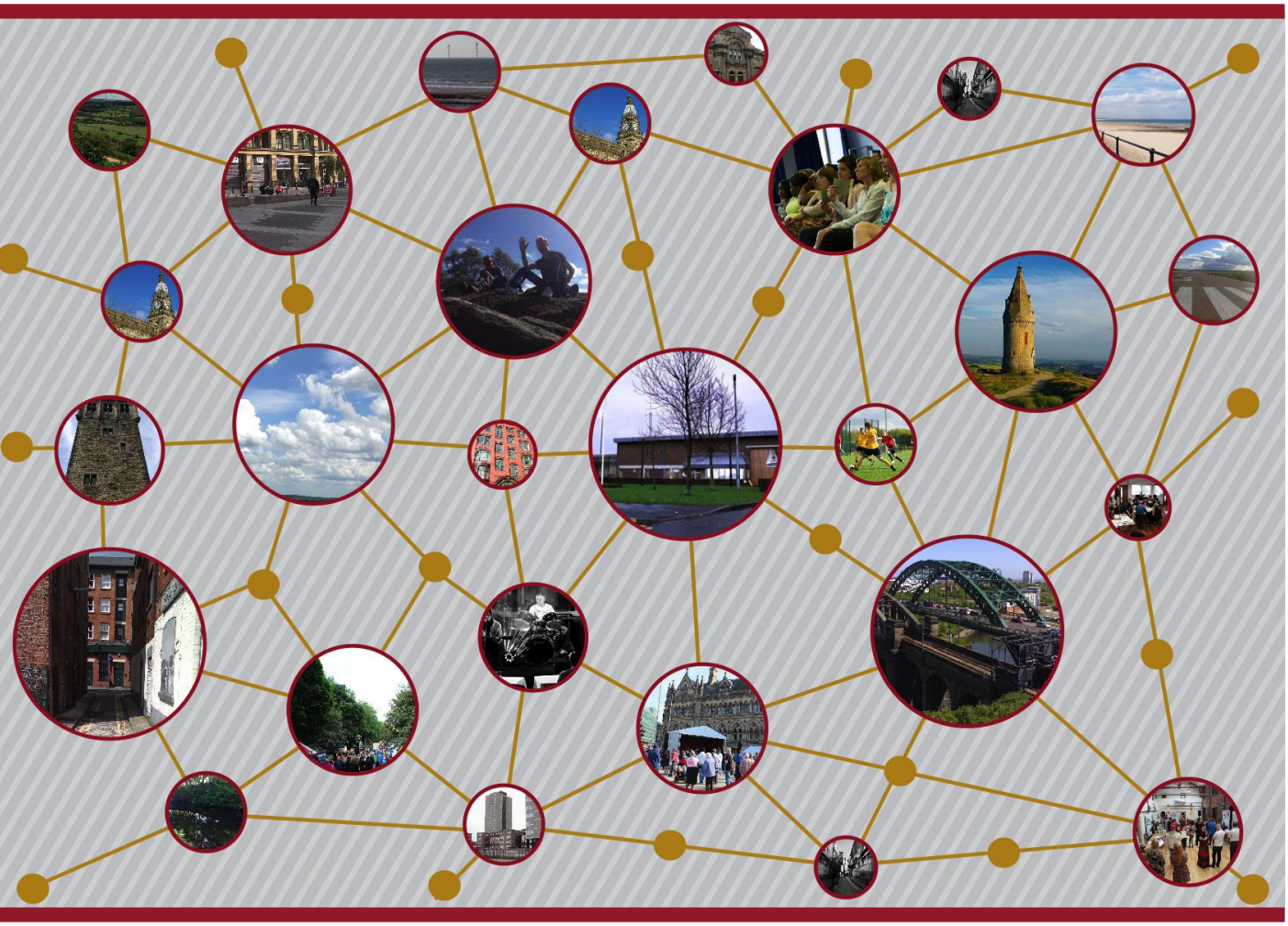
# COMPANY NARRATIVES IN A DECLINING INDUSTRY



A REPORT BY IAN WARDLE: LIFELINE CEO

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**Lifeline's conformity and departure from dominant industry narratives set within an account of the growth, maturity and decline of the drug treatment industry.**

# FOREWORD

This paper looks at the UK drug treatment field from its emergence in the 1970s to its current position today. In so doing, it focuses on Lifeline's first 25 years and examines those periods when Lifeline could be said to have stood outside the dominant narrative of the growing drug treatment field.

The paper also identifies how closely our industry has followed the twists and often very radical turns of government policy and how in turn treatment providers have developed company narratives that conform to these changing industry norms.

The paper draws to a close by examining the current state of the drug treatment industry and discusses the 'threadbare' state of its current core narrative. The paper concludes by arguing that company narratives will no longer be able to rely upon a growing industry with strong government backing. Henceforth drug treatment providers will need to develop strong individual company narratives based among other things on much greater workforce investment.

# INTRODUCTION

**Company narratives broadly speaking involve exercises in branding, product and service claims, pricing strategies, market positioning plus the usual other underlying philosophies of value and uniqueness.**

A core assumption here is that such company narratives are very significantly shaped and determined by the context of their parent industries. A further assumption is that industry narratives, in turn, are significantly influenced by macro narratives whose force derives from the social, economic and political priorities of the time. These two assumptions are strongly true in the case of the drug treatment industry.

Over the course of the past forty-five years, the drug treatment industry has been profoundly shaped both by the changing social climate and various political and economic priorities governing the perceived threats of problem drug use. For much of this period, the industry and its workforce have grown. However, this growth profile has recently been reversed and, as a consequence, the industry's medium and long term future are subject to considerable uncertainty. Drug treatment is not considered a public health priority. The cost of treatment interventions is prohibitive. The professional efficacy of drug treatment has been and still is subject to considerable scrutiny. Accordingly, the current recovery based strategy is fully consistent with reduced investment, a strong emphasis on de-professionalisation and the re-ordering and downward prioritisation of drug treatment as a public health and social policy priority.

With few exceptions, over the period from 1982-2008, the company narratives of drug treatment providers in the UK were developed and sustained within the dominant framework of a strong industry narrative. This strength was, in turn, based on the prioritisation of drug treatment by successive governments. This process of policy prioritisation and the threats to the broad public that it reflected always went well beyond any narrow concerns about the health of drug users. The concern was always to try and safeguard the broader population of non drug users. Accordingly, the drug treatment industry thrived as a result of three major government policy decisions connected successively with the onset of: mass heroin use (1980-1986); HIV/AIDs (1987-1995) and crime (1995-2010). The recent national strategic policy emphasis on recovery, far from

signaling a new 'third wave' of investment, is functioning as an effective rationale for reversing the process of investment and growth. This de-prioritisation of drug treatment is accompanied by a progressive, procurement-driven disinvestment in the field.

