The Drug Treatment Workforce

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Reducing harm, promoting recovery, challenging inequalities

Lifeline Project

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Preface: Workforce Development: For a Common Shared Learning Agenda

The challenge of developing a shared national agenda around the creation of a recovery-oriented workforce must address certain realities. In particular, it must address the current ways in which our field produces knowledge and expertise. Ours is an ever more competitive environment and treatment providers spend ever more time and effort in attempting to secure for themselves a knowledge-based competitive advantage.

It may be felt that much of the decisive thinking around workforce development in our field takes place within the 'black-box' of an organisation's confidential business. Providers themselves may well subscribe to and support this proprietorial approach to workforce development, despite the apparent difficulties of connecting any organization's existing workforce strategy to objectively measurable treatment successes.

From this point of view, therefore, the opportunities genuinely to share and collaborate may seem limited. On the other hand, over the course of the past 40 years, our field has built an impressive reputation for producing cutting edge knowledge and expertise. We produce knowledge variously via the publication of specially commissioned reports, peer-reviewed journals, guidelines, inquiries and investigations as well as numerous other publications and communications. Much of our best learning and knowledge production has been developed and disseminated expressly in order to raise field-wide awareness and understanding and, moreover, with a clear intention of improving standards universally and not at all on the basis of some privileged and restricted criteria.

I support the production of a more fully-developed and shared analysis of workforce-related issues in the drugs and alcohol field and am keen to expand the currently-available, public sphere debates, reports and commentaries upon our workforce, its competence, composition and future development.

I am further of the view that any relevant understanding of individual recovery-based job roles and competencies is closely connected to the more fundamental challenge of commissioning and constructing successfully functioning recovery-oriented treatment services.

In this respect a developed understanding of an industry-wide recovery-oriented workforce strategy will emerge only from an examination of the challenges thrown up by current developments in commissioning, service operation and practice development. These developments are profoundly influenced, in turn, by the broader processes of marketisation and commodification of public services. This latter point is beyond the scope of this paper which seeks only to describe recent history and current practice in the context of creating a recovery-oriented work force.

Introduction

The first part of this paper identifies three distinct phases of thinking around the drug treatment workforce: phase 1. 2001-2005; phase 2. 2005-2008 and phase 3. 2007-2013. The second part of the paper focuses on four key roles at the heart of many newly established recovery-oriented treatment services: i) Clinicians; ii) Practitioners; iii) Managers and iv) Peer mentors and other recovery-oriented non-salaried roles. Part three of the paper looks very briefly at how organisations might develop sustainable, ethical, and productive workforce development strategies. The conclusion argues for a strong consensus on what constitutes successful treatment performance and also for a shared learning agenda in the ongoing development of our understanding of workforce requirements in the treatment field.

Part One: Three Recent Phases of Workforce Development: (1) 2001-2005; (2) 2005-2008; (3) 2007-13

The first phase identifies the workforce strategy put in place during the period of the first national drug strategy subsequent to the establishment of the NTA in 2001. In this first phase, the primary objective was rapid workforce recruitment designed to scale up our industry in order to meet strategic treatment targets. In May 2002, The Drug and Alcohol National Occupational Standards (DANOS) were launched. These standards were regarded as the cornerstone of a workforce development strategy that required significant increases in the number of competent workers and the range of skills they possessed.

The second phase emerged under the NTA's 2005 Treatment Effectiveness Strategy and was further developed via the Birmingham Treatment Effectiveness Initiative, (BTE). This second phase was built upon an understanding that efficacy in treatment required much more than just a prescription. It sought clear advances in engagement, key working, and the correct and successful deployment of evidence-based psychosocial interventions. This phase sought both to consolidate the emphasis on individual professional competence and also to begin to look at the competence of organisations. It sought quite explicitly to move away from a model dominated by quantitative targets, numbers in treatment, waiting times, etc., to a model where issues of coherence, effectiveness and quality were dominant.

The third phase emerged as a result of sustained criticism of the UK treatment system and in particular its over-reliance on methadone. It built upon some of the work of phase 2, but in the context of a much more radical critique centred on a belief that drug users could recover from addiction. These critics of harm reduction advocated a much more person-centred and recovery-oriented approach that would be built around the service users strengths rather than their deficits.

This approach was frankly critical of the professional standards of the workforce and their attitudes to the possibility of recovery. This phase partly overlapped the second phase, but unlike the second phase questioned the role and practice of professionals. It was highly critical of treatment services and argued for fundamental change, not incremental improvement. The powerful emergence of the recovery movement served to overtake and somewhat eclipse the Treatment Effectiveness strategy.

This third phase grew in momentum over the course of 2007 and 2008 and by 2009 saw the NTA make a major turn towards recovery which was fully incorporated into the national drug strategy of 2010: *Reducing Supply, Restricting Demand, Building Recovery.* The 2010 strategy called for the newly established National Skills Consortium to help build an inspirational recovery-oriented workforce. This represented a departure from a workforce discourse largely focused upon individual worker competencies and skills and placed much greater emphasis on a whole systems approach centred upon recovery as an individual, person-centred journey.

