5 Years of Recovery: December 2005-December 2010. From Challenge to Orthodoxy

Introduction

All those of us who have spoken about and, to varying degrees, spoken-up for recovery must, and do, regularly measure the distance travelled and the progress made on *The Road To Recovery.* And all of us, in our very different ways, may express some disappointment about the direction things have taken and the limited progress made. In this brief account, however, my wish is to chronicle the rapid rise of recovery in the British policy and treatment context, to very briefly examine the reasons for its extraordinarily rapid impact and to describe its transformation in this period from a marginal critique to the governing orthodoxy.

Recovery: What is it?

Within the drug treatment policy field and, more broadly speaking, across the broad substance abuse treatment industry, there is no unanimity of view about recovery, what it is and how to achieve it. For some it consists in a range of intensive, institutional therapies administered on behalf of a 'diseased' population of 'addicts' seeking 'real recovery' and 'total abstinence'. For others, recovery eludes definition and has no end point but is a difficult-to-pin-down process of self-defined improvements, some of which may be very difficult to measure. For yet others, recovery stands above all for an end to the vested interests of clinical, psychiatric and psychotherapeutic exceptionalism; a movement of peer-led, community building, a radical mixture of politics, grass-roots activism and spirituality. And finally, at least for the purposes of this brief account, there are those, myself included, who want to strip down our existing, mainstream treatment services and reconstruct them from both an organisational and cultural point of view.

Whether one is driven by abstentionism, communitarianism or a desire for mainstream transformation, the diverse and often mutually antagonistic strands of recovery-oriented thinking and practice have never come together to form a strong, consensual policy community. There has been no agreement about ends just as there has been no agreement about means. Nevertheless, virtually all of us now within the substance abuse policy and treatment industries, whether from pragmatism or principle, speak, with various degrees of fluency and commitment, the language of recovery.

The Irresistible Rise of Recovery.

How then, in spite of its internal contestation and factionalism, has recovery, in the relatively short space of five years, established an irresistible momentum that first brought it to national political prominence and then made it the cornerstone of the incoming coalition's 2010 drug strategy?[1]

For descriptive purposes, one can break this first five-year period into two halves. The first period, I date from December 2005 until May 2008. The second period dates from June 2008 until December 2010

Recovery Period 1: December 2005-May 2008. A Full Frontal Assault

In this initial 30-month period, recovery effectively replaced harm reduction as the key shaping influence in both policy and practice across the UK drug treatment industry. By the time Scotland's *Road to Recovery,*[2] the UK's first national recovery-based strategy was published in spring, 2008 many of the decisive exchanges between harm reduction and recovery had already taken place. This is the period when, from a number of quarters, a full frontal assault was made on the existing harm reduction orthodoxy. An assault that throughout 2006 and 2007 built up an irresistible momentum generated by policy analysts from the political right, residential treatment providers, researchers, and senior executives from within the drug treatment and policy field itself.

In order to understand how the seemingly impregnable orthodoxy of harm reduction was challenged, defeated, and superseded, we must first briefly examine the evolution and transformation of harm reduction from its inception as vigorous, innovative public health model to its mature form as a strategic, top-down tool of risk-management and crime reduction.

Harm Reduction: Its Evolution and Supersession.

Broadly speaking, one can identify two traditions within the harm-reduction movement that had, in successive paradigmatic shifts, held sway since the onset of mass heroin use during the early 1980s.

There was, on the one hand, a radical, public health wing emerging and gaining strength throughout the 1980s. This constituency was keen to 'normalise' drug use as a mass phenomenon, ethically indistinguishable from other mass forms of legal drug use. The 'normalising' strand of harm reduction grew strong in a practice sense largely as a result of its innovative and highly effective responses to the threat of HIV/AIDs posed by shared injecting drug use. It gained further momentum during the late 1980s and early 1990s as a result of the mass wave of recreational, 'party' drug use described so well by Howard Parker[3] and others.

Overall, this evolving and developing public health approach to harm reduction championed a non-judgmental approach and was an alliance of prescribing clinicians, ethnographers, epidemiologists, media personnel and drug service staff. In extreme variants its acceptance of drug use seemed, to some, to stop little short of celebration.

From the mid 1990s onwards, this approach to harm reduction was displaced, marginalised and neutralised by the growth and development of a more pragmatic, stigmatising form of harm-reduction based on the newly-evidenced conviction that a massive expansion of methadone maintenance treatment would significantly reduce acquisitive crime. This was the key policy gain that inspired New Labour in its final years of opposition and was the cornerstone of Labour's new 10 year National Drug Strategy, introduced in 1998.

