SDF
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

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Executive Summary

Background

Burnout amongst front line workers in drug and alcohol services has been highlighted as a key issue which can impact on staff wellbeing and as a result on the ability of staff to offer high quality support which helps engage and retain people in treatment and support services**.** Regular exposure to drug related deaths (DRDs), near fatal overdoses (NFOs) and the cumulative effect of supporting people with complex needs including trauma combined with other challenges within the sector such as high caseloads and staff shortages result in staff feeling overstretched and may lead to 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.

Methods

The evaluation used a mixed methods approach. Quantitative data was gathered via a staff survey, which included two validated tools, the Areas of Worklife Survey (AWS) which measure job stressors that contribute to overall burnout and the Maslach Burnout Inventory (MBI) which measures burnout and the frequency people experience feelings of burnout.

Participants were also asked supplementary questions specific to the drug and alcohol sector relating to causes of burnout and also about supports available to them in order to respond to or prevent burnout. Forty staff completed the online staff survey.

Qualitative data was gathered via in-depth interviews and focus groups with frontline service staff and service leads which explored experiences of burnout in services in more detail. Sixteen frontline staff and seven managers/service leads contributed.

Key Findings

Quantitative findings

- **Specific challenges for the sector:** Exposure to high rates of DRDs and NFOs, high caseload sizes and lack of specialist services to signpost to were all particular challenges cited for the sector. Three quarters of respondents (75%, n=30) cited the exposure of high rates of DRDs and NFOs, half (50%, n=20) cited high caseloads and over a third (37.5%, n=15) identified lack of specialist services to signpost to.

- **Areas of worklife survey (AWS):** AWS responses showed some strong indications of workplace factors that could lead to burnout. In particular there was a clear pattern of a greater risk of burnout amongst NHS participants compared to the Third Sector. The greatest potential cause of burnout was workload.

- **Maslach Burnout Inventory (MBI):** 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.

- **Impact of COVID-19:** COVID-19 impact was mixed, over a third (37.5%, n=15) noted more staff absence and turnover with 40% (n=16) noting no significant change. The

majority noted changes to service delivery, especially in terms of greatly reduced face to face contact which was seen by the majority (77.5%, n=31).

- **Support:** The main supports used for issues relating to burnout were supervision (87.5%, n=35) and more informal support such as support from family and friends (55%, n=22) or peer support (45%, n=18).

Qualitative Findings

Common themes from the qualitative findings were grouped in to causes of burnout, the three domains from the MBI (burnout, depersonalisation and personal achievement) and finally prevention and support.

Causes of 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. Stigma was also a perceived consequence of asking for help.
- Personal factors such as caring responsibilities

Emotional exhaustion/burnout:

- 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.

- Lived experience could be both an asset or a potential vulnerability. 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.

- Management style and organisational culture could contribute to feelings of burnout. Protective and preventative factors included autonomy within roles, trauma informed workplaces and ensuring awareness and open dialogue about burnout was at the forefront. 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. For some, it presented opportunities such as more effective and efficient engagement with clients or flexible working styles. It was however generally highlighted as an additional source of burnout, 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.

Depersonalisation:

- Regular exposure to high stress e.g. fatal and near fatal overdose of clients, could lead to feelings of depersonalisation in some, especially where they had experienced high volumes and regularity of DRDs and NFOs, as they became desensitised and numb to it. Such experiences could suggest a level of empathetic distress fatigue. 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 casual 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, 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.

Personal achievement:

- 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.

Prevention and support

- 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.

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 principles if we are to maintain a consistent, competent and healthy workforce.

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 a 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 raisie 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 Of Death Prevention and Maintenance Work:** It is key that we help staff and society to better value drug death prevention and maintenance work. 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.

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