Increasingly, recovery from drug dependence is posited as a community-based, peer led activity best built by those with lived experience. As a consequence, the limited horizon for drug treatment professionals is focused on managing a greater number of shorter treatment episodes within a rapidly reducing resource envelope. Thus the radical idealism of community driven recovery complements perfectly the concomitant disinvestment in high cost, professional, treatment interventions that fall well outside the most pressing population-wide, health inequities.

As a consequence of the aforementioned trends, the industry narrative can no longer realistically support a range of company narratives based on growth, sustainability, professional efficacy and public health relevance. Against this backdrop of industry decline, company narratives can no longer rely upon the marketing of those marginal differences that distinguish their particular brand, safe in the knowledge that they are nestling within and sustained by a supportive industry environment. In this regard, we can clearly observe the instrumental and routine narratives of many providers. These narratives take various forms and appear in standard reporting to trustees, the Charity Commission and other stakeholders. However, such accounts rarely originate from and speak to a profound sense of a particular company's historical uniqueness or, for that matter, a sense of any integrated strategic response to present and future challenges. These incidental narratives have, nonetheless, been adequate against the background of a strong, well-favoured industry with its own incontestable narrative.

Henceforth company narratives must go beyond the merely routine. Routine company narratives only flourish when their parent industry tells a strong story.

# LIFELINE'S FIRST COOL DECADE: 1971-1981. (COOL IN A SEVENTIES SENSE)

## What of Lifeline's various 'company narratives'? How closely have they followed our parent industry's narratives as they, in turn, responded to broader social anxieties?

Lifeline was founded in 1971: the same year as Greenpeace, the same year as Friends of the Earth and the same year as ASH. This was also the year that the Misuse of Drugs Act became law. From the outset, the intention was to establish Lifeline in a residential setting. Lifeline's founder Dr. Eugenie Cheesmond wanted to establish a community with up to 30 residents. Lifeline's arrival was written up in the alternative press of the time as follows: "A day centre with a drug-free policy has opened in Manchester to provide for young addicts and anyone else in need of the facilities it offers."[i] The article described Dr. Cheesmond as being "incensed at official methods of handling the drug problem, particularly among young people. She believes that when they aren't punitive, they're incompetent because they work on the principle of using substitute drugs to reconcile the addict to the same social situation that drove him to drugs in the first place."

Bing Spear, Chief Inspector of the Home Office Drugs Inspectorate from 1977 to 1986 recalls Lifeline's view of the prevailing orthodoxy as it was in 1981. "The Lifeline Project was critical of a system which encouraged people to see themselves as 'sick' and where the siting of treatment centres in psychiatric hospitals added 'overtones of insanity and uncontrollability'."[ii] Lifeline was very much part of the alternative culture of the time and frequently railed against the medical professions and psychiatry in particular. Lifeline also maintained a strong stance on abstinence throughout its first decade. In September 1981, Lifeline published *Out from the Shadows,* its 10th Anniversary Report. Lifeline was critical of the *Brain Report* that had been published in 1965 and recommended the establishment of the specialist Drug Dependence Units (DDUs) under psychiatric leadership. The author of *Out from the Shadows*, Project Co-ordinator, Rowdy Yates said, "Essentially, the failure of the Brain Report was the failure to look beyond addiction to explore the possible factors which

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might lie behind the manifestation of such grossly unorthodox behaviour. The assumption of a physical/medical model of addiction effectively pre-empted such an analysis and paved the way for the current promotion of maintenance prescribing as the foremost tool of the Statutory sector with social work (Psychology, Counselling, Groupwork, etc.) forced to take a back seat both in terms of status and financial resources."[iii] Regarding the relationship between the Voluntary Sector and the Drug Dependency Units ('Clinics') Rowdy Yates said: "By and large the Voluntary sector and the Clinics eyed each other with mutual distrust; the Voluntary agencies complaining of the insularity of the Statutory sector and its failure to meet post-detoxification and non-medical needs whilst the Clinics generally saw the Voluntary sector as a group of well-meaning but hopelessly inefficient amateurs of dubious professional pedigree."[iv]

**During its first decade, Lifeline was not part of the mainstream, but our company's narrative was informed and enriched by a strong counter-cultural narrative.**

This antagonism was eventually to end, however. The wave of mass heroin use at the very beginning of the 1980s caused considerable public alarm. The government responded with a Central Funding Initiative, the first major investment in community-based, drug treatment services. Lifeline formed a close partnership with the NHS and with the regional NHS Drug Dependency Unit based at Prestwich Hospital in Manchester. One of Lifeline's greatest allies of that time was the lead consultant psychiatrist at the regional unit, Dr. John Strang. The focus of the new services was on the large number of young unemployed people who had fallen foul of heroin. The dream of an abstinence-based rehab was no longer Lifeline's key objective. Harm reduction beckoned and with the 1988 publication of the pioneering ACMD report on *AIDS and Drug Misuse*, the drug treatment world turned 180 degrees on its axis. As the national panic around HIV/AIDs gathered momentum our industry narrative changed and organisations like Lifeline adjusted their company narratives accordingly.

For Lifeline, the first decade was tough. Writing elsewhere of the first decade of Lifeline's existence, Rowdy Yates says: "We achieved a great deal that was of value to drug users. And we did it against the odds. For most of the seventies we employed only three staff. Never, until after 1979 was the staff team more than five. Often we literally ran out of money. We always survived. But only because of the commitment of the staff and volunteers."[v]

During its first decade, Lifeline was not part of the mainstream, but our company's narrative was informed and enriched by a strong counter-cultural narrative. The struggle to survive was a struggle born of conviction. Much of what Lifeline believed in its early, 'alternative' years, however, was later held up to very critical scrutiny in Rowdy Yates book, *If it weren't for the Alligators.* He describes the organisation's long encounter with 'therapy' and its perceived value to impoverished, low-status, non-residential services like Lifeline as follows: "Therapy would deliver us a limited amount of power over our customers. Therapy would enhance our professional standing amongst colleagues from within the National Health Service. Therapy would provide the reward of seeing some customers 'grow' and the justification for excluding those who refused to 'grow'."[vi] He describes the impact on Lifeline thus: "Everything became a therapeutic exercise. Everything had a personal growth pay-off. [a]lmost all our work was interlaced with therapeutic notions. It gnawed away at everything we did."[vii] "For the majority of our customers, their problems were those of homelessness, unemployment, poverty, illiteracy, loneliness. But we wanted to see more. We wanted to dig down to the personal growth bedrock. Thinking back, it seems as if it had never occurred to us that it can be hard to 'grow' when you can't read and write and you don't know where you're going to sleep that night."[viii]

The abandonment and thoroughgoing disavowal of the 'therapeutic' counter-culturalism of the seventies was conducted with relish throughout the eighties and nineties. Rowdy Yates notes: "In the end it was the dramatic escalation in drug use at the end of the seventies which tore us out of the therapy trap."[ix] On the down side, sections of Lifeline's leadership felt the absence of any substantial, counter-cultural legitimising narrative.

