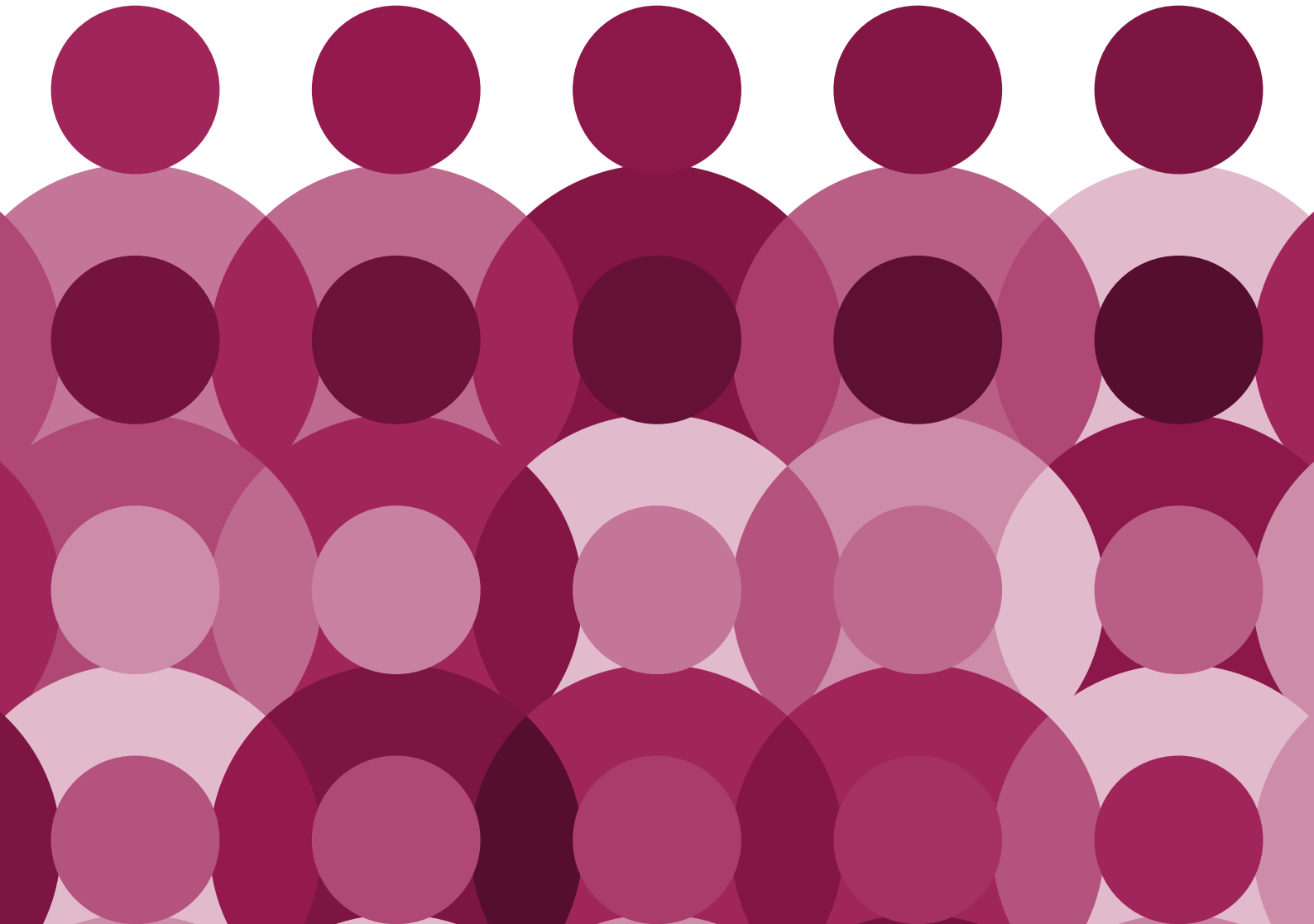
Factors that influence employees' perceptions and experiences of working within the treatment and recovery sector in England

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Conflict of interest statement

Prof John Strang is a clinician and academic who has worked with local, national and international government and non-government agencies to develop and test new approaches to tackling addiction and related problems. Through his employer (King's College London), he has received research and project grant support from a range of government and charitable research agencies and charitable organisations. Through the university, he has also worked with pharmaceutical and technology companies, from some of whom the university has received project grant support, honoraria and/or consultancy payments. In the past three years, these have included MundiPharma, Camurus AB, PneumoWave, Accord and Navamedic, alongside medication or device supply (PneumoWave, CMI and Catalent) to develop or study potentially improved formulations and devices. His employer (King's College London) has registered intellectual property for an innovative buccal naloxone formulation with which Prof Strang is involved, and he has been named as an inventor in a patent registration by a pharmaceutical company for a concentrated naloxone nasal spray. He is also named as a Patron of Addiction Family Support (formerly DrugFAM), a UK-based registered charity, and supported by the National Institute for Health and Care Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London.

Since 2022, Prof Joanne Neale has received research funding from pharmaceutical companies Mundipharma and Camurus AB and honoraria from Indivior and Camurus AB for conference presentations and dissemination activities relating to drug treatment (including Buvidal) and recovery through her university (King's College London). She has also received honoraria from Addiction and the International Journal of Drug Policy for editorial work and from the Canadian Centre for Recovery Excellence for participating in an Expert Reference Group for a national survey of recovery from alcohol and other drug use.

Between 2019 and 2022, Prof Tim Millar was Chair of the Data Monitoring Committee for the investigator-led, industry-funded Extended-release Pharmacotherapy for Opioid Use Disorder (EXPO) Trial of depot buprenorphine preparation a (non-pecuniary) (EU Clinical Trials register 2018-004460-63).

As of December 2025, Dr Nicola Kalk is the Chief Investigator on the NIHR-funded, investigator-led research study BUILD2depot (NIHR206657), for which Camurus AB provides in-kind support to her employer.
The other authors of this report declare that they have no competing interests.

RAND Europe received sales data for quantitative analysis from Camurus AB in this project. This was non remunerated and Camurus AB did not receive early access to report methodology or findings.

Preface

This report is part of a wider RAND Europe evaluation of the former UK government's 10-year drug strategy investment in the Treatment and Recovery Portfolio in England (D-SITAR). As part of the Portfolio, and following Dame Carol Black's 2019–21 independent review of drugs, the Department of Health and Social Care (DHSC) has been providing additional funding to local authorities to improve treatment and recovery services for people who use alcohol and/or other drugs. In 2023, RAND Europe and partners King's College London, South London and Maudsley NHS Foundation Trust, the University of Manchester and the University of Queensland were awarded a grant by the National Institute for Health and Care Research (NIHR) to evaluate the implementation of the first three years of the investment.

This report presents the results of an evaluation of the workforce transformation programme. This evaluation is accompanied by four further evaluations of priority areas of the Portfolio, focusing on the Housing Support Grant, Lived Experience Recovery Organisations (LEROs), mental and physical health service integration and the provision of depot buprenorphine, as well as a process evaluation of the first three years of implementation of the Portfolio. The results of these evaluations are described in separate reports.

This project is funded by the NIHR Policy Research Programme (NIHR205228). The views expressed are those of the authors and not necessarily those of the NIHR or DHSC. This work was produced by the Health and Care and Defence, Security and Justice teams at RAND Europe under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care.

Keywords: workforce, alcohol, drugs, treatment, recovery, lived experience, peer support.

Executive summary

Background

A key component of the former UK government's 10-year drug strategy is to create a world-class treatment and recovery system through the Drug and Alcohol Treatment and Recovery Workforce Transformation Programme (hereafter workforce transformation programme). The programme is led by the Office for Health Improvement and Disparities (OHID), which is a unit within the Department of Health and Social Care (DHSC), and delivered in partnership with NHS England Workforce, Training and Education (NHSE WT&E, formerly Health Education England). The workforce transformation programme vision is to create a sustainable workforce that is multidisciplinary and has the capability and capacity to help people to reduce harm and start and sustain recovery. To realise this vision, the programme aims to:

1. **Attract new workers** with the right skills and experience into the sector as well as develop sustainable pipelines into the sector.
2. **Train a new generation of regulated professionals** to work in the sector.
3. **Develop career pathways** into and within the sector, including retraining existing staff and volunteers as well as exploring the development of new roles.
4. **Retain and further develop skilled and experienced staff** in the sector.
5. **Increase the skills mix** in the sector, including the quality of supervision and line management provided to frontline staff.
6. **Improve service quality,** including reducing caseloads.

Study aims

To help understand how the workforce transformation programme can support the development of the treatment and recovery workforce as part of the former UK government's 10-year drug strategy, the current study aimed to address the two following research questions (RQs):

1. What are the contextual and attitudinal factors that influence employees' perceptions and experiences of working within the treatment and recovery system?
2. Do contextual and attitudinal factors change over the course of the delivery of the workforce transformation programme?

Methods

This research was conducted during the first three years of implementation of the former UK government's 10-year drug strategy and thus the early stages of the workforce transformation programme. Given this timing and the flexibility inherent in the workforce transformation programme, this formative process evaluation focused on understanding implementation at the local level from a systems perspective using the Consolidated Framework for Implementation Research (CFIR).

Data were collected across three phases (2024–2025) through to and including:

- Interviews and focus groups with commissioners, treatment provider leads and staff, and Lived Experience Recovery Organisation (LERO) leads and staff; and
- A workforce survey.

We used the Job Demands-Resources (JD-R) model to understand how different contextual and attitudinal factors influence the experience of people working in the alcohol and/or other drug treatment and recovery sector, bringing together our qualitative and quantitative research findings.

The study was informed by input from several advisory groups (Experts, Commissioners, Workforce and Public), along with regular input from patient and public involvement and engagement experts and team members with lived and living experience of treatment and recovery that contributed to the study during meetings with co-investigators. We sought the involvement of these groups at multiple stages of the evaluation, including:

- **Characterising the intervention:** review of logic model, including identification of missing items considered important to service providers and users;
- **Evaluation design/conduct:** review of data collection instruments (including participant information sheets and consent forms) and discussion of data collection and analysis protocols to ensure they are acceptable, appropriate and ethical;
- **Synthesis:** discussion of findings and possible interpretations of results in context; and
- **Dissemination and impact:** development of plain English summaries for inclusion in reports and creative dissemination (with potential involvement of advisory group members if desired).

Key findings

We found that people working in the alcohol and/or other drug treatment and recovery sector in England were generally very engaged and committed to their work, and that this commitment was maintained over the first three years of the drug strategy investment. This was the case even though staff also highlighted the demanding nature of roles in the sector. The emotional and mental demands involved in supporting people in treatment and recovery were due not only to high caseloads – that are often still much higher than best practice of 40 cases – but also to the psychological burden of working with people who were often unwell, vulnerable or at risk of death. We found that a substantial minority of staff sometimes, often/very often or always felt burnout at work. We also found evidence of moral distress, including sadness and frustration in response to feeling unable to provide people with an adequate level of care, or conflict between the ways participants wanted to provide support to people and the priorities of the organisations they worked for. These job demands can be balanced by ensuring access to sufficient job resources that help people to achieve their work goals or stimulate career progression and development.

The drug strategy funding delivered through the workforce transformation programme was well-received by the alcohol and/or other drug treatment and recovery workforce. Our findings suggest that the investment over the first three years of the drug strategy has already enabled organisations to sustain, increase or strengthen some contextual and attitudinal factors linked to key job resources, improving the experience of people working in the sector. These include:



Team and supervisor support. Most people in the treatment and recovery sector experienced a supportive work environment, and this supportive work environment was retained over the study period. Further investment may be needed to ensure sufficient support is available not only initially but also during the first few years of employment to protect staff against exhaustion and burnout and safeguard a supportive team culture.



Partnership working and communication between staff within the sector and across sectors. Effective cross-sector partnership working can alleviate some demands experienced by the treatment and recovery workforce. In contrast, miscommunication with other staff within the treatment and recovery sector can negatively affect service provision.



Career progression and development. The drug strategy funding has stimulated investment in career development at the local level, and initiatives for career development and progression were seen in the initial study and short follow-up period. The absence of a clear career pathway for some roles, however, contributes to challenges in staff retention. Thus although we identified some signs of progress regarding career progression and development, our research also indicates that continued investment in this area is both needed and wanted by the treatment and recovery workforce.

These areas can be strengthened further with ongoing additional investment and prioritisation. While the funding was well-received and supported expansion in some areas, in others it was felt that the investment only restored services that had previously been lost due to disinvestment in the sector. Additional support is needed in key areas such as:



Respecting diverse knowledge and experiences. We found that staff expressed differing views and perspectives on what the role of treatment and recovery should be to people who use their services. These differences include *what* services should support people to achieve (e.g. a recovery journey that may involve medication and/or abstinence) and *how* services should support people. Perspectives also differed on staff skills, particularly the role and benefits of lived experience versus training and education and how these can be integrated. Establishing a shared vision for recovery that respects diverse perspectives and experiences could help not only to bridge divides between individuals and organisations but also to develop integrated systems that enable staff to work towards a common goal with mutual respect and effective collaboration.



Financial stability and equity. Many staff feel their salary is not commensurate with the demands of their role and their skills and expertise. The short-term nature of the drug strategy funding has created job security concerns for the workforce, which did not change over time. If organisations aim to ensure pay parity, pay progression and job security, this could help to alleviate challenges relating to workforce recruitment and retention, which would also improve team environment and working conditions for existing staff.

Recommendations

The funding to implement the workforce transformation programme was well received across the participants in the study. Although most members of the treatment and recovery workforce are passionate about their work, many feel they are under resourced and undervalued. Our findings suggest that it is not necessarily the nature of the work itself that leads to people leaving the sector, but factors such as workload, availability of support and resources, salary levels and job security – which are all amenable to change – that ultimately affect people's desire to continue to work in the treatment and recovery sector. In addition to these factors, moral distress – whereby people feel that they cannot deliver the level of care they believe is necessary – was raised in our findings. Areas where further efforts could be directed to improve the experience of the workforce are outlined below.



Central government should work with local authorities (LAs) and treatment and recovery providers to determine a funding timeline and commissioning cycle length that would provide appropriate security for both services and staff. This would increase staff recruitment and retention and improve the perception of the

sector as a long-term career option. Developing timelines collaboratively would alleviate some concerns about communication between central government, LAs and treatment and recovery providers regarding funding.



Central government should continue its additional investment in the treatment and recovery workforce, expanding funding to make further recruitment of senior and supervisory positions feasible. This will improve capacity at the local level to provide both technical and pastoral support for staff, particularly those in less experienced roles and those who are new to the sector, and help them to manage the mental and emotional demands of their roles and develop appropriate skills to manage a therapeutic relationship within safe boundaries.



Central government, LAs and treatment and recovery providers should continue, and potentially expand, efforts to develop clear career pathways and career development support for core job roles within the treatment and recovery sector. This would improve retention of the existing workforce and potentially increase the appeal of a career in the sector for new staff. It could also help to address pay disparities between organisations. The value of different qualifications and expertise, including lived experience, should be addressed as part of career development to promote mutual respect and recognition.



LAs and treatment and recovery providers should review and address pay disparities between equivalent roles in the NHS and third-sector services. This should include assessment of pay levels in similar positions outside the alcohol and/or other drug treatment and recovery sector. This will help to address challenges with recruiting new staff to the workforce and potentially improve retention rates.



LAs and treatment and recovery providers should work together to establish a shared vision of their local systems of care and design a workforce that is cohesive and ensures any gaps are filled. This would help to reduce gaps in understanding or appreciation of colleagues' roles and how they fit into the wider systems of care. Establishing a shared vision for recovery that respects both clinical and lived-experience perspectives can help not only to bridge divides between organisations but also to develop integrated systems that enable staff to work towards a common goal with mutual respect and effective collaboration.



