

Subject to Change: Identity, Culture and Change in the Alcohol and Other Drugs Sector in Tasmania

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Contemporary rehabilitation industries are increasingly being scrutinised by those in radical and critical scholarship, amid calls for more incisive critiques of the status quo and more emancipatory research agendas to address mounting inequalities (McLaughlin, 2011). Institutions and workforces involved in the rehabilitation of citizens deemed in need of reform are of interest to critical scholars because they form the coalface at which to observe the anticipated and unintended consequences of policies, discourses and practices of social control. Challenging official and mainstream assumptions about these institutions and systems often gives rise to vital opportunities for what Scraton (2002, 2007) aptly calls 'speaking truth to power.' There is a pressing need for frank and fearless truth-telling, especially in areas where nearly everything is government run or reliant on government funding, for example, the alcohol and other drugs sector and offender management sector in Australia and elsewhere. The former sector remains closely related to the work of the latter, given the history of Western drug policy (i.e. criminalisation), the advent of therapeutic jurisprudence and drug courts, and the burgeoning numbers that make up the shared 'client' group reflecting the complex but well documented links between drugs and crime (see Seddon, 2006; Hammersley, 2008). Extensive research by the Australian Institute of Criminology demonstrates that, for police detainees and for incarcerated offenders, substance use or misuse is implicated in approximately two thirds (66%) of all criminal offences (Payne & Gaffney, 2012). Empirical findings and large scale data about the drugs-crime nexus need to be situated and analysed in their social, political, legal, economic and cultural context. Valuable insights have been gained, for example, from critical perspectives on the policy agendas, structural implications and real world failings of the War on Drugs and punitive responses to people who use illicit drugs, including appraisal of the human and economic costs and benefits of years of prohibitionist populism (see Welch, 1997; Jiggins, 2005; Douglas & McDonald, 2012).

Most analyses and commentaries arising from the critical school of thought (broad church that it is) focus on the rights and prospects of individuals or groups of individuals who are subject to intervention. The findings of critical research projects often result in calls for systemic reform and sweeping change, informed by the experiences, rights and needs of these individuals and groups. Indeed, there are ample moral and intellectual arguments to be made for this to continue. However, while by no means mutually exclusive, the argument and focus here turn to the impact of structural issues and inequalities on *practitioners* and *workforces*, and the need to speak truth about issues of power and control in how rehabilitation industries function. Such concerns are important in their own right, as well as for how they directly impact on the quality and quantity of services on offer to individuals in the care and control of these systems.

Firstly, a caveat. The following discussions need to be prefaced with acknowledgement that there is no one 'culture' or 'identity' that can define the practitioners, workforces and organisations that make up the alcohol and other drugs sector in Tasmania or across Australia. Nor is there a singular reform or change process at work. Likewise, it is erroneous to suggest there is one unified monolith known as 'government' with a clear policy agenda or attitudinal bias to the workforces and sectors it governs and funds. As observed by Garland (2006), it has been too easy for sociologists and criminologists to discuss the cultural as an analytical dimension of social relations that exists somewhere between structure and agency, which often leads to speaking of culture in ways that imply collective entity, or as a variable that can be manipulated by senior managers or governments to enhance effectiveness or productivity (McNeill, Burnett & McCulloch, 2010). Understanding culture cannot simply be a means to an end or, if it is, resultant attempts at reform are likely to fail because they are predicated on morally and conceptually flawed grounds.

Culture is not just an influence on what we do and a factor in working out how we can do it better; it is about who we are and how we construct our identities... Neglecting questions of the relationships between culture, identity and morality lies at the heart of many failed attempts to change or reform practices. (McNeill *et al.*, 2010: 7)

Understanding culture requires engaging with complexity and diversity, values and value tensions, and considering multiple meanings in their situated contexts. The focus of this paper centres on the nature and impact of culture and change in the alcohol and other drugs (AOD) sector in Tasmania, with reflections that

bear some relevance to the wider Australian stage. The discussions that ensue represent *emerging* insights (rather than polished findings) from the field and the author's critical reflections from the standpoint of a researcher and a worker, albeit offered with an eye to the literature.