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Throughout the 1980s Lifeline made a slow and uneven transition from a position of radical abstentionism to one of radical harm reduction. The early to mid eighties saw Lifeline moving away from its own brand of radical, countercultural, therapeutic abstentionism towards something much more conventional. Lifeline played an important role in the establishment of the new Community Drug Teams. Rowdy Yates describes it thus: "By the middle of the 'eighties, we were already one of the largest drug projects in the country; with a team of fieldworkers seconded to Community Drug Teams across Greater Manchester and a large and well-respected training unit. Outside the organisation, things had begun to change dramatically too. Every health authority district in Greater Manchester and Lancashire had established a Community Drug Team. Many of these

Teams included Lifeline workers. For the first time since the establishment of England's therapeutic communities in the 'sixties, there was a bridgehead between the National Health Service and the voluntary sector drugs field. …Not only that, but many of these new services looked to agencies, such as Lifeline, to lead the way. To establish the ground rules."[x] Thereafter, if you looked carefully behind the radical, street-oriented Lifeline you would discern the new pragmatic Lifeline. The Lifeline that wanted to grow and prosper. Henceforth, like most of rest of the rapidly expanding Third Sector of the time, we had two separate narratives and at least two separate audiences. Lifeline was by no means unique, however. Many other substance abuse charities managed this same transition. Elsewhere in his book, Rowdy Yates describes this new relationship with the statutory sector in a less flattering way: "We had leapt into bed on the first date with the Health Service and lay there purring like a fat cat that had avoided getting kicked out with the empty milk bottles."[xi]

A later unpublished account written by Mark Gilman in 2001 looks back on this time: "With hindsight it is questionable whether Lifeline's contribution to the Community Drug Teams was special or different. In practice, we found ourselves arranging methadone prescriptions alongside everyone else in the CDT. To this day there are people who joined CDTs at that time who will spend the majority of their working lives arranging and monitoring substitute prescriptions."[xii]

The decision to build Lifeline in partnership with the NHS was taken because the scale of heroin use was outstripping the capacity of services to cope and the epidemic required treatment and management. Lifeline's leadership may not have felt entirely comfortable about moving away from its predominantly counter-cultural positioning, but its decision to work closely with the NHS was surely the right one.

Throughout Lifeline's history, and for that matter throughout the history of our sector, there has been an ambivalence about our proper role and this is reflected in Lifeline's own narratives about its own history and practice: commitment gives way to fatigue, idealism to pragmatism, conviction to compromise. Almost certainly, however, the 'compromises' and the 'cop-outs' involved in building Community Drug Teams in the mid 1980s were necessary steps in building an effective mass response adequate to the challenges of that time. The dilemmas, the self-recriminations, the wish to be seen as rebellious, all of these are still alive and well in our field. 'Cool' or not, this experiment in inter-agency working mapped the fault line on which our modern industry still sits. The Lifeline Fieldwork Section was an early exploration of that difficult, but critical set of relationships between the

statutory and the non-statutory, the clinical and those with a different kind of experience and knowledge.

For both Rowdy Yates and Mark Gilman, the onset of HIV/AIDS gave Lifeline the opportunity to be 'cool' again. For Rowdy Yates: "It was the emergence of AIDS in the middle of the 'eighties which allowed us to hone up the edge of our increasingly blunted sword."[xiii] "AIDS was the exercise bicycle we jumped on just in time. And we pedalled like mad to get rid of that unsightly flab."[xiv] And for Mark Gilman: "Just as the flame of authenticity was glowing ever dimmer in Lifeline, HIV and AIDS came to the rescue. …In the absence of any research evidence and without any policy support, Lifeline allowed itself to be informed by its heart. Needle exchange felt like the right thing to do. And while we were at it we decided that it would be a good thing to educate drug injectors by giving them a 'Smack in the Eye'. We lost some clinical staff who didn't like it but we were radical again. It felt right…it felt good."[xv] This move from abstentionism to harm reduction was radical, and for many in the Third Sector it felt right. For some in the field, however, harm reduction wasn't always going to feel so cool, or radical or 'right'.

Speaking of 'Smack in the Eye', Rowdy Yates insists it wasn't just a comic: "It was the point at which our trajectory, and that of our colleagues in the Health Service, once more parted company. And the further away we got, the harder we pedalled."[xvi] However, all this stuff about being cool and rebellious and it 'feeling right' is of secondary importance to something much more fundamental in Lifeline's history; something that sits deeper than a wish to be an outsider. Rowdy Yates speaks directly to this when he identifies the real significance of 'Smack in Eye': "Suddenly, we found we had re-opened the line of communication. And it worked in both directions."[xvii] Lifeline had rediscovered how to engage with its beneficiaries.

Rowdy Yates' recollections were published in 1992. Mark Gilman was writing in 2001. In 2010, Lifeline conducted an organisation wide consultation on values. This involved direct consultation with over 80% of our workforce. Out of that consultation came two key values: 'Maintaining Integrity' and 'Effective Engagement'. Consultations about values are quite obviously an opportunity for an organisation to ask itself what it is, what it stands for, and why it matters. Of course many of our employees won't come to work with these values uppermost in the minds; many wont even remember them. The 435 people who have worked for Lifeline for less than two years certainly weren't consulted about our values; they weren't here at the time. These values, however, whether one holds them dear or not, are right at the heart of what the Third Sector is supposed to bring.

# LIFELINE'S SECOND COOL DECADE: 1986-95

**The seventies had been Lifeline's first 'cool' decade. Tainted as it was with 'therapy' this was to become a decade that our organization's historians later disavowed.**

With the onset of AIDS, Lifeline embarked upon a second 'cool' decade. Three things stand out: firstly, Lifeline's brave decision to set up a needle exchange without any real cost recovery strategy in place; secondly, Lifeline's production of a new range of radical, biting and humorous publications and thirdly, Lifeline's close engagement with the wave of mass recreational drug use that swept the country in the late 1980s and early 1990s. During these years our service building and our partnerships with the statutory sector took a back seat. There are almost no people working for Lifeline today who were with the company during this decade. For some, however, this remains the Lifeline narrative with which they wish most closely to identify.

Over the course of this ten year period, Lifeline sat astride two cultures: on the one hand, a culture of heavy-end, dependent, working class heroin use and, on the other, a mass recreational dance drug culture. The marginality of the first group and the sheer size of the second group pointed to the urgent need for a new, more credible kind of health education. The period opened up enormous scope for innovation. Lifeline responded with a wide range of harm reduction messages delivered in an outspoken, humorous and graphic style. This style proved equally effective with both drug-using cultures. In addition, the young dance drug users appreciated the unobtrusive insider mode of advice and support given in clubs and other venues.

