The 'Road to Recovery'

Where is it coming from, where might it lead? Mike Ashton plots a course through the credit crunch, good intentions, and hitchhiking agendas.

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Inside the sun-ray striped cover of the new Scottish drug strategy (*The Road to Recovery*), three forces are joined in a potentially powerful alliance. Old-style allegiance to **abstinence** hitches a ride on the cover's shiny new vision of '**recovery**',[1] reinvigorating it as a prerequisite for an unarguably good thing: recovery from addiction.

'Recovery' also provides a benevolent rationale for an entirely non-medical imperative – to **save money** by getting patients out of treatment, off welfare benefits, back to work, and paying taxes. In the credit crunch era, Britain can no longer afford for people *not* to recover. Where a few months ago retention remained the yardstick of effective treatment, now the new aim is to get rid of the patients we can no longer afford to retain.

It's the economy, stupid!

In his foreword to the new strategy, Scottish minister for community safety Fergus Ewing joined the dots: "This commitment to recovery, to responding to the desire of people who use drugs to become drug free, lies at the heart of this strategy". Having equated abstinence with recovery, he explained where *The Road to Recovery* was meant to lead: "to increase sustainable economic growth".

Will it do this by saving lives, improving health, enhancing quality of life, making communities safer? Only, it seems, incidentally: "Reducing problem drug use will get more people back to work; revitalise some of our most deprived communities; and allow significant public investment to be redirected".

While in the report, economic advance, especially for the most deprived, is seen as a means of tackling problem drug use, when this reaches the politician's ears, means and ends are reversed, and tackling problem drug use becomes a means to economic advance.

Contrast that with Scotland's mental health services, whose vision is to "improve the mental health and well-being of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems".[2]

Though the drug strategy traces its recovery pedigree to mental health, in that sector the officially endorsed Scottish Recovery Network is clear that "Recovery ... is not about being fixed or back to normal. It is about having the chance to live a satisfying and fulfilling life, as defined by the individual, with or without symptoms."[3]

In mental health and disability, as much as the patient changing, understandings of

recovery are about *society* changing to make a fulfilling and socially included life possible for patients, even *if* they remain unwell and in treatment. As Peter Bates made explicit at the 2008 National Drug Treatment Conference, translated back to the substance misuse arena, whether drug use, the defining symptom of drug problems, remains present is not the issue.

Get off benefits, get back to work

In England the mood music is similar, though emphases and language vary. 'Recovery' has greater currency in Scotland; meaning essentially the same thing, England's slightly earlier drug policy preferred "reintegration". That quickly changed. Deploying the inspirational quality of the term, at the Drug and Alcohol Today exhibition in London on 1 May 2008, Home Office minister Vernon Coaker repeatedly referred to "recovery".

Less deeply than in Scotland, the English strategy too doffs its hat at "abstinence" as the ultimate treatment goal, but abstinence limited to "their drug – or drugs – of dependency", and in practice the English version is more concerned with overcoming dependence than altogether ceasing drug use.

But it is brutally frank about who the strategy is for and what that means for treatment and for the patients. Though personalisation is an important tactic, this is to be within the context of a service geared not to the needs and aspirations of the patients, but to those of society as refracted through politicians all too aware that the boom years fuelled by debt and house-price inflation are over. The crime-cutting agenda is still there, but now, above all, treatment is for getting patients off welfare benefits and back to work.

The change of tack was clearly signalled: "We have ... sometimes focused too much on the individual drug user and not enough on their family and the wider community". For treatment, this new direction means focusing more on getting patients "free from their dependence and being re-integrated into society, coming off benefits and getting back to work".

Consensus to the rescue

Perhaps without meaning to, the UK Drug Policy Commission, a national charity, is set to define recovery in terms which lend "consensus" legitimacy to the government's ambitions. If, as the Commission wishes it to, their statement emerges from the consensus working group to become accepted as the overarching goal for treatment, it could line the entire drug treatment sector up behind the co-opting of treatment to the government's welfare-to-work agenda.