The numbers in treatment, particularly methadone treatment, grew and grew. By 2005, the National Treatment Agency (NTA) could announce at its summer conference that the successful achievement of the UK National Strategy's 10-year treatment target was a

foregone conclusion. It was at this conference that the hegemony of methadone in the UK drug treatment system was first questioned. Research scientists from Texas Christian University, including Dwayne Simpson, showcased the products of their long collaboration, demonstrating a new kind of drug treatment system; one where effective engagement, early gains and more involving ways of assessing and measuring progress were key features. This model was taken up by the NTA and piloted, at first in Manchester and then more effectively and rigorously in Birmingham. One of those researchers leading the Birmingham Treatment Effectiveness Initiative was Dr. David Best.

Key Early Leaders of the Recovery Movement.

David Best, a onetime NTA research lead and researcher at Birmingham University, was to go on to became one of the most committed and fierce advocates of a community-based, de-professionalised approach to recovery. In 2006, Best, a senior lecturer in addictions at Birmingham University[4], and colleagues started to publish research that showed that some drug treatment in the criminal justice system was unchallenging and unstimulating; virtually a therapy-free zone where the prescription was everything. This single piece of research went a long way to presenting the rapidly and recently expanded drug treatment workforce as both under skilled and complacent. There was in effect the implication that clients and staff were lacking in aspiration, direction and any ethical purpose. The chronicity and pessimism of such treatment episodes was about to be challenged by a much more optimistic anthropology, one which refused to accept that addiction and dependence were life-long, relapsing conditions.

Best alongside Mark Gilman, a regional manager of the NTA in the North West, began to mobilise all those who were critical of New Labour's strategy of mass methadone maintenance. Gilman and Best were supremely able to run with the hare and hunt with the hounds, critiquing methadone maintenance whilst using their policy, research and treatment contacts to build effective practice and policy networks: the new recovery movement was being born.

Gilman's emergence as one of the key leaders of the UK recovery movement can be charted from as early as 2005. At the beginning of that year, his presentations and interventions bore all the hallmarks of the prevailing policy and were models of analytic and ethnographic clarity of an entirely orthodox kind. By the end of 2005, he mounted his first major abstentionist conference, '*Getting Clean in the North West*'. From 2005, Gilman's work in the North West of England was to nurture, mentor and fund the new wave of small, inexpensive, residential facilities that were beginning to achieve results with a range of clients, often fresh from prison, for whom conventional treatment had frequently failed. These rehabs provided housing and post-residential support often in the form of peer-led, recovery communities. There were a number of different therapies employed but most were augmenting the dominant philosophy of the 12-step fellowship. For Gilman, one of the most vocal, and persuasive advocates of methadone maintenance in the 1990s, the 12-step fellowship formed the core of his emerging abstentionist politics. His abiding hostility to anything psychotherapeutic was softened by his growing belief that residential treatment married to twelve steps philosophy could effect profound change in hardened criminals.

Mark Gilman has shown an extraordinary ability to anticipate and shape each of the key major changes in drug policy and treatment over the course of the past twenty-five years. An early leader of the multi-disciplinary, community drug teams in the mid-eighties, he had gone on to co-produce with Mike Linnell much of the radical HIV prevention literature at the end of that decade. In the early nineties his ethnographic explorations in the recreational drug scene made a decisive contribution to our understanding of drug use and dance culture. As a criminologist he shaped our views of drugs and crime and the need to effect a deep treatment penetration of problem drug populations, first at the Home Office Drug Prevention Team and then in the NTA. And here he was building a policy network around abstention, community activism and recovery. A network that radiated out from the North West and intersected with other key policy networks that were working hard to undermine the New Labour strategy.

From the political right, Kathy Gyngell from the Centre for Policy Studies had produced regular blogs attacking methadone maintenance and its presumed key architects-- Paul Hayes, CEO of the National Treatment Agency and consultant psychiatrist, Professor John Strang of the National Addiction Centre. Her critique chimed with the work of Deirdre Boyd of Addiction Today[5], particularly in their joint advocacy of residential rehabilitation. Their repeated condemnation of under-investment in residential therapies and their advocacy of abstention as the only real form of recovery contributed significantly to a growing sense of movement in people's thinking about drug treatment.

In Scotland, the iconoclastic Neil McKeganey at Glasgow's Centre for Drug Misuse Research mounted a powerful, sustained, solitary critique of methadone maintenance, developing a body of research that claimed to show that the vast majority of users of treatment services wanted, but were denied the opportunity of abstinence based therapies. McKeganey had been one of the earliest researchers to break ranks with established orthodoxy and challenge, one by one, virtually all of the shibboleths of harm reduction.

Noreen Oliver, a treatment provider in Burton on Trent became one of the most prominent leaders of the new recovery movement. Her BAC O'Connor residential rehabilitation centre in Burton-on-Trent became a showcase of an integrated treatment system able to challenge the typical imbalances of most methadone driven systems. Her links with the influential Conservative think tank, The Centre of Social Justice, made the eventual foundation of her (2009) UK Recovery Group an influential source of criticism of the prevailing status quo.