Phase 1: 2001-2005 -- building the harm reduction workforce

Today, in 2013, the rapidly changing landscape of drug treatment raises a number of questions about the current status of our industry's workforce and leadership. Both were recruited under very different circumstances at a time when both numbers in treatment and an accompanying workforce expansion were critical objectives.

As a result of the introduction of Agenda for Change in December 2004, some NHS treatment workers were able to benefit from a nationally negotiated reward and conditions package that was unavailable in other sectors. Without discussing the merits of this award, it is clear that it was unsustainable over the longer term and frequently permitted incremental advancement as an entitlement rather than a performance reward.

The workforce grew steadily over the course of the first 10-year national drug strategy (1998-2008), but particularly in that period subsequent to the creation of the NTA between 2001 and 2005. The government and the NTA were strongly of the view that containing and managing problem drug users through a strategy of treatment retention and opiate substitute maintenance would be effective in reducing crime.

The pressures of a rapidly expanding treatment system frequently rendered the therapeutic and psychosocial component of the key work role virtually insignificant. These pressures resulted often in a clinically driven and sedentary, appointment-based casework approach.

Not surprisingly, in these circumstances of rapid recruitment, where many new workers were unqualified, our workforce development emphasis was upon the 'professionalisation' of the field via individual professional development in the context of the acquisition of skills, competencies and qualifications.

Phase 2: 2005-2008 -- the Treatment Effectiveness Strategy

The second phase was initiated by the NTA in 2005. This phase was introduced on the back of the strategy's clear successes in respect of progress to towards the targets set out in the national strategy which, at that time, still had three years to run. It was argued at the NTA summer conference of 2005 that the best way to build on that success was to make a significant turn from quantity to quality.

The concept of the treatment journey was brought strongly to the fore and this enabled a close collaboration between the NTA and the Texas Institute of Behavioral Research. The work of Dwayne Simpson and colleagues became more widely known as a result of two national pilots. The second national pilot in Birmingham, the Birmingham Treatment Effectiveness Initiative (BTEI) saw a strong team featuring amongst others, Dr. Ed Day and David Best.

Best's work at this time straddled his preoccupations with the service user experience and treatment effectiveness. His research study of 344 attenders at four through care and aftercare teams in Birmingham revealed that, on average, clients only received 93 minutes of treatment per month. This finding reinforced a growing conviction in the UK treatment field that despite the growth in treatment capacity, there was lack of both intensity and extensity in therapeutic treatment provision. David Best, as a result of this study and a growing belief that professional services were not the answer, grew to be ever more critical of the pessimistic assumptions and the sub-optimal performance of much British drug treatment.

The Birmingham Treatment Effectiveness Initiative, however, building strongly on the work from Texas, has had a lasting importance in terms of identifying a range of intuitive and powerful system-wide interventions designed to raise standards and bring coherence to the treatment journey. Simpson and colleagues' work pointed to the importance of change, not just on the part of individual workers, but also on the part of organisations. According to BTEI: "Evidence also tells us that the way a drug treatment service is organised and managed can have as much -- if not more -- impact on client outcomes as the interventions on offer and the characteristics of an agency's clients.[1]

The Texas initiated work on 'organisational readiness' has continued and in March 2012, Patrick Flynn, from the Institute of Behavioral Research at Texas Christian University and colleagues introduced a special issue of the Journal of Substance Abuse Treatment dedicated expressly to organisational dynamics within substance abuse treatment. The introduction to this special issue presents a conceptual framework designed to help describe the various components of dynamic organisations and states. "Substance abuse treatment programs represent complex human activity systems in which multiple actors, including clients, counselors, and managers are nested. Furthermore, treatment programs are nested within the broader environmental context of resource allocation and regulatory enforcement." [2]

Another key report from this period, very much in keeping with the theme of treatment effectiveness, was the *Nice Guideline 'Drug Misuse: Psychosocial Interventions'*

(2007). This report sought to identify value for money evidence-based, psychosocial interventions. A key application of the NICE guideline was to provide a blueprint for commissioners and providers in respect of core, key-working competencies as opposed to more specialist interventions that required a more intensive approach.

The NICE guideline was rigorous in its application of the evidence base and was controversial, both in terms of its inclusions (Contingency Management) and its exclusions (CBT). It did, however, provide a comprehensible blueprint for providers wanting straightforward guidance on those necessary and approved competencies that front line drug workers and, in particular, key workers should command.

The professionalising strand of thinking which linked the NTA's *Care Planning Practice Guide* (2006) with the NTA's *Routes to recovery series,* featuring in particular the Birmingham Treatment Effectiveness Intervention is also evident in the publication of the *Nice Guideline* and the follow up NTA/British Psychological Society publication, *Psychosocial Interventions for Drug Misuse--A framework and toolkit for implementing NICE-recommended treatment interventions*. *(2009)*. Taken together, this is an important, coherent body of work.

