Carole Sharma

Since the late 1990s, there has been significant investment in drug treatment services to the point where the major providers constitute a medium size industry. But has the expertise of the workforce kept pace with such rapid commercial development? **Carole Sharma**, Chief Executive of the Federation of Drug and Alcohol Professionals (FDAP) discusses the issues with **Harry Shapiro**

As well as being CEO of FDAP, you also lead the team that delivers on the work programme of the Skills Consortium (SC). Can you explain more about the SC and its origins?

Up to 2006, the NTA had workforce development as one of its core activities. Then there was a change of priorities until around 2010, when the NTA realised it needed to do more in this area because in the end it is the workforce that delivers everything; it's not about bricks and mortar, it's about people. In the 2010 Drug Strategy, it was stated that the workforce needed to change and become more ambitious for the clients. The implication was that the workforce was letting things slip, allowing people to stay on methadone without actually doing anything with them. Some of that was an assumption, but even so, up until then, the big push had been to get people into treatment and retain them. Then when we got to 2010 and the new government, commissioners got more interested in outcomes and it started to be measured more formally.

So the SC came in as an NTA device predicated on the principle that workforce development is the responsibility of the employers and so the way forward was to get together a consortium of employers and the other stakeholders like the sector skills councils, the professional bodies, representatives of the universities and so on, including service users. And because it started with the NTA, it was only about drugs, but FDAP and others pushed hard for it to include alcohol which it does. The NTA continued to support it and put a lot of resources in, but as it got nearer to the start of Public Health England, it was important that the SC became fully independent – and with Department of Health funding, that's what happened. So the SC Secretariat is comprised of DrugScope, FDAP and Adfam.

So if the idea of the SC is to get the workforce fit for purpose, it suggests that currently it isn't. Would that be fair?

Well, I feel that I have a responsibility to advocate for the workforce and so I think that sometimes it is as fit for purpose as it is managed to be. There are more good apples than bad. And if workers are held and managed in a good learning environment, I think we are chock full of people who want to learn, develop and do good things. You have to have commitment to work in this sector. Back to the early days of the NTA, when I worked there, we got Cranfield University School of Management to do a big workforce survey (a training needs) – and one of the comments Cranfield made was that there was a deep psychological relationship on the part of the staff for the job they were doing. And people do stay a long time, they might move around the field a fair bit, but they don't move out.

In terms of professionalism – has the workforce kept pace with sector growth? Does the need for a SC suggest that workforce is lagging behind or is it that the bigger providers already have in place effective workforce strategies, so the SC is in effect bringing along the others, getting them up to speed?

Certainly it is in the interests of the bigger providers to have effective training programmes and they do. It is harder for the smaller providers because it costs money. Also don't forget that the biggest provider is still the NHS and they are going to have many more non-specialist professional staff. So it is the job of the SC to make sure that

those people are extra competent in drugs and alcohol in the form of CPD. There is also a need to help the smaller providers, many of whom are extremely innovative. So the existence of the SC doesn't suggest that the workforce is incompetent, but what we do need is a proper career structure, and a way to get everybody qualified. And that isn't making it so difficult that people can't join, but it means being quality assured as a practitioner.

So the SC not just for the smaller providers – we do need a nationally agreed competency framework which we are working on with Skills for Justice, so that employers can have a clear understanding of what's qualified and what's not. And also what work is appropriate for the qualifications like the difference between a Masters in Addiction and NVQ Level 3. The competency framework helps you sort that out which in turn helps you plan what qualification groups you should be having in your workforce.

Should there be a profession called 'drugs workers' that has got the same status as nurse or social worker?

I am duty bound to say yes to that because I'm the boss of FDAP and FDAP is a putative professional body. If 'professional' means licensing, workers having to prove that they are up to the job, continuing professional development and the kind of badging that goes with that all to help the outcomes for drug and alcohol users – then yes. Would a recognised profession help employers understand the work more fully and drive professionals along? Yes it would. Do I think it would help drive the competency of managers and team leaders who are really the people who produce the workforce? Yes, I do.

There was almost a move towards the end of the Labour government to have 'counsellor' and even 'drugs worker' as 'protected titles' whereby you can't call yourself that unless you are registered with the Health and Care Professions Council. Nor can an employer put you in that job unless you are registered and if they do, they may face prosecution and a fine up to £5000. That was statutory licensing, but we have moved away from that because of the cost to central government of administration, to something more like 'rigorous voluntary licensing'.

Is it too easy to become a frontline drugs worker?

It can be quite easy and I have heard stories where this has happened mainly in the commercial sector. But I think employers are pretty good at picking people and there is a route in for people who don't have any qualifications which is volunteer, maybe become a relief worker and apply for a job. Organisations are also qualifying their volunteers, so that way you can start to get the building blocks of professionalism.

Let's talk about the so-called Two Year Rule whereby it was deemed unwise to employ somebody in a drug service until they had been 'recovered' for two years. This was never a genuine rule simply guidance from back in the day. But is it valid?

As you say, there is no such thing as the two year rule and every organisation should adhere to good practice in human resources around drug and alcohol in the workplace policies, occupational health and supervision and appraisal. And of course, there is an issue around who you ask about former drug use and who you don't. If you are faced with somebody who was a client, then you know, but what about somebody else who has come from the outside, maybe a nurse. Are you going to ask them to disclose? So my principle view is that you should have really good robust human resource management policies and practices in place for everybody.

So what about somebody who is perhaps your ex-client, now six months out of rehab?

Nothing wrong with that, not least because two years doesn't mean anything. When I was at City Roads, I admitted somebody who relapsed after ten years of working in the field – and it took him ten years to realise he shouldn't have been doing the work, by which time he was a middle manager. But as the employer, you need to be clear about a potential employee's mental and physical health, and they need to be clear how you would handle drug and alcohol in the workplace. It's about looking after people and supervising them properly.

So what about the competence of managers in the field and their training and development?

When it comes down to it, these are the people who drive delivery both of the workforce and the outcomes for the client group. I think they do need more work on how to respond to poor performance, good supervision and appraisal skills, how to create a learning environment, making it alright to fail, making it alright for the workers to talk about their client work almost immediately. And managers should not have large caseloads, they can't do two jobs. When Cranfield did that training needs analysis, among the managers, dealing with poor performance was the highest need across the country – and yet that should be Job One. That was back then but I still think there is a need to focus on that still. And in the Skills Hub (see below) you will see elements of building management skills as a part of developing care.

The career structure is fairly flat – practitioner then manager. But we need to think of senior practitioners who can teach other practitioners and those who can teach volunteers – so you have a bit more of a hierarchy. And front line workers need a lot of development to make that switch to management.

In terms of the SC, what does success look like?

One, a clear career structure across drugs and alcohol. Two, a good link with public health. Three, everybody understanding what 'qualified' means, a clear competency framework to work to and access to training and education. And I would love to see licensing and everybody with a little badge that says 'drugs/alcohol worker'. That would mean something to both the practitioner and the public.

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