Trends and Tensions in the Alcohol and Other Drugs Sector

Over the last 20 years, the Australian alcohol and other drugs sector has 'experienced unprecedented changes that have major implications for the development of a responsive and sustainable workforce' (Roche, 2009: 194). With changing patterns and trends in substance use and misuse have come significant amounts of change and development in the sector. Since the late 1980s, drug researchers have consistently concentrated on advancing addictions treatment, evidence based practice and knowledge of 'what works' in order to improve the productivity and effectiveness of service delivery. Following this, the sector has been flooded with new and promising tools, programmes and clinical standards and guidelines, as well as reinventions of longstanding approaches. Advances have ranged from improved medical treatments (e.g. pharmacotherapies, detoxification and withdrawal management) through to improved psychosocial interventions (e.g. brief interventions, cognitive behavioural therapy, motivational interviewing, mindfulness techniques), new screening and assessment tools (e.g. comorbidity screening tools like PsyCheck), more forums and support options (e.g. specialised therapeutic communities, online interventions, SMART Recovery groups), and new evidence about overlapping complex needs (e.g. links between post-traumatic stress disorder and substance misuse). These new tools and options have flooded the sector in the same two decades where broader macro processes of neoliberalism, economic rationalism and associated business-like quality improvement regulation and reporting structures have come to dominate understandings of 'success' in intervention and service provision. Practitioner and organisational performance is monitored and surveilled with accountability and reporting mechanisms perhaps more than ever before, changing notions of what constitutes 'quality' and 'improvement' and raising questions of according to whom?

Subsequently and perhaps unsurprisingly, in order to effectively upskill practitioners to keep pace with increasing professionalisation pressures, workforce development efforts over this period have largely relied on two main approaches:

1. *education and training* of practitioners in the uptake and implementation of 'what works' in evidence based practices; and
2. *capacity building* projects and initiatives at the sectoral level (usually through peak bodies) and the organisational level.

It seems that these two approaches will retain favour as key drivers of improvement and reform, if the *National Drug Strategy 2010-2015* is anything to go by (Ministerial Council on Drug Strategy [MCDS], 2011). In the Strategy, the AOD workforce is conceptualised almost purely in terms of their qualifications and skills, with 'an appropriately skilled and qualified workforce' measured by their ability to 'function with maximum effectiveness' headlining the workforce priorities for the next few years (MCDS, 2011: 20). Nine of the eleven workforce development priorities are explicitly about training and education and/or capacity building, with the remaining two identifying the need to support worker wellbeing and to address issues of workforce turnover (MCDS, 2011: 21). Paradoxically, while the National Strategy repetitively states the necessity of a 'systematic approach', nearly all of the workforce strategies and priorities target practitioners (not organisations or broader governance and funding structures, nor the conditions, politics and cultures that exist therein) to improve and expand their capacity.

Cash strapped organisations and their workers may be happy and willing recipients of fresh rounds of training and professional development, for the intellectual stimulation as well as (understandably) a welcome "day off" from the coalface of one of the hardest working sectors in health. However worthwhile, the focus on building the agency and skills of individuals belies deeper issues at the heart of why training and capacity building seem to be the only approaches finding favour with funding bodies. Another more radical and controversial reading of the situation calls into question the agendas behind the push by governments for change and improvement of what are predominantly meagrely funded community sectors. Critics of such trends cast training and capacity building as technologies of neoliberal governance and as illustrative of processes of responsabilisation of practitioners under pressure to professionalise and perform to survive in the competitive marketplace of health and human services (Phillips & Ilcan, 2004; Connell, Fawcett, & Meagher, 2009). The value judgment implicit in this is that practitioners are valued by their capacity to accomplish improved service delivery and

client outcomes – outcomes which are, in reality, influenced by many more factors than the résumé and skills of any given worker, no matter how burnished their credentials.

A narrow focus on surface level solutions and embracing ‘the new’ in the hope of moving beyond the current impasse has distracted from fully understanding the depth and extent of the issues in ‘the now.’ If local and national AOD workforces are to become more responsive and sustainable, more needs to be known about the context, conditions and culture in which practice and reform take place. Little if any Australian research and scholarship has been devoted to analysing issues of identity and culture in the alcohol and other drugs sector, and few studies have been conducted into the nature and impact of change and capacity building on the sector’s workforce (for an example of one recent sectoral study, see Craze & Mendoza, 2011).