Late in the process,[4] the Commission's definition included: "Voluntarily sustained control over problematic substance use which maximises … participation in the rights, roles and responsibilities of society". What the Commission's working group[5] hopes to achieve by this is partly to defend substitute prescribing and controlled substance use as valid pharmacological ingredients of recovery alongside abstinence, while at the same time directing attention beyond the drugs to broader lifestyle and social improvements, objectives largely shared by the government's National Treatment Agency (NTA).

As I write (11 June 2008), this special health authority is featuring the

Commission's work on recovery in its "treatment and reintegration conference", keen to see some such consensus widely accepted. But the payoffs for the NTA and the government go well beyond this.

Armed with such a definition – not self-servingly their own, but promulgated independently and accepted by the field – never again would they be defenceless against the accusation that 'their' treatment system leads only 3% of patients to recover from addiction,[6] the import of the charge levelled against them last year by the BBC, which spotted that just this proportion emerged from treatment "drug-free". Even if continuing to use illegal drugs, given this definition, England's tens of thousands of patients leaving treatment as planned or retained on methadone could still be added to the recovery tally.

Whether this will wash with public and politicians is still in the balance. It will remain hard to argue that a treatment which leaves patients still using illegal drugs has truly been 'successfully' completed.

Recovery is working – and you agree!

For the politicians and public servants, who like tidily interlocking pieces from which to construct their policies, another benefit of the UKDPC's definition is its compatibility with the drug strategy's welfare-to-work agenda.

Since it is the government above all which defines the "rights, roles and responsibilities" *of society*, such a definition would give it the whip hand in deciding what counts as successful treatment and whether patients are recovered, a privilege gifted it by the treatment field if the consensus takes hold. What our ministers will mean by that phrase is back to work and no longer burdening the state, including its health services.

The process could pave the way for building the state's welfare-to-work agenda in to the therapeutic objectives of every treatment service which aims to facilitate 'recovery'. If the pieces fall in to place, services will have to see employment and allied social outcomes, not as a means of achieving recovery, or a fortunate product of having done so, but as the essence of recovery itself, and remaining on benefits as a sign that recovery has yet to be attained.

Take a pause and shift ground slightly to tobacco or alcohol. Would we say someone who has sustainably stopped or controlled their smoking or drinking, but still hasn't found a job and is still on benefits, maybe even still offending, has failed to recover from their addiction? Probably not, yet this is what we plan to say when the ground shifts back to illegal drugs.

Driven as it may be by good intentions, the Commission's consensus process is itself a model of patient-*non*centredness. No matter how cross-cutting the consultations, the aim is to construct a formulation applicable to our 200,000 odd patients, who may have their own *individual* ideas of what for them constitutes recovery.

As grasped and interpreted by policymakers, this formulation will judge patients as falling short, even if *through no fault of their* own, job opportunities, stable housing, and resumption of parental responsibilities. have been denied or are unavailable.

Better perhaps, as in mental health the Scottish Recovery Network insisted, to leave

recovery to be "defined by the individual" – though the way would then be clear for an attempt at gaining national ascendancy in who owns 'recovery' which places abstinence at its core.[7]

The patient's responsibility

For good or ill, the objective now being built in to recovery by Scottish and English administrations could hardly be more ambitious: conjuring paid employment out of a hostile environment and faltering economy for some of our most deeply troubled and disadvantaged citizens, who have typically spent a decade or more not gaining qualifications and an attractive employment record, but a criminal record and the stigma of addiction.

Who will bear the blame if this doesn't work out? The new English drug strategy was at pains to be "clear that drug users have a *responsibility* to engage in treatment in return for the help and support available". Once engaged, "In return for benefit payments, claimants will have a *responsibility* to move successfully *through* treatment and into employment" (all italics added).

