CULTURE SHIFT

Joy Barlow on the impact of the recovery agenda on workforce development.

The drug policy landscape and its focus on recovery, enshrined initially in the Scottish drug strategy in 2008 and then the UK strategy in 2010, required a sizeable shift in workforce development. For the first time in many years, workforce development in the drug and alcohol field is properly on the agenda. Thus it is imperative to ask what we mean by workforce development and how it supports the recovery focus.

Workforce development is more than training courses and academic programmes. Professor Anne Roche and her colleagues at Flinders University have defined it as: "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 individuals, organisation and structural factors, rather than just addressing education and training of individual mainstream workers."

If this is the case, then service design, organisational systems and 'setting' all need to be part of a broad, comprehensive and multi-faceted approach. The workforce is already multi-faceted and multi-professional. It should include strategic and comprehensive planning, organisational change, personal development, entrepreneurship and innovation. We still have a long way to go in this regard, after all this is a far cry from a few days of training on a specific topic.

The refocusing on recovery as the main plank of drugs policy requires major service design and re-design, a substantial investment in partnerships between organisations on the continuum of recovery focussed interventions, and an understanding from commissioners about what kind of services are truly recovery focussed. Such services would express hope and possibility for change, identify strengths and value the person's wishes, hopes and dreams.

THE TRUTH IS THAT THE RECOVERY FOCUS DEMANDS A MORE COMPLEX RESPONSE FROM WORKFORCE DEVELOPMENT THAN HAS BEEN APPARENT PREVIOUSLY

Staff should no longer see themselves as the 'experts' but a resource to harness information and support. Relationships are key in any recovery-focussed intervention. Relationships with professionals and the relationships an individual is able to build or regain with family and the community. Other areas of the recovery focus should concentrate on training, education and gendered responses to service delivery – women and men may require different interventions, and they may have different goals. At every point of an intervention, professionals should be able to evaluate effectiveness and be willing to change. An individual will define the integration of all outcomes of interventions into a model of recovery. If personalisation means anything at all, it means exactly that – interventions are personalised, not part of a 'sausage machine' like approach to treatment and rehabilitation. Recovery, at the earliest opportunity, becomes the focus of all treatment modalities, and through the establishment of an expert care management system is the single integrated gateway to treatment. This may conflict with a 'payment by results' culture, but if we are truly wedded to a recovery approach, which is person-centred, the principles of practice will need to be defended.

All of this means that we need to lay a much greater emphasis on attitudes, values and principles of practice. Of course, staff still need to have skills and some very specific knowledge, but

we do need people who, to quote Mike Ashton speaking on the Film Exchange on Alcohol and Drugs site, are "socially skilled". The fostering of empowerment and engagement with users of services is a prime prerequisite in a recovery focussed workforce. Relationships, cultures and issues of identity are fundamental to change and development for individuals. Staff need to recognise and be sensitive to the potential 'tipping points' which will be the prime factors to the beginning of any recovery. Skills in action planning and the ability to help users of services in self-management will be vital. Assertive outreach to those who remain ambivalent to the recovery focus will be needed as motivation may change over time (what William White has called "supportive stalking"). Thus contact with agencies is vital to support and enhance motivation.

Staff will be key to all of this. But who are the staff we are talking about? We have established that the workforce is multi-faceted and multi-professional. It includes those in universal services (such as health, social care and education) because they have a key role in identifying a problem or concern, in assessing it, or making an appropriate referral. The importance of this role cannot be over estimated. The specialist workforce will include those in health, such as medical, nursing, psychology, those in social work, and those providing specialist services. One does wonder about the definition of the job 'drug worker' these days.

Into this mix we now bring those who are entering the workforce in a less traditional sense, for example those who are in recovery themselves. They must be appropriately accommodated into workforce development. Peer support and mutual aid along with family members, may have as much impact on the recovery of an individual as the

traditional workforce. Also, if we accept the tenets of Biernacki's research in the USA in the 1980s, that those who recovered from heroin use without formal treatment did so because, to paraphrase, they "saw themselves differently", then a lot of different people will help support that way of thinking.