A significant number of provider organisations were able incrementally to keep up with the strategy and its key guidelines, toolkits and reports; many weren't. And notwithstanding the new introduction of an organisational perspective, workforce strategy at this time was still substantially focused upon the competencies, skills and qualifications of individual workers.

Our collective memory about the recent tumultuous events in the British drug treatment system is in danger of forgetting this very important, albeit rather brief phase of developmental thinking about workforce strategy and standards. The introduction of an organisational perspective represented a distinct step forward. An advance that quickly became obscured as a result of the much higher profile criticisms of drug treatment by the recovery movement.

Phase 3: 2007-2013 -- building the recovery-oriented workforce

Phase three of the development of workforce thinking was slow to develop. The recovery movement had first begun to make an impact in 2006. In the autumn of 2007, however, the subject of the perceived failure of the British Drug Treatment System, particularly in respect of its failure to get people off drugs, became a prominent national media story. The fires were fuelled both by journalists and by critics of drug treatment, the National Treatment Agency and methadone prescribing. Some of the most potent critics came from within the field.

One set of internal criticisms came from established professional interests within the field who argued principally for a different direction for treatment, in particular the wider adoption of residential rehabilitation.

Other criticisms advanced a more fundamental critique of an overly professionalised and medicalised field exerting an undue influence on government policy. These

critics condemned the prevailing approach in which therapeutic interventions were conspicuous by their absence and where the use of important community assets was virtually ignored. The critique of the typical caseworker became commonplace. Drug workers, it was claimed, had managed to cut down meaningful therapeutic activity to an absolute minimum during casework encounters with clients that yielded little more than script-related pleasantries.

The reputation of medical elites and mainstream caseworkers alike came under persistent and critical scrutiny during 2007 and 2008. The harm reduction philosophy that was the corner stone of British drug treatment strategy was depicted as little more than a cynical exercise in rendering a large treatment population docile and less liable to indulge in drug-related offending.

Professor Strang's expert group, in the 2012 report, *Medications in Recovery*, puts it thus: "The ambition for more people to recover is legitimate, deliverable and overdue. Previous drug strategies focused on reducing crime and drug-related harm to public health, where the benefit to society accrued from people being retained in treatment programmes as much from completing them. However, this allowed a culture of commissioning and practice to develop that gave insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence. "[3]

The 'crime dividend' that had served as an increasingly powerful legitimating factor over the course of the 1st national drug strategy was no longer sufficient justification for "parking people on methadone." By 2005, over 40% of the annual investment in drug treatment was targeted at such crime reduction interventions. By the end of 2008, the policy of harm reduction, methadone prescribing and crime reduction had lost the full and unqualified support of many senior politicians and policy makers.

The recovery movement was, therefore, importantly a critique of professionals and professions, a critique of services and a critique of a strategy that seemed to make no effort at all to help people recover. No wonder then that in the early years of the recovery movement, commissioners and providers struggled to come to terms with an analysis which defined their role as part of the problem rather than part of the solution.

The recovery movement was convergent, but not identical, with the increased prominence of personalisation. A new approach which, at this time, was challenging the traditional social care workforce in the name of greater choice and freedom for service users. The recovery movement was also convergent, but not identical, with a consumerism that championed choice in services, something that seemed to be particularly lacking in drug treatment services.

The recovery movement was able, during this period, 2006-8, to effectively advance a new form empowerment, where people in recovery were one of the most authoritative sources of expertise and inspiration for other people in recovery. With a few honourable exceptions, most professionals working in community settings were regarded as unreliable at best, and downright problematic at worst.

In 2009, the NTA began to develop a recovery-oriented analysis of its own. This represented nothing less than the systematic reorientation of the mainstream drug treatment field to recovery. This major readjustment contained a significant acknowledgement of the need for change. It built skillfully on the Treatment Effectiveness strategy and didn't advance any specious claims to have been "doing recovery all along". Over the course of this period, the NTA developed more detailed positions on recovery and identified abstinence as a desirable treatment outcome. Despite some initial reservations, the NTA was able to reforge its strong alliance with senior clinicians around the need for a fundamental reorientation.

Over the course of 2009, recovery went from being a serious and often unfriendly critique to the new national orthodoxy. And in 2010, with the publication of the new national strategy, *Reducing Demand, Restricting Supply, Building Recovery*, recovery had arrived as the cornerstone of the new national treatment strategy. In 2010 the NTA launched the National Skills Consortium,
a major new recovery-oriented workforce initiative.

The Consortium was able to gather around it commissioners, the Royal Colleges and a large number of key providers. There followed a period of development designed to integrate the professionalising thrust of the Treatment Effectiveness years with the new, non-professional energies unleashed by the recovery movement.