Alcohol and/or other drug commissioners should review how services create a supportive environment for staff with the intention of creating a standardised approach. This would help to ensure that less experienced staff are supported by more experienced staff and those in supervisory positions in a practical and emotional sense. Activities could include the review of plans for immediate practical support in an emergency, mechanisms and regulation of supervision, reflective practice and provisions to support wellbeing.

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Abbreviations

CFIR	Consolidated Framework for Implementation Research
DATRIG	Drug and Alcohol Treatment and Recovery Improvement Grant
DHSC	Department of Health and Social Care
D-SITAR	Drug Strategy Investment in Treatment and Recovery
GP	General Practitioner
ICS	Integrated Care System
IPS	Individual Placement and Support
JD-R	Job Demands-Resources
LA	Local Authority
LERO	Lived Experience Recovery Organisation
NIHR	National Institute for Health and Care Research
NHS	National Health Service
NHSE WT&E	NHS England Workforce, Training and Education
OHID	Office for Health Improvement and Disparities
RQ	Research question
RSDATG	Rough Sleeping Drug and Alcohol Treatment Grant
SSMTRG	Supplemental Substance Misuse Treatment and Recovery Grant

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Chapter 1. **Introduction**

Dame Carol Black's independent review of drugs highlighted deterioration of the treatment and recovery workforce in England in recent years in terms of quantity, quality and staff morale (Department of Health and Social Care 2021). This deterioration was partly attributed to:

- **Caseloads ranging from 50 to 100 people,** where best practice is 40 people or fewer. High caseloads were reported to reduce quality of care and effectiveness of treatment, and to increase the risk of work-related stress and burnout.
- **Decreasing availability of training places for prospective staff,** which has resulted in declines in specialist roles.
- **The frequent retendering of treatment services,** creating unstable working environments. This instability has led to recruitment and retention difficulties as the sector is unattractive to healthcare workers compared to other settings.

The findings from the Black review echo research from the UK and internationally regarding the experience of people working in the treatment and recovery sector.

While there is widespread acknowledgement of the demands placed on the health and social care workforce and their implication for workforce wellbeing and retention, there has been substantially less research on the experience of those working in the alcohol and/or other drugs sector[1] specifically (Bird & Henning 2025; Crick et al. 2025). Working in the treatment and recovery sector is consistently reported to be mentally and emotionally demanding. This is due to a combination of high caseloads and the psychological burden of working with people who are often unwell, vulnerable or at risk of death (Bird & Henning 2025; Kostadinov et al. 2021; Missouridou et al. 2021; O'Donnell et al. 2022). These demands can lead to fatigue, burnout and, ultimately, departure from the sector (Bird & Henning 2025; Missouridou et al. 2021; O'Donnell et al. 2022; Klingemann et al. 2024; Kostadinov et al. 2021). These negative aspects of roles may be exacerbated if the pay and conditions offered in the sector are not felt to be adequate given the nature of the work. Some research on the Australian treatment and recovery workforce found that pay that is often perceived to be unsatisfactory and a lack of job security contributes to intentions to leave the sector (Kostadinov et al. 2021). A lack of pay parity between workers in different organisations within the sector has also been identified as a negative factor (Roche & Skinner 2021).

1 While the Department of Health and Social Care tend to refer to 'drugs and alcohol', we have opted to use this term in keeping with the academic literature on the topic.

Despite the demanding nature of the work and associated high risk of burnout in the treatment and recovery workforce, people working in the sector report high levels of engagement and job satisfaction, which supports employee retention (Skinner & Roche 2021; Missouridou et al. 2021; Roche et al. 2021). Support from colleagues and supervisors, combined with appropriate work intensity and an organisational culture open to change, have been identified as key to ensuring continued workforce engagement in the treatment and recovery sector (Skinner & Roche 2021). Support from colleagues and supervisors within the sector has been frequently identified as having a positive impact on exhaustion and disengagement and thus reducing burnout and improving retention (Klingemann et al. 2024; Klingemann & Wieczorek 2024; Missouridou et al. 2021; O'Donnell et al. 2022; Vilardaga et al. 2011; Skinner & Roche 2021). There is limited evidence on the role of organisational innovation in the treatment and recovery sector, but this wider examination of factors (beyond the individual) is aligned with the broader shift in workforce development towards a systems approach (Roche & Nicholas 2016).

A key component of the drug strategy is the creation of a world-class treatment and recovery workforce and system through the Drug and Alcohol Treatment and Recovery Workforce Transformation Programme (hereafter workforce transformation programme). This programme takes a systems approach to addressing the workforce issues outlined in the Black review. It is led by the Office for Health Improvement and Disparities (OHID), which is a unit within the Department of Health and Social Care (DHSC), and delivered in partnership with NHS England Workforce, Training and Education (NHSE WT&E; formerly Health Education England). The workforce transformation programme vision is to create a sustainable workforce that is multidisciplinary and has the capability and capacity to help people to reduce harm and start and sustain recovery. To realise this vision, the programme aims to:

1. Attract new workers with the right skills and experience into the sector;
2. Train a new generation of regulated professionals to work in the sector;
3. Develop career pathways into and within the sector;
4. Retain and further develop skilled and experienced staff in the sector;
5. Increase the skills mix in the sector; and
6. Improve service quality.

The workforce transformation programme consists of multiple products led by OHID and/or NHSE WT&E, and the initiation and delivery of some products have already been completed. For example, three drug and alcohol workforce censuses,[2] the capability framework,[3] the strategic

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2 See (as of 6 March 2026): https://www.hee.nhs.uk/our-work/mental-health/drug-alcohol-treatment-recovery-workforce-programme/drug-alcohol-treatment-recovery-services-workforce-census

3 See (as of 6 March 2026): https://www.england.nhs.uk/long-read/capability-framework-for-the-drug-and-alcohol-treatment-and-recovery-workforce/

plan[4] and specialist training opportunities in some roles have been completed, are ongoing (e.g. mental health wellbeing practitioners), or are soon to be released (at the time of data collection).

Roles in scope of the programme

There are certain roles and settings that are the focus of the workforce transformation programme (Table 1) and are explicitly considered in the products created.

Table 1. Roles within scope for some products within the workforce transformation programme

Role	Strategic plan	Capability framework	Workforce census
Drug and alcohol workers	Yes	Yes	Yes
Senior drug and alcohol workers	In forthcoming updated version	Yes	No
Children and young people's drug and alcohol workers	Yes	Yes	Yes
Peer support workers	Yes	Yes	Yes
Nurses	Yes (and nursing associates)	Yes	Yes
Psychological professions	Yes	Yes (only practitioner clinical, counselling and forensic psychologist roles)	Yes
Pharmacists that are directly employed by treatment and recovery services	Yes (and pharmacy technicians)	Yes (and pharmacy technicians)	Yes
Addiction psychiatrists	Yes	Yes (but role profile only)	Yes
Non-consultant grade doctors	Yes	Yes (but role profile only)	Yes
Social workers	Yes	Yes	Yes
Volunteers	Yes	No	Yes
Family support workers	In forthcoming updated version	Yes	Yes
Counsellors	Yes	Yes (but role profile only)*	Yes
Leaders and managers	In forthcoming updated version	Yes (but role profile only)	Yes
Commissioners	Yes	Yes	Yes

** A separate addiction counselling competency framework was developed and published by the British Association for Counselling and Psychotherapy in parallel, see (as of 6 March 2026): https://www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/addictions-curriculum/*

4 See (as of 6 March 2026): https://www.england.nhs.uk/publication/10-year-strategic-plan-for-the-drug-and-alcohol-treatment-and-recovery-workforce-2024-2034/

Settings in scope of the programme

The workforce transformation programme is applicable in the following settings:

- Local authority (LA)-commissioned adult and children and young people's community alcohol and/or other drugs treatment and recovery, residential rehabilitation and inpatient detoxification service providers, including NHS and third-sector providers and some LA-delivered service provision.
- Services funded by LAs through local treatment budgets and those funded by the public health grant, Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG), Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG), Individual Placement and Support (IPS) and any other alcohol-and-other-drug-treatment-and-recovery-related direct grant from OHID to LAs.[5]
- Lived Experience Recovery Organisations (LEROs), which are organisations led by people with lived experience of recovery that deliver a range of harm-reduction interventions and peer support, and help people to access and engage in support.
- LA alcohol-and-other-drug-specific commissioning teams in public health.

Roles and settings out of scope of the programme

The following roles and settings are out of the scope of the workforce transformation programme as they are not part of the LA-commissioned treatment and recovery workforce:

- Non-specialist workers who screen and refer into specialist drug and alcohol settings.
- Pharmacists and pharmacist assistants in retail, community pharmacies and hospital pharmacies (only pharmacists directly employed by treatment and recovery services are within scope).
- General Practitioners (GPs) treating people dependent on alcohol and/or other drugs but not commissioned to do so by an LA as part of a shared care arrangement with a specialist alcohol and other drug treatment service, or as part of an LA-commissioned primary-care-led or other specialist treatment service.
- NHS England-commissioned treatment teams in secure settings.
- NHS England-commissioned alcohol care teams.

There has been limited prior research conducted on the experience of the treatment and recovery workforce in the UK. The findings from the current research study add to the limited evidence on the workforce in the UK alcohol and/or other drugs sector, answering two research questions (RQs) outlined in the next section.

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5 Note that these funds for treatment and recovery have since been consolidated into a single Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG).

1.1. Research questions

To help understand how the workforce transformation programme can support the development of the treatment and recovery workforce alongside additional investment, the current study addressed the two following research questions:

1. What are the contextual and attitudinal factors that influence employees' perceptions and experiences of working within the treatment and recovery system?
2. Do contextual and attitudinal factors change over the course of the delivery of the workforce transformation programme?

This research was conducted during the first three years of the strategy (2022–2025) and thus the early stages of the workforce transformation programme. Given the timing and the flexibility inherent in the workforce transformation programme, this formative process evaluation focused on understanding implementation at the local level from a systems perspective (Rogers & Woolcock 2023; Zaykowski 2021).

The current study addresses research questions that focus on employees' perceptions and experiences of working within the treatment and recovery sector. As such, the perceptions and experiences of people who use these services are out of scope of this study.

Chapter 2. **Methods**

2.1. Research overview and evaluation framework

An overview of data collection, mapped to the evaluation research questions, is shown in Table 2. Data were collected over three time points: Phase 1 (January 2024–July 2024); Phase 2 (August 2024–June 2025); and Phase 3 (March 2025–June 2025). A full description of the methodology is provided in the Methods Report (Strang et al. 2026), including patient and public involvement and engagement and dissemination activities.

Table 2. Methodology used for each research question

Research question	Data collection method	Data type	Data origin	Data collection timepoint
1. What are the contextual and attitudinal factors that influence employees' perceptions and experiences of working within the treatment and recovery system?	Analysis of workforce census data	Structured survey data	The workforce of the treatment and recovery sector (see Table 1 for roles in scope)	Phase 1
	Workshop	Semi-structured qualitative data and structured questionnaire	Commissioners	Phase 1
	Interviews	Semi-structured qualitative data and structured questionnaire	Head of treatment service	Phase 1
	Focus groups and interviews	Semi-structured qualitative data and structured questionnaire	All roles in scope identified in Table 1	Phase 2
2. Do contextual and attitudinal factors change over the course of the delivery of the workforce transformation programme?	Workshop	Semi-structured qualitative data	Commissioners	Phase 3
	Interviews	Semi-structured qualitative data and structured questionnaire	Workforce members who participated in Phases 1 and 2 (even if they left the treatment and recovery workforce)	Phase 3

As shown in Table 2, Phase 3 was used to collect findings to address the second research question exploring change over time. Participants in Phases 1 and 2 may also have reflected on changes over time; however, it was the participants of Phase 3 who were explicitly asked to reflect on changes that had taken place between the two periods in which we interviewed them. In this report, the findings of all data collection conducted in Phases 1 and 2 are referred to as 'initial' (i.e. initial study interviews or initial study survey), whereas the findings of interviews conducted in Phase 3 are referred to as 'follow-up' (i.e. follow-up interviews, follow-up surveys).

The study was informed by input from several advisory groups (Experts, Commissioners, Workforce and Public), along with regular input from patient and public involvement and engagement experts and team members with lived and living experience of treatment and recovery during meetings with co-investigators.

This evaluation takes a systems perspective, viewing organisational settings in which workforce development is implemented as complex systems (Luke et al. 2024). The Consolidated Framework for Implementation Research (CFIR) was used to facilitate this approach in terms of defining the core concepts and developing the implementation research logic model (see Annex B) that were used in the development of data collection tools (Damschroder et al. 2022a; Damschroder et al. 2022b; Smith et al. 2020). For further information about the CFIR and how it was used in this study, please see the Methods Report (see Annex B). The logic model also supported the thematic analysis of the qualitative data (Beek et al. 2025; Kiekens et al. 2022) and the synthesis of our findings in relation to the Job Demands-Resources model (Bakker & Demerouti 2017; Schaufeli 2017), both of which are discussed further below.

2.2. Interview and focus group procedures

2.2.1. Recruitment

All participants were given a participant information sheet and written, informed consent was obtained prior to data collection. Full details of the number of participants in interviews and focus groups conducted in the Drug Strategy Investment in Treatment And Recovery (D-SITAR) evaluation with stakeholders involved in planning, commissioning, providing and using treatment and recovery services can be found in the Methods Report.

Phase 1 (initial study)

Participants included commissioners, treatment provider leads and LERO leads. As described comprehensively elsewhere (see Methods Report), **commissioners** from across England were recruited for workshops involving questions on all areas of the broader study, including one question on what factors would make it easy or hard to deliver the workforce transformation programme. A list of **treatment providers** by Integrated Care System (ICS) and LAs was used by the study team to identify 15 treatment providers to recruit for interview that did not overlap with

areas selected for Phase 2 data collection. Providers were purposively sampled to ensure a mix of NHS and third-sector providers. Contact details for prospective participants were obtained via public websites and internal networks. OHID initially scheduled an information session with **LERO leads** for the study team to introduce the project and invite those interested in participating to provide their contact details. The study team also used a list of contacts retrieved from conducting a census of publicly available information online. All LERO leads for which contact details could be identified were approached. As shown in Table 3, we conducted 42 interviews and one commissioner workshop in Phase 1.

Phase 2 (initial study)

Ten case study sites across England were selected that were diverse in regard to funding received (in terms of amount and grants received), interventions delivered or planned, the population of people who use treatment and recovery services, and geography. Within each case study, **commissioners, treatment provider leads and staff** and **LERO leads and staff** (if a LERO was present) were recruited to interview and/or focus groups. As shown in Table 3, we conducted 84 interviews and 24 focus groups in Phase 2. The case studies recruitment covered all evaluations; a full account of the methodology employed is in the Methods Report.

Phase 3 (follow-up study)

We had intended to re-interview 25 staff members who had been interviewed in Phase 2 to examine change over time. Due to the delays experienced in Phase 2, however, we restricted the potential Phase 3 participants to Phase 1 participants and Phase 2 participants who had been interviewed at least five months prior (i.e. we recruited in May/June 2025, and so included participants who had first been interviewed before December 2024). We approached participants who had provided consent for recontact during Phase 1 and Phase 2, aiming to interview five commissioners, ten treatment provider leads and ten treatment provider staff members. In total we invited 61 participants to a Phase 3 interview; 31 did not respond and we received nine automated responses to state our email was undeliverable. As shown in Table 3, we conducted 21 interviews and two commissioner workshops in Phase 3.

2.2.2. Data collection

Data collection was completed online for Phases 1 and 3, and both online and in-person for Phase 2. Microsoft Teams was used for all online data collection. Interviews were recorded and transcribed verbatim by a professional transcription company where participants consented to this; in the few instances where they did not, a member of the research team took notes. The findings from this report are based on 147 interviews and 28 focus groups or workshops (see Table 3).

