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Scotland's Alcohol and Drugs Workforce: A Compendium of Mixed-Methods Research

HEALTH AND SOCIAL CARE

social research

Scotland's Alcohol and Drugs Workforce: Reference groups

Key Findings:

A series of reference groups were held with key stakeholders from the third sector, NHS and rural areas currently delivering drug and alcohol services. Participants were sourced from responses to the survey of alcohol and drugs services, and key findings emerging from these reference groups are as follows:

- The shortage of skilled workers in the drug and alcohol sector is due to a number of factors including training, remuneration, the challenging nature of the work and the location of services;
- Retention is also a challenge for the sector because of a lack of opportunities for career progression, challenging working conditions and financial barriers – both for individual employees and at service level;
- There can be issues around the design of services, especially in rural areas. The local nature of service design means different areas face different issues;
- People with lived experience are a valued part of the workforce. However challenges remain around their recruitment and retention. These include facing stigma in more rural areas, the elevated risk that working in high-stress environments has for their recovery, and potentially having to return to the service they worked for if they start using drugs or alcohol again.

1. Introduction

Scottish Government announced a National Mission on drug-related deaths[1] in January 2021 to address Scotland's record numbers of drug-related deaths. Similarly Scotland's alcohol death rates are also consistently higher than those of England and Wales, as well as the rest of Europe[2]. In addressing these challenges the Scottish Government is committed to building a resilient and skilled workforce in the drug and alcohol treatment sector.

To support this work Health and Social Care Analysis have undertaken a programme of work to better understand the drug and alcohol workforce. This includes both summarising existing datasets and generating new data. This paper reports on the findings from a series of reference groups held with NHS, third-sector and rural (both NHS and third-sector) alcohol and drug services. These sessions sought to clarify, expand on and enrich data on Scotland's alcohol and drug workforce which was gathered through the adjoining survey.

2. Methods

Three reference groups, lasting an hour each, were conducted in March 2022. These three reference groups were undertaken separately with third sector providers, NHS services, and rural providers (comprising a mix of third-sector and NHS positions). They were led by three analysts from Health and Social Care Analysis, and were attended by two, four and six representatives from these three service types, respectively[3].

While discussion was left relatively open, questions (see Annex 1) were centred around four key themes which had emerged from the survey; recruitment, retention, service design and lived experience. A number of findings were common to all services taking part in the reference groups, however some were specific to each service type. This report summarises findings across these four areas in turn.

3. Key Findings

3.1 Recruitment

Discussion around recruitment focused primarily on barriers which services faced in recruiting a skilled workforce. There were some areas of commonality emerging across services – for example, a shortage of workers with the necessary skills and experience to fill vacant positions – but distinct challenges were also faced across these different service types.

3.1.1 Shortage of skilled workforce

All services noted a shortage of skilled workers to fill existing vacancies, however this issue was particularly acute amongst NHS services. Two highlighted that this had led to stiff competition between NHS drug and alcohol services, and between other departments, for staff:

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[1] Scottish Government (2021). *National Mission*. [online] Available at: https://www.gov.scot/policies/alcohol-and-drugs/national-mission/.
[2] National Records of Scotland (2021). *Alcohol-specific deaths*. [online] Edinburgh. Available at: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths.
[3] Ten services were invited to take part in each reference group, but demands associated with workload and absences resulted in reduced numbers attending.

> "We've got 3 areas here [in our NHS Health Board] and it's like robbing Peter and Paul to get staff off each other."

There was agreement across all services that there was a shortage of nursing staff. One provider noted two particular challenges which were facing the nursing workforce; the continuation of the old pension scheme for a cohort of employees who were nearing retirement at 55 years, and the impact of Brexit on reducing the number of nurses who were eligible to work in the UK:

> "There's still 2 or 3 years of the cohort [who are retiring at 55], so again we're going to be depleted with retirement. Unless those staff come back, but if they do come back they'll only come back part time."

> "The local university takes too many international students, so they just go home. So we're trying as much as possible to recruit when the students are coming through, and getting placements with us."

Some services reported that they had worked to upskill their existing workforce, and that this had had a positive impact on having the necessary skills within their service. However, another NHS service noted that retraining band 3 and 4 nursing staff through the HNC scheme was unattractive at present, as it meant that nurses had to take a substantial pay cut:

> "It's a big drop from having a salary down to a ten grand bursary. So if we could actually support the further two years we'd have a much faster response of people working and qualifying and remaining in the areas they're actually employed in."