The Skills Consortium was able to build on the work of National Centre for Education and Training on Addiction at Flinders University, South Australia. NCETA had recognised that workforce development requires "A multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug related problems. Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers" [4]

The Skills Consortium acknowledged that an adequate, fully developed approach to workforce development must take account of the major role of provider organisations in workforce development. It also recognised the role of commissioning partnerships in setting a new range workforce requirements and expectations. The Consortium's Skills and Evidence Research Group, through Mike Ashton, produced a multi-level matrix identifying appropriate learning interventions for Individual Workers, Organisations (at both team leader and manager level) and Systems (Commissioning Partnerships).

The NTA also developed the web-based Skills Hub for the Skills Consortium. The Hub represented a significant marrying of professional, psychosocial evidence-based interventions with the new recovery-oriented practices. The Consortium received a major boost when the 2010 Drug Strategy identified its role in respect of facilitating an "inspirational' recovery-oriented workforce. The strategy’s chapter on Building Recovery in Communities spelled out, through the chapter's sub-headings, the following message: "Recovery is an individual, person-centred journey, built on the

recovery capital available to individuals, in a system that is locally led and locally owned, where all services are outcome focused, delivered using a 'whole systems' approach, by an inspirational recovery oriented workforce…" [5]

The insistence that the strategy be "…delivered by a whole systems approach by an inspirational recovery-oriented workforce" has spurred a considerable development in our approach to developing a systems approach to. Within the treatment system, our understanding of policies of visible recovery; of segmentation and strength-based working; of stronger linking to mutual aid and of the role of peer mentors and recovery champions is all much better developed and integrated than it was three years ago. Undoubtedly there has been a significant level of incremental innovation involving the introduction of the new front line recovery roles and interventions. The next sections examine some of the key roles in the new recovery-oriented workforce.

Part Two: The Recovery-oriented workforce development: Key Roles

The structure of many recovery oriented substance abuse services varies from service to service. A common, somewhat simplified structure would include, however, the following roles: (1) Clinicians (2) Practitioners (3) Managers and (4) Peer mentors and other recovery-focused non-salaried staff.

Clinicians

The Medications in Recovery report published in July 2012 was a great leap forward in determining those circumstances where recovery would be a safe option for even those whose medical needs were the most pronounced. This identified the doctors and nurses as being in the forefront of innovation and set out the conditions under which their contribution would facilitate meaningful recovery in all patients, not just those with high levels of calculable recovery capital.

On the new, potentially more risky approach, Medications in Recovery states that: "The more ambitious approach outlined will sometimes lead to people following a potentially more hazardous path, with the risk of relapse (or at least occasional lapse) as they seek to disengage from the OST that has supported them. Individuals (and their families), clinicians and services need to understand this potential risk. They need to approach the change with careful planning and increased support, and include a 'safety-net' in case of relapse." [6]

The Recovery Oriented Drug Treatment Group, chaired by Professor Strang, identified the strong commitment of the broad medical community and other key field stakeholders to a radically new approach to pharmacological interventions. The report, alongside the introduction of an updated Core Data Set, provides a platform for a more proactive, safer and more ambitious approach to medically assisted recovery.

Doctors and other key medical personnel are thus at the heart of the new recovery-orientation. The work of the RODT Expert Group and the Royal Colleges' Working Group's *'Delivering quality care for drug and alcohol users: the roles and competencies of doctors'* comprise an important set of resources upon which to build.

The challenge for services is to create an operational environment that facilitates and integrates the new clinical practice by providing an "accessible and integrated 'offer' of treatment that is personalised and optimised to promote and support wide recovery objectives for every person in treatment." [7]

Practitioners

In the new recovery services there will be a number of different practitioner roles. There will be practitioners who are there to deliver specific interventions around, for example, housing, employment and group work. There will also be recovery coordinator roles. These roles (variously titled according to provider preference) can be seen to have evolved across time from their original role as caseworkers. This original *caseworker* role was refined and reformulated at the time of what I have called the second phase of workforce development (2005-9).

As a result of the NTA Treatment Effectiveness Strategy and the *NICE Psychosocial Guideline*, the role of *key worker* evolved to incorporate a range of role-specific psychosocial competencies delivered across the key stages of the treatment journey. This role reformulation specified the importance of treatment pathways and the importance of skilled networking and appropriate onward referral.

The further, significant evolution of this core, coordinating role is evident in the recent emergence of the *recovery coordinator.* This role has emerged semi-spontaneously in the new, localised environment in which drug services are now commissioned and constructed.

In many of the new treatment systems the role of assessment has been separated off and is no longer necessarily the preserve of the key worker. In fact, one of the distinctive features of current commissioning in this post 'Models of Care' era is that the treatment journey is often specified in such a way as to involve two or three different providers carrying responsibilities for different functions and phases of treatment.

Where a treatment system specifies individual contracting arrangements for functions designated as a) Intake/Assessment, b) Treatment and c) Recovery, for instance, the question of whether there is a common set of front-line, main grade, psycho-social competencies is interestingly posed. The increasing fragmentation of systems, the emphasis on new skills and competencies and the more specialist functions of contracted services and workers may make the typology of' key worker' role less helpful as a heuristic for understanding whole systems.