Table 3. Data collection by job role for Phases 1, 2 and 3

	Initial study				Follow-up	
	Phase 1		Phase 2		Phase 3	
	Interviews	Workshops	Interviews	Focus groups	Interviews	Workshops
Commissioners (or local leads for Phase 2)	0	2 (n=27)	20 (n=27)	0	5 (n=6)	2 (n=37)
Treatment provider leads	15 (n=16)	0	19 (n=23)	0	10	0
Treatment provider staff*	0	0	33 (n=34)	19 (n=123)	6	0
LERO leads	25 (n=27)	0	8	0	0	0
LERO staff	0	0	0	5 (n=32)	0	0

Number of participants in interviews and focus groups or workshops is shown in brackets e.g. (n=).
** Treatment provider staff includes prescribers.*

2.2.3. Data analysis

For **Phase 1 (initial study)**, data were indexed deductively according to CFIR constructs and inductively according to themes that arose from the data. For **Phase 2 (initial study)**, data were indexed deductively according to RQ1 and inductively building on themes developed in Phase 1. For **Phase 3 (follow-up)**, data were indexed deductively according to RQ2 and inductively according to themes that built on those developed in Phases 1 and 2. For each phase, members of the study team (n=4) chose one transcript to index individually. The study team then met to discuss their indexing line-by-line and harmonise understanding before proceeding with the rest of the transcripts. All indexing was conducted using the software program MAXQDA. The study team reviewed all the text indexed to the research questions to capture key themes and evidence. After multiple team discussions, the study team synthesised the key themes and subthemes emerging from the data.

2.3. Workforce survey procedures

The workforce survey was used to collect data on employees' sociodemographic characteristics as well as their perceptions and experiences of working in the treatment and recovery sector. The workforce members recruited at each phase of data collection were:

- **Phase 1 (initial study):** commissioners; treatment provider leads; LERO leads.
- **Phase 2 (initial study):** commissioners; treatment provider leads and staff; LERO leads and staff.
- **Phase 3 (follow-up):** commissioners; treatment provider leads and staff.

2.3.1. Survey measures

Questions included sociodemographic questions created through collaboration between OHID and the study team or taken from the UK Census (e.g. age, gender), as well as measures taken from literature: the Utrecht Work Engagement Scale (Schaufeli & Bakker 2004); the Copenhagen Burnout Inventory (Skinner & Roche 2021), the Perceived Stress Scale (Edwards et al. 2008); and the NHS Staff Survey (NHS 2025). The full survey can be found in Annex A.1.

2.3.2. Data collection and sample

The survey was optional and completed online (via Smart Survey) for all interviews in Phases 1 and 3, and a mix of paper and online in Phase 2. Surveys were conducted alongside the interviews and focus groups and so followed the same timings: the initial study surveys (Phases 1 and 2) were conducted January 2024–July 2024 and August 2024–June 2025, respectively. The follow-up surveys (Phase 3) were conducted at least five months after their corresponding Phase 1 or Phase 2 interviews. All surveys were conducted during the implementation of the workforce transformation programme. Phase 1 had 52 respondents, Phase 2 had 189 respondents and Phase 3 had 16 respondents. Sample characteristics of the treatment and recovery workforce in Phases 1, 2 and 3 are shown in Annex Table A.2. The most common job role among respondents in Phases 1 and 2 was a drug and alcohol worker (35.8 per cent; n=86). When we revisited the workforce in Phase 3, most respondents had 'other' roles (50.0 per cent; n=8), with the remaining staff being commissioners, drug and alcohol workers and regulated professionals. Note that open text was not provided, and so we do not know the roles of respondents who reported to have 'other' roles. The majority of survey respondents in Phases 1 and 2 were in full-time employment (80.3 per cent; n=191), on a permanent contract (74.1 per cent; n=163), worked directly with people who use alcohol and/or other drugs[6] (80.0 per cent; n=192), supervised others (60.5 per cent; n=144), agreed that there were appropriate and achievable career development pathways (77.1 per cent; n=182) and identified as White (82.4 per cent; n=197). Approximately half of the sample had been working in the sector for over five years (53.8 per cent; n=129), had lived experience of alcohol and/or other drugs (56.3 per cent; n=135), identified as female (57.6 per cent; n=137), and were aged between 36 and 50 years (43.4 per cent; n=104). For those who completed the Phase 3 follow-up survey, notable differences from Phases 1 and 2 include that the majority were older (aged over 50 years old) and did not have lived experience of alcohol and/or other drugs.

In this report, the terms 'regulated' and 'unregulated' are used to describe professional groups within the sector. This reflects the language used in the workforce strategic plan. 'Regulated' refers to roles that require an essential level of training for registration with a professional body to be able to fulfil the role (as per the Professional Qualifications Act 2022). 'Unregulated' refers to people who, at the time of data collection, do not need to have an essential professional qualification and registration with a governing body for the purpose of their role. Unregulated roles

6 While DHSC tends to refer to 'drugs and alcohol', we have opted to use this term in keeping with the academic literature on the topic.

currently make up the majority of the workforce, with drug and alcohol workers making up 50 per cent of the treatment provider workforce, and are critical to the provision of high-quality care.

2.3.3. Data analysis

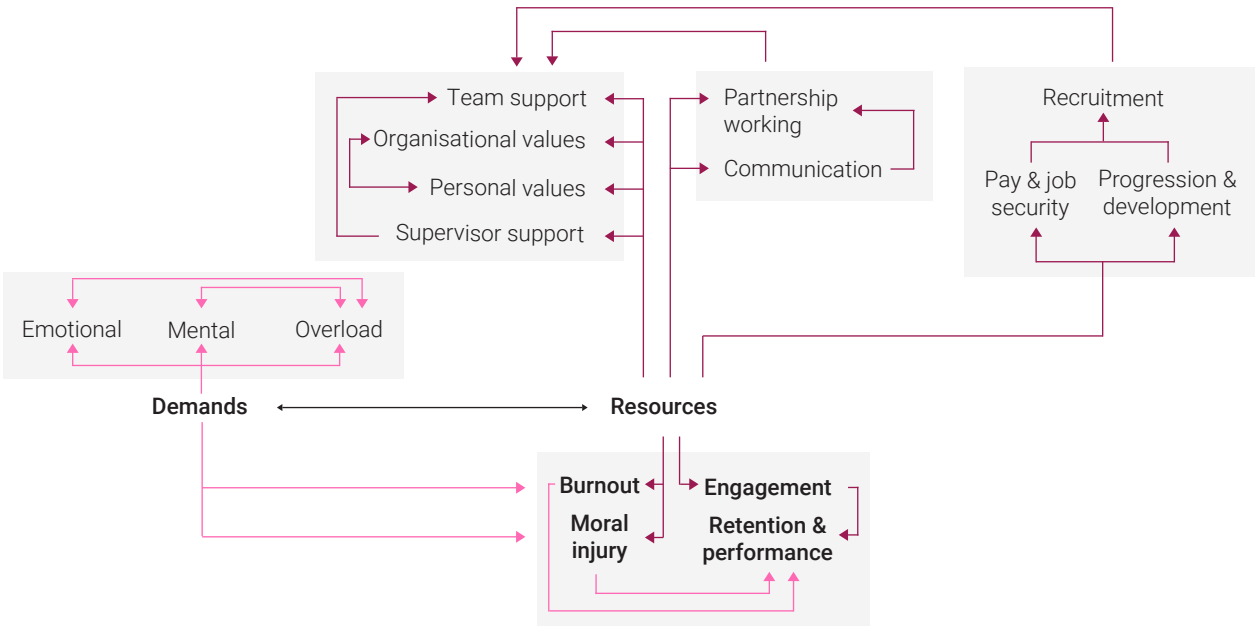
As the surveys were completed either on paper or online, all surveys were initially collated and harmonised into one dataset. Statistical disclosure control was implemented so any categories with five or fewer respondents were collapsed or obscured; to prevent deductive disclosure from totals where there is only one suppressed number in a group, the second lowest were suppressed, which was sometimes greater than five. Data suppression was carried out for all Phase 3 results as this is a smaller sample; we narratively describe the sample, without citing precise numbers.

Phases 1 and 2 were analysed together for the initial study and Phase 3 was examined separately as the follow-up study. First, descriptive statistics were used to describe the characteristics of the sample. Secondly, diverging stacked bar charts were used to display the distribution of responses of the whole sample for each of the questions in each of the measures. Thirdly, diverging stacked bar charts were used to display the distribution of responses for each measure stratified by key sample characteristics. Due to a low sample size and a potential bias among Phase 3 respondents, differences between groups and change over time were not examined. For those who did not provide an answer to a question, missing data were shown in the sample characteristics table; for the univariable and bivariable analyses, however, missing data were removed. Analyses were conducted using the R statistical software (R Core Team 2025).

2.4. Overall synthesis approach

We used the Job Demands-Resources (JD-R) model to understand how different contextual and attitudinal factors influence the experience of people working in the treatment and recovery sector, bringing together our qualitative and quantitative research findings (see Figure 1 for our simplified model). This well-established psychology model states that job characteristics can be broadly conceptualised as either **demands** that have psychological or physiological costs for the worker or **resources** that support the worker to do their job by balancing these demands (Bakker & Demerouti 2017; Schaufeli 2017).

Figure 1. Simplified job demands-resources model for the treatment and recovery workforce



Light pink arrows indicate demands and the impact of their presence or absence; dark pink arrows show the same for resources. Grey squares indicate how concepts are grouped together within the text of this report. Source: RAND Europe

Job demands and job resources can be physical, psychological, social or organisational. Job resources support the worker to undertake their role, reduce psychological or physiological costs involved in doing so, or facilitate personal development or career progression. The balance of job demands and job resources influences a person's experience of their role and workplace, as well as their job satisfaction and performance, level of engagement or burnout, and ongoing commitment to their role (Bakker et al. 2014). How the balance of job demands and resources affects someone's experience may be moderated by other factors, such as personal resources (e.g. resilience, flexibility). Within the healthcare workforce, burnout may be coupled with moral distress and/or moral injury. Moral distress is defined as the emotional distress that arises out of feeling unable to do what you believe is right (UK Clinical Ethics Network 2025) and moral injury is this cumulative distress over time, originating from moral conflicts that occur when a healthcare professional is unable to provide adequate care due to insufficient resources or organisational policies and structures (Dean et al. 2024; Grumbach & Willard-Grace 2025). As shown in Figure 1, levels of engagement, burnout and moral distress/injury all contribute to both retention of staff and their performance (including quality of care). We report our findings following the structure of our JD-R model, shown in Figure 1.

The JD-R model is useful for understanding how job demands and job resources interact and are influenced by contextual and attitudinal factors. This report, however, summarises data collected from people working in a range of organisations (e.g. LEROs, treatment providers, LAs), job roles and hierarchical levels (i.e. leadership, non-leadership). It cannot therefore provide precise insights into how the JD-R model may apply to specific roles. Rather, we have used the model as a framework for structuring our findings and identifying potential areas for future research and policy development across the treatment and recovery system.

Our results integrate the findings from the qualitative interviews and focus groups conducted in Phases 1 and 2 for the initial study and Phase 3 for the follow-up study (see Table 3) with the quantitative data collected from the workforce surveys administered at each phase. Note that throughout the interviews and focus groups, participants referred to the various funding sources dedicated to the investment in the treatment and recovery sector since the launch of the strategy (e.g. the Portfolio and the SSMTR grant) interchangeably or as the 'drug strategy funding'. The participants were aware of the investment made over the previous three years, but did not differentiate between specific funding sources (for further details on the funding roll-out of the drug strategy, please see Parkinson et al. 2026). Consequently, the various funding sources, and what they have been spent on, will be referred to in the findings as the 'drug strategy funding' or 'drug strategy investment'.

2.5. Dissemination

We have worked with our advisory groups to develop dissemination and engagement strategies following the National Institute for Health and Care Research (NIHR) dissemination guidance (National Institute for Health and Care Research 2019). While these plans are still being confirmed, we expect our dissemination activities for this report to include:

- The submission of academic papers for publication in high-impact, policy-relevant journals such as *Addiction* or the *British Journal of Psychiatry*.
- The creation of dissemination tools, including infographic summaries, slide decks, policy briefings, media interviews, blogs and podcasts/videos. These tools will be primarily for people in the treatment and recovery workforce (e.g. LERO staff, treatment provider staff and volunteers).
- The presentation of key findings to specific audiences within DHSC and other local and central policy and practice stakeholders, including commissioners in local government.
- The submission of abstracts to present findings at relevant conferences in the UK and abroad, including the Society for the Study of Addiction's annual conference.

Further information on our dissemination plans is provided in Section 7 of the Methods Report.

Chapter 3. **Results**

In Section 3.1 we discuss the emotional, mental and organisational demands involved in working in the treatment and recovery sector. We then turn to the key resources available to members of the workforce to support them to balance the demands of their roles. These include: team and supervisor support and people's values and beliefs regarding treatment and recovery (Section 3.2); partnership working and communication (Section 3.3); and financial stability and career development (Section 3.4). In Section 3.5 we bring these findings together to reflect on the implications for the treatment and recovery workforce regarding engagement, burnout and moral distress/injury. Where data permit, in each section we reflect on change in these factors over time, noting that in some of the initial study data collection (Phases 1 and 2) participants reflected on changes made since the drug strategy investment, as well as in the follow-up interviews (Phase 3).

3.1. Emotional, mental and organisational demands in the treatment and recovery workforce

Members of the treatment and recovery workforce consistently reported that their work inherently involved a high level of emotional and mental demands due to the complex needs of the people they support, and that their workload was high due to the number of people they support and the range of tasks that need to be completed in delivering that support.

3.1.1. Supporting people in treatment and recovery can place a high psychological burden on staff

Many staff members in the initial study, across several roles and case study sites, acknowledged the psychological burden of working with people who were often unwell, vulnerable or at risk of death. One staff member described it as 'heartbreaking sometimes watching people die' (Treatment provider managers focus group 1, Site 2, Phase 2), while another described feeling 'helpless' and 'hopeless' upon being unable to offer a referral to mental health services to someone who used their services (Treatment provider staff focus group 3, Site 5, Phase 2). Some staff described feeling sadness and frustration when they were unable to meet the needs of people who used their services, whether due to systemic barriers, resource constraints or service limitations. Examples included being unable to offer detoxification services, depot buprenorphine

or practical provisions like a bus pass, or being unable to support people who were experiencing homelessness. Others described feelings of guilt and anxiety, and spoke of the emotional weight of hearing traumatic disclosures without being able to offer adequate support.

Feelings of sadness and upset were expressed by a few staff even when they were working in what they described as a supportive environment: in one focus group, treatment staff who had noted that there were 'very many feelings of togetherness' within their site also noted the sadness inherent to their role (Treatment provider staff focus group 1, Site 6, Phase 2). Where staff did not have access to a supportive team and/or supervisor, they described feeling isolated and overwhelmed by such interactions:

> I'll be on the phone and its instant threats of "I'm going to commit suicide" and you've got to be able to process and work around that so quickly, but you're left by yourself to have to deal with that. (Treatment provider staff focus group 2, Site 9, Phase 2)

One treatment staff member in the initial study reported that in their experience it appeared to be newer staff and those who lacked experience who struggled with these emotional demands of the role. This may be connected to the sense of responsibility staff feel for people who use their services:

> [T]here's parts of your job that are emotionally and practically quite demanding, you know, and I think all of us probably take a bit of personal responsibility over our service users and that can be difficult if you don't have the experience behind you. (Treatment provider staff focus group 1, Site 7, Phase 2)

In the workforce survey data from the initial study, however, it was staff who had been in the sector between three and five years who were most likely to report that their work was emotionally exhausting often, very often or always (38.5 per cent; n=10), compared to 21.9 per cent (n=7) of those in the sector less than a year, 25.5 per cent (n=12) between one and three years and 27.4 per cent (n=34) more than five years (see Annex A.3.1).

