support and paid time off when needed. The combination of self-initiated, systems, organisational and managerial supported strategies were key in providing person centred prevention and support.

Given the potential barriers some staff can experience in seeking help such as stigma, the ongoing challenges of the sector and the additional pressures that COVID-19 has brought, it is crucial to ensure there is an organisational culture across all sectors within the substance use field which is centred around collective care if we are to maintain a consistent, competent and healthy workforce that can adequately respond to the ongoing public health emergency of drug related deaths and harms.

7. Recommendations

The findings suggest the following recommendations for consideration in order to prevent and appropriately respond to burnout.

1. **Caseloads:** Realistic maximum levels of caseloads should be better considered and regular reviews of staff caseloads looking at the balance of client complexity, levels of crisis support and recovery focused work within staff caseloads will help mitigate

against staff burnout. Where possible staff should have protected time for caseload support and dedicated staff for duty roles or groupwork should be considered to ensure protected time is achievable.

2. **Training:** There is a clear need to improve awareness and recognition of burnout within the sector amongst both frontline staff and managers. Dedicated training aimed at both staff and managers to raise awareness and help develop a better understanding of how to prevent, recognise, prevent and support staff experiencing burnout should be considered.

3. **Identification:** Regular screening for burnout should be conducted so as to identify early warning signs and prevent progression of burnout which may result in ill health, staff absence or staff leaving the sector. Tools such as the Professional Quality of Life (proQOL) Health offer a free self-assessment that can be used on an individual or organisational level.

4. **Stigma:** Challenging stigma needs to occur on personal, cultural and structural/societal levels, covering individual practice, workplace cultures and norms, service policies and protocols and raising awareness of stigma within the wider community including the media. There is a clear need to tackle organisational stigma locally in order to improve partnership working, improve communication and build better relationships between the third and statutory sectors.

5. **Reframing Death Prevention and Maintenance:** It is key that we help staff and society to better value drug death prevention and maintenance. Such activity may enhance compassion satisfaction which can be protective for preventing aspects of burnout. Not only should it be valued no matter what the end goal is, but equally it is amongst the most important substance use work conducted as ultimately it keeps people alive so that people *can* recover.

6. **Communication of The National Drugs Mission:** Organisations should better communicate the aims of their work and the value and necessity of frontline staff's role in the delivery of The National Drugs Mission to Reduce Drug-Related Deaths, both organisationally and societally. This work should include celebration of

retaining vulnerable people in treatment, a key protective factor in preventing DRDs and should be regular features of initial induction, ongoing training and support and supervision.

7. **Prevention:** All staff should have access to regular supervision, opportunities for reflective practice, clinical or external supervision opportunities, time off where needed and chances for more informal team communications and team building. Good communication within staff teams, ensuring staff are listened to and are made to feel valued is essential for fostering a positive organisational culture . Management support to help staff identify and engage in prevention activities and self-care strategies including exercise, relaxation activities, socialising and mindfulness would be a helpful part of prevention.

8. **Support:** Crisis support such as structured debriefing that is person centred should be offered for any NFO or DRD experienced by staff. Appropriate follow up which should include an offer of bereavement counselling should also be implemented. Particular attention should be given to people's individual circumstances which may contribute to burnout such as lived experience or caring responsibilities. All staff should have access to workplace counselling or employee assistance type supports, longer term or more specialist supports should be offered as part of this offering where required.

8. Limitations

This evaluation provides a snapshot of the experience of frontline staff and managers working in the drug and alcohol sector in Dundee. It builds our understanding of the causes and impacts of staff burnout within the sector but findings may not be representative to staff across Dundee due to the sample size. Recruitment from the peer and volunteer workforce was very limited so findings are more representative of the larger groups represented, namely the third sector and the NHS.