Nevertheless, there are good reasons to avoid unnecessary complexity in the

specifications of the new recovery job roles and some form of core co-ordination will clearly always be necessary: hence, the role of recovery coordinator. This role is potentially much more, however, than an updated version of what has gone before, notwithstanding its coordinating function. It is not necessarily a role that easily transfers from traditional service settings. The new recovery-coordinator, in addition to the psychosocial competencies identified as part of the Treatment Effectiveness Strategy and the *NICE Psychosocial Guideline*, will need to develop a range of new, recovery-oriented skills and aptitudes.

The ethos, ambience and aspiration of a recovery-oriented service could hardly be more different from many of our unreconstructed, prescribing services. One cannot straightforwardly transform these services by incremental means and what holds true at service level also applies to a significant proportion of the workers employed by these services.

Where assessment remains integral to any key worked, and coordinating role, the new strengths based assessments build on and go a clear step on from the triage and health assessments previously used. Strengths-based assessment and co-production around a recovery plan are just one element of the new job roles, however. These roles call for a genuine openness to working alongside service users in an empowering and facilitative way.

A well-balanced recovery-oriented treatment service provides a range of choices. Clients are able to access group work, medical services, training and educational opportunities, volunteering roles, peer mentoring, different kinds of information and advice and a range of cultural and community based activities. The choices on offer relieve pressure on the casework coordinating function and will enable the 'working alliance' between the worker and the client to develop beyond the application of what Jim Orford calls the technology model of psychological treatment. Orford describes how this model has been "likened to a technique which, supported by a manual and good training and supervision, can be delivered to a high standard so that ‘therapist differences’ cease to be important. The therapist is the medium through which a standard technique is applied at a high level of fidelity." [8]

In a similar vein, Bruce Wampold calls for a move away from what he describes as the 'medical model’ of psychotherapy towards a 'contextual model'. "The contextual model emphasises the commonalities among therapies. All therapies involve the relationship of a client and therapist, each of whom believes in the efficacy of the treatment.” [9]

In our field, we may believe in evidence-based treatment, but from the point of view of a recovery-orientation, it is useful to understand the distinction that Bruce Wampold makes in *The Basics of Psychotherapy* between two traditions in psychology. "The scientific tradition has provided evidence that psychotherapy is remarkably effective and has established the legitimacy of psychotherapy in the health care delivery system. The humanistic tradition has laid the foundation for the caring, empathic, and meaning-making aspects of the practice of psychotherapy." [10]

Recovery-oriented roles also require the development of reciprocally facilitative relationships with mutual aid groups of all kinds, including recovery communities and often demand the facilitation of proprietary recovery programmes. These programmes are not standalone groups, or exercises in harm reduction or information giving; they have clearly focused recovery objectives and differ in terms of content, structure and intensity.

We are used to separating out our discussions of 'psychosocial interventions' on the one hand, and mutual aid, on the other. In his book *Circles of Recovery,* Keith Humphreys asks, "How specific are the mediators of AA's effectiveness?" His answer describes a surprisingly close convergence between these two ostensibly quite different approaches: "Changes in active coping behaviours, cognitive appraisal of the advantages and disadvantages of drinking, and self-efficacy may seem more the stuff of cognitive-behavioral psychotherapy than of a 12-step self-help organization. But even the most spiritually minded AA meetings and texts offer extensive practical advice, which any cognitive-behavioral theorist would endorse even though the jargon would be unfamiliar: monitor for relapse-promoting cognitive distortions ("no stinking thinking"), adopt behavioral changes that are congruent with more positive mood ("fake it until you make it") and use stimulus-control methods to eliminate alcohol consumption ("avoid slippery people, places, and things") [11]

In addition to the appropriate psychosocial competencies and recovery-based skills, workers in recovery-oriented services need to have, a customer-orientation that is positive, welcoming and skillfully tailored to the service users' various needs. It is well to have mastered node-link mapping, but underpinning all those therapies that workers wish quite rightly to acquire and practice is an even more basic set of competencies and attitudes that need to be in place.

Circumstances of change and uncertainty can make employees defensive, apprehensive and unwilling always to give of their best. Nevertheless, many drugs workers seem, notwithstanding their qualifications, to have an absence of what are sometimes referred to as "soft skills": the ability to communicate, empathy, basic cognitive understanding, punctuality, appearance and flexibility. Our industry needs to recognise and address this shortcoming as a matter of urgency. Without courteous, empathic and skillfully tailored facilitation as standard, it is inconceivable that our workforce could ever claim a recovery-orientation that was in any sense inspired.