Some staff did express a matter-of-fact attitude to death as being part of the job. Many staff members reported a high rate of death related to drugs among people who use treatment and recovery services but did not otherwise report any attitudes or emotion to it. Phrases like 'people die' (LERO staff focus group 1, Site 7, Phase 2) or 'death is part of what we do' (Treatment provider staff focus group 1, Site 6, Phase 2) were used to describe the frequency with which staff encounter loss. This pragmatic stance was echoed by others who noted the increased risk of drug-related deaths among the ageing cohort of people who use their services. Some of

this pragmatism may be a result of 'compassion fatigue', which one staff member viewed as an expected consequence of their role:

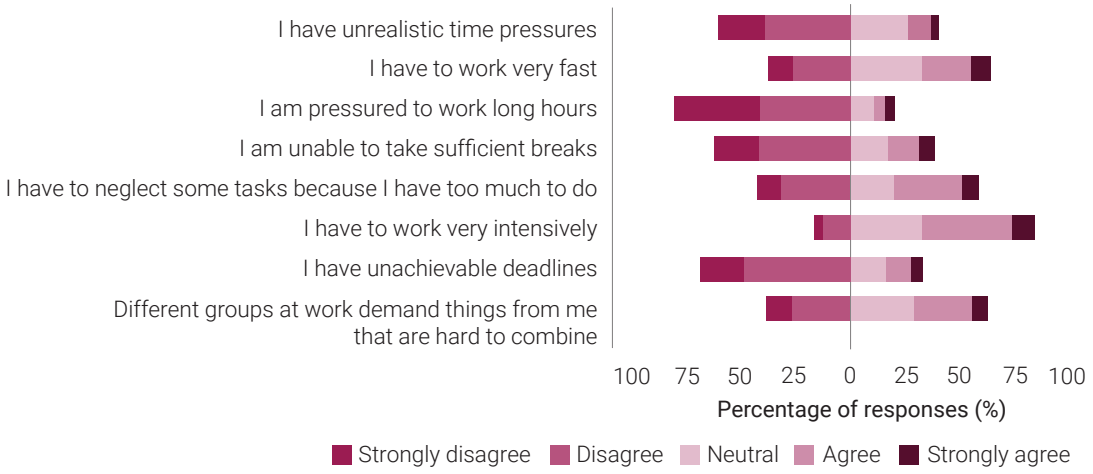
> [S]omebody spoke to me three years ago… And they were talking about compassion fatigue, and I'd never heard of it, and didn't really think it was a thing. But it is. It is a thing, because to be in this job, you have to be empathetic and show empathy, which means taking on how other people are feeling, and that just naturally drains your cup. (LERO staff focus group 1, Site 1, Phase 2)

The emotional and mental demands of working in the sector did not appear to have changed over time within our short follow-up window. This topic was returned to by our follow-up interviewees, predominantly treatment staff not in a leadership position. They spoke of the difficulty of absorbing distressing disclosures without sufficient time or structure for decompression. Similar percentages of staff agreed or strongly agreed that their work was emotionally exhausting in the follow-up survey conducted at least five months after the initial survey: 31.2 per cent (n=5) in Phase 3 versus 27.5 per cent in Phases 1 and 2 (n=63).

3.1.2. The volume of work undertaken is viewed as a significant source of stress

Providing treatment and recovery support places substantial demands upon the workforce. The overall stress and pressure felt by the workforce is reflected in the survey results (see Figure 2 and Annex A.3.2). Participants in the initial study responded most consistently to questions regarding work intensity and working hours. Half (50.7 per cent; n=119) of respondents agreed or strongly agreed that they work very intensively and 37.2 per cent (n=87) of respondents agreed or strongly agreed that they have to neglect some tasks because they have too much to do. Conversely, 79.9 per cent (n=187) of respondents strongly disagreed or disagreed that they are pressured to work long hours. Responses to work intensity varied by group. For example, the groups with the highest percentages of respondents who agreed or strongly agreed they have to neglect some tasks because they have too much to do were: staff identifying as Asian or Asian British (56.2 per cent; n=9); those who do not work directly with people who use alcohol and/or other drugs (48.9 per cent; n=23); commissioners (47.4 per cent; n=9); those who had been in the sector over five years (46.1 per cent; n=59); and staff who supervise others (44.1 per cent; n=64). Conversely, the groups with the lowest percentages were: those who worked directly with people who use alcohol and/or other drugs (34.4 per cent; n=66); staff who do not supervise others (27.3 per cent; n=26); staff identifying as Black or Black British (25.0 per cent; n<5); peer support workers (14.3 per cent; n<5); and those who were new to the sector (12.1 per cent; n<5).

Figure 2. Workforce responses to eight questions on 'demand' from the Perceived Stress Scale (n=241)



The extent to which the workforce felt their work was intense varied by the length of time they had been in the sector. For instance, 57.8 per cent (n=74) of respondents in the initial study who had been in the sector for more than five years agreed or strongly agreed that they work very intensively, compared to only 21.9 per cent (n=7) of those who had been in the sector less than a year. With some exceptions (see Annex A.3.2), there were greater percentages of respondents who had been in the sector longer who agreed or strongly agreed with the demand statements (e.g. 'I have to work very intensively') compared to those who had been in the sector for a shorter period.

Many staff in the initial study cited the volume of work that they were expected to do, both in terms of quantity of work (i.e. a high caseload) and in terms of supporting people who may have a complex array of needs, as a source of ongoing stress. This was felt to contribute to challenges with staff retention.

Across most of the case study sites, many staff noted their high workload, reporting individual caseloads ranging between 50 and 120 people. The demand for treatment and recovery services was reported to have increased and some staff members stated that funding for staff positions had not increased accordingly, leading to increased caseloads. Some staff reported not having enough capacity to complete the administrative tasks associated with meeting the people on their caseload or manage the diversity of tasks that needed to be addressed, adding to the pressure they feel.

> [C]aseloads are really high but also the amount that we're expected to do, like here we're not just a substance misuse service; we're asked to do everything, you know, we've got to help you with your Personal Independence Payment (PIP) application, your housing, we're doing this with your passport, all of this, so we're basically a care coordinator in every part of these clients' lives, which makes it really challenging when you've got 60 clients on your caseload. (Treatment provider staff, Interview 1, Site 9, Phase 2)

Some treatment and recovery staff experienced a higher workload because they took on tasks outside their job remit.

> Other organisations as well can be quite infuriating to deal with because they'll just bat everything back…we've become like social workers. Even though these clients have social workers, even the social workers bat stuff back, so we end up doing everything.… Probably, that's because their substance misuse problem is the primary problem that is the cause of all the other problems. We end up as that, the primary solution. (Treatment provider staff, Interview 1, Site 1, Phase 2)

A few staff members commented on how a reduction in team size due to turnover created a negative experience for them. Primarily, staff reported feeling stressed and unsettled because the lack of retention places extra pressure on the remaining workforce.

The drug strategy investment in the workforce has partially alleviated workload concerns. For staff from some services in the initial study, the drug strategy funding was viewed as welcome but still insufficient to achieve a consistent and adequate workforce to meet the needs of the people who use their services or maintain service quality. This view was reflected predominantly by staff in non-leadership positions from just over half the case study sites. At one site, reduced funding resulted in attrition of clinically qualified staff from their workforce:

> There were seven nurses in our team and the funding went down to one nurse and I'm the only one that's still working in the speciality. Everyone else has moved out of the speciality because, you know, there was no money and I just find it heartbreaking. (Treatment provider staff, Interview 2, Site 5, Phase 2)

In the follow-up interviews conducted at least five months after the initial interviews, high caseloads and high demands from people who use treatment and recovery services were still reported by staff to be contributing to low morale, despite the drug strategy investment. The unmanageable caseloads limited their ability to deliver intensive person-centred care, particularly for individuals with multiple and complex needs, an issue that was viewed as still being largely under-recognised in resource planning.

> The resources that we have haven't changed since last year, we need more staff to be able to spend quality time, caseloads are high, mistakes are made sometimes because you're just fighting fires. (Treatment provider lead, Interview 3, Site 1, Phase 3).

Greater proportions of follow-up survey respondents than respondents in the initial survey reported high levels of demands in the workplace. For example, around two-thirds reported having to work intensively and half the respondents reported having to neglect some tasks because they have too much to do. Around a third of the sample reported having unrealistic time

pressures and/or unachievable deadlines. The follow-up sample is substantially smaller than the initial sample (16 respondents versus 241 in the initial study), however, so the difference between the percentage of participants reporting these demands in the initial and follow-up samples should not be interpreted as indicating an overall increase in demands across the sector.

3.2. Supportive workplaces and personal and organisational values

Most of the workforce reported that they worked in a supportive team and had good supervisory or managerial support, which helped to alleviate some of the demands of their work. Some staff also reflected, however, that maintaining or increasing staffing levels, which contributes to a supportive workplace, was challenging. We also found that staff expressed differing perspectives on what treatment and recovery services should support people to achieve in their treatment and recovery journey, and how they should be supported in this by service staff. Personal perspectives affected how people approached their work and could lead to friction between staff members with differing views, or who misunderstood each other's remit, as well as dissatisfaction when organisational expectations did not match personal values.

3.2.1. Most people in the treatment and recovery sector experience a supportive work environment

The presence, or absence, of a supportive environment may shape how staff experience and balance the demands of their work. While the treatment and recovery sector is undeniably challenging, many staff in the initial study were able to cope when they felt part of a team, had access to supervision, and were recognised and supported by both their organisation and commissioners. The support noted in the interviews was mirrored in the workforce survey from the initial study, where over three-quarters of respondents agreed or strongly agreed that they had both peer support (83.5 per cent [n=198] to 85.7 per cent [n=204] across statements) and managerial support (76.7 per cent [n=181] to 87.7 per cent [n=207] across statements) in their roles in the sector (see Figures 3 and 4; Annex A.3.3; and Annex A.3.4).

Figure 3. Staff responses to five questions on 'managerial support' from the Perceived Stress Scale (n=241)

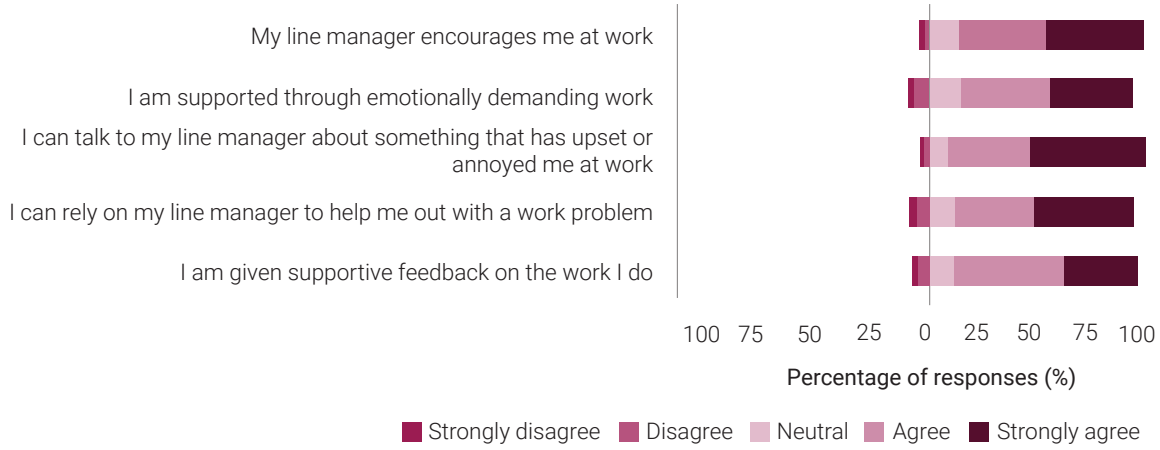
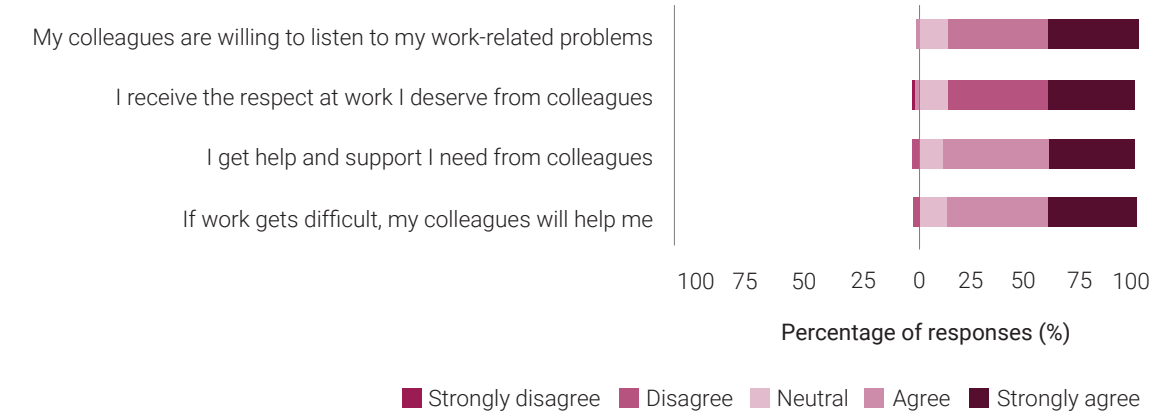


Figure 4. Staff responses to four questions on 'peer support' from the Perceived Stress Scale (n=241)



In the interviews and focus groups from the initial study, a supportive environment was described as one that included: practical support during incidents, such as stepping in when a crisis occurred; a feeling of trust based on staff feeling that they could rely on and learn from one another, and that they were safe to ask questions or admit when they did not know something; and supervision and regular check-ins, where staff were asked about not only their wellbeing but also their wider aspirations. Good managers were felt to be visible, approachable and protective, and directors who were 'very in touch' and knew what was happening on the ground were particularly valued (Treatment provider lead, Interview 1, Site 4, Phase 2).

A supportive relationship between staff and management was not universal. A few treatment staff from a small number of sites from the initial study reported that they felt unsupported by their management and that their service had a 'blame culture' (Treatment provider staff focus group 2, Site 9, Phase 2), which made staff want to leave the service.

The high level of team and supervisor support in the sector has continued. In the follow-up study, conducted at least five months after the initial study, one treatment staff member reported that despite the strains experienced in their service over the past year, the culture of peer support within the service had not changed throughout the drug strategy funding period. Other staff in the follow-up study noted the support they felt from their peers and partnerships.

> I think the overall culture of staff supporting each other and working hard to try and provide the best service they can for their clients, I would say that's still there. I feel that's still there. (Treatment provider staff, Interview 6, Site 8, Phase 2)

Another staff member in the follow-up study noted that it is this support network among peers that can help manage the emotional and mental load of working in the sector.

> And you have to just sort of sit and take it [traumatic content heard in the service] in and I think sometimes younger people tend to be so shocked and it's having that support mechanism in place for them so they're not off-put by what's being heard, they have other people in place. (Treatment provider staff, Interview 1, Site 8, Phase 3)

The consistency of peer and managerial support was also mirrored in the follow-up workforce survey, where over three-quarters of respondents agreed or strongly agreed that they had peer support (between 83.5 per cent and 85.7 per cent across statements; n>11 for all) and managerial support (between 76.7 per cent and 81.9 per cent across statements; n>11 for all) in their roles.

3.2.2. Expanding teams can increase peer support, but this may be impeded by recruitment difficulties and training needs

Developing and maintaining a supportive environment was linked to staffing levels. Case study sites in the initial study that experienced a low staff turnover reported positive experiences from this, including the impact on morale of having a manageable workload, and how staff retention brings more stability and creates a happier, valued and more motivated team. One team member felt that the lack of turnover indicated that staff were supported. Others noted that more manageable caseloads helped staff retention.