The truth is that the recovery focus demands a more complex response from workforce development than has been apparent previously. This is not about 'necessary competencies', and I for one am grateful that we no longer have a focus on competency frameworks and occupational standards. I know some will shout me down, but workforce development has always been more than having and showing competency in certain domains of skills. Workers in the field of drugs and alcohol have always required empathy, confidence and the ability to think beyond their own profession and agency boundaries.

The work we expect people to be competent in is complex, requiring a wide range of skills and knowledge. For some, these are reflected in levels of qualifications and accreditation. The work is challenging and it is often difficult to achieve success with and on behalf of individuals. It is frequently ethically fraught, involving hard decisions between the interests of the users of services and those of their families and communities. The work requires sound, professional judgment, often to be exercised autonomously. It is about recognising the theoretical base for practice. It is not only about how you do your job, but how doing your job makes you feel. Nowhere is this more obvious than in the learning and development for those who deal with the impact of parental drug and alcohol problems on children. This is the 'problematic underside' of drug misuse that has unavoidably moral connotations which impinge upon practice.

The work of STRADA (Scottish Training on Drugs and Alcohol) has been progressing for ten years now. We have seen the growth of the wider workforce, as drug and alcohol misuse permeates most professional practice in the 'helping' professions. We have seen a significant recent policy shift, and have always had to take cognisance of other wider policy shifts, particularly around the protection of vulnerable children and adults.

For the first time in Scotland we now have a statement from the Scottish government and the Convention of Scottish Local Authorities (COSLA) on 'Supporting the Development of Scotland's Alcohol and Drug Workforce'. Published in December 2010, it is addressed to anyone who has a role in implementing outcomes for an individual, families or communities experiencing problematic drug and alcohol use.

It acknowledges the need for strategic leadership and indicates the responsibilities of those who make decisions at a national and local level. It requires alcohol and drug partnerships to carry out training needs assessments and to take account of the capabilities of the current workforce. It gives roles and responsibilities to commissioners of services, professional bodies and education and training providers and managers and individuals. Most importantly, it sets out learning priorities for all levels of the drug and alcohol workforce. The statement also includes a Training Needs Analysis guide – provided on the NHS Health Scotland website and based on a template used by STRADA since 2005 – and a report on service users' views of workforce development needs.

All of this is very reassuring and should assist in the development of all involved in drugs and alcohol work, to provide better services to support individual, family and community recovery. However it is pertinent to record the final sentence of the introduction to the statement: "The whole of the public sector in Scotland will be looking to reshape services to deliver better outcomes with potentially smaller budgets and we need a skilled workforce to do this effectively." At least it's honest.

This leads to me consider what works in learning and development in alcohol and drugs. This is not an easy question to answer as robust, independent evaluations of learning and development courses are few and far between. A European-wide survey undertaken in 2006 for the International Think-tank in Education and Training in Addictions (I-ThETA) found that evaluation is mostly done by providers themselves. Only exceptionally are the effects of educational inputs researched. In a book I edited in 2010, Donald Forrester lays great stress on the commitment to evidence-based practice and on the importance of reflection, high quality supervision and the link to reflection on practice. All of this is based upon evidence that it would work, if it were put into practice.

In 2010, the Independent Inquiry into maximising recovery from drug and alcohol misuse in Scotland, called 'Melting the iceberg of Scotland's drug and alcohol problem', notes the challenges facing all of Scottish society, particularly those professionals involved in drug and alcohol misuse prevention, treatment and recovery. In the Inquiry we called for people to work more closely together, co-operate and undertake through mutual learning how they fit into the continuum that supports recovery. We wished that all professionals might feel released to "bring themselves to work". This means that they are not hidebound by professional dogmatism, silos and entrenched thinking; that they can truly support the achievable ambition of recovery.

So in conclusion it is not all about changes in systems and strategies. It is also about changes in culture, relationships and identity. 'No changed structures without changed cultures': it is very similar to what we are saying about recovery for users of services. The workforce and those whom it supports travel the same road – together.

Joy Barlow is the Head of STRADA (Scottish Training on Drugs and Alcohol)