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"Integrity. That is Wellbeing": A Qualitative Investigation of Drug Health Service Staff Wellbeing

Short Title

Drug Health Service Staff Wellbeing

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Abstract

Introduction

Drug health service staff were exposed to short term wellbeing initiatives during the COVID-19 pandemic, but wellbeing needs are of ongoing concern. This paper addresses how staff working in a drug health service understand their own wellbeing needs and ways they need to be supported.

Methods

Qualitative descriptive study including four focus groups and two individual interviews of drug health service staff. Participants (nineteen in total) were drug health service clinicians, managers, executives, or administrators. Verbatim transcriptions of recorded interviews and focus groups were deidentified then analysed for main themes. Extracts of the data illustrate findings.

Results

Results are presented under three headings: 1) working in the drug health services 2) wellbeing initiatives to date and 3) suggestions for wellbeing programs specific to drug health service staff. A key finding was that wellbeing is of concern across all categories of staff, but that without being embedded in a workplace culture characterised by trust and integrity, wellbeing activities are unlikely to be effective.

Discussion

Trust and integrity needing to be embedded into workplace culture for wellbeing initiatives to be effective is a nuanced and multifaceted understanding of wellbeing for drug health service staff. The importance of context for wellbeing activities was explained with practical suggestions of what and how wellbeing initiatives should be offered, and who should be involved.

Conclusions

Although a small and targeted study, the findings nonetheless offer guidance to future consideration of drug health service workplaces, and to further research into the topic of wellbeing.

Keywords: Staff wellbeing; wellbeing initiatives; workplace culture; workplace stressors in health

Introduction

Wellbeing at work is a complex notion that includes engagement, happiness and positivity [1]. Schulte, Vainio [2] describe wellbeing as "a summative concept that characterizes the quality of working lives" (p.422). In a healthcare context, staff wellbeing is associated with optimal patient outcomes and staff retention [3]. Wellbeing programs have positive effects on safety, absenteeism, staff retention, productivity and creativity [4]. During the COVID-19 pandemic, wellbeing initiatives offered recognition to healthcare staff whose work conditions were altered in unprecedented ways [5, 6].

Nurses working in drug health services cite work intensity, overwhelming demands, and a lack of resources as significant barriers to delivering patient focused care [7], conditions which were exacerbated during the COVID pandemic, as described for Australian frontline workers [8] and drug health teams [9]. Drug health service staff, whose patients continued to deal with addiction and associated mental health concerns through the pandemic, faced unique concerns related to spreading of the virus due to syringe use [10]. Wellbeing of staff and organizational adjustments made due to COVID are recognised to have value in the post pandemic era [11]. Whether interventions put in place during the pandemic or at other times have been appropriate and effective for drug health service staff is uncertain. This study aims to inform future decisions about wellbeing programs for drug health service staff. Drug health staff offer their perspectives on wellbeing and initiatives needed to support them in the post pandemic era and beyond, through participating in focus groups that are described qualitatively.

Burnout is a widely used term in workplace contexts whose definition has been revised and refined since first adopted in 1974 [12]. Most definitions of burnout include exhaustion, cynicism and detachment [13]. Patient care is impacted by burnout in healthcare workers [14]. The risk of burnout and associated impact on patient care is highest when that care is complex, where death may occur, or where attention to emotional needs is high, such as in drug health [15]. Wellbeing programs are often designed to reduce burnout through care for self and peers [16]. Yet, although patient care is optimised when staff wellbeing is high, wellbeing is a complex notion that is not always simply addressed by focusing only on personal skills [1]. Adding to the complexity is that burnout and engagement at work (one indication of wellbeing) can be experienced simultaneously [17]. Wellbeing and associated attempts to ensure it in workplaces is thus a complex issue [18].

Wellbeing amongst healthcare workers has received increasing attention with many publications describing features of wellbeing, but few offering evidence to support interventions [19]. Searby and Burr [9] used qualitative methods to investigate Australian and New Zealand drug health service staff wellbeing during COVID. Their findings included a significant impact from COVID. Drug health team members displayed concern about their personal circumstances as well as concern about COVID related organizational changes. They described concern about the workforce (including risk of redeployment), service delivery models (such as telehealth replacing face to face contact) and increased risk for highly vulnerable patients (due to increased use of illicit drugs during lockdowns). They cite ongoing risk of staff shortages for this specialist group of healthcare workers and conclude that although COVID restrictions have eased, further research into the wellbeing of drug health staff is needed to ensure service delivery is sustainable.