In both cases, the messages were direct, non-judgmental, and utterly unapologetic. In both cases, Lifeline was completely committed to this very distinctive form of harm reduction. Our mission was 'to tell the truth about drugs'. Lifeline would not have been able continuously to push our freedoms to such limits without a loose but influential national network calling for a much less punitive approach to drug policy. An approach based on education and regulation rather than punishment and prohibition. This milieu included journalists, police officers, doctors, researchers and both national and local politicians. Lifeline stopped short of outright campaigns for law reform, but was part of this strong normalising tendency.

During this period Lifeline built a major partnership with Manchester City Council. Manchester 'Safer Dancing Partnership' was the perfect marriage of Manchester's nighttime economy boosterism and Lifeline's endless appetite for street credibility and self-promotion. We were very close to Greater Manchester police at the time. GMP had a radical, community driven approach to drug use. Their officers were enjoined to understand that arresting drug users was no better than "shooting fish in a barrel". They went to great lengths to radicalise the force around issues of drug use and crime. The city council, under council leader Graham Stringer, was integrating policing, social services and economic regeneration in a dynamic mix that brought together a range of key stakeholders with a radical and forward thinking agenda. Drug use and drug related crime were important parts of that agenda.

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In terms of narrative, our company story of the time was pushing at all the assumptions that had so carefully been built up by our industry over the previous twenty years. Drug use wasn't deviant, it wasn't a disease, if anything it was a by-product of an emerging post-industrial society. In point of fact, drug use (not misuse or abuse) was normal. Howard Parker's[xviii] longitudinal Alcohol and Offending Survey established the scale of young people's drug use in the north west. His research and its yearly updates provided evidence to challenge those who doubted that young people's drug use was now 'normal'. Lifeline's narrative pushed hard at our industry's dominant narrative at this time. Within the field some admired us, although many more found us trying.

During the early and mid 1990s the mass use of drugs like Ecstasy and Cocaine led many senior policy makers and professionals to the view that the real harm came from penalising drug users and that the logical, sensible and compassionate response was to improve education and de-penalise certain kinds of recreational use. Ruth Runciman's Police Foundation report 'Drugs and the Law'[xix] was published in 2000. Its main recommendations reflected the views of the strong minority who felt that the law needed to address the realities of modern drug use and the prohibitive demands it placed on modern policing. By this time, however, the climate of opinion had changed. The period between 1988 and 1990 known as 'the second summer of love' was long gone. The press campaigns for

legalisation had subsided and the harms associated with recreational drug use were made more clearly prominent.

Between 1993 and 1995, much of what Lifeline had build in the eighties was being dismantled. The Training Unit, the Field Work Section, the Bail Assessment Unit and the Regional Office itself all went. In 1995, we sat down with our major fund holder and declined their assistance; we were asked to get back on board with the regional strategy and we said no. In 1996, however, Lifeline took stock and decided it was time to rebuild some bridges.

# LIFELINE RECONNECTS WITH THE MAINSTREAM INDUSTRY NARRATIVE: 1996-2005

**Within our industry, the dominant treatment narrative, shaped by the 1982 Advisory Council on the Misuse of Drugs report *Treatment and Rehabilitation* and given its first concrete expression in the establishment of Community Drug Teams, had retained its primary position.**

Indeed, this narrative was to shape the industry and its providers for the next twenty years. It would take the onset of the recovery movement to challenge the treatment model that went from strength to strength throughout the 1990s, reaching its peak in the period following the establishment of the NTA in 2001. Despite the heady dance-drug years of the early 1990s, for most third sector and statutory services, the treatment paradigm had retained an unbroken relevance. Lifeline, on the other hand, had ridden the waves of drug normalisation as long as they came rolling in. Lifeline now needed to decide not whether to get back on board but how best to clamber back. The way back in was via work in prisons.

**The NTA arrived in 2001. In partnership with senior clinicians and academics, it re-energised the medico-penal compact so characteristic of the British treatment system and first put in place by the Rolleston Committee of 1926.**

One of Lifeline's earliest Criminal Justice services had been the Induction Unit. This aptly named service was a bail assessment service designed to divert users from custody and into treatment. For all Lifeline's counter-culturalism, this service, established in 1978, was quite a tough regime. The programme was varied and demanding. Drug use was forbidden and resulted in breach. This high quality programme was strongly approved by Greater Manchester Probation Service. It's ethos predated the later treatment paradigm which was very much more tolerant of people in treatment 'using on top'.

In the mid-1990s, within Lifeline, there was a strong wish to rebuild our criminal justice work. In 1995, our first prison worker, attached to HMPs North West Region, took up post. Over the following years, Lifeline won two significant contracts to work in North West Prisons. In the national procurements of 1999 and 2004, Lifeline won major contracts to provide services right across the north of England. Between 1995 and 2005, our prisons expansion was by far and away our major area of contract growth. We also expanded our work with young people. This latter was less prominent and was driven not by Safer Dancing, but by the tiered approach recommended by *The Substance of Young Needs*, the influential 1996 report on the 'treatment' of young drug users. With the acquisition of Unit 51, a large, Third Sector, West Yorkshire prescribing service in 1999, Lifeline had fully re-established itself within the mainstream industry. Our publications still shocked, informed and amused, but by the end of the millennium we were well and truly back on board. And that is where we have stayed to this day. Lifeline has responded to the industry lead and, as a treatment provider, conformed to the mainstream industry narrative.

With the arrival of the New Labour Government in 1997, our industry received another tremendous investment boost as the link between drugs and acquisitive crime came to the fore as a social and political issue. This was the second harm reduction revolution. The first harm reduction transformation had been designed to protect the public from HIV/AIDS and its spread by injecting drug users. The second harm reduction revolution was designed to protect the public from property crimes committed by the same group.

Under the new government, drug treatment was the major weapon against certain kinds of property related crime. Translating the clear policy into effective practice took a little time. The early experimentation with a Drug Czar was brought to an end and the decision was taken to establish a national arms-length agency, the National Treatment Agency. The NTA arrived in 2001. In partnership with senior clinicians and academics, it re-energised the medico-penal compact so characteristic of the British treatment system and first put in place by the Rolleston Committee of 1926[xx]. This Rolleston type solution for the new millennium rapidly picked up speed. The new industry narrative was clear and unambiguous: drug treatment brings a major crime prevention dividend. It a key part of Government policy and it is popular with the electorate.

The job of the industry was to attract people into treatment and to keep them in treatment. Treatment usually involved opiate substitution therapy. The industry geared up and grew in size to meet the new demand. One of the first national targets of the ten-year (1998-2008) strategy to be hit was the workforce target. This target was reached in 2005. During these years, Paul Hayes, CEO of the NTA enjoined treatment providers "to paint

from a restricted palate". Paul's word was law. Innovation was a dirty word. Some within the industry resented the links with crime and didn't want to be thought of as criminal justice workers first and drug workers second. For this minority group, the New Labour crime prevention version of harm reduction represented a major challenge to their integrity and the integrity of the broader field. Notwithstanding these views, the NTA, with full government backing, set a very clear and confident industry narrative and the vast majority of providers were very happy to set their own company narratives accordingly. The industry as a whole had never been stronger.