Some NHS services noted that, because of the need to fill band 6 nursing positions in particular, nurses with relatively limited experience were being promoted to these roles. This meant that managers and other staff in these services had to provide more support and mentoring input, which could lead to suboptimal situations:

> "People are taking anything just now to be honest. I'm hearing that some people don't have the right skills or experience and they're getting [promoted to a] a band 6… they must just be wanting to fill that position."

Finally, some respondents spoke about the recruitment challenges that the whole of the health and social care sector are facing at present. There are more staff needed across all services, and consequently those working in the sector are in high demand. This level of competition for staff meant that services might have fewer applicants for roles, or none at all, and may have little choice about who they employ because of the need to fill roles. One third-sector provider said;

> "Recruitment? Oh dear. Yeah… A nightmare. It's just really, really hard. The competition between services is absolutely huge over this way."

3.1.2 Financial barriers

All three service types cited financial barriers as core challenges they faced in recruiting for vacant positions. Third-sector providers noted that the salaries which they were able to offer were considerably smaller than NHS and other statutory providers, and that this posed a substantial barrier to recruiting a skilled workforce.

The short-term funding cycles available to third-sector providers were also considered a substantial hurdle to recruitment. One provider highlighted that the one-year funding cycles of ADPs meant that they only received funding on a rolling annual basis, and that they spent a large proportion of time applying for other pots of funding. The short-term and precarious

nature of funding which was available to services had a knock-on effect on the working conditions they were able to offer staff. Many third sector participants in these reference groups were employed on one-year fixed-term contracts, which created an additional barrier to recruitment in the third-sector compared to NHS services:

> "We've got an allocation of fixed-term, one year posts from the additional ADP money. Can't fill them. Who wants to be on a one year fixed-term post when they can do down the road and get permanent? It's an absolute nightmare."

> "The thing is… our service is contingent on the various streams of funding it's bringing in. And we don't have one main source of funding. So we're constantly chasing money to keep the service going."

Those running services in rural areas suggested that, alongside greater travel costs – noted below – the cost of living in rural areas compounded these financial barriers to attracting individuals to working in their services:

> "The wages don't match the level of what's expected of someone. And others living in areas like this will know that the cost of living is so much higher here. And the wages don't reflect that. And that stops people even considering drug and alcohol services."

3.1.3 Challenging nature of work

A further barrier to recruitment was the challenging nature of work in the drugs and alcohol sector. This was compounded by the comparably poor pay in relation to other, less challenging forms of employment;

> ''And the amount of pressure that's on nurses. I've done both. It's horrendous. You're better off going to work in Aldi. And it's better money. It's not attractive to work here."

Others noted that, while welcomed to some extent, policy shifts such as the uplift in Scottish Government funding and the implementation of MAT Standards had intensified pressures on those working in the sector:

> "But the pressure that's putting on services we already know were underfunded, and have been for years. And now it's like 'let's get it sorted, and let's get it all sorted right now'. We all work there because we care about our clients. I feel for anyone working in drug and alcohol services just now. And expectations being political now. There's a bit of a strange brew at the moment, because we've been ignored for years, and there's a lot to catch up from."

One issue raised by NHS services in particular was the substantial challenges in recruiting nurses to work in alcohol and drug services, given that working conditions for nurses in ward settings were preferable to working in the community. Staff in wards had longer and more flexible working hours and, unlike those working regular 'nine to five' hours in community alcohol and drug services, were able to work overtime to top up their wages. Further, the nature of the community work was considered more challenging, particularly due to the reduced support network around the individual worker:

> "I see my peers earning a third more in their monthly wages working in a hospital ward with nowhere near the same level of responsibility."

Understandably, challenges related to travelling while working in community positions, not seen in ward positions, were particularly pronounced in rural services, and provided a substantial barrier to recruitment;

> "The travelling expenses are becoming ridiculous. The petrol prices go up, but the allowances don't. And the area we're in, you can travel eighty or ninety miles a day seeing patients. It's as well just working in a ward than coming out to a community."

These cumulative factors made working in a ward setting a far more attractive prospect for nurses.