Aims

This study aims to understand how drug health service staff understand what is needed to support their wellbeing. Adopting a qualitative methodology, this study seeks to uncover the lived experience of drug health service staff wellbeing and to identify expectations of how wellbeing can be supported for this specialty area.

Methodology

Approach

This study employed a descriptive qualitative approach [20] to analyse audio recorded focus group discussions and individual interviews. The principles of principles of reflexive thematic analysis [21, 22] guided the qualitative description.

Participants and Recruitment

Nursing, medical, administrative, management, and executive staff who had been employed for at least 12 months in the drug health service of a local health district in Sydney, Australia were invited to participate in either a focus group discussion or individual interview, conducted either online (via Teams) or face-to-face.

Data Collection

The second author arranged all focus groups and interviews and was present as an observer. All focus groups and interviews were conducted by an experienced qualitative researcher (fifth author) who had no working relationship with any participants. Data was collected during May and June 2023.

The researchers developed a topic guide to address the following:

1. Need for a wellbeing program for drug health staff.
2. Content and format of a wellbeing program for drug health staff.
3. Exclusions from a wellbeing program for drug health staff.

Data Handling

All focus group discussions and interviews were audio-recorded, transcribed verbatim, and de-identified. The transcripts were formatted for import into NVivo Release 1.7.2 (Lumivero, 2024, www.lumivero.com). Participants were not offered the opportunity to review transcripts due to using focus groups to collect data, meaning that separating the contribution of a single participant from the group they attended would not have been possible.

Data Analysis: The descriptive qualitative analysis was conducted in three stages:

1. **Stage One:** A research associate (fourth author) with no connection to the data collection process familiarised themselves with the transcripts and conducted an initial round of inductive coding using NVivo R.1.7.2
2. **Stage Two:** A second research associate (third author), after familiarizing themselves with the transcripts, reviewed and modified the list of codes in NVivo R.1.7.2. Previously identified codes and their definitions were refined.
3. **Stage Three:** The qualitative researcher (fifth author) who conducted the focus groups and interviews undertook the final stage of analysis. This stage involved re-familiarisation with the transcripts, examining the identified codes to

generate themes pertinent to the study aims. The process and findings were discussed with the third author, and any disagreements were resolved in discussion.

Quality Assurance

Researchers who worked on the data collection, handling and analysis completed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklists [23] to ensure accountability and transparency in all methodological decisions.

Ethical Considerations

Ethical approval for the study was granted by the South Western Sydney Local Health District Human Ethics Research Committee. Participation was strictly voluntary. All participants provided consent for their involvement in the focus groups or interviews.

Results

Nineteen participants from the Drug Health Service team volunteered for the study. Seventeen contributed to one of four focus group discussions (labelled below as FG1, 2, 3, and 4) and two contributed to individual interviews (labelled below as Individual Participant). Focus groups and interviews were scheduled for the convenience of participants. Scheduling resulted in participants with loosely similar roles being included in each of the focus groups. Clinicians participated in one focus group (FG1) and the two individual interviews, managers participated in two focus groups (FG2, FG3), and administrators and executives participated in one focus group (FG4). The grouping, which arose from scheduling focus groups for convenience, not by study design, nonetheless allowed differing priorities and experiences among clinicians, managers, and administrators to be shown. Participant agreement was evident during all the focus groups. The expression of similar views may have been the result of the loose grouping of employment type by focus group.

Participant accounts indicate that attention to drug health service staff wellbeing is necessary, multifaceted and needs to be sustained. Three themes were generated during the analysis: 1) working in drug health services; 2) wellbeing initiatives to date; and 3) future drug health service staff wellbeing programs. Table 1 provides an outline of the main points under each heading. The findings are presented below under those three headings with extracts from interviews to illustrate.