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10. Appendices

10.1 *Analysis*

Quantitative Analysis was undertaken by the project team. The staff surveys were administered using Survey Monkey to administer two validated instruments for measuring staff burnout, the *Areas of Worklife Survey* (AWS, Leiter & Christina Maslach, 2006) and the *Maslach Burnout Inventory* (MBI, Maslach and Jackson, 1981). Both surveys use a Likert scale, asking participants to rate their agreement or disagreement with a range of statements that can be used to measure burnout. Answers to each question were converted into numeric values. For example, in the AWS, if a participant strongly agreed that they "have enough time to do what's important in my job," this was converted to a score of "5". If they strongly disagreed, their score was "1". Multiple similarly themed questions were grouped into *subscales*, an overall score for a certain aspect of burnout. For example, the subscale of 'Workload' is the average score of several questions about the *amount* of work, the *time* available to do the work, and whether work impedes upon *personal interests* or bleeds into *home life*.

10.1.1 Areas of Worklife Study (AWS)

The AWS is a validated survey instrument for measuring the factors that can contribute to burnout. Using a 5-point Likert scale, participants are asked to rate their agreement or disagreement with questions about different areas of their worklife: Workload (WL), Control (CONT), Reward (REW), Community (COM), fairness (FAIR), and Values (VALS). High scores indicate high agreement that there is a good match between the individual and their workplace. Low scores indicate a mismatch. For example, if a participant strongly agrees that they "have enough time to do what's important in my job", this produces a score of "5". If they strongly disagree, their score is "1". The AWS measures multiple job stressors that can contribute to overall burnout, it is not a direct measure of burnout itself.

The AWS tool measures multiple job stressors that contribute to overall burnout. These are distinct organisational factors that are measured separately and therefore cannot be combined into an overall burnout score. The subscales are 'Workload,' 'Control,' 'Reward,' 'Community,' 'Fairness,' and 'Values.'

In excel, the average subscale scores for each participant were calculated by following the scoring instructions in the AWS manual. The data were imported into the statistical analysis software R Studio, and ANOVAs were conducted to compare the average scores between different groups of participants. If the ANOVA result was statistically significant (indicating means were not equal) a follow-up Post Hoc analysis was applied to measure the difference between specific groups, using Tukey's HSD Test. The main comparison of interest was between participants in different work sectors: Third Sector, Community-Led, Health and Social Care, Local Authority, and NHS. In practice, most participants were either Third Sector or NHS, so the most significant comparisons were between these two groups. Boxplots were produced to visualise the differences in AWS subscale scores between groups. In interpretation, we were interested in three issues: 1) the significant differences between groups, 2) the absolute values for all the groups, e.g., scores above 3 indicate general agreement, below 3 general disagreement, and 3) comparison to the average scores in the AWS normative sample (available in AWS manual). The normative sample helps to assess whether the burnout scores in this sample were high, moderate, or low when compared to a more general population, with reference to the distribution quartile cut off values. The

percentile cut-offs vary for each subscale and are available in the AWS manual.

Table 1 shows the AWS scores between sectors. Figure ! shows the visual comparison between groups for each subscale.

Table 1

	Charity/ Third Sector (N = 22)	Grassroots/ Community-led (N = 1)	Health and Social Care (N = 1)	Local Authority (n = 2)	NHS (n = 14)	ANOVA	P Value
Mean AWS Workload (SD)	3.5 (0.8)	2.8	2.6	3.7 (0.1)	2.4 (0.8)	F = 4.3	0.007
Mean AWS Control (SD)	3.9 (0.6)	3.8	3.3	4.0 (0.7)	2.9 (0.8)	F = 5	0.003
Mean AWS Reward (SD)	4.0 (0.7)	4.0	2.8	3.9 (0.5)	2.7 (1.0)	F = 5.3	0.003
Mean AWS Community (SD)	4.1 (0.8)	4.8	3.2	4.0 (0.3)	3.1 (0.8)	F = 3.8	0.01
Mean AWS Fairness	3.6 (0.7)	3.3	2.0	3.7 (0)	2.9 (0.6)	F = 3.4	0.02
Mean AWS Values	3.9 (0.6)	3.3	4.0	3.6 (0.5)	3.1	F = 2.5	0.06

Figure. 1.