Taking the thirty year period between 1980 and 2010, investment in drug treatment went from something in the region of £15 million to a figure in excess of £800 million. And during the 'boom' years from the founding of the NTA in 2001 until 2008, it hardly mattered what our various company narratives were. The money was flowing and there was enough to go round for all of us. Small organisations became medium sized and medium size organisations grew large. During this long period, our industry had already enjoyed three distinct conjunctures, each bringing regular fresh waves of fresh investment: to fight addiction in the early eighties; to fight HIV/AIDs later in the same decade and to fight crime with New Labour after 1997. During these long years, and certainly during the 'bubble' years of the new millennium, providers barely needed a narrative. We just needed to position ourselves in the right place and the money would come our way. By and large, this was the case throughout the late 1980s, the whole of the1990s and then on through the first decade of the millennium. These latter were the 'retention in treatment' years. At the beginning of 2007 few realised that the principles that had informed our industry for the best part of 30 years were soon to be fundamentally challenged. Henceforth, all talk was of recovery.

# THE DRUG TREATMENT INDUSTRY FACES THREE CHALLENGES AND MOVES FROM MATURITY TO DISINVESTMENT: 2005-2014

**The past nine years have seen our industry face three challenges: the challenge of professionalism, from 2005-2007, the challenge of recovery, from 2008-2009 and the challenge of austerity, from 2010 to the present.**

The most successful providers in pure growth terms have more than weathered these storms. This latter period of growing prosperity for our leading treatment providers has been achieved against the backdrop of an industry whose central narrative is contested within government and within our field and looks increasingly threadbare. If our industry's narrative is showing signs of wear, what is happening to the narratives of successful providers in this current period? Whilst we are still able to squeeze the most out of the present, what are our prospects for the future? What would we wish for our workforce? In order to be successful over the next period, what will we have to achieve and how will we go about it?

## THE CHALLENGE OF PROFESSIONALISATION

In 2005, the National Treatment Agency launched a major drive intended to help professionalise our field. This decision was taken in light of the rapid expansion of the workforce and the tacit acceptance in large parts of the field that treatment equalled methadone maintenance and very little else. This challenge was presented as a need to move beyond our success in hitting quantitative targets to a new era of quality provision based on workforce engagement and excellence.

## THE CHALLENGE OF RECOVERY

In 2008, our field was subject to a major, semi-orchestrated range of criticisms about its efficacy and its ethos. This second major challenge was mounted by a burgeoning recovery movement that sought and secured a fundamental re-orientation of our field.

## THE CHALLENGE OF AUSTERITY

In 2010, the new coalition government, responding to the global crash, began to build its recovery strategy on the back of a broader austerity driven approach to public sector reform. The new cost pressures demanded a fresh definition of treatment efficacy, a definition built around the notion of the 'successful completion'. According to this definition, success was measured by increasing the numbers of people completing and exiting treatment and not coming back.

Today, in 2014, one can see very clearly that the more successful providers have enjoyed continuous growth over the whole period of the coalition government. This growth has been underscored by the 2012 'expert report' *Medications in Recovery Re-Orienting Drug Dependence Treatment*.[xxi] This report, after the ructions of 2008 and 2009, helped to re-build a consensus within the drug treatment field by identifying a legitimate and complementary role for both treatment providers and for mutual aid. In reassessing, reassigning and repositioning these roles, it sought to harmonise what had become a contested field.

On the surface, large scale, mainstream providers have successfully met this threefold challenge. The growth of the major providers has continued apace over the past nine years and has actually accelerated over the lifetime of this government. All are able to speak of a committed and highly professional workforce, all claim to have embedded a recovery orientation and all are able to claim greater competitiveness without price pressures having any adverse impact on quality. These claims are all made in a routine way, however, and are, in any event, not subject to a great deal of further examination and analysis, either by the company's concerned, or on the part of researchers and policy makers.

## THE CHALLENGE OF PROFESSIONALISATION: THE NTA'S TREATMENT EFFECTIVENESS STRATEGY 2005-2007

In some respects, the period between 2005 and 2007 represented the calm before the storm. If 2005 was the year the national strategy's workforce target was hit; it was also notable for other reasons. It can be regarded as the year in which the NTA reached its absolute peak. Much that followed can be seen as a long, tactically masterful, rearguard battle with a host of hostile forces. In 2005, at the NTA summer conference, we were introduced to a new three part proposition: i) methadone wasn't enough; ii) our rapidly expanding workforce was badly in need of professionalisation and iii) there was to be a significant rehabilitation of therapy.

The rehabilitation of therapy was particularly interesting. Firstly, at a national level, therapy had never been reviled in the way it was in parts of the north west of England. It had nevertheless been largely marginalised as a result of the widespread introduction of methadone maintenance. As such, it was entirely appropriate that the subject of what drug treatment amounted to, or should amount to, should be raised and discussed in a serious way. The NTA drew extensively upon the work of Dwayne Simpson and colleagues[xxii] from the Institute of Behavioural Research at Texas Christian University to effect their partial rehabilitation of therapy. This wasn't the world of seventies' therapies, however. This wasn't a series of attempts to put people in touch with themselves, or with something more meaningful than themselves, or something that required a deep, personal opening up to a third party. This was a much more workaday therapy and it centred on the 'treatment journey' and the role of the 'key worker'. Much of this was recognisable to substance abuse practitioners and made sense in a way that other, more esoteric approaches, did not. Put simply, Dwayne Simpson's approach identified the treatment journey with key phases: an orientation phase, an engagement phase, a treatment stage and a re-entry phase. Simpson's phases actually had content beyond the prescription. His models of engagement went beyond 'hanging out'. Most astonishingly, these journeys actually had a reasonable chance of coming to a satisfactory end. Simpson and his team developed

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models of engagement, models of self-evaluation and ways of determining whether or not an organisation was ready for change. It was a whole system approach. Simpson's detailed presentations set out a whole integrated complex of interventions and approaches in a way which made it perfectly apparent that there was a radical, evidence-based alternative to methadone-only treatments and that this approach could be tailored both for specific populations and particular organisations. After the conference, three pilots were organised, but Simpson's models and methods needed more time than they were given. Soon after the fundamental narrative of drug treatment from the very top down was to be rewritten.