Table 1: Three themes (working in drug health; wellbeing initiatives to date; future wellbeing programs) presented alongside key issues raised by participants during focus groups and interviews

	Theme	Key issues raised by participants during focus groups and interviews
1	**Working in Drug Health Services: clinicians, managers, and administrators**	• Staff exhaustion Aggression towards staff Vicarious Trauma Work overload • Incomplete and inadequate staff teams • Nursing culture sets expectations of resilience, influenced by generational shifts • Lack of opportunity / encouragement to manage work stress exacerbated by nursing culture • Burnout • Lack of certainty in the workplace • Tangible impacts on staff functioning (for example on sleep) • Expectation of self-management of wellbeing, regardless of whether contribution to lack of wellbeing is work or personal • Administrative staff exposed to same stresses but not to the same level of clinical information.
2	**Wellbeing initiatives to date**	• Informal support from colleagues • Formal support systems (leave, employee assistance, supervision) • Initiatives to recognise and reward staff (limited by availability and budgetary constraints)
3	**Future drug health service staff wellbeing programs**	Formal, informal and reward based initiatives should be available to staff. Wellbeing programs should be: • Accessible, with time allowed to be specifically assigned for online and face to face activities • Embedded in integrity and trust, delivered in a culture and teamwork and no tolerance for conflict Consider workload and staffing required • Sustained and not crisis driven • Consultative All levels of staff, including clinical and managerial staff, should be involved in wellbeing, with consideration of the need for outside experts to contribute.

1. Working in Drug Health Services: clinicians, managers, and administrators

Working in Drug Health was described as emotionally and physically exhausting due to the psychological element of nursing patients experiencing substance use disorders who sometimes present with aggression directed towards staff.

"*the aggression is obviously a reality but even though we have a slogan that zero tolerance in our facilities but it's happening on a regular basis in our facilities and we need to tolerate that to certain extent"* (FG2).

"we're working with the most, you know, marginalized that group in society with, you know, complex issues of trauma and you know, complexity so that in itself, the client group that we're working with and of course that's going to have a huge impact on us" (FG4).

"…we don't actually do daily nursing skills so we're expected to make up for those things so communication, withdrawal management, sometimes our patients can be a little bit personality disordered or they can be unwell or they can be quite demanding so it does take a toll sometimes" (FG1).

Vicarious trauma was reported, whereby clinical staff were exposed to events that they experienced on a personal level, either due to some triggering in their own lives or because of the close relationship with patients due to the nature of the work.

"we deal with the vulnerable population group that is really they've got a lot of traumatic experience maybe from childhood as well so they share all this information with us every time, every time they come to see us so that may affect our well-being as well as clinicians" (FG4).

Drug health staff described being overloaded due to inadequate staffing levels.

"I've had up to a month with no doctor at all absolutely not a single doctor on any day of the week if one clinician is on unplanned leave also we can't we can't cope with the demand on the floor. So the work will accumulate and so for the next day next day so we don't have enough time to even, sometimes we don't have we don't get breaks so we even skip our tea break or afternoon break" (FG2).

Participants described taking on roles of counsellor, social worker, and occupational therapist due to lack of staff, which also contributed to their level of mental exhaustion. One participant described the demand at work as not having time to breathe.

"yeah it's too much and we don't have time to work well breathe no-one can do all of that well" (FG 1).

Participants linked demonstrations of resilience in stressful work situations to nursing culture.

"because it's a culture thing nurses are, I don't know, you don't show that you are bleeding every day. It's something that's drummed into us, it's part of the identity of a nurse. You don't really say I'm bleeding. It's just the old culture and it will probably continue for the next 30 years." (FG2).

Not demonstrating resilience was considered by some to risk being seen as weak.

"sometimes you can feel the tension with staff as well.. they may not say it because it can be taken as their weakness or, you know, you know, some may think that they're not managing, you know, there's a lot of, I suppose people are trying to self protect by not expressing how, you know, they actually are feeling and how the work is affecting them" (Individual Participant).

"You worry about it going down that tangent (laughter) then it takes too long or a lot of the time people don't want to express their feelings or yeah don't come across as weak or anything" (FG1).

Managers described generational shifts in resilience. Their perception was that less resilience is shown by staff members than might have been expected in decades past, whilst acknowledging that conditions for nurses may have progressed so that perhaps less resilience is actually needed.

"I agree to seeing staff come in that are less resilient. Our younger staff especially, like has been said, you know, " I I haven't you know I haven't agreed to work nights or at weekends," but you know that's the nature of being a nurse. We're finding a lot less resilience. You know, 20 years ago nurses tended to eat their young, which I don't think happens as much these days." (FG3).