AWS Workload
Workload
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role
AWS Control
Control
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role
AWS Reward
Reward
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role
AWS Community
Community
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role
AWS Fairness
Fairness
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role
AWS Values
Values
0
1
2
3
4
5
3rd Sect.
Comm.
H&S Care
LA
NHS
Job role

10.1.2 Maslach Burnout Inventory (MBI)

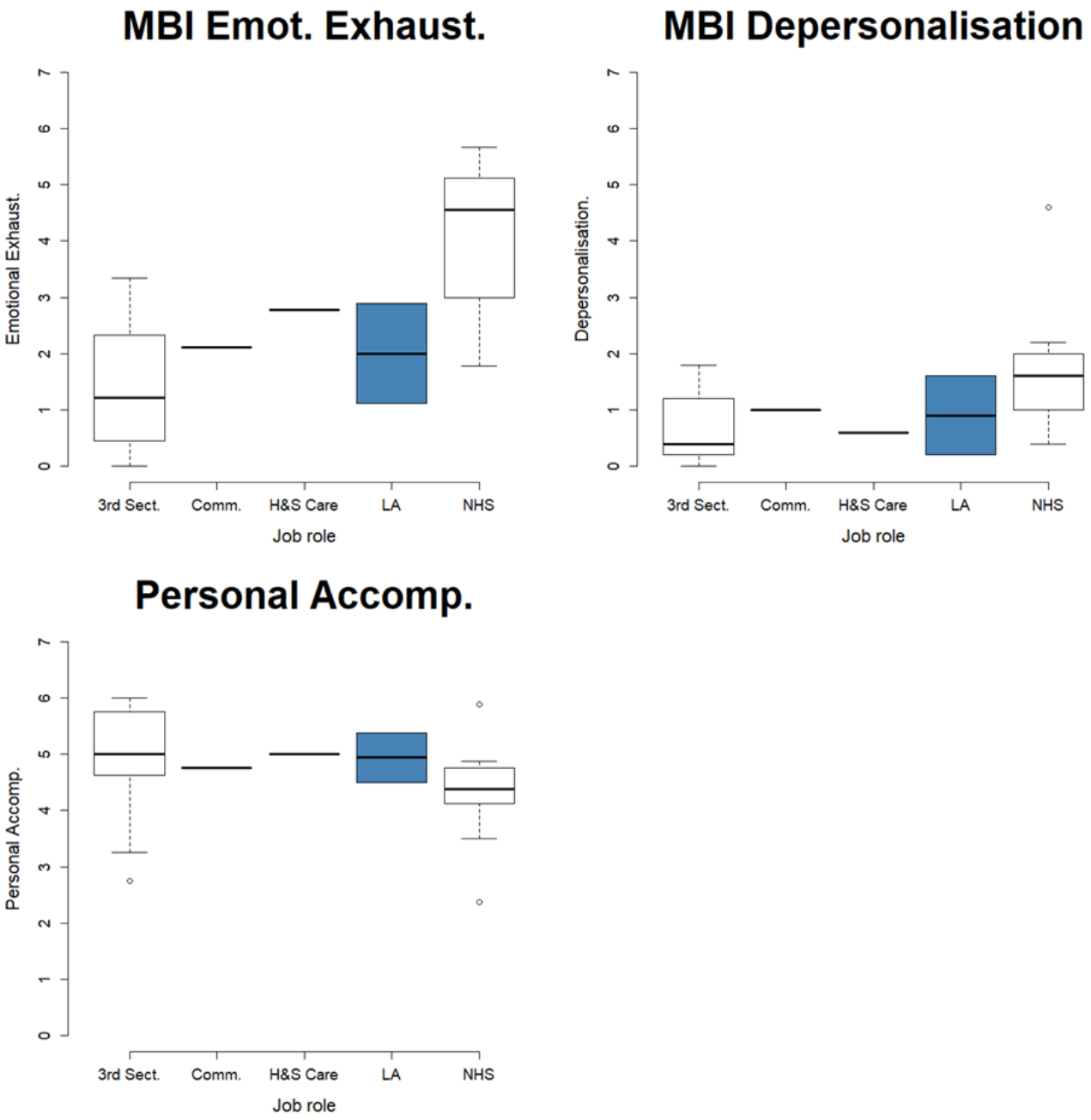
The MBI is a more direct measure of an individual's experience of burnout. Using a 7-point Likert Scale, the MBI asks participants to indicate how frequently they experienced feelings of burnout. The three separate feelings measured are: Emotional Exhaustion (EE), Depersonalisation (DP), and Personal Accomplishment (PA). Burnout is indicated by high scores for EE and DP, and low scores for PA. Participants respond to questions such as "I feel burned out from my work" using a frequency scale ranging from 0 (never) to 6 (every day).