> [I]f an organisation maintains lower caseloads, I think you're going to have better staff satisfaction, less staff sickness and stress, and those things. So more likely to retain staff with their skills and knowledge for the area and the service users, that sort of thing. I think that has a big positive knock-on effect. (Treatment provider staff, Interview 1, Site 7, Phase 2)

Many staff in the initial study noted that there was only a finite pool of candidates from which to recruit staff and expand their workforce. New positions were said to be filled primarily by existing staff (i.e. moving staff members into new roles within the same organisation rather than recruiting external candidates). This resulted in a need for more recruitment of positions that were now vacant.

> There's a limited pool of people to draw on and you can be ending up robbing Peter to pay Paul, is that what they say? Moving people around the system. (Local lead, Interview 2, Site 2, Phase 2)

Many staff in the initial study, predominantly in leadership positions, expressed negative feelings after witnessing experienced staff leaving the workforce and noted how a lack of skilled workers leaves people who use the services unsupported. One treatment lead noted that the amount of expertise that had been lost in the sector in the last 15 years was 'an absolute travesty' (Treatment provider lead, Interview 1, Site 5, Phase 2).

Many other staff members in the initial study – both in leadership and non-leadership positions – from a number of areas commented on the challenges that arose from working with an unskilled workforce. A few staff members in leadership roles noted that knowledge and skills had depleted in their sites and that it took time, energy, effort, investment and resources to train inexperienced staff and build a stable and skilled team, all of which was challenging to do in a busy and under-resourced environment.

> Trying to recruit new people takes time. They seem to think there's this magic number of people out there begging for a job.… It takes time for people to be trained as well. We've had some adverts out for coming up to three years now and we still haven't filled those posts because they're so specialist. You know, and we can only give short-term contracts because we don't know where the money's going to come from in future. (Commissioner focus group 2, Phase 1)

Training new, unskilled staff increases the workload for existing, experienced staff. One staff member in the initial study described the knock-on effects of training-related absences, noting that others had to conduct extra work while colleagues undertook training. Many staff in leadership positions – both treatment leads and commissioners – expressed the pressure and relentlessness they feel around continuously training new staff.

3.2.3. The initial drug strategy investment has resulted in a larger and more diverse workforce in some areas

The additional funding from the drug strategy investment generally facilitated supportive working environments through enabling all our case study sites, as well as other areas consulted in the initial study (i.e. Phase 1), to recruit more staff to expand and diversify their workforce.

The introduction and expansion of specialist roles was generally perceived positively, enabling services to tailor the care they provided to people and to ensure their workforce had access to the additional skills required to help people with complex needs. Regulated and unregulated professional roles, including trauma psychologists, speech and language therapists, assertive outreach workers, dual diagnosis specialists, cognitive behavioural therapists and social workers, were introduced across all sites in the initial study.

> [T]his money's allowed us to enhance that and continue to go in that direction, which I think has been a positive thing without a doubt. We have general nurses, we have mental health nurses, we've got pharmacists, we've got prescribers, we've got key workers, and we have got some very experienced key workers as well. So we've got a very good multidisciplinary range. We've got a consultant, obviously who's on site. So I think we've got a robust base. (Treatment provider lead, Interview 1, Site 10, Phase 2)

An increase in staff numbers was reported by many staff members in the initial study to have translated into a reduced and more manageable caseload, enabling staff to spend more time with people who use their services and conduct higher-quality work.

> It's been a breath of fresh air…to receive this was just almost, "Okay, you can do more of what you know you need to do and that you want to do"…it's just got wider. We've got more staff. We've got more space to be creative… through that we've reached people we weren't reaching before. And we've come up with creative ways of doing things still within the confines of the budget, but it's just been freeing. It's been quite significant. (Treatment provider lead, Interview 3, Site 5, Phase 2)

Several staff from many of the case study sites reported expanding their workforce and service capacity, and improving the quality of care they offered to the people who use their services, including varying their service offerings. Some leaders reported that they have been able to meet their targets for staff recruitment with ease. They shared that they have seen their teams flourish with new members and their services have become well-established and well-resourced.

> [T]here were some really amazing additions to the service and we recruited really easily into those roles. Some of them were from within and then we had to backfill. But all those 12 roles, as soon as the money was available, we managed to recruit into them. (Treatment provider lead, Interview 12, Phase 1)

In contrast, at other sites, including some of the same case study sites, treatment provider leads and staff reported that the funding simply brought their services back to capacity, correcting years of underinvestment, or was sufficient to maintain their services but not expand. Some staff in leadership positions (i.e. commissioners and treatment or LERO leads) in the initial study

stated that the drug strategy funding overall was insufficient to cover the costs of recruitment, training and staff development needed to expand their workforce and meet the workload. Many staff in leadership positions in the initial study said they were unable to achieve staffing targets due to communication delays regarding drug strategy funding allocations, and that the timing of receiving the funding made it difficult to spend the money and recruit in the required timeframe. This was reported to have led to unfilled posts.

Additionally, the drug strategy funding was said by some staff in leadership positions to have been used primarily to recruit more unregulated roles rather than regulated roles. As a result, it was reported that those in leadership positions were stretched in their capacity to recruit and manage an expanded team, as well as deliver in their own roles. In general, there was a sentiment that many local areas were still working with the bare minimum number of posts, to the detriment of service quality and morale.

> [T]he resource is underwhelming. And being forced to cut away to the point where it's not necessarily a skeleton crew, but it's definitely tight, means that we can't provide that well-documented and well-researched evidence that suggests that it's the soft moments that make a significant difference in terms of recovery outcome. (Treatment provider lead, Interview 2, Site 1, Phase 2)

Two staff members at the same site in the initial study noted that while the funding has led to their caseloads being reduced, they were still unmanageable, with one staff member in a leadership position reporting staff burnout and sickness in their team as a result. These sentiments regarding increased capacity that still fell short of making the work manageable were echoed in the workforce survey in the initial study. While three-quarters of respondents agreed or strongly agreed that they had adequate materials, supplies and equipment to do their work (76.5 per cent; n=179), less than half (45.9 per cent; n=107) agreed or strongly agreed that there were enough staff for them to do their job properly (see Annex A.3.5).

Increasing the capacity and diversity of the workforce is still a work in progress. In the follow-up study, all staff interviewed acknowledged their appreciation of the drug strategy funding. They reported that it had been beneficial for their services, including expanding their capacity, enabling them to provide specialist services and overall improving their quality of care. The positive benefits of expanding the workforce were reported in our earlier interviews as well as the follow-up interviews. One treatment lead in the follow-up interviews stated that the drug strategy funding was like 'an injection of enthusiasm and opportunity' (Treatment provider lead, Interview 4, Phase 3).

Some staff in the follow-up study did note, however, that they had not yet reached the goals they intended to achieve. For example, two staff members reported that while they had seen a reduction in caseloads over the course of the drug strategy funding, they were still not at the ideal level to deliver high-quality care; they were still working towards this goal. Many staff reported that recruitment remains a challenge. Some staff noted that this difficulty in recruitment was general, while others reported this to be related to certain roles, such as regulated professionals (e.g.

nurse prescribers, clinical psychologists). This was echoed in the follow-up survey, where a similar percentage of participants to the initial study reported that they agreed or strongly agreed that they had adequate materials, supplies and equipment to do with work (81.2 per cent; n>11) and that they had enough staff to do their job properly (37.5 per cent; n=6), indicating that while there has been an increase in funding and therefore capacity, it is still insufficient to meet the demands on the service.

3.2.4. Members of the workforce expressed diverse views on the best way to support people in treatment and recovery

Staff described different views and perspectives on *what* their support was intended to achieve for people using their service. While some viewed recovery as being defined by abstinence from alcohol and/or other drugs, others took a broader perspective in which abstinence may or may not be the ultimate goal of a treatment and recovery journey. Staff also differed in their perspectives on the importance of independence and the degree of support that treatment and recovery services should offer to people. One treatment staff member in the initial study felt that their colleagues could fall into 'enabling or rescuing' people rather than empowering them (Treatment provider staff, Interview 3, site 1, phase 2). A few participants in the initial study, largely treatment staff or treatment service leads, expressed concerns about the people who use their services becoming dependent on services, which was felt to undermine their autonomy, and emphasised the importance of change being led by people who are using the service themselves.

> Let's get away from this idea that we're the solution, we're not. We're a 9 to 5 service. We're open 9 a.m., we shut off 5 p.m., the clients have got to live out there 24 hours a day and the weekend. (Treatment provider staff, Interview 1, Site 1, Phase 2)

Their view appeared to be that the role of services was to empower people who use their services to take ownership of their recovery journey: people who use their services need to 'do the work themselves' (Treatment provider staff focus group 3, Site 2, Phase 2). In contrast, some staff in the initial study prioritised 'relationship-centred care', which favoured being present and responsive to the needs of people who use their services or emphasising shared identity where staff had lived experience of alcohol and/or other drug use themselves. Although this approach was more common among staff working within LEROs, it was not uniformly adopted. For example, one LERO staff member reported that their CEO had adopted a philosophy of discouraging dependence on their service and instead promoting it as something intended for those who 'want to do any work on themselves' (LERO lead, Interview 1, Site 4, Phase 2).

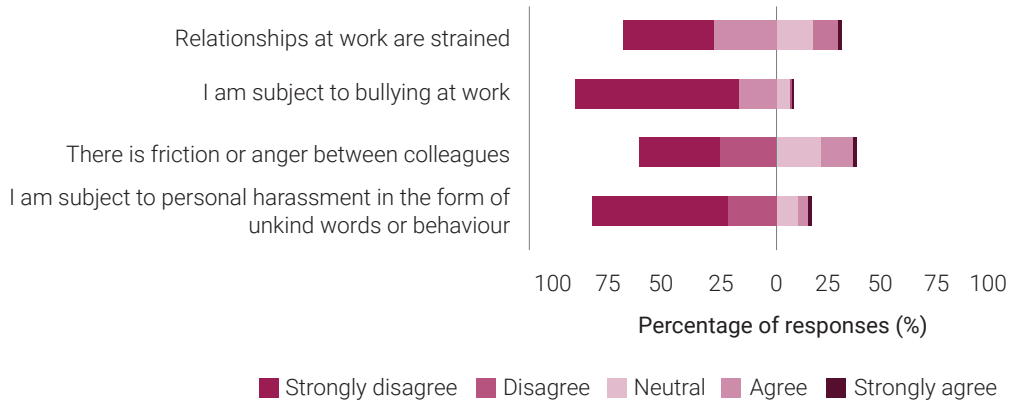
Viewpoints on *how* people should be supported in treatment and recovery, including the value of medicalised interventions, also varied between staff both between and within the same areas and organisations in the initial study. Many staff viewed lived experience as a valuable form of expertise and emphasised striking a balance between learned and lived-experience roles. Some treatment staff, however, often in the same sites as those who saw a clear value in lived experience, expressed doubts about the appropriateness of support provided by those with lived experience when it was not combined with formalised training: 'lived experience doesn't mean

anything unless you've got the skills' (Treatment provider staff focus group 3, Site 5, Phase 2). Conversely, some LERO staff felt that first-hand experience enhanced empathy and credibility, and were critical of colleagues perceived as working 'straight from a book' (LERO staff focus group 1, Site 8, Phase 2). Some staff, often those with lived experience, felt sceptical about a medicalised approach to recovery. This was often connected to their personal beliefs regarding the importance of abstinence.

Different staff attitudes towards recovery and the role and goal of services could cause friction when beliefs and approaches were in conflict with the expectations of other staff or with organisational values and policies. The flexibility of staff who were willing to, for example, avoid formal procedures like risk assessments in favour of personal judgement, clashed with colleagues who prioritised governance-focused, risk-averse approaches. Similarly, differing views on the accessibility of services and staff could cause disagreements. One treatment staff member in the initial study described conflict occurring as a more 'liberal' attitude towards the role of treatment services led some staff to relax policies like when people who use their services should be allowed to access the building. Multiple LERO staff expressed a willingness to be available outside of formal hours, with some LERO staff perceiving treatment services' fixed hours as lacking 'dedication' (LERO lead, Interview 2, Site 7, Phase 2), or viewing treatment staff as overly 'clinical' and 'rigid', to the detriment of people using their service (LERO staff focus group 1, Site 1, Phase 2). However, a treatment lead from one site in the initial study expressed concern with their local treatment service staff's preference for *not* working overtime or on weekends.

In the workforce survey from the initial study, most respondents were clear about their role and how it fit in with the aim of their organisation (see Annex A.3.6), but a minority of respondents did report interpersonal conflict with colleagues, including strained relationships, friction between colleagues or personal harassment (see Figure 5 and Annex A.3.7).

Figure 5. Staff responses to four questions on 'relationships' from the Perceived Stress Scale (n=241)



Some treatment and recovery staff in the initial study said they often felt their organisation's values did not align with their own, particularly where an emphasis on administration or metrics was felt to detract from providing care. One treatment staff member felt that concerns with making sure they had completed paperwork could eclipse a focus on what people who use their services need. Similarly, a few treatment staff in the initial study expressed frustration that they were not able to spend as much time with people who use their services as expected. A few staff members did connect a reliance on numbers with 'medical' and 'clinical' models (Treatment provider staff focus group 1, Site 3, Phase 2), with one staff member in a leadership position reporting pride in hitting their metrics, in contrast to 'humanistic, very touchy-feely' services that were less interested in figures (Treatment provider staff focus group 1, Site 7, Phase 2).

Although treatment and recovery staff did not always hold the same views about recovery, such differences did not always preclude them working well together. In one site from the initial study, where LERO staff disagreed with the medicalised approach of the treatment provider, the LERO was integrated into the treatment service and staff from both organisations frequently worked together. At another initial study site, the LERO appeared to have a separate remit from the treatment service, which enabled the organisations to work together despite having different approaches. While they were 'quite respectful of that' (Treatment provider staff focus group 3, Site 4, Phase 2), there was limited integration or lateral relationship development between LERO and treatment staff:

> [I]t's very much us and them. Like they're separate. And there's quite a lot of corridor comments around kind of like, "Oh, they'll do their thing, we'll do ours," or just disagreements over certain things that, yeah, I think people take quite personally. And I think both services deliver a really good service, but I don't necessarily think they're cohesive across the two… It definitely feels like it's two separate services. (Treatment provider staff focus group 3, Site 4, Phase 2)

Values and perspectives on appropriate treatment and recovery approaches remained diverse over time during the study period. In follow-up interviews with treatment staff, as in interviews from the initial study conducted at least five months prior, there were diverse perspectives around approaches to treatment and recovery and the role of lived experience. The mix of staff with lived experience and staff without was reported to be an important balance, which one treatment staff member felt had recently veered towards prioritising lived experience and become 'less professional and too emotional' (Treatment provider staff, Interview 5, Site 2, Phase 3). The same staff member reported no longer enjoying their work environment because of this recent shift in focus. One treatment provider lead reflected in a follow-up interview on how the drug strategy

funding has brought additional investment to the clinical side, which has corrected the focus on the recovery side and so brought balance to the services that they can provide.

> There's a lot of emphasis placed on recovery and the psychosocial support that people need, but individuals with substance misuse do have physical health needs as well born out of years of health neglect or poor access to services. So what I would like to see more of is that balance, the right balance between psychosocial recovery oriented support, but also a good clear focus on people's physical health improvement and health prevention. (Treatment provider lead, Interview 5, Phase 3)

Another staff member in the follow-up study reported their own recent drive to welcome people with lived experience into their service. Indeed, treatment staff members from the initial study reflected on the improved integration of lived experience into services over time as well as clinical roles' growing respect of lived experience.