Burnout was a term to be avoided according to some participants, due to lack of specificity of the term and the uncertainty the term was applicable.

"you know, I don't like the word burnout because it doesn't say anything burnout basically. What do you mean by that? It's like then they start saying how they don't feel full" (FG3).

The label of burnout was, however, used by one participant, although also with a lack of certainty as to what is occurring.

"I think they develop burnout. I couldn't say that they get depressed. Who knows, or a actual diagnosis I couldn't say that because I don't know what goes on in their life. But I do think they get tired, irritable and they get burnt out " (Individual Participant).

Lack of opportunity or encouragement to manage work stress meant that vulnerabilities demonstrated by some staff would not be followed up.

"*no nothing constructive out of it essentially just sort of saying it for the sake of saying it when you try to pry more nothing sort of happens"* (FG1).

"I don't think burnout's really addressed for anyone, no I just don't see it" (Individual Participant).

Nursing culture may not encourage admitting to feeling stress, but participants nonetheless reported being aware of its effect on performance and personal functioning.

"*I know that a lot of times I hear staff saying that they're feeling quite stressed*" (Individual Participant).

"Sometimes physical exhaustion and mental exhaustion that takes its toll on your mental health" (FG1).

"we learn to kind of, I don't know, we find our own coping skills and I think that's maybe why drug health are a little bit off the wall" (Individual Participant).

A tangible impact on staff was on their own sleep.

"*it can obviously, you know, affect their sleeping pattern if you've got someone with, you know, you know, complex patients with a lot of issues, you know, it's, it's, it's quite common for people to take that home as well and worry"* (Individual Participant).

Managers tended to leave the responsibility for staff to manage their own wellbeing, whilst at the same time acknowledging a lack of support for their staff.

"I also give them strategies on how to handle um manage their patients difficult cases and also I told them to always be mindful of their mental health" (FG1).

"and so and that and also vicarious trauma and we take it but we don't have any adequate support to ease from those traumas we get" (FG2).

Personal life challenges mixed with work pressures are difficult for managers to address. One participant described a manager's

response to demonstration of emotion about a personal issue that was having an impact on work.

"*oh I don't do soppy. I don't do soppy"* (FG4).

Administrative staff in drug health are physically placed to work in clinical units but without clinical responsibilities. When patient related stress arises, they are impacted by the mood of their colleagues. Without being privy to clinical information or debriefing for privacy reasons, administrative staff are left guessing as to what the cause of the unhappiness is, and may take on some that stress themselves, even assuming that they may have contributed in some way.

"it's different cause you still feel the pressures and the stresses of whatever is happening in the unit amongst the clinical staff and it's hard to sort of move forward sometimes not understanding and having all the information "(FG4).

In summary, working in drug health whether as a clinician, manager or administrator presents challenges due to the emotional aspects of the job. Experience at work may have an impact on both professional and personal lives. Staff are expected to manage their own wellbeing. Insufficient staffing and work demand leave little time for staff to develop either individual or team strategies for managing workplace challenges. Stress and its effect on drug health staff is recognised within the team.

2. Wellbeing initiatives to date

Participants described their experience of support for their wellbeing to date to be from informal support from colleagues, formal support available to all staff by the health system (such as employee assistance, leave, and clinical supervision), and initiatives to recognise and reward staff.

Informal support from colleagues may be available during daily nursing huddles (planning/debriefing sessions), but that level of informal support does not carry any obligation of follow up or resolution.

"we have our daily nursing huddle… sometimes it can be just informal it [wellbeing] does come up just in passing like I said very informally …it feels like you you raise it and suddenly everyone wants to pitch in then its all you you talk about and then, if it doesn't get talked about, it's as if it never happened" (FG1).

The realities of nursing demands and nursing culture are not conducive to relying on informal means for staff wellbeing.

"I guess so like this huddle that they go on sometimes a little long and we've got like we've got medications due and medications after breakfast, I guess I guess you worry about it going down that tangent (laughter) then it takes too long or a lot of the time people don't want to express their feelings or yeah don't come across as weak or anything" (FG1).

Despite the limitations of informal support, participating managers feel that huddles are a way to monitor wellbeing.

"At least, you know, we have meetings once a month. We have huddles every day. We're always checking on their wellbeing." (FG3).

Some participants assume that because the workforce consists of healthcare professionals, they will naturally provide support to one another.