Ameliorating such gaps and silences in existing knowledge becomes of increasing urgency when considered in light of current and anticipated workforce turnover. Practitioners are leaving, at alarming rates. A recent Tasmanian AOD workforce survey by the peak body, the Alcohol, Tobacco and other Drugs Council of Tasmania [ATDC] (ATDC, 2011: 68) involving respondents from 18 organisations reveals some concerning prospects and trends:

- 75% of respondents have worked in their organisation for five years or less (with 21.5% of these having worked in their organisation for less than 12 months);
- At an organisational level, 75% of respondents do not intend to stay with their current employer beyond the next five years;
- At a sectoral level, a 50% workforce turnover can be anticipated within 3 years, with minimal differences observed between managers and staff in their intentions to leave the sector.

Other surveys suggest similar trends and prospects at a national level, with five years being the median length of service in the AOD sector (Roche & Pidd, 2010). A National Centre for Education and Training on Addiction (NCETA) survey found that 54% of workers had thought about leaving their job, and 31% of workers planned to look for a new job over the next 12 months (Duraisingam, Pidd, Roche & O’Connor, 2006). Interestingly, along with poor remuneration which is a commonly cited problem (Duraisingam *et al.*, 2009), the lack of respect and stigma associated with working in the AOD sector was specifically identified in the survey findings as one of the barriers negatively affecting staff retention (Duraisingam *et al.*, 2006).

A perpetual cycle of education, training and capacity building initiatives can continue to be invested into the alcohol and other drugs sector and its workforce in any given jurisdiction in Australia or indeed nationwide, however, the practice wisdom and experience will be lost if the mass exodus continues. That is why workforce and organisational development urgently need to extend beyond education and training initiatives to encompass professional, organisational, structural and cultural factors in order to better understand what helps and what hinders effective development being realised (Allsop & Stevens, 2009). It is to some of these factors to which we now turn, with revelations from a Tasmanian study suggesting the AOD sector may indeed be facing deeper issues than have been previously identified.

The Study: Emerging Reflections on Identity, Culture and Change

The research presented here originally started by looking at how alcohol and other drugs practitioners work with people with complex needs, with a restricted focus on effectiveness and best practice interventions. It quickly transposed into a more complex, and ultimately more interesting, exercise in seeking to understand a sector grappling with its own complex needs in the midst of change. The author conducted in-depth interviews with 30 practitioners working in the alcohol and other drugs sector and related stakeholders in criminal justice in Tasmania. Interviews took place at various locations around the state over a two year period from May 2010 to May 2012. Sampling and recruitment of participants was intentionally broad to reflect the diverse stakeholder perspectives within the AOD sector, with the occupation and work role of participants ranging from different types of frontline practitioners (e.g. counsellors, doctors, social workers) through to different types of senior and strategic workers (e.g. managers, consultants, advocates, sectoral leaders). Data from this study is also complemented by the findings of a recent Tasmanian alcohol and other drugs workforce survey (see ATDC, 2011). While there is not enough space to canvass the depth and breadth of the research findings here, much of the data from practitioners is hopeful and inspiring, demonstrating how much they care about what they do and that they are good at what they do, despite the challenges. Yet their concerns tend to converge on issues of culture and sustainability as well as a desire to *be the change*, to be actively engaged in

advocacy and reform processes, instead of being subject to change, passively responsible for coping with the changing goal posts as governments stop and start funding cycles, projects and constantly alter reporting templates.

It is becoming increasingly clear that practitioner understandings of the identity and legitimacy of the alcohol and other drugs sector are mediated by the context and conditions in which they find themselves working in. The impact of structural pressures and inequalities has not gone unnoticed at the coalface:

“I think the nature of being under-resourced and stretched and competitive is that you get in this survival mode, and feel undervalued and stick with what your core business is... It is desperate, compartmentalised, and that is added to by the way services are geographically located. There are multiple layers and reasons that have stopped us moving forward... We need more of that sharing of professional practice wisdom – we have very limited opportunities. That is the climate and culture that has been created from having diminished resources – survival mode.” [senior practitioner]

“Workers in the sector actually feel like they don’t have a good name. It’s not a good place to work; the pay’s not great; the conditions aren’t fantastic. You have massive caseloads and you’re overworked and underpaid and underappreciated.” [frontline practitioner]

These factors are not unique to Tasmania and are reflected in the wider Australian workforce development literature identifying factors affecting retention (Duraisingam, 2005; Spooner & Dadich, 2009, 2010). Importantly, such under-resourcing amid growing caseloads is illustrative of moves towards more generic ‘broker’ models of service provision. This type of case management helps to cater for the masses within the given fiscal constraints, ensuring alcohol and other drugs services continue to achieve excellent outcomes on a shoestring budget. It may also detrimentally affect existing retention and future recruitment, by negatively impacting practitioner perceptions of their work. Seasoned practitioners who have been in the system for a long time may see their best work (working with the ‘whole’ person over time, building trust) as increasingly devalued or sidelined in exchange for taking on more surface level screening, assessment, referral and group facilitation, not to mention keeping up with bureaucratic demands of more paperwork, risk management and evaluation requirements (White & Graham, 2010). Paradoxically, practitioners are there to help (tasked with helping to reduce harms, risks, costs etc) and yet they are not necessarily afforded the chance to truly engage in the depth of the work of a helping professional, nor offered satisfactory levels of help and support themselves.