## THE CHALLENGE OF RECOVERY: 2008-2009

The recovery movement grew from a small-beginning in 2005 to a major force capable of shaping UK drug treatment policy by 2008. A decisive moment came when the BBC Today Programme reported on the drug treatment field in October 2007. This report focused, fairly or otherwise, on the 'fact' that very few people in treatment appeared to be getting better. As a result of this report and a growing set of accompanying criticisms, the prevailing industry narrative of 'retention in treatment' was seriously undermined and quickly began to be replaced by a model of treatment that favoured recovery from addiction. The ensuing discussions about this model divided our field and caused a considerable and profound revision in our most fundamental ideas about what drug treatment was for. In the years that followed, the leadership of the NTA was challenged on several occasions and attempts were made to persuade the government to shut it down. On July 1st, 2008 the UK Drug Policy Commission [xxiii] [xxiv] produced a 'consensus' statement on recovery. This was designed to slow down what seemed to be an unstoppable march towards a model of recovery that privileged abstention from all drugs. During 2008 and 2009 the NTA made a considered turn to recovery. By the time the new Coalition government produced its first fully-fledged recovery-oriented strategy in December 2010, it was apparent that some of the initial storm had been weathered. In July 2012, the expert group led by Professor John Strang published *Medications in Recovery. T*his report succeeded in further rebuilding a consensus across the field by setting out a model of a recovery oriented treatment system which enabled all persuasions to work together in the best interests of service users. Still, there was contestation, however, both within government and within the field. Nonetheless, the national policy, embraced by all parties, had moved from a position of

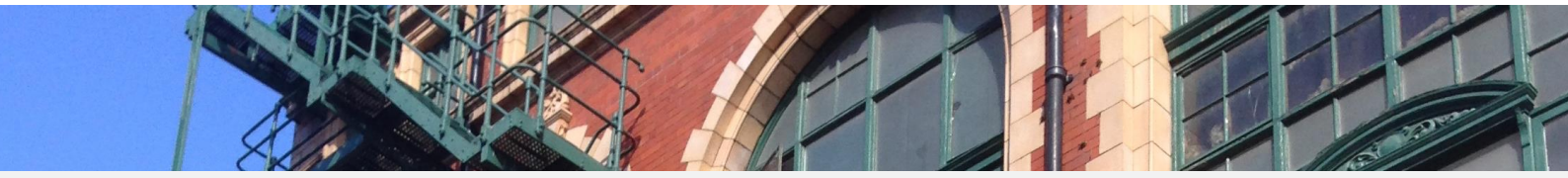
**It was inevitable, therefore, that the emerging recovery movement and its policy framing would be firmly entwined with and influenced by the financial crisis and the austerity policies that emerged.**

unchallenged harm reduction to one of unambiguous recovery in the space of eighteen months. This rapid transition occasioned the fundamental rewriting of our dominant industry narrative.

At around the same time as recovery was establishing itself as the dominant force in British drug treatment policy, the world was entering an irreversible and catastrophic global financial crisis. It was inevitable, therefore, that the emerging recovery movement and its policy framing would be firmly entwined with and influenced by the financial crisis and the austerity policies that emerged in a very clear form with the election of the new Coalition government in 2010.

## THE CHALLENGE OF AUSTERITY: 2010-2015

Post 2010, what had been true from our industry's earliest history proved to be true again. Once more, our industry's narrative was deeply shaped by the broader national, social and economic climate. Our industry, with rare exceptions, had always followed the twists and turns of government strategy and this proved still to be the case. In fact, it has never been more true than during this most recent period of austerity. If the years of 'retention in treatment' were driven by a fear of crime, then our current recovery orientation has just as clearly been driven by the economics of austerity. We know that the economic reality of cuts in social sector and health spending have been managed to some degree by setting public health priorities. Drug treatment is not one of them. That is just one of the reasons why our industry's narrative is rather threadbare. Our industry narrative is still firmly ensconced within a recovery orientation. More and more, however, the official narrative is beset with and undermined by a number of different factors. Some of these factors are only now emerging and then not in any particularly clear or definitive form. Nevertheless as trends they are discernible. These trends can be identified as follows: fragmentation, shrinkage, monopoly and contestation.



# OUR CURRENT INDUSTRY NARRATIVE

## FRAGMENTATION

The scaling down and eventual demise of the NTA (2013) has contributed to a lack of national leadership and a reduction in emphasis on service improvement and workforce development. The localist emphasis of Coalition policy and strategy has led to a fragmentation in commissioning.

This fragmentation inhibits an informed overview and makes an objective examination of commissioning practice difficult. As regards those factors influencing commissioning decisions, it is unclear that there is a level playing field. Commissioners have become increasingly prone to pressures and influences that make objective commissioning decisions more difficult. Most providers, 'winners' and 'losers' alike, would express doubts about the reliability and impartiality of much current commissioning. Importantly, it is difficult for most providers to discern any clear adherence to industry wide quality markers. The prioritisation of 'Successful Completions' as the key performance indicator has undoubtedly impacted negatively on service and workforce quality as discrete, identifiable and important markers in the choice of providers. The elevation of this particular key performance indicator, notwithstanding its role in managing disinvestment and in financial incentivisation, has resulted in a narrowing of commissioning focus. The monitoring of a very narrow range of 'technical targets' susceptible to various forms of manipulation combined with the hollowing out and fragmentation of the commissioning workforce has not served to encourage a national, regional or local focus on quality.

**The scaling down and eventual demise of the NTA (2013) has contributed to a lack of national leadership and a reduction in emphasis on service improvement.**

## SHRINKAGE AND THE TRANSFER OF LIABILITY.

Shrinkage in the form of planned disinvestment is now a frequent factor in driving procurement with the key priorities being the transfer of liability and radical year-on-year reductions in contract value. Irrespective of any company-specific claims concerning workforce quality and core service improvement, the key prerequisites of 'winning' large-

scale drug treatment contracts are: a) the absorption via transfer of high-liability workforce costs combined with b) strict compliance to radical, year-on-year reductions in income. This is not a game for small or, for that matter, medium sized, players.

## MONOPOLY

As with all open procurement processes, up to and including outright privatisation, the trend is toward a reduction in choice and a clear trend toward the semi-monopoly of a small number of providers. Only a very small handful of the largest providers (3 or 4 at most) will be in a position to commit to the unrestricted acquisition of liability. In terms of these trends, even medium-sized providers may well be subject to attrition and shrinkage in their core markets. In effect, as the commissioning process becomes ever more subject to strict economic exigencies, large treatment contracts will be bought rather than won.

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For those companies wanting to approach 'large player' status, but who lack the financial and technical wherewithal to win bids, or are unwilling completely to abandon the strict management of liability, there is the merger route to growth. The literature, not to say hard experience, warns of the pitfalls of this approach. It's expensive, messy, time-consuming and taxing of those precious resources within any company unable to bring about and sustain rapid changes in culture and performance.

For many small players the crisis is already existential; with each contract loss the wolf gets ever closer to the door. For these companies, the decision to merge, (or, more accurately, the decision to be acquired), needs to be made well in advance of that small range of critical crisis points which point unmistakably to the end; a difficult decision to take whilst there are still real tangible signs of viability.

