

‘An inspirational recovery-orientated drug and alcohol workforce: how to deliver the drug strategy commitments’...

CONFERENCE BRIEFING

“What can we learn from each other?”

This was the question William Butler, chair of the Substance Misuse Skills Consortium, asked at the start of the Consortium’s first annual conference. The answer gradually revealed itself during the following hours, as a series of treatment providers from around the country gave presentations that described and explained how they were getting to grips with the recovery and workforce agenda set out in the new drug strategy.

The delegates who made it to the oversubscribed event – billed as ‘An inspirational recovery-orientated drug and alcohol workforce: how to deliver the Drug Strategy commitments’ – packed into a conference room at Regent’s Wharf in north London at the beginning of June to listen to the various speakers, which also included clinicians. The conference then looked back on the progress made since the launch of the Skills Consortium, and

turned its attention to the future and the many opportunities and challenges it holds – “During this time of transition we need an open, honest, respectful and reflective debate,” said Butler.

The day’s presentations touched on a range of ideas, issues and concerns, among them the need for better integration with other sectors, the importance of developing and working with community groups and recovery communities, how to provide appropriate treatment at the right time, and the vital roles the approach and attitude of the workforce play in underpinning their professionalism and effectiveness.

All the presentations from the conference are available to view, in full, on the Skills Consortium website, www.skillsconsortium.org.uk, but over the next couple of pages you can read about some of the most popular, interesting and thought-provoking moments...

Why the Skills Consortium?

The Substance Misuse Skills Consortium was formally launched in 2010 as a sector-led body dedicated to improving the skills of the substance misuse treatment workforce in England. Today it has 150 member organisations and 130 associate members. Its stated aims are to:

- **Grow and enhance the competence of the treatment workforce**
- **Promote coherent, evidence-based and ambitious practice that delivers safe and sustained recovery for drug users in treatment**
- **Provide benchmarks of excellence and effectiveness that all can use as they strive to achieve these.**

The coalition government’s 2010 drug strategy handed the Skills Consortium a central role in “Delivering a whole systems approach ... by an inspirational recovery-orientated workforce”

DELEGATE FEEDBACK: WHAT DID YOU FIND MOST BENEFICIAL ABOUT THIS EVENT?

- “Hearing a broad range of topics and initiatives to move services into recovery focus”
- “The extensive mixture of people/presentations and the openness of approach to challenging issues”
- “Getting a clearer understanding of the potential challenges and opportunities ahead; and how they may be used to best effect for the benefit of service users”
- “The multiagency approach to recovery; how it is being addressed in many ways, the good range of examples”
- “The Q&A sessions and networking opportunities”



You can watch the full conference presentations at the Skills Consortium website. You will also find the Skills Hub there, which has over 300 resources to help the workforce deliver recovery-orientated interventions. Click on www.skillsconsortium.org.uk

Exploring the recovery agenda

Ten providers each gave a ten-minute presentation during the conference. They had varying organisational structures, took different approaches to treatment, and have pursued a variety of methods in responding to the recovery and workforce agenda:

Integrating recovery communities and treatment systems/services

Antony Heaven at the Westminster Drug Project explained how it had uncovered a strong culture of recovery among its clients, workers and volunteers, and that it was now working to help this blossom. It is now asking workers how they can help build ambition among clients, and how they can embed this ambition as part of the service provision. It is also beginning to install recovery activities as part of its central framework. "We're learning as we go," he said, "it's evolution not revolution."



CRI's Peter Sheath talked about how they had got the support of workers, partners and clients in developing a "recovery ethos". This involves promoting "recovery-focus" among staff and clients, reducing the dominance of medical solutions while sticking to the evidence base, and increasing the involvement of mutual aid groups, recovery centres, peer mentors and recovery champions. The result was they now have "more clients in recovery than are using".