The Manners Matters review, in the words of its authors, "is about how treatment services can encourage clients who make an initial contact to return and stay the course. …Our focus is not so much on what services do, but how they do it, and how this can create a bond with the people who come to them for help. While which treatment 'technology' is delivered typically makes little difference, how it is done can transform the client's response. The principles are simple: the same human qualities which cement relationships outside treatment also do so within it." [12]

The *NICE Psychosocial Guideline* was produced immediately prior the emergence of the recovery movement in this country. Despite this, its relevance, with one possible

exception, is still unquestioned. We are not, from that point of view, in a post-NICE space. Nevertheless, we must be open to new approaches and methods, and, equally importantly, those traditions that emphasise the quality of the therapeutic relationship and all those details that go to make it real.

Managers

"A half century ago Peter Drucker (1954) put management on the map. Leadership has since pushed it off the map. We are now inundated with stories about the grand successes and even grander failures of the great leaders. But we have yet to come to grips with the simple realities of being a regular manager." [13]

Within the confines of the substance abuse treatment field, the role of the service manager has not been the subject of regular and dedicated study. Within provider organisations, managers are often described as playing an important role in a range of activities bureaucratically described as 'operations'. This designation does not fully grasp the significance of the manager's role, particularly over the course of extended periods of significant cultural and organisational change.

In respect of the core objectives of provider organisations, the role of service manager could hardly be more important and is arguably the most important area of focus in respect of constructing a successful recovery-oriented front line service. If the field is able to identify, recruit and train enough of the right kind of manager, it will have a profound impact on the quality, commitment and degree of integration of our senior clinicians, our front line workers and our non-salaried recovery support staff.

The span of accountability of a service manager: key integrations

One can describe the role of a successful and effective manager in a number of different ways. One approach is to examine their role from the point of view of two of the major challenges of integration.

Team Building --The Integration of experts, practitioners and experts-by-experience.

Team building in a recovery-oriented service will involve the challenge of integrating clinical specialists, front line practitioners and peer support workers. In their 2012 guide for commissioners, providers and clinicians, the working group of the Royal Colleges of General Practitioners and Psychiatrists state that "Doctors are well placed to champion recovery and play a leadership role in those they support and in the professionals with whom they collaborate across a range of services" [14] The report continues: "more specialist doctors have responsibility to be closely involved in the full range of key management decisions on service design and development." [15]

Creating a cohesive, integrated team of people of vastly different pay grades, professional backgrounds and levels of experience is critical. Put another way, successfully integrating the respective contributions of experts on the one hand, and experts-by-experience on the other, falls principally to the service manager.
In this respect, Keith Humphreys describes the challenges of that often uncertain relationship that managers' face when working with mutual aid groups as follows: "Most professionals are aware of the potential bias of those who feel they owe their

lives to self-help organisations. What many professionals appreciate less …is the bias of professionals in favour of professionally controlled interventions." [16]

Integrating Health and Wellbeing: i) Drugs and Alcohol; ii) Prevention and iii) Recovery and Service Provision and the Wider System of Recovery.

In April 2013, "Local authority-based public health will become responsible for commissioning drug and alcohol prevention, treatment and linked recovery support…" [17] As one would expect, in the latest commissioning advice, there is a palpable sense that the commissioning of alcohol and drugs are now more closely convergent than ever and, moreover, that prevention and treatment are likewise part of single unified perspective.

In addition, therefore, to optimising services through the enhancement of core and specialist competencies and the development of effective treatment pathways, service managers will focus ever more concretely on specific measures designed to enable communities to take action in support of their own health and wellbeing. These more developed partnerships with people and communities are at the heart of the move toward prevention. They are also at the heart of developing recovery.

Service managers' direction of travel in this regard may well follow the trajectory described in the RSA report on Whole Person Recovery: "We began with the idea that personalisation, the pinnacle of user engagement and user-centred approaches, was the ultimate aim. We soon found that this did not do justice to the potential that existed within individuals we met and the communities we worked in. In concentrating on how to personalise services by embedding a user-centred approach, it became apparent that this was only one component of a much wider system of recovery. This meant that the projects focus began to expand beyond the arguably narrow, albeit ambitious, personalisation agenda to the inclusive recovery agenda." [18]

Service managers and commissioners, working together, are critical local architects of strategies to help develop the full range of community assets, including mutual aid, peer support, recovery networks and recovery communities.

In a period of localism and increased competition, two sets of questions are posed for provider organisations. The first set concerns the degree to which organisations support the development of shared learning agendas as opposed to a more restricted, private pursuit of knowledge production. These questions were touched upon in the preface and will be summarised briefly in the conclusion. The second set concerns the degree to which localism encourages, indeed calls for, a radical decentralisation of strategy and decision making on the part of organisations.

In this context, the role of locality-based service manager has assumed a strategic significance. Many provider organisations will be led towards a radical decentralisation of decision making, one where managers will, in effect, be running their own businesses within the framework of their organisation's well-defined, high level objectives. One of the benefits of having capable managers with clear strategic intent operating at local and area levels is that they don't need much supervision and

many of the costs of running a large control-oriented organisation will be unnecessary.

The new, locally empowered managers will be developing a whole systems approach, both as part of the parent organisation, but also equally critically, as part of local communities of practice where they will be helping create a joint dynamic of decision-making, resource allocation and the setting of common objectives.