## CONTESTATION

Contestation remains. Our field can be construed in two completely opposed ways. Firstly, as a field where there is a consensual approach to recovery with a happy set of partnerships between treatment professionals and mutual aid groups. This topography is

advanced and described in Medications in Recovery. Secondly, and alternatively, as a field where there is competition for resourcing between, on the one hand, mainstream 'treatment providers' who offer something stopping short of recovery and, on the other hand, advocates of 'real recovery' where abstinence is the only defining feature of legitimate recovery and only certain prescribed modalities of intervention have the skills and provenance to supply it. This latter view is closely associated with the Centre for Social Justice as well as a number of providers from within the rehab industry.

# CONCLUSION: FACING THE FUTURE

**This paper has focused in part on Lifeline and, in particular, its first 25 years. During this period Lifeline's narrative wasn't always neatly circumscribed by the dominant narrative of our industry.**

For our first ten years, there was barely an industry to conform to. In our first decade Lifeline's led a hand to mouth existence and with other newly formed street agencies formed an oppositional culture based on the solidarity of a common analysis. In Lifeline's second 'cool decade' (1986-95), Lifeline definitely did depart from the already well-established treatment narrative of our rapidly growing industry. This took Lifeline to a position of high national prominence. Eventually, however, as the tide turned against those who championed the normalisation of drug use, Lifeline reverted to a model of development that conformed much more closely to the dominant industry narrative.

From the election of New Labour in 1997 until 2008, a period which saw the first 10 year national drug strategy, our industry's narrative was again clearly and straightforwardly derived from government policy. The growth in our field over this period led, in 2005, to a major self-examination designed to enhance the capabilities of our workforce following a period of major recruitment. In 2008, our field faced a major internal and external challenge which questioned its commitment to recovery. From 2010, our field began to experience disinvestment. After a slow start, this process is now beginning to bite.

**At this time, however, our industry's overarching narrative is less confident than at any time since the early years of our field in the 1970s.**

Even so, major drug treatment providers have prospered during this latter period of challenge and, notwithstanding the scale of current cuts, have continued to grow. At this time, however, our industry's overarching narrative is less confident than at any time since the early years of our field in the 1970s. At that time, charities like Lifeline lived under the threat of extinction. They had no secure funding base. The national case for drug treatment had not been made. Today, the national case for maintaining drug treatment at the levels it has enjoyed over the past thirty years is not strong. The crime dividend is much less

clearly a vote winner and drug treatment is not a public health priority. What are the issues and challenges that our successful drug treatment providers face? And how is this reflected in their current narratives?

How do our most successful treatment providers fare when our industry is on the cusp of a very significant and possibly irreversible decline in investment? How best should they approach the challenges of retaining and, if possible, expanding their foothold in core drug and alcohol treatment markets? Beyond these core markets, how do wealthy treatment providers invest in the future? In particular, how best should they equip and empower their workforces in response to industry decline and both internal and external critique? What should the various core skills of our profession be?

Certainly, all major providers will wish to win more business in core drug and alcohol and alcohol markets. In addition, they will continue working to develop service and contract models that enable them to make major gains in the increasingly dominant privatised supply chains of outsourced 'prime provider' contracting, prevalent in both health and criminal justice procurement. The recently announced results of the Transforming Rehabilitation procurement show some big winners and some significant losers. Whatever the scale of expansion, all providers will want to grow to the point where they can provide a wide range of upwardly mobile and other development options for their workforces, with particular emphasis on service management, service development and practitioner roles. Of course all providers would hope to be able to create the best growth and development environment possible and to ensure that all staff, volunteers and beneficiaries are clear that they are in the right place to develop their potential to the maximum.

In our field, every practitioner, every manager and every executive, irrespective of which company they work for, will be asking themselves what exactly it means to work for this company, in this industry, at this time and in this climate.

## WORKFORCE INVESTMENT

Lifeline is one of those companies that have virtually doubled in size in the last three years. In June 2014, of 936 employees on our payroll, 435 had been with us for two years or less. For treatment providers who are growing rapidly, this will be a common pattern. In part, it is the result of competitive tendering and the resultant transfers that take place to winning bidders. This compulsory mass migration is a result of upheavals that no one has consistently challenged. It actually promotes a workforce that with each transfer, each

goodbye and each hello, becomes ever more inured to the speciousness of most company narratives. After all, was any of this really necessary? Competition, we are told, is there to stimulate change. Moving large numbers of people from employer to employer with such deadening regularity serves no meaningful purpose, however, and inhibits continuity, stability and development. In this fragmented, shrinking, quiescent environment, it is now left to individual companies to begin to chart their own course. For many, the first step will be to turn radically towards workforce investment.

**Moving large numbers of people from employer to employer with such deadening regularity serves no meaningful purpose, however, and inhibits continuity, stability and development.**

At various times, our industry has waxed eloquent about quality and over the years some of this has fed through to treatment providers. In their own right, treatment providers have been quite capable of gilding their own lily on the subject. Quality understood as workforce investment and service improvement has never been the main story, however, and as a sub-plot it has never carried much conviction. The one clear chance our industry had to professionalise and bring a quality driven approach to its work was the 2005 Treatment Effectiveness agenda, introduced by the NTA and featuring the work of Dwayne Simpson and colleagues from Texas Christian University.

Simpson's model emphasised engagement. This wasn't the kind of 'street-cred', 'hanging-out' type of engagement much beloved of the early field and its ethnographers. Simpson introduces the notion of 'node-link mapping', a way of actually co-working with service users in what we now call a strength-based way. Unfortunately for most providers, this exciting new intervention was as far as it got.

From a historical point of view, one can argue that events conspired to derail Simpson's agenda. It may be, however, that it was already running out of steam when the recovery movement burst onto the scene in 2007. Either way, this agenda was not and probably could not have been imposed from the top. Much of his work and, in particular, his diagrammatic modeling survives in countless service models, many of them designed by business developers working for major treatment providers.

Of course, discussions about workforce quality aren't necessary going immediately to set the place alight. Frequently, discussions about quality have been associated with the wrong

kind of agenda; an agenda where somebody else always seems to know best, one involving someone from HQ; a constraining, homogeneous agenda.

Certainly if you look at our field, right across the third sector and the independent sector, none of us have ever had a stand out reputation for workforce investment or service quality. And even up to this day, if you asked most workers in the field, "which company has a hallmark of genuine quality?" most of us would say, CEOs included, "it's not like that." And indeed, it isn't. When our industry narrative was strong, our company narratives could pretty much take care of themselves. Most senior executives in the field could talk a good game on quality, but really growth was the only significant marker of health and wellbeing in our industry. It still is.

**Frequently, discussions about quality have been associated with the wrong kind of agenda; an agenda where somebody else always seems to know best, one involving someone from HQ; a constraining, homogeneous agenda.**

Workforce quality and service improvement are always presented as being high on the agenda of treatment providers. But in reality, how much progress has been made over the long ascent of our industry. And now that our industry may be in decline, how are we to effect those changes our business developers claim come as standard.