Alastair Sinclair of the UK Recovery Federation explained the ideas behind asset-based recovery and working. Its approach is that people already in recovery are the assets that make further recovery possible. What's more, it's important to make these assets visible, and to see citizens and communities as co-producers, rather than recipients, of health. The key benefits of the asset-based approach are that it promotes community networks,

relationships and friendships that provide lasting help and care – leading to renewed hope and commitment, less stigma, and better empowerment and control for clients.

Segmenting the population, and engaging the recovered

Haydn Cavanagh at Halifax/Calderdale NHS said that while it considered all its clients were on the road to recovery, it had to ask "where are they on the road, and where are they going?" Every client was interviewed and assessed, and then segmented into groups: pre-contemplators, contemplators, stallers, and recovering. The treatment service is now geared towards getting the individuals in each group to move onto the next step. It's also set up to ensure the knowledge and experience of the recovered isn't lost – "their visibility is important".

Patrick Gormley at StreetScene described how they'd developed strong links with local partners, including colleges and training providers, JobcentrePlus, housing associations and landlords.



This amounts to a programme for full reintegration, including employment – so by the time they leave treatment, clients have had experience of training, education and work, and have structure to their lives.

Rapid reengagement: not letting clients drift

Gemma Fairburn at Turning Point explained that its aim in the wake of the drug strategy is to improve throughput and increase

The right treatment at the right time

Vicki Beere from Project 6 in Keighley explained how it operated according to three principles: first, that drug use is symptomatic of wider problems, and needs to be treated as such; second, that people need to be in the right part of the treatment system, at the right time; third, that there are many areas of excellence in treatment that can be learnt from and built upon – "there's no need to reinvent the wheel". One of its initiatives has been



introducing intensive 12-week programmes, which are built around small, closed therapeutic communities, require daily commitment, and aim to build confidence, trust and skills. The service also promotes a workforce with empathy and positive regard, that can reflect on its practice and looks to build self-efficacy. "If the worker doesn't believe it, how can the user? We aim to have the right staff, with the right competencies, at the right time and in the right part of the recovery system."



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positive exits – the service is working especially hard to reengage clients in treatment, or to ensure they exit drug-free. Workers keep up the engagement with clients via telephone, email, texts, and home visits,



and ensure they are more involved in their own treatment plans. For those coming back to treatment, there are amended care plans

and a lot of hand-holding – and of 36 clients reengaged in the past six months, only one has subsequently dropped out.

Mapping: the basis of collaboration

Many of the speakers talked about treatment maps, and how their services were using them to support the recovery agenda. Jan Moring at GMW in Manchester explained how it had adapted the maps for use during difficult conversations with clients, such as encouraging them to attend their sessions – “It helps to make it more of a constructive process”. The service also uses map to support family work, and trains workers to use the maps effectively.

Training: new ways of ensuring workers have the right skills and use them properly

Jan Moring at GMW described how the service was now training workers to strict competency standards, via a more intensive and structured programme. Workers are observed applying their skills in practice; feedback is given in a one-to-one setting; and there is an independent accreditation process. It’s made all the easier with in-house training and a transparent process: “We are developing consistency and embedding skills in practice.”

Patrick Gormley at Streetscene explained the service’s clear pathways for recovered users to develop as workers themselves.

From providing peer support, to becoming a volunteer, then working as night staff, there are escalating skills and competencies needed to progress to each stage. “They move at their own speed, we put them under no pressure.”

Learning from mental health recovery

Avon and Wiltshire Partnership’s Ian Dickinson described how it had segmented its clients into ‘care clusters’ with each cluster presenting a particular set of challenges, which require a tailored package of interventions, otherwise known as care packages. These combine various elements, to be delivered by different staff with different competences, and draw from Routes to Recovery, relevant NICE guidance, and UK clinical guidelines. Added to this, they are developing a service culture that promotes ‘recovery values’ and attitudes among practitioners, and aims to deliver a structured approach to review and recovery planning.