Building on these sentiments are even more direct acknowledgements from different practitioners that the sector struggles with fundamental issues of identity and legitimacy which, for many, contribute to a lack of pride and feelings of insecurity about the work and the sector. While these topics were not actually part of the line of questioning in interviews, many practitioners’ conversations naturally turned to such issues:

“There’s a lack of pride about what we’re doing and who we are and why we’re doing it and all that sort of thing. I don’t think we’ve got a strong enough identity of being who we need to be as a sector... It’s about having a grown up sector too. I think that’s a bit about the maturity, or lack of, of the sector in the sense of being able to say “I’m really proud of what I do”” [senior practitioner]

“I think pride and identity are the two things I would tackle... No wonder AOD people, government and community sector, feel insecure at the moment.” [capacity building practitioner]

“We don’t do a lot of that self promotion and celebration. We celebrate our client outcomes but we don’t celebrate ourselves as a service.” [senior practitioner]

“One of the challenges I feel is this: alcohol and drug services don’t have, at this point, the level of respect or identity across the broader health sector. Rightly or wrongly, that’s the reality. I’m not saying “because we’re bad people” or anything like that. The reality is that I don’t think other areas of the health sector believe we are a real player – at this point in time.” [senior practitioner]

Vivid comments from one passionate practitioner went so far as to acknowledge the reciprocal links between a lack of a cohesive identity and esteem amongst AOD practitioners and the sector’s workforce and the ways in which they are perceived and treated by those in power.

“There’s a lack of pride in the ATOD sector. There is a real sense of disengagement... I don’t know how exactly to describe it, except to say it kind of feels like ATOD workers are urchins. In the Dickensian sense, they’re the Oliver Twists, they’re kind of outcasts and they’re very separated, and nobody really knows who each other are until you get them into a room. I was in an [ATOD sectoral consultation group] recently, and one of the questions that was asked was “would you recommend working in the ATOD sector to people that

weren't in it? Would you actively recruit?" The people around my table said no they wouldn't because first of all they don't know how to define the sector, they don't know who to send it to, or who to send them to and secondly they don't see that it's a very good sector to work in. I think that that is terribly problematic because if there isn't a sense of collegiality, if there isn't a sense of pride in their work and a sense of importance in what they're doing, then how are we going to ever convince policy makers and government heads that they're worthy of consulting with and collaborating with? If they don't see any value in themselves, how the bloody hell is everybody else going to?" [practitioner]

Several participants in the study expressed interest in wanting change and making the sector and its development more sustainable, but were circumspect about how and by whom this might be achieved. Top down strategies alone seemed to raise the ire of the change weary and change wary practitioners who had already seen so many economically and/or electorally driven reforms. Even senior practitioners did not express much faith in the ability of key government funding bodies such as the Commonwealth Department of Health & Ageing (DoHA) or the Tasmanian Department of Health & Human Services (DHHS) to inspire and lead positive change, while meaningfully engaging with clients, practitioners and organisations in the process. In any case, these organisations are not without their own challenges in workforce turnover and managing organisational change.

Changing the Way We Think About Change

While concerted efforts to update practice and change professional and organisational cultures in the alcohol and other drugs sector have been driven, for the most part, by good intentions, they have yielded mixed results and mixed feelings. At one level, intense concentration on aligning interventions with the evidence base of 'what works', thereby emphasising the instrumentality of practitioners (what they do and how they do it) has yielded well documented returns in streamlining service delivery. For many, the roll-out of tools, programmes and standards across the different occupations and organisational contexts that make up the AOD sector represent positive steps in the right direction.