Once again, Dwayne Simpson[xxv] and colleagues' work contains answers. In addition to being an integrated set of tools, Simpson's body of work is tailored very specifically towards a view of quality that sees it emerging from an organisation's particular characteristics, its particular strengths and weaknesses and, most importantly, its readiness to change.

In a brief introduction to the role of staff survey's in organisational change, Simpson and the team from Texas Christian University put it thus: "Every organisation has its own "personality" as characterized by its structure, climate, and staff skills. It is not surprising that these features also are related to how well staff perform their duties as well as to agency effectiveness and efficiency.

**Organizations are in an almost constant state of flux – sometimes seismic – so it is helpful to know if changes seem to be for the better or for the worse.**

Organizations are in an almost constant state of flux –sometimes seismic – so it is helpful to know if changes seem to be for the better or for the worse. Most scientists agree that by diagnosing attributes of an organization, however, its functional strengths and weaknesses can be identified and addressed."

The prioritisation of workforce investment as a priority ingredient in any company's narratives must, therefore, speak very particularly to that company and its stakeholders. As such, key quality markers must: a) endorse and reflect company values; b) inform, at a most basic level, its management practice; c) contribute to the learning and development of its workforce; d) actively promote the engagement and feedback of all service users and e) enhance the overall performance of its services.

These quality markers should be integrated in a consistent and coherent development environment. They need to be demonstrable and self-evident. Successfully establishing and implementing such an improvement process will be difficult. Neither will it guarantee success in business development in the short term. As resources shrink, however, a thoroughgoing investment in our workforce and an accompanying focus on service quality will inform key decisions in ways which strengthen every aspect of a company's reputation.

## ENGAGEMENT

The human resources profession and workforce development consultants have long been interested in how to promote 'full engagement' in the workforce. The Towers Perrin survey of 2005 asked 86,000 employees working for large and medium-sized companies across 16 countries to respond to a number of statements in order to measure the degree to which they felt engaged in their work. A sample of the statements follows:

a) I really care about the future of my organisation;
b) I am proud to tell others I work for my organisation;
c) My job provides me with a sense of personal accomplishment;
d) My organisation inspires me to do my best;
e) I understand how my unit/department contributes to the success of the organisation;
f) I understand how my role in my organisation is related to my organisation's overall goals, objectives, and direction;

g) I am willing to put in a great deal of effort beyond what is normally expected to help my organization succeed.

The researchers findings were that only 14% of employees in the sample were 'fully engaged'. 24% were disengaged. Everyone else was in the middle. A second Towers Perrin study found that 21% were 'fully engaged' and only 8% were disengaged. In this study, however, the 71% who were in the middle, i.e., 'moderately engaged' were further broken down into the 41% who were partially engaged,'enrolled' and the remaining 30% who were partially disengaged, 'disenchanted'.

Clearly, whatever one makes of this kind of study, it is important that providers are able, however they choose to do it, to secure detailed, unbiased and regularly updated information on the degree of engagement of their employees, their volunteers and their beneficiaries. This will go some considerable way to determining whether an organisation needs to change and, just as importantly, whether it has a readiness to change.

## Recovery

Directorate, service-level and individual engagement is necessary if we are to secure a genuinely corporate commitment to key elements of the drug strategy. Although the recovery movement coincided almost exactly with the global crash of 2008, recovery is about much more than austerity economics. And the profound message of hope it brings to growing numbers of people is hugely important in these difficult times. Our field still hasn't fully embraced recovery as an important philosophy of care and an equally important way of life. Perhaps the criticisms to which our field is subject have made us defensive; when senior government ministers are openly critical we have a tendency to retrench. But we shouldn't. The truth is some of us just wish recovery would go away. It asks too many questions: of us; our organisations; our history; our comfortable lifestyles and our failure to inspire. If some of the recovery rhetoric is beginning to sound stale, it may be because substantial sections of our field can't and don't want to live up to it.

## Harm Reduction

At the same time, we should focus ever more closely on all those who seek and need extended, perhaps life long, care. Currently, ours is a strategy of a single KPI. The economic reasons for this are much stronger than the ethical ones. The philosophy of the 'Successful Completion' can lead us to neglect that large group of patients whose needs grow greater,

not less, with the passing years. For this group, real quality care must go far beyond needle exchange and opiate substitution treatment. Now more than ever we need that range of inter-connected skills and specialisms that only the NHS can provide. The partnership between the Third Sector and the NHS must be rebuilt. The Third Sector has a lot to offer, but the home of clinical excellence in connection with complex cases must lie with the NHS. If those of us in the Third Sector and the Private Sector could just stop building our empires for one moment, then surely we would see how important it is to campaign together for a strong role for the NHS in substance abuse treatment and complex care.

Unfortunately, some in our field believe that one can only be loyal to one thing; either it has to be recovery, or it has to be harm reduction. This mentality falls far short of the kind of engagement necessary if we are to strive towards and achieve a quality agenda that embraces all services users needs. Many of us working in the field are convinced that a successful treatment system must integrate recovery and harm reduction. This surely is not beyond us.

The world of competitive tendering is driving a lot of smaller providers out of existence. Unfortunately, this tendency towards monopoly cannot be justified as some kind of inexorable march towards quality. If only it could! In the course of our daily lives and in our constant dealings with utility companies, transport companies and banks, we all know that privatisation doesn't lead to greater choice. Equally, we understand only too well that the depressing drive toward monopoly doesn't lead to better services: if only it did.

**Unfortunately, some in our field believe that one can only be loyal to one thing; either it has to be recovery, or it has to be harm reduction.**

Those treatment providers that are still getting bigger and who aren't in immediate danger of extinction have never had a greater responsibility. Our wealth, for some of us are wealthy, must be invested with great skill and co-ordination and not wasted on exercises in company boosterism dressed up as innovation. As a field we need to be able to speak with a much clearer voice, a genuinely independent voice and not one that is ever more dependent on the good graces of the government of the day.

Our is a complex field and a compassionate one. For years our futures seemed assured. Now it's different. The future beckons, but it also threatens: for individual workers; for many small to medium sized providers and ultimately for our whole industry. Organisations in our sector have short memories and only allow themselves to focus on

the near future. Anniversaries may call forth a certain kind of nostalgic historiography and business planning may require a brief forward view, but, beyond that, Third Sector organisations in our field do not usually choose to set foot. This may be because most Third Sector organisations are absorbed principally in the day-to-day business of survival and growth. To this end, they are keen not to stray too far from the current industry narrative and will tend to view the past very much as something to be forgotten.

As the industry narrative grows progressively less united and less persuasive, however, only companies within that industry with a strong reputation for quality will survive. For the first time in the history of the modern drug treatment sector the future of our industry depends on the strength of the narratives of the companies that comprise it.

**Ian Wardle**

**December 2014**

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