These are just some of the most prominent leaders of the emerging recovery movement that made such a powerful impact in the 30-month period from December 2005 until May 2008. Their agitational forms of networked activism provoked little in the way of organised response until 2008.

Recovery Period 2: June 2008-December 2010. A Growing Orthodoxy

The second period can be dated from June 2008 until December 2010. In this period, Recovery became, in effect, the new orthodoxy. From being owned by a small number of disconnected activists, analysts and executives it became the collective property of government and the broad drug policy and treatment field.

During 2008, there were two notable responses to the emergence of the new recovery movement. The first was Mike Ashton's paper, *The New Abstentionists,* published in January 2008. The second was the UK Drug Policy Commission's (UKDPC) *Consensus Statement on Recovery,* published in July 2008.

Mike Ashton's The New Abstentionists

In January 2008, Drugscope published Mike Ashton's *The New Abstentionists*[6]*.* Ashton is probably unique in the British Substance Abuse Treatment and Research Field. He is held in such esteem that he is regularly and wrongly claimed as one of their own by virtually every major strand of opinion within the field. Ashton's paper was a penetrating and wide-ranging discussion of recovery set within a range of concerns, not least those about the abstentionist element in much of the new recovery thinking.

Ashton's approach brings a deep knowledge of the history of our field as well as a detailed and constantly updated knowledge of research and evidence. His work for Findings and his papers such as *The New Abstentionists* show him able both to examine the strengths and weaknesses of research findings and also to illuminate historically widely held concerns about the quality, relevance and integrity of substance abuse treatment.

We know, thanks to Ashton's work, that many of the questions we are asking today aren't as a result of a profound break with are past, but are more accurately reworkings of questions and challenges that we have long faced. *The New Abstentionists* is neither pro or anti abstention as a treatment goal. Rather, it set out to question research, clarify what is meant by abstinence and situate the current debate in a longer-term search for treatment excellence. Ashton also, raised briefly the subject of recovery and abstinence in the context of shrinking financial resources. A matter that has become ever more acute since the publication of this paper.

Of course less money usually means less treatment. It may mean that treatment episodes are briefer and that the results required are to be delivered with less staff and with less resources. The hard economics of the shrinking public purse are inescapable. At the same time, therefore, it is not surprising that our new philosophies in addition to asking more of treatment services, also ask more of clients. The social contract that binds state and citizen has shifted steadily over the past thirty years. The notion of citizen entitlements has increasingly become hedged around with conditions. Conditionality is, in the context of drug treatment, the requirement that the client make a positive contribution to their own recovery. This has a positive element in so far as personalised services bring service users a much greater involvement in their treatment and care. Co-designed services are a very positive development and enable the field to break from a model that presumes a client-deficit which specialist intervention will diagnose and fill. These new asset-based forms of working are an important part of the recovery movement and are increasingly present across the health and social care fields, albeit variously described and labeled.

The UKDPC's Recovery Consensus Group

In July 2008, The UK Drug Policy Commission[7] Recovery Consensus Group produced a vision of recovery described in the following statement: "The process of recovery from problematic substance use is characterised by voluntarily-sustained control over

substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society."

The group, which had been convened in March of that year, was concerned about the increasing polarisation of the debate around recovery and was keen to begin to shape the debate in a more consensual direction. Those of us who formed the group were anxious that recovery didn't become simply equated with abstinence. Neither did we feel disposed to attempt to define recovery. The group's work focused upon recovery as a process where a key feature was "the voluntarily-sustained control over substance use". This acknowledged all kinds of recovery, not just those that were associated with 'treatment'. It also acknowledged the importance of recovery as a personally owned journey shaped and defined by the person undertaking it. For some this was too vague, a cop-out and an equivocation. Nevertheless, the group, probably for the first time in a formally constituted group setting began to explore the fraught issue of conditionality.

By maintaining that recovery involves "participation in the rights, roles and responsibilities of society", the Consensus Group was beginning to acknowledge that recovery requires more than the adoption of traditional patient status; it is something that requires its own agency and brings its own demands. The discussion that led up to this position was one of the most important in the group's overall deliberations and showed a willingness to get to grips with the changing face of welfare and the profound implications that this has had for the duties and responsibilities of citizenship in this new world of scarcity. This changing ideology and the shifts it betokens in particular areas of social intervention is of course every bit as significant as debates about methadone and abstinence.

The NTA's turn to recovery

In 2009, the NTA's slow and considered turn to recovery picked up pace. In March 2008, they had published a series of reports on ITEP called *Routes to Recovery*[8]*.* This explicit 'recovery' rebadging of the work first showcased at their 2005 conference showed a recognition that the new realities had to be recognised. More significantly, by April 2009, Paul Hayes, NTA CEO, was able to tell Guardian readers that the NTA's long-term data-tracking system was showing a much more dynamic and refined picture of recovery and the increasingly strong role that treatment was playing[9].