As with the AWS, mean MBI subscale scores for each participant were calculated in Excel. The data were then imported to R Studio for between groups ANOVA/Post Hoc comparison and visualisation of boxplots. The main analysis of interest was the between groups difference, but we were also interested in the absolute values, e.g., an average score of 3.5 would mean respondents on average felt emotionally exhausted several times a month.

Table 2 shows the MBI scores between sectors. Figure 2 shows the visual comparison between groups for each subscale.

	Charity/Third Sector (N = 22)	Grassroots/Community-led (N = 1)	Health and Social Care (N = 1)	Local Authority (n = 2)	NHS (n = 14)	ANOVA	P Value
Mean MBI Emotional Exhaustion (SD)	1.4 (1.1)	2.1	2.8	2.0 (1.3)	4.1 (1.3)	11.2	<.0001
Mean MBI Depersonalisation (SD)	0.6 (0.6)	1.0	0.6	0.9 (1.0)	1 .7 (1.1)	4.2	0.007
Mean MBI Personal Accomplishment (SD)	5.0 (0.9)	4.8	5.0	4.9 (0.6)	4.3 (0.8)	1.2	0.3

Figure. 2.



10.1.3 COVID-19 Lockdown

Respondents were asked additional questions about “the main differences in how your service is delivered since COVID-19?”. They were presented with a set of statements and had to select the ones that applied to their experience of lockdown. Statements related to having less face-to-face contact with services users, increased/decreased working hours, increased/decreased caseload, and a free text box. Analysis involved calculating the

proportion of participants that agreed with each statement, demonstrating which of these differences in service delivery were most frequently identified. Free text comments were also analysed and thematically interpreted along with the qualitative findings.

10.1.4 Individual and Open-Ended Responses

This analysis focused mainly on aggregate mean scores, which can overlook some of the variation in high or low results for individual respondents. Open ended responses were analysed to get a sense of more individual feelings of burnout, with the individual survey responses of selected participants also considered. Specific examples of high and low burnout scores (and associated open ended responses) have been presented to get a better sense of individual experience.

10.1.5 Qualitative Analysis of Interviews and Focus Groups

Qualitative information from the service lead interviews and staff interviews were transcribed, and thematic analysis conducted for the purposes of identifying possible service developments and improvements. Interviews were transcribed and imported into NVIVO for thematic analysis by the evaluation team. A set of inductive codes were generated by the lead evaluator in an initial wave of coding. These codes were used by the rest of the research team to code the rest of the data. These were relatively high-level codes such as ‘management style’, ‘causes of burnout’, ‘dealing with fatal and non-fatal overdose’, ‘protective factors’, etc. The codes and themes were discussed in evaluation team meetings and organised into a general structure. The MBI survey was used as a structuring guide, and the various themes were organised under the three key headings of the MBI: Burnout, Depersonalisation, and Personal Accomplishment.