The results from the follow-up survey conducted at least five months after the initial study survey were similar with regards to role definition and interpersonal conflict. Most respondents were clear about their role and how it fit in with the aim of their organisation, and there was only a minority who agreed or strongly agreed there was friction or anger between colleagues and strained relationships at work.

3.3. Partnership working and communication

Where treatment and recovery staff had cross-sector working relationships in place, this was generally reported to have had a positive impact on service provision and work environment. Some participants, however, reflected on communication challenges between organisations within the treatment and recovery sector that could affect service provision.

3.3.1. Effective cross-sector partnership working can alleviate some demands experienced by the workforce

Where staff in the initial study were part of organisations that engaged in cross-sector partnership working, they noted that working across different pathways in the systems of care (e.g. criminal justice, mental health, physical health, housing services) helped them to meet the diverse needs of people in treatment and recovery. They also commented that collaboration between organisations made it a more pleasant experience, as different organisations were not in competition but working together to solve problems.

Treatment staff, LERO staff and staff in leadership positions in a few sites from the initial study reported that the ease and strength of their partnership working was due to the co-location of multiple services in one shared physical space.

> We've got mental health practitioners sitting within the substance use services. We've got substance use practitioners sitting within mental health services. We've got substance use practitioners sitting in long-term medium-secure units, psychiatric hospitals. So it's given us the resources to be able to do that, and vice versa. (Treatment provider lead, Interview 1, Site 3, Phase 2)

At another site from the initial study, although services were in separate buildings, some staff members from each service were physically located in other services' buildings, which enhanced the collaboration of staff and promoted a positive perception of partnership working. One staff member in a leadership role reported this to be the best outcome of the funding. This site also conducted a forum in which the local organisations could come together and connect, which was seen by a staff member in a leadership role to be a positive initiative that increased connectedness within the wider workforce. As with the co-located sites above, these positive sentiments from partnerships were noted by treatment staff, LERO staff and those in leadership positions.

Other sites from the initial study neither shared physical space nor had staff members located in different buildings. Many staff across roles were nevertheless able to give examples of positive ways of working between different parts of the system. A few leadership staff noted that the funding had allowed them to build more robust partnerships, where links had previously been more tokenistic.

> I think at a local level, we've got mature, strong partnerships. We have really close links with housing, and we have really close links with our mental health trust. We have close links with the voluntary sector, and primary care are engaged. They're wanting to work and to improve services. So I think from a partnership perspective, we are strong but we were strong before this. It just helps overcome any challenges or bumps along the way. (Local lead, Interview 2, Site 8, Phase 2)

Not all staff in the initial study had uniformly positive experiences with cross-sector partnership working. In a focus group at one site, treatment staff felt frustrated by the need to 'continuously explain' to doctors in the NHS-run service what their role was and who the people who use their services were (Treatment provider staff focus group 2, Site 9, Phase 2). Other staff noted that they experienced multiple barriers and were treated poorly when interacting with other health services. Some staff members expressed that while there were some positive experiences of partnership working, their services did not yet feel connected, and acknowledged that this would take work.

> But there's a lot of work that has to go on in the background to develop and build the partnerships. It doesn't just happen by magic, particularly if you have different providers or different things, that can cause disruption. (Local lead, Interview 2, Site 4, Phase 2)

3.3.2. (Mis)communication with other staff within the sector can negatively affect service provision

Working relationships with central and local government were acknowledged as important, but there were mixed experiences of these relationships across the case study sites. Some staff in leadership positions from the initial study felt there were clear lines of communication with local and central government, that they were supported and that the needs of their workforce were understood by key stakeholders. This was echoed by commissioners who noted a positive relationship with the providers in their area, enabling them to disseminate funding and recruit quickly.

> [T]here's clear lines of communication from OHID to the commissioners to us as a service and then from me to the team. So everyone I hope knows which direction we're going in and why and how it's funded. (Treatment Provider lead, Interview 2, Site 7, Phase 2)

Staff in leadership positions from other sites in the initial study, however, reported not feeling well connected to or understood by central government colleagues.

> Government; I don't know. It doesn't feel particularly well connected because I think the true picture of what it's like to work in a service, you can't describe to anybody until they're working in the service. So, there will always be a natural disconnect. I don't think the workforce particularly feels heard. (Treatment provider lead, Interview 3, Site 5, Phase 2)

Across several sites, staff described feeling misunderstood by their colleagues in different roles, particularly when it came to the scope and limitations of their roles. These misunderstandings led to misplaced expectations, frustration and operational inefficiencies. One treatment staff member explained that colleagues frequently referred people to their services for trauma support, assuming they could provide trauma-focused therapy, yet in reality their role was more constrained.

Elsewhere, treatment staff from one focus group expressed concern that LERO colleagues were overpromising to people who use their services, such as suggesting access to rehabilitation services that were not realistically available due to budget constraints. This was felt to create tension between treatment staff and LEROs when expectations were not met.

The drug strategy funding has improved within-sector communication in some services but was insufficient to achieve the desired communication in others. These tensions may be exacerbated by pressures within the system that the drug strategy investment has seemingly not been able to address in the early stages of funding. One treatment provider lead from the follow-up study noted a systemic reliance on treatment and recovery services to coordinate care across fragmented systems, a role they say they struggle to take on with their current resources.

> So the amount of resource that takes up, with things like multidisciplinary teams, case conferences, court reports, the amount of work we have to do with housing agencies, with mental health, with even community services like food banks, probation, are very demanding. We are often the point of contact for a lot of these clients who are chaotic and complex and come with a load of different issues, and often other services send them to us to sort out their drug and alcohol problems and then they'll sort out their mental health, then they might be able to get stable housing. (Treatment provider lead, Interview 3, Site 1, Phase 3)

Another treatment staff member suggested that even with the additional funding from the drug strategy, the volume and complexity of need in their area – and the requirements placed on staff in order to enable partnership working – would require more staff than the funding can realistically support. Many treatment staff and leads from other areas, however, did feel that the funding had enabled them to better coordinate with other services, because they had 'more time to be able to think and plan, to coordinate things' (Treatment provider staff, Interview 1,Site 7, Phase 2) and build stronger relationships.

> We've built those relationships up through those workers. Five or six years ago, when we first sort of looked at this new contract, we had none of that. Over the last 18 months, that's been so much more robust because of the funding for these workers to do that role. (Treatment provider staff, Interview 3, Site 8, Phase 2)

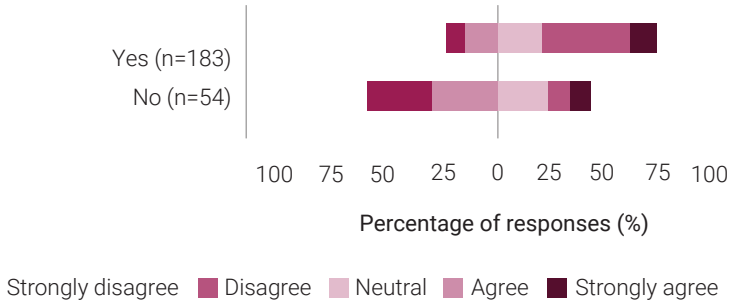
3.4. Financial stability and career development

The key factors where members of the workforce felt improvement was needed were overall pay levels and pay parity within the sector between NHS and third-sector services, and job insecurity. Many staff highlighted the need for further improvement in career progression pathways and career development to help retain existing staff and recruit new staff to the treatment and recovery sector.

3.4.1. Many staff feel their salary is not commensurate with the demands of their role and their skills and expertise

A common theme among many staff across the case study sites in the initial study was that they were poorly remunerated for their work, considering the stress, skills and responsibility involved. One treatment staff member said that their salary was 'bottom rung' but their responsibility was 'huge' (Treatment provider staff focus group 3, Site 4, Phase 2). In the workforce survey from the initial study, less than half (45.9 per cent; n=107) of respondents agreed or strongly agreed that they were satisfied with their level of pay (see Annex A.3.5). The groups with the highest percentages reporting to agree or strongly agree that they were satisfied with their level of pay were: commissioners (68.4 per cent; n=13); staff aged between 36 and 50 (56.2 per cent; n=54); those that had appropriate and achievable career development pathways (54.4 per cent; n=93); those who were new to the sector (50.0 per cent; n=14) or had been in the sector a long time (50.4 per cent; n=64); and staff identifying as White ethnicity (47.6 per cent; n=168) (see Figure 6 and Annex A.3.5).

Figure 6. Staff responses to 'I am satisfied with my level of pay' by those who responded 'Yes' or 'No' to 'Would you say you have appropriate and achievable career development pathways in your current role?'



The groups in the initial study with the lowest percentages of satisfaction with pay were: staff aged between 18 and 25 (25.0 per cent; n<5); staff who identified as Asian or Asian British (31.2 per cent; n=15); drug and alcohol workers (31.3 per cent; n=26); those who had worked in the sector for between one and three (37.0 per cent; n=17) or three and five years (33.3 per cent; n=9); and those who reported that they did not feel they had an appropriate or achievable career pathway available to them in their current role (18.5 per cent; n=10). Results from the workforce survey in the initial study indicate that improving pay may help to retain staff in their role and the sector. Higher percentages of respondents who reported being satisfied with their level of pay disagreed or strongly disagreed that they had intentions to leave their job. For instance, among those who strongly disagreed with the statement 'I often think about leaving this organisation', 58.6 per cent (n=51) were satisfied with their level of pay, whereas among those who strongly agreed with the statement, no one was satisfied.

Concerns about inadequate remuneration were raised by many leadership and non-leadership staff in the initial study. Staff in non-leadership positions stated that their own salaries were inadequate, while those in leadership positions acknowledged that their staff were inadequately compensated.

> When the person you're working with dies, you are the person who's going to coroners. Do you know what I mean? You're the person who's standing up in coroners having to justify, for want of better word, your practice, et cetera. And so I do feel that there is a feeling that the role should be both validated and financially rewarded for the level of responsibility and accountability that it does carry. (Treatment provider lead, Interview 1, Site 10, Phase 2)

Even though some staff noted that their motivation for working in the sector is altruistic rather than financial, the pay and conditions did not match up to what their role entails:

> [Y]ou do get quite emotionally invested, people don't go into these job roles because they just want to make quick cash…and naturally as a result of that people do get quite invested and the amount that you have to deal with, the salary really does not add up for it, and the risks that you have to manage. (Treatment provider staff focus group 2, Site 9, Phase 2)

Additionally, there appears to be a lack of parity in pay within the treatment and recovery sector, particularly between NHS and third-sector services, which translated for some into a negative perception and experience. A few treatment and recovery staff in the initial study noted a salary inequity between third-sector services and NHS services in their area. For example, one case study site with a third-sector provider and NHS provider at the same service has a pay discrepancy among the equivalent roles, a fact which was commonly known among the staff and noted as 'unfair' (Treatment provider staff focus group 1, Site 7, Phase 2). A few staff members – both in leadership and non-leadership positions – acknowledged both the inequity of pay for the equivalent roles between the NHS and third sector, as well as a lack of clear career progression in the third sector, which lacks a banding structure comparable to that in the NHS.

> [T]here are now people on my course and in my equivalent role working in the NHS that are on thousands of pounds more than me, which is s**t. (Treatment provider staff focus group 3, Site 4, Phase 2)

A few staff noted that this pay discrepancy was the reason, in addition to less attractive employee benefits such as pensions and other entitlements, that they struggled to attract regulated professionals to the third sector.

> [I]f you can get yourself a clinical psychologist, it's incredible, but they're so rare and they don't want to leave the NHS and, of course, commissioners understand that, but central government doesn't understand that. (Treatment Provider Lead, Interview 2, Phase 1)

The pay discrepancy between different providers was noted by a small number of staff members to stem from competitive tendering, which was reported to disadvantage smaller organisations, such as LEROs.

Others noted the pay discrepancy across different providers and across the same providers in different areas of the country. For instance, one staff member in a leadership position noted that their geographical location was tricky because salaries were higher slightly north, while the cost of living was lower slightly south. Staff in one area from the initial study said their geographic

location allowed them to pay staff at higher rates, which had led to greater retention and the ability to hire better staff overall.

> [T]he reality is if you live in [area], this means we've been able to pay some higher wages or advertise it at a higher rate where we needed to, which then helps keep staff and also get good staff. I think that's had a big impact. (Treatment provider lead, Interview 3, Site 6, Phase 2)

Some staff in the initial study did feel sufficiently remunerated. This satisfaction was linked by staff to having a pay scale, a pay review or pay that was benchmarked to the NHS. For instance, one staff member noted that, after the publication of Dame Carol Black's independent review of drugs, their staff were paid in a bracket equivalent to NHS staff and this benchmarking to the NHS pay structure was received positively. A few LERO staff members also highlighted their organisation's effort to align payment structures across the organisation and the sector.

Some leaders in treatment services from the initial study had introduced other benefits to make third-sector salaries attractive or used other strategies by which salaries could be increased among their workforce, including extra funding through supplementary grants, requesting extra money from commissioners and conducting training to upskill staff.

> [T]he NHS has received and does receive probably slightly favourable pay conditions to the third sector. We've introduced things like move contracts, which are flexible contracts which allow us to employ someone in the [redacted] and then we can move them about. (Treatment provider lead, Interview 4, Phase 1)

There appears to have been limited change in pay satisfaction and disparity to date. In the follow-up study conducted at least five months after the initial study, commissioners and treatment staff reported that the sector remains less attractive in terms of pay compared to the NHS or LA positions, which they reported not to have changed over the period of the drug strategy funding. One treatment staff member reported that their colleagues 'leave here to go to work for the Council' as the positions are 'better paid' (Treatment provider staff, Interview 4, Site 3, Phase 2). A similar percentage of respondents in the follow-up surveys were satisfied with their level of pay (56.2 per cent in Phase 3 [n=9] versus 45.9 per cent in Phases 1 and 2 [n=105]). Similarly to the initial study, this disparity in pay was reported to contribute to instability in the sector due to staff moving frequently between providers. The disparity in pay may, however, be viewed positively or negatively depending on where someone is employed; indeed, it was framed as positive by a staff member from the NHS, who reported that they have reached a position with low sickness, high retention and training opportunities, which they acknowledge could be attributed to their higher salaries than third-sector equivalents.

3.4.2. The short-term nature of the additional funding has created job security concerns for the workforce

A very common experience among the treatment and recovery workforce in the initial study was a sense of uncertainty and concern surrounding the funding from the drug strategy. This related to delivery timings, amount of funding available, types of contracts, whether the funding would continue, inability to plan for the service, and what this insecurity meant for them personally and for the future of the services they provide. Indeed, some commissioners reported that the short-term nature of the funding limited their long-term strategic planning.

> We've lost a lot of experienced staff members working in substance use because they're just fed up with the amount of changes and the way we commission over five years. You know, it would be nice if we could commission for a longer period of time. (Commissioner Focus Group 1, Phase 1)

While the drug strategy funding was welcome, its short-term nature raised concerns among many staff in the initial study, primarily those in leadership positions, who feared that the progress made could be lost once the funding ends. Some staff members in non-leadership positions emphasised that short-term contracts undermined the work that they had only just begun, which led to frustration. For example, one staff member was preparing to reduce their caseload in anticipation of the completion of their 12-month contract and subsequent end to the service, despite high demand for the service they provide.

> [F]or me, the fact that that is a one-year post is really problematic because we're already winding it down and it feels like it's only just getting up and running and we've got tons of referrals, tons of staffing wants, people to do… That's my frustration really is that I think we've done really good things with both of them [a trauma psychologist and speech and language therapist] but it's just too short. (Treatment provider staff focus group 1, Site 3, Phase 2)

Concerns regarding job security have not changed over time and this has negatively affected staff retention. In the follow-up study, many staff members reported that the short-term nature of the funding and anxieties stemming from the uncertainty around the continuation of the funding had not changed over time. One treatment staff member noted that the reliance on short-term contracts in the sector means that there are always people leaving, which puts a strain on resources in the services, whether that be the costs of continuous recruitment or the resources of the remaining staff left to cover the tasks.