"I don't feel like there's an assumption because I do feel like everyone kinda does check in on each other. Like you're right. And as nurses, you just sort of debrief anyway" (Individual Participant).

Other participants do not consider informal means to translate to feeling they are supported.

"You know where is often its people left in silence thinking well I've just gotta deal with it" (FG1).

Formal support includes an Employee Assistance Program (EAP) that involves reporting to a member of staff from outside of the drug health unit. EAP visits to drug health staff occur monthly, providing an opportunity for staff to debrief on issues that have arisen.

"As far as the wellbeing we do have a person who comes in here like once, I believe once a month from EAP. And she does like a talk to staff, well, she lets us basically debrief about, you know, whatever stress we going through at work. So that kind of helps as well " (Individual Participant*).*

EAP visits may not coincide with shifts, meaning that some staff members miss out.

"But it is very hard to find a suitable time to conduct the session because you know even so, we had to wait for at least 1 1/2 months to find that timing, we don't have any free time to allocate that one-hour session so this is the problem we face even though we would like to support staff but it's very hard to find several timings" (FG2).

EAP is also considered reactive to a particular event, not preventative or focused on overall wellbeing.

"It's not very well advertised at all like new people come through and well this is a leaflet among other leaflets which you put aside, you don't remember it's also very reactive" (FG1).

Supervision is a form of formal support that was previously available and is missed by some participants.

"I think there's a lot of like in the past we had clinical supervisions and now we have the lack of, there's a lot of people who wants to attend it but there's none" (FG1).

For some, supervision should be mandatory.

"I think we need to bring back mandatory supervision monthly clinical supervision" (FG 1).

For others, supervision was not highly valued, the way it had been experienced in the past

"So within drug health and not even just drug health, I have never sort of been or very rarely have I been offered supervision and when I have had supervision, I thought it was very poorly run and it wasn't done very well" (Individual Participant).

Initiatives to support wellbeing through rewards and acknowledgement are offered across the health district. During COVID, when health staff worked in unprecedented conditions, recognition and reward for the whole health service was evident in the form of relaxation and distraction activities such as head massages and pet therapy for staff.

"And the 15 minute massages that they had, they had a massage voucher yeah, relaxing the massage thing, I did it once – I liked it relaxed everybody during that time for just a few minutes it redirected everyone again" (FG 1).

"*I have no idea who initiated that suddenly it was during Covid. I think well it must have been management I suppose. And we just had a masseur coming on site and giving people massage here…a student was coming in and seeing staff, which I found I can't, I can't do that"* (Individual Participant).

The wellbeing initiative of reward (exemplified by massages and pet therapy) experienced by participants was not sustained beyond a short period during COVID.

"that staff well being thing was very rushed, very quick and most things didn't happen except for some of the pet therapy and the

massage, which was very welcomed .I think for most, but it was like a once off and that's over it never mentioned again" (FG4).

Budgets for staff wellbeing have in the past been allocated to managers, but with very short periods to allocate the funds so that in some cases they could not be utilised.

"It was literally just we've been given this money for wellbeing and this was like 2 weeks before the end of the financial year you let's go around the units and see what they need and what they got to get and they mean things that happen in two weeks I mean, they were promised a new TV for the unit or a new coffee machine for the unit well, you know, by the time the money went through, the quote had expired and then we went back to square one" (FG2).

Managers often take on the responsibility for rewarding staff themselves, rather than waiting for district wide initiative, particularly when they know their staff are under pressure. At the same time managers do recognise that short term rewards are inadequate to address workplace concerns.

"*There's a ward that's critically understaffed. Ohh yeah. Well, here's a pizza party"* (FG3).

As an example, some managers bring in lunch for staff, but without a planned initiative.

"It's just all very random and impromptu like this week, I made a vegetable soup and shared it with the team" (FG2).

Transforming Your Experience (TYE) is an initiative within the health district that was investigated that is aimed at improving the work experience of staff and patients received but only passing mention in a few focus groups, indicating that it was not identified as a wellbeing activity for many participants. Formal support, in the form of various types of leave such as sick leave, family and community services leave, was raised in just one instance. When clinical staff take leave, further burden is borne by remaining staff who must cover their own duties and those of the staff who are on leave, so that encouraging staff to take leave may not be a solution to group wellbeing.