10.2 *Project materials*

10.2.1 Participant information sheet

Identifying & preventing burnout in front-line services for people who use drugs and alcohol Participant Information Sheet

Background

Scottish Drugs Forum (SDF) is facilitating a project that aims to explore the understanding and self-reported levels of burnout among staff in front-line services for people who use drugs and alcohol in Dundee city. The project is funded by the CORRA Foundation and is supported by Dundee Alcohol and Drugs Partnership. Due to the restrictions in place for COVID19, all parts of the project will be delivered remotely via telephone, e-mail, and video call. The project will help services to identify the cause and effect of staff burnout and explore how burnout can be prevented amongst front-line staff. The findings from the project will increase understanding of the implications of burnout among front-line staff and support the development of a toolkit designed to prevent burnout and provide strategies and solutions when it does occur. The project has been registered with NHS Tayside Clinical Governance.

How will the project be carried out?

The first two parts of the project involved semi-structured interviews with service leads and an online survey for staff who work in front-line services for people who use drugs and alcohol. This third phase of the project explores the themes that are emerging from the survey. We are offering two methods of involvement in this phase as we are aware that burnout can be a sensitive issue, and you may feel more comfortable discussing your experience on a one-to-one basis. Alternatively, we are running a focus group to discuss the topic and you may prefer to participate in a group-based discussion on burnout. The topics covered will be the same in both. You are being invited to take part in this part of the project due to your work in front-line services for people who use drugs and alcohol and you can opt to participate in **EITHER** a one-to-one interview **OR** a focus group. Both the interviews and the focus group will be conducted via Microsoft Teams.
The interview/focus group questions are designed to explore your experiences of burnout in your current role, the aspects of your work that have the most impact on your well-being, the main factors that could prevent burnout, and what types of support and resources do you access to support your wellbeing at work. You do not need to have completed the online survey to participate in the interview/focus group.

Who is carrying out the Service Lead interview?

The interview/focus group will be conducted by the SDF Development Officer.

What will be done with the information I give?

The interview/focus group will be recorded and transcribed for analysis. The recording and transcript will be stored securely and will be accessed only by SDF staff working on this project.

The information provided in the interview/focus group will be anonymised and the anonymous transcripts will be analysed. Emergent themes will be used to provide a report to Dundee ADP and to inform the development of an online toolkit to address burnout in front-line services.

Will my responses be confidential?

We guarantee that the answers you give, and anything said to the Development Officer, will be kept confidential. **Your anonymity is guaranteed.** We may use quotes you give when reporting, to back up our findings. The quotes will be anonymised. ***However, if you inform us you are planning to harm yourself or others, we have an ethical duty to inform the relevant services.***

Do I have to participate?

Taking part in the interview/focus group is your decision completely. You do not have to take part. If you choose to take part, you can decide to answer all or some of the questions. You are also able to leave the interview/focus group at any time without giving a reason. You are also able to ask questions, or clarify, any part of the interview/focus group questions with the Development Officer if you need to.

How long will the interview take to complete?

We have trialled the interview/focus group and the time to complete usually takes around an hour.

Are there any benefits to taking part?

Your contribution to this project will increase our understanding of burnout and how it impacts on front-line workers in services for people who use drugs and alcohol. The information gathered from the project will be provided to Dundee ADP for dissemination. In addition, the information will be used to develop a toolkit to support services to identify and prevent burnout amongst staff.

Are there any disadvantages to taking part?

You might find that participating in the interview/focus group triggers upsetting thoughts or feelings for you. If this happens, you will be given an opportunity to take a break from the interview/focus group or to withdraw from the project. If you require additional support, the Development Officer will support you to seek out appropriate support through local and national support services.

How do I give consent to take part?