> "I'm a newly qualified nurse…You're taking a pay cut to work in the community. You've extra travel expenses on top of that. You've no opportunity for overtime. I can understand why people don't go for it. We had a band 6 advertised three times before someone came and took it."

While recruiting staff was noted as being challenging across all services, one provider noted that the nature of prison work, in particular, had meant that recruiting individuals with the right experience and skills to work in this environment was particularly difficult:

> "The hardest posts to recruit to are prison posts. You've got to want to work in a prison. Prison craft is something that… you have to acquire. It's not taught. And it's a challenging environment to work in. They're really hard posts to fill, and hard posts to keep filled."

3.1.4 Issues Specific to Rural Services

All of the rural services in these reference groups found recruitment challenging:

> "The vacancies sit for a long time. We've been advertising permanently for a year and a half for various band 6s. You're looking for people to move their entire world to move to a place like that. It's not inviting."

A number of factors accented the aforementioned recruitment challenges for rural services. In addition to the infrastructure and transport issues listed above, the rurality of services had important implications for availability of affordable housing in the local area:

> "We've had people be successful in applying for jobs, getting the jobs, but then giving them up as they've nowhere to go to."

> "Infrastructure really lets us down, with the housing market. There's no property available to let. So they have to buy, but our house prices have absolutely rocketed. So I think that's a bit of an off-putter, particularly given it's a lot of short-term contracts, trials rather than committing to long-term posts."

A number of services from rural areas also highlighted that it was challenging to encourage individuals to return to work in a rural service when they had moved to attend university in cities elsewhere, given the opportunities available in urban areas:

> "People go away to the city to train at university, and there's just so many more opportunities in the city for people to stay around there."

> "It's difficult for service development, the recruitment. They tend not to come back, because they maybe get a role in the city. So it's hard… it's hard. People from another areas may see the positives, but there's a lot of negatives living rurally, both personally and professionally."

3.1.5 Impact of Covid

An NHS provider noted that Covid-19, and associated social distancing measures, had impacted their ability to take on students for placements. This was significant as NHS

services in particular seemed to rely on recruiting students who had placements with them to then work in their services:

> "Taking on students, we can only take 1 student at a time. So the social distancing is strangulating[sic] how many we can take on. So I'm hoping Covid restrictions can ease so we can get more students. Giving students good placement experiences and going from there… that's your next set of staff, you're trying to plant seeds there. But it's one at a time now, and it used to be a lot more."

3.2 Retention

While some services reported that they had a number of core individuals who had been working with them for years, the majority of services across the three service types noted challenges in terms of retaining staff long-term. Many of these mirrored the difficulties associated with recruitment, alongside a number of distinct challenges.

3.2.1 Lack of opportunities for progression

The relatively small nature of third-sector services and rural services meant that there were few opportunities for career progression among the workforce compared to other employers. For staff who wanted to progress to more senior roles, to earn more money or to gain experience at a higher level, this could be a deterrent to staying in the sector. The manager of one service noted;

> "Anyone who wants to come in needs to kick me out if they want to make more money."

In rural services, where a service might be the only one operating in that locality, this issue could be even more pertinent as there was not even scope for career progression by moving to another service nearby. Some people did not want to move from their locality, or to travel long distances for work, in order to progress their career. They therefore had to sacrifice the possibility of career progression:

> "People like myself have returned back here to work, but I know there's nowhere to go in terms of career progression…I've done this post 15 years and there's not any space for me to do anything else, I'm just committed to staying here."

3.2.2 Challenging working conditions

Again, the challenging nature of employment in the drug and alcohol sector was noted across the board in the context of retaining staff. This issue was compounded by the relatively low pay which many of those working in community settings faced, as well as by the increased workload and pressure on staff due to the difficulties recruiting individuals to existing vacancies:

> "You're coming in to do a harder job, because there's not anyone else there to support you. We've got very few staff in there doing everything. So there's huge pressure on staff because of the vacancies. There's a huge increase in the number of my staff who're on antidepressants, and are not coping. Because they're exhausted. It's down to staffing levels, but also got these other pressures. So people are leaving quicker, they're looking at other jobs thinking 'well the pressures aren't as bad in that other job'. The pressure is huge in this job, and with pay cuts… I don't think anyone recommends this job anymore."