In summary, support mechanisms are in place, both informal and formal, but these are not consistent or necessarily available equitably across all workers. It appears that some initiatives are transitory due to budgeting or policy. Staff have difficulty utilising supports due to workload and scheduling constraints.

3. Future drug health service staff wellbeing programs

Participants all considered wellbeing programs for drug health service staff to be necessary. Participants described wellbeing for drug health service staff as multifaceted. Their discussions included *what* is needed to contribute to wellbeing, *how* wellbeing programs should be implemented, and *who* should be responsible.

<u>What</u> should wellbeing programs consist of?

Participants expressed support for the formal, informal and reward based initiatives that were available from time to time and suggested a range of additional skills and activities they consider important for drug health staff.

Wellbeing activities identified by participants as helpful were as follows:

- *Regular staff debriefing away from clinical duties, occurring fortnightly, which might involve counselling or coaching, and that was not linked to performance reviews*
- *Staff orientation and ongoing mentorship to explain and remind about formal support structures and how to access help*
- *Meditation/Relaxation/Exercise at the start of the day, as a buffer to allow shifting mindset to work*
- *Self-Care and care for colleagues, including coping strategies such as nutrition, recognising burnout, how to support the wellbeing of colleagues, prevention of serious effects due to vicarious trauma, separating work from home life*
- *Acquiring relevant skills such as managing challenging situations, de-escalation skills, managing aggression*
- *Team building*
- *Clinical Supervision and support for attending external courses*
- *Pedastalling to recognise qualities of staff members which could be done anonymously*
- *Reward with gifts (hampers, pens, food) that occur at regular intervals to form an ongoing program that is budgeted for*
- *Recognition (for example certificates), promotional opportunities for individuals and team recognition and professional development*

<u>How</u> should wellbeing programs be implemented?

How wellbeing activities were supported was seen by participants across the focus groups and individual interviews to be essential for benefit to be derived. They did not believe that any activities would be effective without managers and executives creating a context that supported wellbeing. Participants welcomed all initiatives aimed at wellbeing but expressed strongly that wellbeing was not just a single entity to be offered for a short time but needed to be embedded in the workplace culture to be effective. Access/ time, integrity, workload, and workplace culture were all discussed as instrumental in how wellbeing programs could be offered.

Access / Time

Access to wellbeing programs was identified as important.

"I feel like there's supports out there for you know for staff debriefing and counselling and things like that but I feel like they not as put forward or as easily accessible as they probably could be. I just feel like if they were more easily accessible or you know there was more available it would probably help" (FG1).

Quarantined time for wellbeing was considered by participants to be an indication of support from management for their wellbeing.

" where we're not on the floor where it's not like we got medications to do where it's not a time restraint like one where we can actually debrief away from everything" (FG1).

"we need to redesign our clinics etc to free up more time for dedicated time for this well-being and some other sort of issue to care for these issues. At the time I think we are more putting more oh importance to run the clinic on a daily basis" (FG2).

"I think it should be quarantined time … people need to be told, "it's OK." You can delay that job and quarantine this time to look after yourself because if you look after yourself you look after your patients better and make better informed decisions" (FG2).

Ensuring time and opportunity for professional development from management was raised.

"like there needs to be encouragement for professional development so I think having that time and support to do that is

really important" (FG4).

The format of wellbeing activities as face to face or online was discussed. Online sessions that were available were noted as convenient, but promoting wellbeing was considered to need time in face to face group settings. Knowing that management had sanctioned time for staff to attend wellbeing activities felt like support for staff.

"I mean now we are in this computer world, you know, and most of the things are on computer, but even the intensity of work we do, we are really, really busy and there, there are times that we don't have time to actually go online and attend trainings like that. However, when they're done in a group setting, I suppose then the management's aware that this is going to happen and and being in a group, I think it's very nice because it kind of, kind of gives it that, other than, you know, a person sitting in front of a screen and just" (FG4).

Integrity

Integrity and trust were identified as essential to any wellbeing initiative. Trust in staff to want to do their job optimally and believing they have the skills to manage their own wellbeing was identified as part of wellbeing.

"everything comes back to trust you've got to trust you know share any share any particular hassles they may have on that day" (FG1).

"the best impact from a session would be when it gives people an understanding of tools that they can use as a clinician or as a manager to manage their wellbeing" (FG3). *"Wellbeing is good culture. It's good processes"*.(FG3).