Before you start the interview/focus group, to show that we have given you this information, we will ask you to sign a consent form. The Development Officer will ask you to add your name to the Consent Record and return it via e-mail. This consent form will be kept separate from the data we collect. Due to the COVID 19 restrictions in place and the remote nature of the project, informed consent will be recorded electronically.

What if I have questions or concerns?

We want you to feel completely comfortable and informed before you take part in the interview/focus group. The SDF Development Officer's details are below. If you have any questions or concerns about your involvement in the interview/focus group, please feel free to contact Kate at any time, and she will do her best to respond to you in a timely manner.

10.2.2 Consent Form

Identifying and preventing burnout in front-line services for people who use drugs and alcohol
One-to-one Interview/Focus Group
Participant Consent Record

This form is kept separate from the evaluation data.

Please read each statement and tick the boxes if you agree.

1.	I confirm that I have read and understood the information about the evaluation, as provided in the Participant Information Sheet.	☐
2.	I have been given the opportunity to ask questions about the evaluation and my participation.	☐
3.	I voluntarily agree to participate in the evaluation. I am aware the interview/focus group will take approximately 1 hour to complete and will be recorded.	☐
4.	I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	☐
5.	The procedures regarding confidentiality have been clearly explained to me. I understand that all my responses will be anonymous.	☐
6.	I know and understand what will be done with the information I provide in the interview/focus group	☐
7.	erstand that if I tell the Development Officer that I am likely to harm myself or others, they will have to inform the appropriate people to ensure that myself and/or others are safe.	☐
8.	consent for the interview/focus group to be recorded and transcribed for the purposes of the project. I understand the recording will be stored securely and will not be accessible to anyone other than project staff.	☐

Participants Name_____
Participants Signature _____ Date _____

Development Officer Name _____
Development Officer Signature _____ Date _____

10.2.3 Staff Survey

Link to online survey https://www.surveymonkey.co.uk/r/FWVRP93

10.2.4 Service Lead Interview Topic Guide

Identifying and preventing burnout in front-line services for people who use drugs and alcohol

Ref: _____ **Date** _____

About you

How would you describe your gender? _____

Age _____

Job title _____

Job level/NHS Band

- Support worker
- Project Worker
- Staff Nurse
- Health Care Assistant
- Other _____

Highest Qualification

- No qualifications
- Standard Grades
- Highers
- SVQ (please give level) _____
- NC
- HNC
- HND
- Degree
- Post graduate qualification

Do you have lived/living experience of recovery from drug and/or alcohol use?

- Drug Use
- Alcohol Use
- Drug & Alcohol Use
- Mental health problems
- No
- Prefer not to say

About your job

- NHS
- Third sector/Charity
- Grassroots/Community Led
- Other _____

Does your role involve (tick all that apply?)

- Supporting front-line staff
- Direct provision of support to service users/recipients?
- Counselling
- Prescribing (Methadone/ Buprenorphine (including Espranor/ Buvidal)
- Signposting
- Recovery activities (give details) _____
- Other (give details) _____

Job Status

- In paid employment
- Volunteering

Number of hours worked each week _____

How long have you worked/volunteered for this Organisation? _____

How long have you worked/volunteered in this role? _____

How long have you worked/volunteered in the sector? _____

How is your service delivered? (tick all that apply) – Pre COVID19

- By appointment
- On-line
- By telephone
- Drop-in
- Outreach
- Assertive outreach
-

What are the main differences in how your service is delivered since COVID-19?

Exploring Burnout

Understanding

- What is your understanding of burnout and the impact it can have on individuals?
- What, in your opinion, are the main trigger points for burnout?
- What, in your opinion, are the particular challenges of working within the substance use sector that affect levels of burnout?

Experiences

- What's your experience of supporting staff members when they are experiencing burnout?
    - prompt: how much of an issue is it?