One service spoke about successfully recruiting newly qualified nurses to band 5 positions, but losing them after a year or two because of the challenging nature of the role. As they noted, "…It's quite a lot of pressure for a first year."

In rural services – particularly in smaller services –the lack of wraparound support meant staff were compelled to take on extra work to ensure the service functioned. Caseloads could also be quite complex, and working alone (or in a small team) without wider supports brought additional workload and stress. Respondents felt this was not understood at higher service levels and so staff might not be appropriately compensated nor supported:

> "We don't have clinical supervision in our area… It's fine when things are going okay, but when things are going wrong… A lot of our services are Monday-Friday 9-5, and people are carrying a huge amount of risk. And when things go wrong, these people carry the can, and that's wrong."

> "I do absolutely everything myself. And your job kinda takes over your life. I hear myself speaking about balance to clients, you know I can't do it, I just can't do it."

3.2.3 Financial barriers

Again, financial barriers were a central challenge to retaining staff. Many of these mirrored those noted above in the context of recruitment, including poor wages, insecure tenure, short-term contracts, and the discrepancies between ward-based and community work. While this was the case across all services, one NHS rural service highlighted that:

> "Basically retention is difficult because the wages don't accurately reflect the work that you do. Very often they're part time jobs, and people are having to take two or three part time jobs to make ends meet."

Moreover, the short-term nature of contracts, stemming from the short-term funding cycles available, presented challenges. One NHS provider suggested that:

> "Part of our funding stream through the ADP are that they're fixed-term posts. Some of them are only for one year, so that can cause a lot of anxiety. So they're looking for other posts and moving about. That guarantee about getting extended… you can't say to staff that's going to happen.'

3.3 Service Design

That service design takes place at a local level enables services to respond to local needs. There were mixed experiences in the reference groups about locally-designed services. Some thought they had a good range of local offerings:

> "Historically it's just been us. But we've got good options there just now"

> "We're built up and we've got good transport links, so we're spoilt that way. We've got more third sector stuff going now."

However, others stated that there were limited services available, especially in relation to residential rehabilitation. Perhaps unsurprisingly, this was more of an issue for rural areas, where (as mentioned previously) the lack of wraparound services lead to the phenomenon of service managers being 'single person services'.

3.3.1 Lack of residential rehabilitation services

The lack of accessible residential rehabilitation services was noted by several participants.

> ‘We have a real issue here with residential rehabilitation, because there isn’t anything basically. For someone to go into residential, it all comes down to cost. There seems to be a real ‘can’t you do it in the community’. And that’s a real challenge here, because everything is concentrated in one area. So that provides challenges for everyone involved’.

However, others commented that residential rehabilitation was not always appropriate for the people they worked with as leaving, and especially returning home afterwards, was logistically complex. So sometimes detoxing in the community was right for their locations and the people who used their services.

3.3.2 Training and Development

The importance of ongoing training and skills development for the workforce is a major theme across the suite of research we have undertaken. Access to training and development was an issue in the reference groups for those from rural services, echoing sentiments expressed in the survey. Some noted that the impact of Covid had meant more training being available online, which meant they could access more training more easily:

> “There’s training that we couldn’t possibly have accessed before. So going through Microsoft Teams has been really beneficial for us”

However, others noted that some more specialised training offerings could not take place online, and thus had considerable time and cost implications to access it. One person also noted that while online training was good, it was better to be able to physically meet for training as this provided support and networking opportunities.

> “I know there’s a lot of online stuff but there’s nothing better than meeting peers and networking…”

3.3.3 Needs assessments

One participant from the third-sector stated that the needs assessment for their locality needed to be reviewed because the data that would provide an up to date, clear picture of how many people needed to use services, or what type of service they needed, was not available. This meant services could not proactively grow in anticipation of increased need and referrals, and instead were constantly on the back foot, applying for additional short term funding to try to meet fluctuating demands.

3.4 Lived Experience

Reference group participants were positive about having people with lived experience in the workforce, and a number of participants reported people with lived experience working in their services. Although this did confer benefits, participants also discussed some of the challenges associated with employing people with lived experience.

3.4.1 Challenges specific to people with lived experience

Several participants noted that people with lived experience – both volunteers and paid employees – made valuable contributions to service delivery. However, this was not always easy for these individuals if they had previously used the service themselves, and especially for individuals who had relapsed and then had to access the service again for support.