As organisation's release managers to fully explore local communities, networks and partnerships, they will at the same time be enabling them to open up fresh business development opportunities and strengthening their own organisation's local reputation.

Peer mentors and other recovery-oriented non-salaried roles

Our views of volunteering have changed profoundly over the years. With the emergence of the recovery movement, we have, quite suddenly, 'discovered' the energies and inspiration that non-paid peer mentors, recovery champions and group work specialists can bring. Indeed, the most inspirational interventions are often provided by people who non-salaried and, in terms of professionally approved competencies, unskilled. One can see such interventions, for example, at service intake, (in order to provide a visible recovery stimulus); in a variety of different kinds of group work; on a one-to-one mentoring basis and in a range of other peripatetic support functions.

Irrespective of qualifications and recognised competencies, it is clear that peer mentors and all the various kinds of volunteers and recovery support workers are, in every sense, a most valuable part of our workforce. In this regard, our tendency sometimes to idealise this section of our workforce, can seem disingenuous given the lack of tangible material reward they get for the contribution they make.

Many organisations do have excellent volunteering policies every bit as thorough and well worked out as their employment policies, handbooks and procedures. And organisations frequently offer first class support and guidance systems and clear frameworks of management and supervision.

In addition to the question of this kind of policy and support framework, however, there is an important matter of the development of a strategy for recovery support workers and all client-centred volunteer staffs. Volunteering can be a vital stepping-stone to fuller, more meaningful and more rewarding integration into society. It can be a stepping-stone to a job.

As yet, however, our workforce strategies for the unsalaried are not of the quality of our in-service volunteer frameworks. Beyond basic descriptions of utilisation, we do not always develop workforce strategies that identify, as a matter of course, the social impact of our various volunteer deployments; the employment and training objectives that are set; or the contribution we expect and have agreed to make to broader local health and wellbeing strategies. Neither do we always set out how

volunteering and the broader utilisation of recovery support roles contributes to our profitability and sustainability and, furthermore, how we reward, or otherwise enhance the non-salaried section of our workforce.

This element of workforce planning should ideally be initiated and managed at partnership level. Equally, however, it should also be high on the agenda of required workforce development in provider organisations. It may be part of a broader recovery-oriented workforce strategy which in turn will be at the heart of an organisation's business development planning.

Part Three: A recovery-oriented workforce strategy

There is a very broad ranging discussion taking place in all Western post-industrial societies about labour markets and the extent to which our economies are going to be able to sustain a secure, well-paid, skilled workforce. In some sectors, the so-called 'hourglass economy' is a clearly emergent trend; one where high- and low-skilled jobs are increasing but many skilled jobs in the middle are being eliminated.

Although the UK substance abuse treatment workforce isn't necessarily moving towards an hourglass shape, there is a well-founded concern about our field's ability to avoid widespread deskilling and casualisation.

Of course any newly composed workforce will have the shape of a structured hierarchy where radically different salaries attach to particular roles within the treatment system. Such inequity, must not however be used to justify a wholesale policy of casualisation, where the field’s skills base is 'hollowed out' and replaced by a low-paid, labour force that is casualised to avoid the overheads that come with hiring full-time employees.

Paying sustainable salaries with an identified rate for the job is critical in this respect. We must bear in mind, however, that some key roles within the workforce, e.g. doctors, will be able to ask for and get salaries which are beyond the control of providers or commissioners to negotiate. In addition, sustainability can only have meaning if we are confident as an industry that we know what the optimum mix of skills looks like, how we can recruit and reproduce a workforce with these skills and, at the same time, maintain and improve the quality of our services without compromising our values as ethical employers.

A recovery-oriented, workforce strategy will be at the heart of business planning. According to the organisation that produces it, it can assume a number of different forms and contain a wide range of priorities. This brief section is intended only to touch upon the issues of values, productivity and sustainability that any workforce strategy would presumably address.

Values, Mission, Ends

A recovery-oriented workforce strategy will embrace competition and collaboration

equally to the extent that they facilitate clear and measurable improvements in recovery-oriented practice as well as all other essential elements of care. It would pursue corporate values emphasising the primacy of front line service quality as a key organisational objective.

It would employ a methodology and strategic process able to identify and specify all those workforce elements essential to the achievement of such primacy, including specifications of quality, scale, diversity and range of service provision.
This process would be driven by an organisational commitment to experiment and trial such approaches as are likely to facilitate the desired changes and advances in service provision.

Productivity

In further pursuit of these values, a recovery-focused workforce strategy would seek to maximise organisational productivity at all levels in order to meet those growth and development objectives necessary for enhancing the quality and range of services.

This approach would be further informed by the search for higher levels of employee engagement. Competency based models of the kind advanced within the field under the auspices of our key leadership bodies do not speak to or inform discussions about accessing higher levels of staff engagement.
It would encourage and authorise flexible opening hours and new technologies as appropriate.