> So you are going to get people leaving, which puts a strain on our resources because now, and that's always around that time is March, people are having to get their annual leave in don't they, and you're short staffed, and people are drained, and some people are burnt out from it and, you know, as part of the management team, we've had these discussions; who can cover this,

> who can cover that, and it's not fair, it isn't fair, so that's then not going to make people feel great is it, well, you know, it's the service users that suffer ultimately. (Treatment provider staff, Interview 2, Site 2, Phase 3)

3.4.3. The absence of a clear career pathway for some roles contributes to retention challenges

Multiple staff in the initial study expressed concerns that a lack of career progression opportunities, coupled with low pay, leads to staff turnover as people move on to other career opportunities.

> [W]e are getting more and more high turnover of newer, younger staff, it's a huge issue. Because people are not necessarily seeing it as a career, seeing it as a stepping stone into something else, which is fair enough for them, but it does present a big issue for us in service. (Treatment provider lead, Interview 15, Phase 1)

Staff from several case study sites in the initial study stated that their career progression pathway is limited to becoming a manager in the same service. Another noted that even after a promotion, the extra responsibility may not be reflected in the salary; therefore, staff may not feel motivated to progress. One treatment staff member noted that their salary is 'not worth the headache we go through' (Treatment provider staff focus group 2, Site 9, Phase 2). Another staff member illustrated this by highlighting the lack of banding structure in their third-sector organisation.

> [W]hen you work for the NHS, there's an increment scale, you know, and you go up every year. So, in your increments, you can become the bottom of 7 or the top of 7. You come to work at [third-sector service], and that's what you're on and that's it. There's nothing going to change. (Treatment provider staff focus group 3, Site 4, Phase 2)

The same staff member cited the lack of clear progression as a reason for the challenge of retaining people in the sector. This sentiment was mirrored in the workforce survey findings from the initial study. Three-quarters of respondents in the initial study (77.1 per cent; n=182) reported that they had an appropriate and achievable career pathway in their role (see Annex A.2.1). However, when looking at those who did not report having an appropriate and achievable career pathway (22.9 per cent; n=54), between a quarter and a third of respondents agreed or strongly agreed that they often think about leaving their organisation (29.6 per cent; n=16), that they will look for a job at a new organisation in the next 12 months (35.2 per cent; n=19) and that they will leave as soon as they find another job (24.1 per cent; n=13), compared to less than one in ten respondents that did think they had an achievable and appropriate career pathway (7.4 per cent [n=13], 7.9 per cent [n=14] and 4.0 per cent [n=7], respectively).

Whether workforce survey respondents from the initial study felt they had an achievable and appropriate career pathway was associated with their perspective on other aspects of working in the sector, particularly job satisfaction, intention to leave (see above) and managerial support (see Annex A.3). For example, among those who had an achievable and appropriate career pathway,

83.1 per cent (n=148) agreed or strongly agreed that they were supported through emotionally demanding work compared to 56.6 per cent (n=30) of people who did not think they had an appropriate or achievable career pathway. Moreover, 54.4 per cent (n=93) of those who had an achievable career pathway agreed or strongly agreed that they were satisfied with their level of pay compared to 18.5 per cent (n=10) of those without an achievable career pathway.

The follow-up workforce survey findings did not indicate a substantial change in concerns regarding career progression in the sector. The majority of the sample (over 85 per cent; n>11) reported that they had an appropriate and achievable career development pathway. However, we were unable to further examine how the follow-up survey respondents' perspectives of working in the sector differed by whether they reported an appropriate and achievable career pathway for their role due to the low sample size relative to the initial study (241 respondents in the initial study compared to 16 in the follow up). It is worth highlighting that we were only able to recontact 34.4 per cent (n=21) of people selected from the initial study for follow-up data collection; those people who did not feel they had a clear career pathway may have left the sector prior to follow-up data collection.

3.4.4. The drug strategy funding has stimulated investment in career development at the local level

Some treatment provider leads and commissioners in the initial study noted that the increased investment in training and progression opportunities they had implemented, including supervision, appraisals and clear and visible career progression, had resulted in a more qualified, competent workforce. They also noted that this had created broader positive change, such as a more pleasant working environment and the ability to tailor skill sets to the needs of the people who use their services. One treatment staff member noted that the 'breadth of training available is perhaps a bit wider than it was, which is really positive' (Treatment provider staff, Interview 1, Site 7, Phase 2).

While staff across several sites in the initial study described training as beneficial when it helped them or their teams perform their roles more effectively, others emphasised the importance of training being tailored to individual development goals.

> I was quite lucky. I've wanted to work with women with additional needs, and the women's team knew that. So, then they picked me up and tailored my training towards that. (Treatment provider staff focus group 1, Site 10, Phase 2)

Staff from some sites in the initial study reported successful implementation of training schemes designed to encourage university students and people with lived experience to join the workforce, which had a positive influence on the teams in terms of capacity and stability. The traineeship programme at one site was reported to help with recruitment difficulties experienced previously and ensure trainees have the required skills. One staff member from a different site noted that they now focus less on recruiting people with previous experience and more on identifying people with a passion for the field.

Local investment in career development has been sustained, but still more can be done to improve perceptions of the treatment and recovery sector as a long-term career option. In the follow-up study, a few staff members in leadership roles noted changes they had made due to the drug strategy funding in terms of creating avenues for career progression. This included

the development of a training programme, 'growing their own' staff, and in-house accreditation. The accredited training that one treatment service lead introduced since the drug strategy implementation helped improve their retention rate. Staff members were enthusiastic and positive about the progress they had made and the possibility of making a role in the treatment and recovery sector a 'destination career'.

> [W]e are developing our own Workforce Development Programme. We are in the process of going through the full application process, getting it ratified by a university so we will be able to offer our own professional qualification to our staff and we would like that to kind of be linked to somebody's development as a practitioner. So I think that that will be transformational and I'm super excited about that. (Treatment provider lead, Interview 4, Phase 3)

One treatment service lead in the follow-up study reported that while they had not made changes yet, they acknowledged that training and developing people in the workforce was an area that they needed to work on. One commissioner noted that another challenge that remains despite the drug strategy funding is the lack of accreditation for workers in the treatment and recovery sector overall, which they say leads to reduced professional development and tempers the attractiveness of the sector.

3.5. Engagement, burnout and moral distress in the treatment and recovery workforce

3.5.1. People express strong dedication to working in the sector

Many staff described their work in the treatment and recovery sector as rich and rewarding, with job satisfaction derived more from helping others than financial gain. For some, the opportunity to help others or to 'give back' after going through the treatment system themselves was a source of motivation and pride. One treatment staff member in the initial study said that they 'have a passion for helping people and wanting people's lives to be different' (Treatment provider staff focus group 1, Site 6, Phase 2). Another staff member from another site said that they 'get that fulfilment, a rewarding experience at helping other people' (LERO staff focus group 1, Site 8, Phase 2).

The majority of the staff members who participated in this study expressed strong commitment to their current organisation (see Figure 7 and Annex A.3.8). Fewer than 15 per cent of staff surveyed in the initial study agreed or strongly agreed with statements expressing intentions to leave their organisation in the near future (8.5 per cent [n=20] to 14.4 per cent [n=34] across statements). Percentages varied across groups, however, such as ethnicity: 11.5 per cent (n=22) of staff identifying as White and 8.3 per cent (n<5) of staff identifying as Black or Black British agreed or strongly agreed that they often think about leaving their organisation, whereas 37.5 per cent (n=6) of staff identifying as Asian or Asian British did. Similarly low percentages were reported in follow-up surveys regarding intentions to leave their role and organisation. There was a substantial minority (around 20 per cent; n<5) who responded neutrally to these statements, which may reflect job insecurity related to funding uncertainty (discussed further in Section 3.6).

Figure 7. Staff responses to three questions on 'intentions to leave' from the NHS staff survey (n=241)

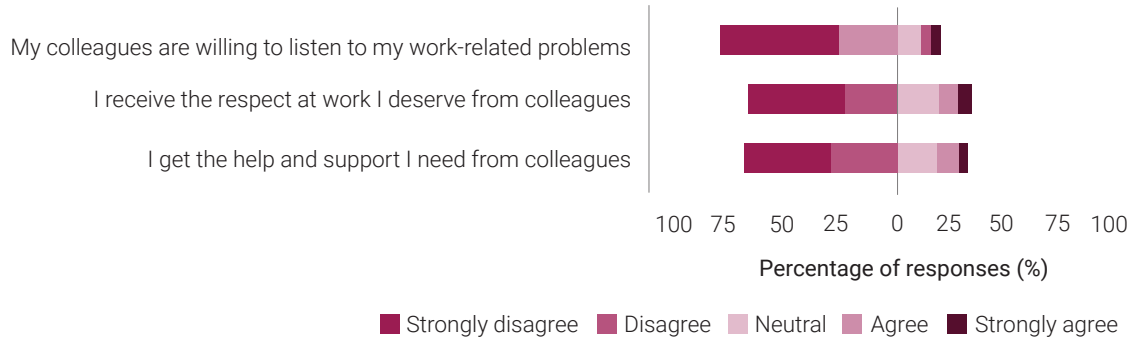
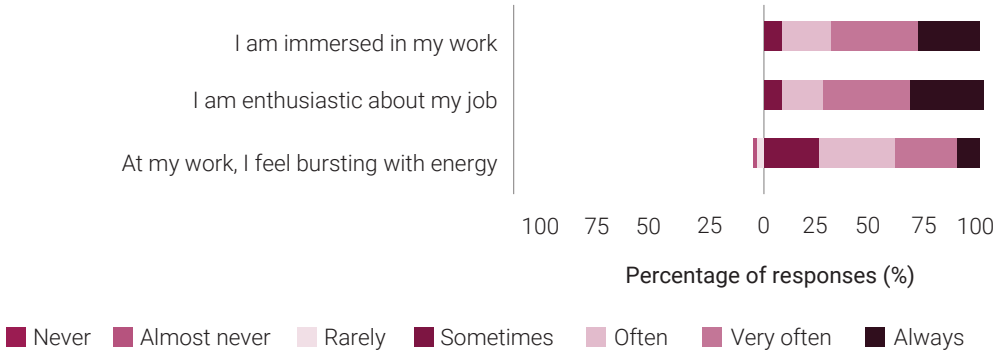


Figure 8. Staff responses to three questions on 'work engagement' from the Utrecht Work Engagement Scale (n=241)



The majority of respondents to the workforce survey in the initial study also reported high levels of engagement in their profession (see Figure 8 and Annex A.3.9). Most respondents reported that they were often, very often or always immersed in their work (90.9 per cent; n=210), enthusiastic about their job (92.4 per cent; n=219) and bursting with energy (70.0 per cent; n=166). This passion was reiterated in the follow-up study, with many staff noting that their motivation and enthusiasm for the sector had not changed. Staff expressed a strong sense of purpose in their roles and compassion towards the people that they serve.

Figure 9. Staff responses to seven questions from the Copenhagen Burnout Inventory (n=241)



3.5.2. Some of the workforce are at risk of burnout and moral distress and injury

There was some evidence of burnout among the workforce (see Figure 9 and Annex A.3.1). For instance, 12.0 per cent (n=28) of all surveyed respondents in the initial study reported often, very often or always feeling burnt out because of their work, and this percentage raised to 38.7 per cent (n=90) when including those who reported that they 'sometimes' feel burnt out because of their work. These percentages varied among groups. Younger respondents reported higher percentages of often, very often or always feeling burnt out because of their work, as did White and Asian/Asian British respondents, as well as respondents who did not think that they had appropriate or achievable career pathways in their role. Similar levels of burnout were felt across employment contracts (e.g. fixed-term versus permanent or full-time versus part-time), whether respondents directly worked with people who used alcohol and/or other drugs, whether respondents supervised others or not, or whether respondents had lived experience. In the follow-up survey sample, a similar percentage of participants selected the 'often/very often' or 'always' responses to the burnout questions.

The levels of tiredness, frustration and emotional exhaustion reflected in these responses is related to both the psychological and organisational demands of working in the sector, as well as the availability of physical, psychological, social and organisational resources to support people to carry out their work to an appropriate standard. As discussion in Section 3.1, many treatment and recovery staff expressed sadness and frustration at their inability to provide people with the level of care they felt was appropriate due to a lack of resources and time. Some staff also felt that the priorities of their organisation did not match their own in terms of the support that should be provided to people who used their service (see Section 3.2.4). This represents evidence of moral distress and potentially moral injury – distress arising from moral conflicts created by an inability to deliver care – which is related to, but distinct from, burnout.

Chapter 4. **Discussion**

We found that people working in the treatment and recovery sector in England were generally very engaged by their work and expressed a high level of commitment to working for their organisation. The satisfaction people derive from working in the treatment and recovery sector, both from helping individuals and contributing to society more broadly, mirrors findings from the international literature (Nagel 2025; Roche & Nicholas 2016; Skinner & Roche 2021). We found that this high level of engagement and commitment appears to have been maintained over the first three years of the drug strategy investment. This was coupled, however, with seemingly incongruous reports of high staff turnover and recruitment challenges. This likely reflects the pressures being experienced in the UK, and internationally, due to an increasingly competitive healthcare job market among regulated professionals (Correia et al. 2025; Roche 2016; Paradise & Wakeman 2024). This may disproportionately affect the treatment and recovery sector due to factors such as lower rates of pay and lack of clear career development pathways, as identified in this research and in the wider literature (Thom et al. 2023; Roche 2016; Crick et al. 2025; Paradise & Wakeman 2024).

Staff also highlighted the demanding nature of roles in the sector. The emotional and mental demands involved in supporting people in treatment and recovery could be a psychological burden for staff, and this was reported at both time points in the research study. Staff reflected that this burden was due not only to high caseloads, that in many areas are still much higher than best practice of 40 caseloads (Department of Health and Social Care 2021), but also to the psychological burden of working with people who were often unwell, vulnerable or at risk of death. These types of job demands are common among people who work in the treatment and recovery sector (Klingemann et al. 2024; Klingemann and Wieczorek 2024; Roche et al. 2021; Roche & Nicholas 2016; Skinner & Roche 2021; Vilardaga et al. 2011; Bird & Henning 2025) and are associated with increased risk of burnout (Bakker et al. 2014). It is worth noting that as additional funding was introduced into the treatment and recovery sector and additional staff were recruited with the funding, the numbers of people entering the treatment services rose (Office for Health Improvement and Disparities 2025). This may explain in part why high caseloads remained throughout the study period.

We identified a substantial minority of our participants in the initial study at risk of burnout (38.7 per cent reported that they sometimes, often/very often or always feel burnout because of their work). In a DHSC-commissioned survey of 2,179 members of the treatment and recovery workforce

conducted between 2024 and 2025, emotional exhaustion was also raised as a challenge by two in five respondents (Crick et al. 2025). In both the current study and the DHSC-commissioned survey, emotional exhaustion was highest in those who had been in the sector for over three years but less than five years (current study) and less than ten years (DHSC-commissioned survey). This type of time-related difference in burnout, with more experienced workers being less susceptible, has previously been identified for the treatment and recovery workforce (Vilardaga et al. 2011). This may reflect a 'survival bias' in that those people with more personal resilience or stronger support networks are less susceptible to burnout and more likely to stay in the sector. These findings reflect the wider international literature on the alcohol and/or other drugs workforce in terms of the types of demands experienced and the associated risk of compassion fatigue, and the experience of concurrent motivation and exhaustion (Bird & Henning 2025; Kostadinov et al. 2021; Missouridou et al. 2021; O'Donnell et al. 2022; Skinner & Roche 2021).