- What's currently in place?
    - Do you have specific policies or procedures?
    - How do you assess/identify burnout within your staff team?
    - How would staff members approach you?
- What are the main challenges for supporting staff members who are experiencing burnout?
- What are your experiences of staff absence or staff leaving related to burnout?
- Are there particular challenges for people within your staff team?
    - BAME people, LGBT+ people, people with lived experience of substance use/mental health/trauma etc
- Are there particular additional challenges of burnout during COVID-19 pandemic?
    - Working from home
    - Access to technology/equipment

Support and resources

- What internal resources do you currently have for supporting staff to identify, prevent and support burnout? (prompts: employee assistance programmes, supervision, debriefs.
- How regular is supervision and do you have specific prompts related to burnout?
- Do you offer mental health days?
- Do you have specific training for managers or staff around burnout?
- What external resources are you aware of for supporting staff to identify, prevent and support burnout? (prompts: self-help, helplines, mindfulness, counselling, wellbeing groups)
- Which ones have you made use of?
- How effective were they?
- Have you developed any resources? If yes, please tell me a bit about them?
- What measures can we put in place to identify and prevent burnout?

Is there anything about burnout in front-line services for people who use drugs and alcohol that we haven't covered, and you think is important? If yes, please give details.

10.2.5 Staff follow up interview/focus group topic guide.

Identifying and preventing burnout in front-line services for people who use drugs and alcohol

Ref: _____ **Date** _____

About you

How would you describe your gender? _____

Age _____

Job Title

Do you have lived/living experience of recovery from:

- Drug Use
- Alcohol Use
- Drug & Alcohol Use
- Mental health problems
- No
- Prefer not to say

About your job

What sector do you work in?

- NHS
- Third sector/Charity
- Grassroots/Community Led
- Local Authority
- Other _____

Job Status

- In paid employment
- Volunteering

How long have you worked/volunteered for this Organisation? _____

How long have you worked/volunteered in this role? _____

How long have you worked/volunteered in the sector? _____

Exploring Burnout – topic guide

What does the term burnout mean to you?
What particular aspects of your work/job role have the most impact on your levels of energy and enthusiasm?

Causes

In your experience what are the main causes of burnout among front line staff in services for people who use drugs and alcohol?
Prompts – how do each of these impact upon feelings of burn out?

- Workload
- Stigma
    - from other services
    - towards the client group
- Fatal and non-fatal overdose
- The value placed on the work you do
    - Within your organisation
    - From other services
    - Within the community
- Workplace conflict/relationships with colleagues

Consequences

In your experience what are the main consequences of front line staff feeling burned out in services for people who use drugs and alcohol?
Prompts

- Voluntary turnover – staff leaving
- Staff absence/off sick
- Impact on Mental health/Emotional exhaustion
- Impact on Physical health
- Stigma – in what ways do you feel stigmatised? How does this impact on feelings of burnout?
- Depersonalisation – impact on empathy and relationships with service users
-

Intervention

What types of support are available to you in your job role if you feel at risk of burnout or are feeling burned out?

Prompts

- One-to-one supervision – if yes how often
    - are there specific questions around burnout as standard?
    - Has your supervisor ever raised concerns with you about your well-being
        - If yes how did they do this?
- Group supervision –
    - how often
    - who with
    - how effective
- Peer support/support from colleagues – is this formal or informal
- Workplace counselling (Westfield Health) – what type of support is available through this?
- Online support/helpline – can you give details of the site – is it for public access?

- Telephone support/helpline – do you have a contact number for this service?
- Family and friends
- Self-care activities – meditation, exercise and so on
- Any other support available

Have you used any of these resources?

How easy were they to access?

How did you access the support
- Through supervisor/line manager
- Self-referral

How realistic are the support solutions on offer?
- Waiting lists
- The number of sessions on offer
    - Too many
    - Not enough
- How they are delivered?
    - Online

Stigma
    - around asking for support if you're feeling burned out
    - around having lived/living experience

Any suggestions for resources that might help identify and prevent burnout in the sector? Is there anything about burnout in front line services that you think is important and we haven't' covered?

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JULY 2022

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