For the NTA the challenge has been to negotiate the wave of criticism that had condemned treatment and labeled the agency as nothing more than a tool of New Labour and, at the same time, to construct a credible policy-driven approach to the new recovery agenda that didn't throw out the baby with the bath water. Claims about drug treatment and its positive impact on acquisitive crime rates had been questioned from all sides over the course of the previous three years. Even so, the NTA remained convinced that the figures stacked up and in August 2009 published *Breaking the Link*[10] which showed positive findings from a sample cohort subject to a data matching exercise that linked the National Drug Treatment Monitoring System and the Police National Computer.

The NTA continued to field criticism. In 2010 following the election of the Coalition Government, voices from within the field made a consistent series of calls for the NTA to be abolished and replaced by an Addiction Recovery Board. These demands gave support to the idea that The Department of Work and Pensions should play a leading role in the treatment element of the national strategy. The NTA survived these calls.

In July of 2010, the NTA was able to announce the formation of the National Skills Consortium. An industry wide body set up to equip our workforce with the skills necessary to facilitate recovery in all its forms. The Coalition's Drug Strategy, *Reducing Demand, Restricting Supply and Building Recovery*[11], published in December 2010, recognised the role of the Skills Consortium in developing a skills framework which supported the recovery agenda through the production of an "Inspirational Recovery-Oriented Workforce".

In September 2010, Professor John Strang was invited by the NTA to chair a group of experts charged with reporting on Recovery-Oriented Drug Treatment. This group was asked to look in particular at how to develop dynamic treatment services where clinicians were focused on recovery from drug dependence, rather than keeping patients unnecessarily maintained in treatment. This group went on to produce a challenging interim report in July 2011[12]. With a sense of urgency unusual for publications of this kind, the report highlighted a range of things that could already be done to transform services.

At the time of writing at the beginning of 2012, the NTA is leading the national Payment by Results pilot[13] which is designed to incentivise rewards for providers meeting abstinence and other key outcomes. The NTA is also working more broadly across the treatment system to ensure more treatment episodes lead to successful drug free completions.

Conclusion

The five-year period leading up to the publication of the Coalition's Drug Strategy has been a period of tumult, discord and far-reaching change. The direction of British drug treatment policy has shifted decisively from harm reduction to recovery; recovery being the form that conditionality and the new social contract has adopted in respect of drug treatment. At times, it felt as if the field was tearing itself apart. Nevertheless, after the first period of challenge and full-frontal criticism, there was a gradually accelerating response from many of the key figures and agencies in the drugs treatment and policy field.

This short account has focused on description rather than analysis. Inevitably, much has had to be left out. One such omission is the influence of our colleagues in the United States; the role of treatment, policy and research in the United States has had a considerable bearing on recovery debates and disagreements in the UK. In particular, the early, decisive, mentoring role of U.S. recovery activist William White was of major importance. White's historical analysis, his sophisticated policy formulations and his even-handedness brought a generosity of spirit and an authority to the UK debate when it most needed it.

I have not attempted any discussion about the prospect of major disinvestment in the British drug treatment system; a prospect which has hung over the field for the past two years. Neither have I raised any of the pressing questions thrown up by the growing integration of drug and alcohol services. Key developments in the initial formation of the recovery movement, including the formation of different groups, networks and federations have also been omitted.

Despite these omissions, however, I have sought to show how, over a five-year period, a fundamental change of direction in a highly sensitive and politically charged area of British social policy has been effected. This change, as I have argued, breaks down neatly into

two sub-periods: the first a period of challenge, the second a period of consolidation and incorporation as the critique was transformed into a new orthodoxy.

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Footnotes

[1] http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010

[2] http://www.scotland.gov.uk/Publications/2008/05/22161610/0

[3] http://informahealthcare.com/doi/abs/10.3109/16066359509005552

[4] http://www.fead.org.uk/contributor.php?contributorid=3

[5] http://www.addictiontoday.org/

[6] http://www.drugscope.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=AA2E7D52-F295-4650-B24C-613D8800D336&mode=link&guid=5c5b10a6032845dba661cf025dc085c8

[7] http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf

[8] www.**nta**.nhs.uk/uploads/**itep_routes_to_recovery**_part1_120309.pdf

[9] http://www.guardian.co.uk/society/joepublic/2009/apr/29/paul-hayes-drug-users-treatment

[10] http://www.nta.nhs.uk/uploads/nta_criminaljustice_0809.pdf

[11] http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010

[12] http://www.nta.nhs.uk/uploads/rodt_an_interim_report_july_2011.pdf

[13] http://www.dh.gov.uk/health/2011/10/drugs-recovery/