> “There have been people who may have lapsed or relapsed and then had to face coming back into our service again so that’s been a wee bit challenging in how we support individuals.”

As mentioned above, services of all types highlighted how challenging and stressful working in frontline drug and alcohol services can be. With respect to people with lived experience, two service providers – one third-sector and one NHS – outlined how exposing them to this type of environment could pose substantial risks, especially earlier in their recovery:

> "There's a stressful environment and I sometimes wonder, are we setting these people up to fail? They're at risk of relapse and stuff and you're putting them into, you know, the NHS is a high stress environment. Are we expecting too much of them?"

> "We see cases where people are overburdened and put at risk of relapse and I certainly know personally of a couple of cases over the years where people have relapsed basically because they were overburdened with work, and they weren't necessarily being paid for it."

Finally, several participants commented that lived experience is not necessarily restricted to one's own experience. It can also include having a family member or friend who uses drugs and alcohol, and many trained professionals in the workforce are in this situation. Indeed, it may have been one of the motivating factors they had for going into this sector in the first place. Therefore it is important to not discount the lived experience of these individuals too

3.4.2 Rural Challenges

A number of the rural services outlined distinct challenges in attracting individuals with lived experience to work in their services. These primarily hinged on the small, close-knit nature of communities, and the reluctance of individuals with lived experience to expose themselves the wider community given the stigmatising attitudes towards problem alcohol and, particularly, drug use:

> "There's huge stigma around drugs here, so getting people to come forward and share experience, people don't want to. We're a tiny community, so people don't want to come forward as being in treatment, or even having been in treatment. Some of our people in our services are our neighbours or family"

> 'I've got clients who I think would make excellent support co-workers, but possibly community attitudes towards these people would create a lot of barriers to them. But I think that's changing, and I think people coming into the area from elsewhere can be more open about their issues, whereas people born and bred here tend to keep that to themselves'

4. Conclusion

The reference groups have complemented and added substantial qualitative context and detail to the workforce survey responses. The information given by participants has allowed us to better understand issues around recruitment, retention, service design and employing people with lived experience in the drugs and alcohol workforce and, together with the wider suite of workforce research, will be used to inform policy going forward.

Annex 1: Reference group questions

1. Recruitment and skills

Key Question:

Our research so far suggests that recruitment of staff is a significant issue for some services. It also suggests there are limited qualification and skills pathways into the sector. Can you tell us about your experience of recruiting to your services and any challenges you have faced?

Prompts:

- What are the specific challenges around recruiting staff with the necessary skills for the third sector/NHS/rural area services? Are these challenges specific to alcohol and drug services? or more general?
- What kind of skills / experience are you looking for in staff?
- Do you know of any services which have successfully overcome these challenges? If so, how did they do this?
- Are there challenges around staff training once they are in the sector?
- What could be put in place to assist with recruitment and skills difficulties?

2. Retention

Key Question:

The survey also highlighted that retaining staff in the sector can be difficult for some services. Is staff retention a challenge for your service? If so why?

Prompts:

- What are the barriers which prevent services in the third sector/NHS/rural areas from retaining staff?
- Are these barriers specific to particular kinds of staff?
- Are there challenges around career progression for staff once they are in this sector?
- What could be put in place to help services retain staff?
- Do you know of any services which have good staff retention? If so, why do you think this is?

3. Service design

Key Question:

Some respondents to the survey said that there were not always the right services in place in their area, for example there were not residential rehabilitation services locally, or services in place for people to move on to. In your experience is there a way in which services could be designed more efficiently?

Prompts:

- What are the barriers to people accessing appropriate third sector/NHS/rural areas services?
- Is there a way services could be designed better? For example increased funding, improved pathways into services, or pathways between services.

- Is there anything which could be done at a national level to support local services to be better designed?

4. Workers with lived experience:

Key Question:

We're keen to hear about the role of people with lived experience in the workforce. Does your service employ people with lived experience in a paid voluntary capacity? If not, are there any barriers which are stopping you from do this?

Prompts:

- What are the benefits / added value of involving people with lived experience?
- Do you specifically recruit lived experience? Either through job criteria or through specific initiatives (e.g. Addiction Worker Training Programme)
- What challenges are there in recruiting and retaining people with lived experience?
- What could be done to address any challenges and make recruitment and retaining easier?