Moral distress – which is related to, but distinct from, burnout – is increasingly recognised as an important factor that shapes peoples' experiences of working in the healthcare sector, including both retention and performance (Dean et al. 2024; Fleming et al. 2023; Grumbach & Willard-Grace 2025; UK Clinical Ethics Network 2025). The UK Clinical Ethics Network defines moral distress as 'the emotional distress that arises out of feeling unable to do what you believe is right, feeling uncertain about what is the right thing to do, and/or being in conflict with others about the right course of action' (UK Clinical Ethics Network 2025). We found evidence of moral distress in the treatment and recovery workforce. Many participants reported feelings such as sadness and frustration in response to being unable to provide people with the level of care they felt was needed. Some participants also reported conflict between the ways they wanted to provide support to people and the priorities of the organisations they worked for. Examples included being unable to offer treatments such as medically-assisted withdrawal or depot buprenorphine, or being unable to sufficiently support people who disclosed traumatic experiences or were in unstable accommodation. These are similar to sources of distress identified in the wider healthcare workforce (Grumbach & Willard-Grace 2025; Rabin et al. 2023; Every-Palmer et al. 2024). Repeatedly facing such moral conflicts and distress, in which care is compromised due to resource or system constraints, leads to sustained moral injury and potentially departure from the sector (Reis & Lesandrini 2025).

Dean et al. (2024) argue that strategies to address moral injury and burnout in the healthcare workforce need to address the causes at societal or policy levels as well as at organisational and individual levels. Our findings suggest that the first three years of drug strategy investment has already enabled organisations to increase or strengthen some contextual and attitudinal factors linked to key job resources, improving the experience of people working in the sector and potentially decreasing the risk of burnout and moral injury. These include a supportive work environment, improved partnership working, and career progression and development. These areas can still be strengthened further, however, and additional support is needed in other key areas, including financial stability and equity, and valuing diverse perspectives on treatment and recovery. Key findings relating to these factors are summarised below.

4.1. Supportive work environments

We found that a supportive work environment can lessen some of the emotional and mental burden and work overload experienced by the treatment and recovery workforce. Two of the main protective factors that staff reported to help them cope with the demands of working in the sector were the meaning they derived from their work and the supportiveness of their colleagues and workplaces. The importance of supportive work environments, colleagues and supervisors in protecting against burnout in demanding roles is well recognised in the wider literature (Bakker et al. 2014).

Participants in this study characterised supportive environments as including practical support during incidents or crises, trust and mutual learning, and regular engagement from supervisors about wellbeing and career development. Staff frequently reported peer and managerial support in their roles, and this was sustained over the course of the initial years of the drug strategy, as reiterated in the follow-up study conducted at least five months after the initial study. Expanding teams to alleviate workload pressures as well as providing training and development opportunities were identified as facilitating the development of a supportive team environment. We found that staff welcomed the additional funding and acknowledged the increased workforce capacity and reduction in their caseload, and the impact this had in some areas in terms of improving team culture and support.

The expansion of the treatment and recovery workforce in England has, however, led to an influx of less experienced workers into the sector. As discussed above, this can place additional burdens on a team, whether that be the time senior staff take to recruit and manage new staff, or the additional workload existing staff take on until new staff are recruited and trained. Further investment may be needed to ensure sufficient support is available not just initially but throughout employment to protect staff against exhaustion and burnout and safeguard a supportive team culture.

We also found that caseloads for many staff had remained high throughout the study period, and the funding was insufficient to achieve a consistent and skilled workforce in some areas, contributing to stress and pressure among the workforce. Similar results were obtained by the DHSC-commissioned workforce survey, conducted three years after the start of the drug strategy funding, in which close to half of respondents agreed that they still had too many people ('far too many' or 'somewhat too many') on their caseload (Crick et al. 2025). The DHSC-commissioned survey did not, however, ask respondents to report the size of their caseload, and so we are unable to comment on how many is 'too many'.

The treatment and recovery workforce has deteriorated over more than a decade through consistent disinvestment (Drummond 2017; Holland et al. 2023; Thom et al. 2023), and workforce shortages in the sector are noted as an international problem (Paradise & Wakeman 2024; Roche & Nicholas 2016). Rebuilding a sufficiently skilled workforce with manageable workloads will take time; as participants in this study commented, there is only a finite pool of potential workers available. However, making the sector more appealing via changes to pay (e.g. pay parity, banding structures), conditions and longer-term contracts may help accelerate this.

4.2. Partnership working

Participants working in effective partnerships with other organisations, either across sectors (e.g. housing services, criminal justice) or within the sector (e.g. treatment services, LEROs), reported that they were better able to meet the diverse needs of people in treatment and recovery, reducing their job demands and leading to a positive working environment. There is some evidence in the wider literature that greater partnership working between treatment services and health or criminal justice organisations can improve outcomes for people who use their services: integrated and co-located care models are associated with improved outcomes and reduced system strain (Hughes et al. 2017; Glover-Wright et al. 2023). Intensive partnership working between criminal justice and drug services was also linked to better outcomes for people who use treatment and recovery services (Best et al. 2010). While evidence on direct impacts on staff wellbeing is limited, studies highlight that collaborative dynamics and shared objectives can emerge from partnership working (Lindberg et al. 2024).

4.3. Career progression and development

Career progression and development is a key focus of the workforce transformation programme with the creation of multiple products, such as psychology and psychiatry working groups and specialist training opportunities. Many components of the programme were only starting to be implemented during the current study's data collection period (2024–2025), limiting the extent of the impact that could be observed within the research timeframe.

Nonetheless, we identified some early evidence that the drug strategy investment had supported some treatment and recovery providers to expand their training and development opportunities and develop more transparent career pathways. Some organisations had developed in-house traineeships and accreditation programmes. These changes were viewed as having improved working environments, staff retention, and quality of care. Some participants highlighted the need for continued investment in this area to ensure the availability of tailored training, and the need for more formalised accreditation for alcohol and/or other drugs workers in the sector to ensure career development. This mirrors calls made by researchers in the treatment and recovery workforce field for more specialised training, beyond core competencies, and clear career development pathways for the treatment and recovery sector (Roche & Nicholas 2016; Roche et al. 2022).

Despite these improvements in career development, some staff repeatedly reported a lack of a clear pathway to career progression in the treatment and recovery sector for alcohol and/or other drugs workers, and linked this to staff retention challenges. Our survey data showed that staff who did not think their job provided an achievable career pathway had stronger intentions to leave their role and/or organisation than staff who did have a clear pathway. A lack of career pathways was also highlighted in the DHSC-commissioned workforce survey, where a third of respondents noted the lack of career opportunities in the sector and this was a common reason cited among those with intentions to leave their role and/or organisation (Crick et al. 2025). Previous research on specific regulated professional roles in the wider UK treatment and recovery sector (e.g. nurses)

has similarly highlighted the sector to be unattractive and difficult for staff retention (Thom et al. 2023). Thus, although we identified some signs of progress regarding career progression and development, our research also indicates that continued investment in this area is both needed and wanted by the treatment and recovery workforce.

4.4. Financial stability and equity

In addition to career development opportunities, efforts to address pay parity may improve job satisfaction, recruitment and retention. A common theme found in the current study was that staff were poorly remunerated for their work, given their reported stress, skills required by their experience of the job, and level of responsibility. This was exacerbated by the current lack of job security in the sector.

Participants in this study most frequently identified salary levels in the sector as a challenge, and this was also identified as a priority for change in the DHSC-commissioned survey (Crick et al. 2025). Concerns regarding pay and job security in the sector have been found in other countries, such as Australia (Kostadinov et al. 2021), as well. In the current study, the amount of remuneration for a role was less critical than a lack of parity across organisations in contributing to negative perceptions and experiences. This disparity in pay was particularly highlighted between NHS services and third-sector services and said to contribute to retention issues among third-sector organisations.

Short-term contracts and a lack of job security were also highlighted as challenges for staff retention. This lack of security, combined with concerns regarding pay and pay parity, may partially explain the apparent contradiction of high staff turnover in a sector where people tend to derive their job satisfaction from helping people rather than financial reward; staff do not necessarily want to leave, but their contracts are short-term, so turnover is high. During the current study period, operational staff and commissioners were informed of continued treatment and recovery funding for an additional year (2025/2026), which may have increased job security. However, the DHSC-commissioned survey examined whether the announcement of further funds changed whether staff reported job insecurity to be a challenge, and no statistically significant change was determined (Crick et al. 2025). This suggests that one year's additional funding may not be sufficient to offset the job insecurity felt by the workforce.

If organisations aim to not only ensure pay parity and pay progression (e.g. via a banding structure) but also provide more job security, this could help to alleviate challenges relating to workforce retention and recruitment, which in turn would improve team environment and working conditions for existing staff.

4.5. Respecting diverse knowledge and experience

We found that differing attitudes among staff regarding autonomy in treatment and recovery, professional boundaries and appropriate training and expertise, including the role of lived experience, could create barriers and potentially impede joint working. When staff were unclear

about each other's responsibilities, or the boundaries of their own responsibilities, this could lead to misaligned referrals and unmet expectations for people who use treatment and recovery services. Conversely, where roles were well-defined and there was mutual respect despite different perspectives, staff were better able to collaborate, complement each other's strengths and deliver consistent, effective care.

Our survey results suggested that while most staff clearly understood their own roles and how they aligned with organisational aims, there may have been gaps in understanding or appreciation of colleague's roles and how they fit in the wider systems of care, particularly between people with and without lived experience. Research into the experiences of peer support workers within alcohol and/or other drugs settings highlight that staff with lived experience commonly struggle with organisational expectations of professional boundaries (Bell et al. 2025; Carver et al. 2025) and situating a relational approach within rigid professional hierarchies (Englander et al. 2020; Piatkowski et al. 2024). The wider literature also emphasises the importance of a clear understanding and valuation of the role of lived experience workers in particular. A recent systematic review of the experiences of peer workers in non-peer-led settings found that the most important condition affecting peer work was whether the organisation genuinely recognised and valued the 'uniqueness of peers' (Chen et al. 2023). Forms of recognition noted in the literature include respecting their experiential knowledge as a form of expertise (Bonnington & Harris 2017) and inclusion in informing policymaking (Duke & Thom 2014), helping other professionals understand the peer role and how it fits within a wider system (Mahon & Sharek 2023), and providing appropriate supervision by someone with relevant expertise (Byrne et al. 2022; Stack et al. 2022).

We identified a range of values and beliefs within the treatment and recovery workforce, but also identified examples of people with differing views working together effectively to support people who use alcohol and/or other drugs. This suggests that an effective workforce does not need to be one in which only a single perspective, or body of evidence, or epistemology is acknowledged and valued; individuals and organisations within the sector need to recognise a diversity of perspectives. Establishing a shared vision for recovery that respects both clinical and lived experience perspectives and recognises the value of evidence-based interventions can help not only to bridge divides between individuals and organisations but also to develop integrated systems that enable staff to work towards a common goal with mutual respect and effective collaboration.

Chapter 5.
Strengths and weaknesses

5.1. Strengths

This study is the first independent evaluation of the Treatment and Recovery Portfolio funding. The study used a mixed-method approach with in-depth qualitative and quantitative aspects, including the use of large, independently collected national datasets. This was a comprehensive, large-scale project that involved a large amount of data collection, including the perspectives of a wide range of stakeholders.

Variation among the ten case study sites selected across England – in dimensions that include level of funding and grants received, geography, level of deprivation, types of interventions delivered and provider type (including both NHS and a range of third-sector organisations) – enabled us to capture a broad spectrum of experiences and implementation contexts.

The use of qualitative and quantitative data enabled the inclusion of many participants in the quantitative data, with in-depth and detailed data included in the qualitative work.

5.2. Weaknesses

The ten areas that agreed to be case study sites in Phase 2 may not be typical of other areas who were not approached or declined the offer to be part of the research.

We have two limitations to note regarding the Phase 3 data collection. First, we received very low response rates for follow-up interviews in comparison to Phases 1 and 2: 21 interviews and 2 focus groups in Phase 3 versus 126 interviews and 26 focus groups in Phases 1 and 2. While the data collected in Phase 3 was not intended to replicate those of Phases 1 and 2, we cannot state that the follow-up interviews are representative of all those who participated in Phases 1 and 2. Indeed, the second limitation of the Phase 3 data collection is that there is a potential bias among respondents who were included in the Phase. We received multiple non-responses to interview requests at this stage, including 'undeliverable' messages from 24 per cent of the treatment provider staff that we recontacted for Phase 3. Those that remained in the sector for at least five months after the first interview may have different perceptions and experiences than those that had left the sector and/or did not want to be interviewed.

Finally, as described in the findings, the workforce is busy and demands are high. We were only able to interview those who had the time or made the time to be interviewed. Those that were interviewed may have different experiences from those who did not have the time to be interviewed.

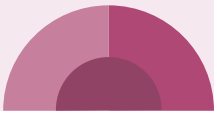
Chapter 6. **Recommendations**

The funding received to implement the workforce transformation programme was well-received across the participants in the study. Although most members of the treatment and recovery workforce are passionate about their work, many feel they are under-resourced and under-valued. Our findings suggest that it is not the nature of the work itself that leads to people leaving the sector, but factors such as workload, availability of support and resources, salary levels, and job security – which are all amenable to change – that ultimately affect people's desire to continue to work in the treatment and recovery sector. In addition to these factors, moral distress – whereby people feel that they cannot deliver the level of care they believe is necessary – was raised in our findings. Areas where further efforts could be directed to improve the experience of the workforce are outlined below.

- **Central government should work with LAs and treatment and recovery providers to determine a funding timeline and commissioning cycle length that would provide appropriate security for both services and staff.** This would increase staff recruitment and retention and improve the perception of the sector as a long-term career option. Developing timelines collaboratively would alleviate some concerns about communication between central government, LAs and treatment and recovery providers regarding funding.
- **Central government should continue its additional investment in the treatment and recovery workforce, expanding funding to make further recruitment of senior and supervisory positions feasible.** This will improve capacity at the local level to provide both technical and pastoral support for staff, particularly those in less experienced roles and those who are new to the sector, and help them to manage the mental and emotional demands of their roles, and develop appropriate skills to manage a therapeutic relationship within safe boundaries.
- **Central government, LAs and treatment and recovery providers should continue, and potentially expand, efforts to develop clear career pathways and career development support for all job roles within the treatment and recovery sector.** This would improve retention of the existing workforce and potentially increase the appeal of a career in the sector for new staff. It could also help to address pay disparities between organisations. The value of different qualifications and expertise, including

lived experience, should be addressed as part of career development to promote mutual respect and recognition.

- **LAs and treatment and recovery providers should review and address pay disparities between equivalent roles in NHS and third-sector services.** This should include assessment of pay levels in similar positions outside the treatment and recovery sector. This will help to address challenges with recruiting new staff to the workforce and potentially improve retention rates.
- **LAs and treatment and recovery providers should work together to establish a shared vision of their local systems of care and design a workforce that is cohesive and ensures any gaps are filled.** This would help to reduce gaps in understanding or appreciation of colleagues' roles and how they fit into the wider systems of care. Establishing a shared vision for recovery that respects both clinical and lived experience perspectives can not only help to bridge divides between organisations but also to develop integrated systems that enable staff to work towards a common goal with mutual respect and effective collaboration.
- **Alcohol and/or other drugs commissioners should review how services create a supportive environment for staff with the intention of creating a standardised approach.** This would help to ensure that new staff are supported by more experienced staff and those in supervisory positions in a practical and emotional sense. Activities could include the review of plans for immediate practical support in an emergency, mechanisms and regulation of supervision, reflective practice and provisions to support wellbeing.



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