Abstinent recovery options

Michelle Foster from the Basement Project in Calderdale said the parts of the drug strategy that appealed to her service were the ideas that “recovery is long-term, it builds on strengths, and the client owns the agenda”. As a recovery community it has chosen the path of abstinence – but offers this in the context of social values AND multiple pathways.



“What drives us is the belief that one user can help another, and the ‘together

we can’ approach,” she said. The service can call on a visible community of abstinent clients, who are now caring for their children and back in work, and is aiming for a “strong safe bridge between treatment services and the recovery community”.

THE CLINICAL POINT OF VIEW

A number of clinical bodies are represented at the Skills Consortium, and representatives from three were at the conference to talk about their reaction to the recovery agenda:

Emily Finch, representing the Royal College of Psychiatrists, looked at



the role of psychiatrists, and explained how many of their competencies, such as pharmacological management, working with dual diagnosis clients, and delivering psychosocial treatment, are relevant to recovery. She said, “We know we have to adapt. We have a clear CPD path and are having courses and masterclasses on recovery. But we put a big emphasis on the evidence base, and as more evidence for recovery emerges, we will become more comfortable”.

Linda Harris from the Royal College of GPs told how GPs work at every level of the treatment system and should be at the centre of the recovery agenda, but



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are facing significant challenges. Two such areas include maintaining the quality of treatment against the huge volume of cases some GPs have to manage; and balancing patient safety against their freedoms. “We must be involved in the transformation,” she said. “I don’t have all the answers, but I know it must be a partnership approach.”

Christopher Whiteley from the British Psychological Society explained how psychologists can be “a resource for recovery”: many of the barriers to recovery are psychological, but the flipside is that psychology can provide the spark for change. The aim of psychological interventions is to build recovery capital. Using their skills, psychologists can promote human, physical, social and cultural capital, but working under the recovery agenda they must focus more on other areas, such as family and peers, and working with partners across the sector and communities.

Mapping the future of the consortium

The presentations during the final session at the Skills Consortium conference covered the work of the consortium itself, and looked at the many challenges it will have to face during the next 12 months and beyond

Ian Wardle, the consortium’s research and evidence work group coordinator, spoke of an “enormous” evidence base for drug treatment, but warned this raised important questions about “how we make sense of it, and how we deploy it”. The Skills Consortium research and evidence brief is to “develop a sector-led consensus and approach to developing the evidence base and the body of research to support effective treatment systems, focusing on emerging thinking about recovery-oriented treatment systems, practice and communities,” though, again, Wardle pointed out that the evidence base has to work for service managers and commissioners, especially in these times of shrinking resources.

Carole Sharma, the consortium’s education and development coordinator, explained in detail its mission to define the workforce, map existing qualifications, identify gaps and omissions, work with the sector to plug those gaps, and develop a qualification and competency framework. “We don’t need lots of new competencies,” she argued, “but we do need a better understanding of what the existing ones are for.” She added that the consortium needs to work nationally with services and other partners, including the sector skills councils, and make good use of its own internal resources.

Finally, William Butler talked about the future of the Skills Consortium. It has made a solid start, he said, being given a central role in the drug strategy for developing an inspirational, recovery-orientated workforce.

In this context, its key ambitions are to grow and enhance the workforce, promote the evidence base, and set benchmarks for excellence. But there is much more to do, especially now it must become independent and self-sustaining. The major challenges now for the Skills Consortium are to cement the desire for its existence throughout the sector, and to prove that it is a feasible organisation – and crucial to these is the support of the big providers that have their own training and development programmes. In the open Q&A session that followed, delegates aired their own views:

“As a small provider, we are facing some huge challenges. We welcome an organisation such as this”

“A quality framework will be important. There is a lot of uncertainty in commissioning drug treatment under the recovery agenda”

“Given the cuts, the competition is not within the sector, it’s between sectors. And while plenty of other sectors cannot prove their outcomes, we can”

“We are still a long way from a whole-system approach”

“If we don’t share, we risk reinventing the wheel in every local area”