At another level, such efforts have distracted from the need to understand the context, culture and conditions in which such practices and proposed changes take place. Concentration on the tools and technologies of practice and their standardisation has surpassed and, arguably, neglected attention being given to issues that remain important to practitioners – identity, values, legitimacy and future purpose (who they are and why they do what they do). Ironically, such widespread standardisation of practice may represent a form of 'professional marginalisation', by displacing the centrality of practitioners as agents of change and imposing tools and procedures that are not sensitive enough to the multifaceted nature of the cultures, practices and practitioners that they seek to change (see McNeill, Burnett & McCulloch, 2010). Instead of displacing practitioners and ignoring the influence of organisational factors, building a stronger identity and greater capacity in the sector needs to start with 'changing the structures, and expected outcomes of these structures, in which people work, not just encouraging a few to use new ways of working in spite of the system' (Allsop & Stevens, 2009: 541).

Re-thinking the reform agenda involves changing the way we think about change. Systemic advocacy in the interests of mobilising context and culture sensitive change takes time. It also necessitates change champions staying in the sector for long enough to see dreams and principles realised in practice. In doing so, there is a pressing need to build the capacity of organisations and indeed the sector to foster and manage change in the face of uncertainty, as well as to improve and expand the means by which this is done. Culture change needs to be approached as a multi-level and long term systems endeavour which cuts across the individual, organisational and sectoral levels (Skinner *et al.*, 2009). Such a process is pivotal on the inclusion of those it affects, therefore it needs to pursue inclusion of clients and practitioners, at all levels, well and truly beyond narrow programme or project evaluations or siloed committees with little political wherewithal. Its success is also dependent on the extent to which (and longevity of which) it is planned, funded, staffed and resourced.

One of the challenges is that those who may seek to 'speak truth to power' (Scruton, 2002, 2007) are themselves often restricted by how their job roles are funded and governed. Nearly all alcohol and other drugs peak bodies, advocacy organisations, and community sector organisations in Australia are reliant on securing relatively short term competitive government funding. Health Workforce Australia (2012), tasked with developing a national coordinated approach to fostering 'change, collaboration and innovation' for a more sustainable health workforce in Australia, is itself a federal government initiative. These stakeholders will continue to be engaged for a narrow set of purposes, such as developing new competency frameworks or consultation on workforce minimum qualifications – i.e. things that target practitioners, not structures or

cultures. Even some alcohol and other drugs researchers have expressed concerns about the potential for regulation and subtle forms of control by funding bodies (Miller, Moore & Strang, 2006), as links are being drawn between 'he who pays the piper' and the research agenda and its tune.

Critical scholars are presented with a prime opportunity to engage in more research, analysis and critique of the potential prospects and stark realities inherent in the current state of the play in the alcohol and other drugs sector – analysis that may, in turn, inform advocacy and progressive policy development. True consensus and co-production are unlikely to be achieved between key stakeholders, especially practitioners and people who use drugs, as long as the disjuncture between the rhetoric and reality of working together towards change exists. Returning to the argument of McNeill *et al.* (2010), neglecting questions of the relationships between culture, identity and morality (including values) lies at the heart of many failed attempts to change or reform practices. A lot of good quality empirical 'evidence' already exists, but the sector needs to be careful to avoid naïve idealism in assuming that careful training and implementation of the evidence will be the key to sustainable change, especially when so much practice wisdom is being lost with workforce turnover each year. The alcohol and other drugs sector deserves to be better understood and more cogently represented than *solely* by those engaged and funded to do short term research projects for a narrow set of evaluative purposes, attached to a specific initiative, funding round or type of service provider and often tied into decisions on whether these things should continue or not. Critical analytical ethnographic and ethnomethodological methods, as well as advocacy oriented research methods led by practitioners and peak bodies are needed, to contrast and complement existing research which is predominantly conducted by a small group of accomplished Australian AOD researchers, many of whom are successful in receiving government funding to conduct the aforementioned plethora of evaluations and consultancies to design the next set of standards and tools. Policies and reforms are shaped by research, as well as by values, cultures, structural pressures and inequalities, and political, fiscal and relational dynamics. The people most affected by policy and reform are those at the centre of the system, individuals with complex needs and the practitioners who support them. For practitioners, what they want, how they feel about their work and those they work with matters; it can explicitly and implicitly affect pride, identity, legitimacy and commitment. More independent research and public intellectual debate is needed on these things to better understand what is really happening at the coalface, as is a greater capacity for diverse voices to speak truth on issues of power and control in rehabilitation industries and workforces. What we don't understand, we are unlikely to be able to sustainably change.

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Changing the Way We Think about Change

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