Sustainability

It would further identify, in a broader organisational context how services can be delivered on a sustainable basis. Sustainability here, would mean a reward system that is able to attract key roles at full market rates, but is also able to benchmark rewards in such a way as to provide an attractive and affordable range of career options for all workers.

A sustainable workforce strategy would also eliminate hierarchies of unnecessary corporate decision-making, devolving responsibility and decision-making wherever possible. It would seek to recruit and train a workforce with the range of skills necessary and would focus upon service modeling the appropriate integration of roles and interventions, prioritising key clinical, front line, mentoring and management roles.

Conclusion

I have described how the recovery message picked up momentum over the course of 2007 and 2008 and how by 2009 the official national policies and guidance on drug treatment had begun to reflect the new, more optimistic and more challenging perspectives embraced by those who had argued for a recovery orientation in British drug treatment policy.

In 2010, with the publication of the new national strategy, *Reducing Demand, Restricting Supply, Building Recovery*, recovery became the new orthodoxy. This transition and the main changes have also been reflected in thinking about workforce strategy. This paper has attempted to show how workforce strategy developed between 2001 and 2013 and has pointed to three separate phases of development.

The preface to this paper argued for a shared national learning agenda around workforce development. I believe that those of us who are most enthusiastic about competition and feel able to thrive in a competitive atmosphere may also wish to consider whether or not there aren't good, pragmatic reasons for a similarly enthusiastic approach to public collaboration and knowledge development.

Striking a balance between public science and private development

Of course in determining the value and feasibility of constructing a shared national agenda on workforce strategy, one must give some indication of what such an agenda would look like. What precisely would we be sharing? Rather than pretending to be in a position to rehearse a definitive set of answers to the questions about a workforce strategy and the developmental context in which it should be set, this paper has attempted to indicate a number of ways of beginning a discussion.

A publicly shared and owned reporting system that measures our real progress as objectively as possible

Firstly, most importantly, and without any shadow of a doubt, I think we need a frank appraisal of the real progress we are making in terms of service performance and the performance of the workforce that is currently in place. The Home Office's May 2012 review of the first 12 months is positive, but it doesn't really provide a detailed picture of our current strengths and weaknesses. We need a rather more frank and detailed assessment of where we are. This, in turn, will raise the issue of what we should be aiming to achieve. We need to embark upon a more intensive and shared investigation and understanding of the new national data. The introduction of Core Data Set J should enable clearer assessments to be made about the impact of systems as a whole and the impact of the different intervention types that the data set measures.

A frank and detailed assessment of our performance informed by the best qualitative and quantitative data at our disposal

What are our ambitions for the treatment system as a whole? The recent statements of the NTA in this regard are helpful, but they are not definitive. We, as a field need a greater sure-footedness in talking about measured performance and need to secure a clearer understanding of what the benchmarks of our ambition should be set. Put bluntly, we need to be able to ask whether are we achieving enough! And we need to be able answer this question clearly and as a field.

If we are able to establish, via any and every means at our disposal, an enhanced, national overview of our performance, informed by the most credible and relevant

sources of data, then we will be in a much better position to see whether our performance as a whole field is best left to local ownership and procurement, or whether localism and the commodification of expertise need to be offset by a public discussion about workforce improvement and innovation.

As previously stated, the view of this paper is that an agenda adequate to the challenges of developing our workforce must seek to build upon and integrate the professionalising workforce agenda, developed through the NTA's Treatment Effectiveness review, 2005-2008 and the introduction of the new recovery innovations described most recently by the 2012 report *Medications in Recovery*.

This agenda certainly should not preclude new approaches to the development of knowledge. Jim Orford's 2008 critique of current research methods and objectives sought "possible reasons for the disappointingly negative results of methodologically rigorous controlled trials of psychological treatments in the addictions field" and cited research concluding "that the randomized controlled trial (RCT) was not well suited for studying treatments for chronic health and behavioral health problems such as substance misuse; and they are not alone in questioning the privileged place that RCTs have been afforded in our field". [19]

There will be a number of perspectives on the scale of progress we are making in respect of creating an inspirational recovery-oriented workforce. These perspectives are not necessarily easily accessed. The embedded nature of much workforce development strategy makes it difficult to compare and contrast the various viewpoints on this matter.

Undoubtedly there has been a significant level of incremental innovation involving the introduction of the new front line recovery interventions. However, incremental innovation will not necessarily transform services in such a way as to make them more productive, more effective and more efficient. Furthermore, incremental innovation will not necessarily produce the range of fundamental organisational changes necessary to ensure a thoroughgoing re-orientation of the workforce.

Such a reorientation will require provider organisations in the field both to build upon, and to go beyond the Organisational Readiness for Change framework established by the Institute of Behavioral Research at Texas Christian University.

A further reevaluation of our current workforce strategies will be one way of enabling services to begin to meet the levels of engagement, competence, and performance necessary to attain the much higher standards of quality and productivity demanded by the recovery agenda.

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Notes

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