"The integrity, that is wellbeing" (FG3). *" so it almost needs like a whole culture of this across the organisation"* (Individual Participant).

Participants described the need for creating a culture of teamwork and not tolerating conflicts when dealing with patients, as part of wellbeing.

"just not tolerating any sort of disagreements between staff when they're on the floor and promoting that sort of teamwork culture" (FG2).

"the proper way, if you've got an issue, you go and speak with their manager or whoever rather than you know that creating that, that negativity, feeding negativity and bringing the whole place down" (FG4).

"I think it's about consistency as well you know staff wellbeing will improve if you do what you say" (FG3).

Workload and Staffing

Wellbeing was not possible without management being able to ensure that work/life balance was not too heavily weighted to work.

"Just making sure that work life isn't exhausting you that much that you lose the balance between work life and home life and you're not just spending all of your personal life you're supposed to be with your family" (FG1).

Ensuring teams included staff with specialist skills, such as social workers and diversional therapists, was described as important to staff wellbeing.

"I mean having other therapists to come in and to share the mental load of the patient care clearly assists and assists on many levels, but obviously assists the patient which is good but assists the team" (FG1).

An equitable workload, calculated in a transparent way, to match resources, was identified as important to staff wellbeing.

"I think there needs to be an algorithm or system for analysing workload for each unit and the allocation of resources. You often find workplaces where staff scream the most that's where they get the most resources and that's a sentiment shared by frontline staff" (FG2).

Wellbeing Embedded in Culture

Wellbeing needs to be sustained and not limited to orientation or when a crisis occurs.

"Ongoing as well it is good at induction but I think staff need like a refresher like maybe once a year or once every couple of years just a reminder and even just really a talk on you know like mindfulness, and gratitude and we're always risk assessing and looking at the negative that I think we get caught in a vortex of negativity and risk rather than positivity and strength building." (FG2).

Without budgets to sustain wellbeing programs, any reward or recognition risk being interpreted as tokenistic.

"Well, here's a pizza party. This is, you know? Yeah, you're doing really well. But sometimes in, you know, if your staff are really burnt out, it can be seen as tokenism" (FG3). *"I would like to hear that the organisation is putting in some practices to make your well-being better ongoing, as opposed to a one day training once a year. That's what I would like to see"* (Individual Participant).

Consulting staff before deciding on wellbeing initiatives would improve effectiveness as to what initiative might support their wellbeing was seen as valuable to tailoring programs to staff needs.

"But why not have a quick 15 minute meeting with your unit and say, is there anything you'd need is that for staff wellbeing?, would a new TV would a new thing like if there's a finance or the budgeting, are we able to do this but not make it like little points in meetings where people are just you know if you can go away and brainstorm with your staff and then come back and have a catch up about it doesn't have to be a meeting every week" (FG4).

Effective leadership was also recognised as part of the culture needed to ensure wellbeing of drug health staff.

"wellbeing has a lot to do with leadership they (nurses) work for leaders and they work for systems that they believe in and that's when they feel fulfilled" (FG3).

Who should take responsibility for wellbeing?

The role of managers and the question of who would be best placed to offer wellbeing training tailored to the specific needs of drug health service staff were discussed by executives in FG4. The following extracts are all from that focus group.

"I suppose someone who it could be even a drug and alcohol clinician, I suppose it could be. Or it could be an independent person, but someone who obviously has an experience in and understands someone who understands our work"

"So they would have to have the programme then maybe for managers as well because then, you know, it would not just be the trauma from, or you know, stress from patients going on to staff it'd be staff going onto manager as well, you know, so it's kind of like whether there should be a programme for staff and then programme maybe for leaders or whatever, I'm not quite sure"

"the person to check in I think always should be the manager but as I said that that also needs to be then looked at I suppose and 'cause managers have a lot of stress as it is, you know."

The results presented support wellbeing that has a role for peers, managers, and outside experts.

In summary, wellbeing may include formal and informal focused

activities, as well as reward and recognition, but is unlikely to be beneficial unless offered in a context of integrity, trust, and consistency. Training and supervision were highly valued, but not frequently available. Some aspects of training were needed to address the specific challenges of working in drug health services , such as de-escalation strategies to deal with aggression, how to manage vicarious trauma, and how to support peers whose wellbeing is suffering. Wellbeing was not isolated to reactive remedies or rewards, but also relates closely to workload, staffing and resource allocation.

Discussion

Participants in this study describe working in drug health services as clinicians, managers, and administrators. Their descriptions are consistent with previous publications (see for example [15, 24]) that explain the challenges of working in the specialty of drug health. Participants explained that working in emotionally laden situations is commonplace, as people experiencing substance use disorders often exhibit aggressive behaviours that might affect all members of the team. Clinicians reported high levels of psychological and emotional burden due to direct patient interactions. Managers and executives highlighted challenges related to resource allocation and organisational pressures. Administrators reported experiencing the atmosphere of stress without understanding the cause. Each form of stress was different; thus, wellbeing is expected to mean different things to each of these groups.

Participants agreed that attention to wellbeing was necessary. During COVID, recognition and reward systems were introduced but not in a sustainable way. Reintroducing past practices such as clinical supervision was supported by participants. Practical suggestions of activities to include in a wellbeing program closely match those identified by Adnan et al [1] who reviewed individually oriented interventions for wellbeing in publications dates between 2016 and 2020. The strategies to develop individual coping that have been mentioned in this study are thus not new information.

Like the participants in this study, attention to individual coping has been described in published literature as inadequate for wellbeing in healthcare. Organisational change needs to occur alongside individually focused activities. Butler et al [24] describe organisational support for wellbeing as related to formal supports like supervision and employment conditions, as well as allowing for open communication. However, participants in this study articulated in greater detail how a supportive context can be created to support their wellbeing. These results go further than just suggesting workload adjustments are needed by explaining how a supportive context can be created by embedding wellbeing into the workplace culture. The discussion amongst participants about trust and integrity and embedding wellbeing initiatives within the culture offer directions for future applications of wellbeing that are nuanced and multifaceted. The findings reported here resonate closely with those reported by Maple et al [8], who analysed responses from Australian frontline health workers collected during the COVID pandemic, as to what future initiatives to deal with a similar situation should include. Maple et al positioned the survey responses they analysed within a context of organizational change and uncertainty due to COVID conditions. Participants in this study described their complex workplace similarly to frontline workers in the Maple et al study, albeit that their conditions are current, not pandemic driven. Both the Maple et al study and the current findings strongly indicate the need for organizational change and workplace culture to support individual wellbeing initiatives. Thus, a contribution from participants in this study is that organizational support is understood to be important to the effectiveness of wellbeing activities offered in the healthcare context. Organizational support is important to staff in the post COVID era. This may be particularly pertinent where day to day work conditions are complex, such as drug health. Whilst wellbeing activities may not be needed by staff every day, the workplace culture that supports those activities does need to be consistent. Cohen et al [25], in their systematic review of organizational supports for health worker wellbeing that spanned publications that included COVID as well as pre and post COVID periods included two Australian studies [26, 27] in their review, neither of which addressed organizational change. The lack of research into the effect of organizational supports on Australian healthcare worker wellbeing reflects a trend in international research. Healthcare workers can articulate that organizational support is needed for their own wellbeing, but that to date research evidence is still lacking.

The study is limited in that all participants were from the drug health service team within a single local health district. Additionally, the loose grouping of participants into focus groups that represent particular employment roles within the team that arose due to the convenience scheduling might have restricted the scope of discussions between participants. Each focus group showed agreement between focus group members, with participants expanding on each other's views, not contradicting one another.

The descriptive qualitative method allowed themes to be generated from the data. Whilst the themes of working in drug health and the interventions experienced to date do not offer new information, the explanation for how a supportive context can be created to contribute to staff wellbeing offers detail and depth to the discussion about how organizational context can support wellbeing. Group discussions with participants from across employment groups may offer additional insights into this topic.

Conclusion

This study contributes to the growing body of literature on staff wellbeing in healthcare settings by providing detailed exploration of the experiences of drug health service staff. The findings underscore the importance of including all team members in wellbeing initiatives that are embedded into the culture that is built on trust and integrity between all levels of staff. Future research could consider longitudinal studies to assess the long-term impact of wellbeing initiatives, to expand studies to examine organisational shifts rather than focusing on individual skills. Further studies might explore the experiences of drug health service staff in different locations and models of care to enhance the generalisability of the findings.

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Responsibilities

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