Rather than (or as well as) the services and their commissioners, patients it seems now have a duty to achieve national objectives as formulated by politicians, and those are to do with national economic retrenchment. Once again, the surprise is not so much that this is the agenda, but that it now seems OK to say these things with a frankness unimaginable within strategies for less excluded and criminalised patient groups.[8]

The society which now plans to blame addicts for failing to recover in these terms, also makes it near impossible for many to do so. Through stigmatisation, criminalisation and exclusion, we push people deeper in to addiction-shaped holes and strip away the supports (family, friends, jobs, housing, respect, self-respect) they might haul on to pull themselves out, creating the 'chronic relapsing condition' falsely located within the patient.

In mental health and disability sectors, understandings of recovery are as much about *society* changing to make a fulfilling and socially included life possible for the patients. Though these are the sectors from which the new vision of recovery claims inspiration, this perspective is largely absent in the debate on addiction treatment.

Money tight? Let's get rid of the patients!

In England, in reality (ie, as targeted and measured) the patients' key responsibility is to stop being patients. The decision has been made that we can (or no longer wish) to afford to retain them. Again, our leaders see no need to hide this, only a need to associate it with the more appealing language of 'recovery'. "Too many drug users relapse, do not complete treatment programmes, or stay in treatment for too long before re-establishing their lives," complains the English strategy.

Where this is coming from has been building up since at least 2002. According to the only public estimates which account for inflation and local funding, since then spending *per drug patient* has been falling. On top of this, there is now a standstill in the absolute level of central funding until 2011 – further per-patient cuts camouflaged as "efficiency savings".

Part of what this 'efficiency' means was spelt out by its staff to the NTA board in

2005: "Moving people *through* and *out* of treatment also improves the *efficiency* of local treatment systems enabling the system to engage with newly presenting clients without having continually to expand capacity" (italics added).

Whither maintenance?

Getting more patients more quickly out the back door of treatment, is how the NTA hopes to square the circle of getting more in the front with proportionately fewer resources. Left stranded by this U-turn is the treatment which best maintains patients as patients: maintenance prescribing.

Unsure how it now fits, at one point the English strategy demotes all drug-assisted programmes to "harm minimisation" measures which encourage drug users to *enter* treatment, then, under "New Treatment Approaches", heralds "rolling out the prescription of injectable heroin and methadone".

Ambiguity was apparent too when NTA staff interpreted the treatment bit of the strategy as "One that's equally comfortable with abstinence and maintenance routes through treatment, but ultimately always focused on maximising the individual's potential to overcome dependency, leave treatment and live a fully independent life".

Seeing *maintenance* as a route *through* to *leaving* treatment seems unduly limiting, but if circles are to be squared, this is what it must become for more patients. In the same breath, retention, recently a yardstick of success, is posed as well nigh incompatible with recovery ("a fully independent life").

Chalk is not cheese

Does any of this mean abstinence is not an important and valid objective; recovery is not a very good thing; helping people get to the point where they no longer need treatment is undesirable; that aids to employment are not essential in the mix of services for predominantly poor and unemployed patients; that employment may not prompt and embed recovery; or that many patients do not aspire to a decent wage which obviates the need for state support?

Of course not. What is questionable is the hitching together of treatment, welfare-to-work, and abstinence agendas, raising the absurd prospect (as one commentator mischievously put it) that our doctors "will have to check our wage slips and benefits status at the same time as they check our pulse"[9] to see if we truly are recovered from addiction.

By virtue of conceding ground on long-term maintenance prescribing, the NTA and the government, ultimately unable to condone continued illegal drug use as a good outcome from treatment, risk being driven towards embracing abstinence from illegal drugs and from their legal substitutes as the ultimate yardstick of success.

This new policy discourse lends itself to stigmatising the addiction treatment patient simply for still being a patient, for now being able to handle their continuing substance use, or for being unable to recover in our terms (even if we prevent them doing that), denigrating their achievements as falling short of recovery. No one has to actually want this to happen for it nevertheless to be a consequence of the shifts in ground.

Let's get real

Is recovery, as anyone might reasonably define it, really likely to be the outcome of all this ferment? If it were, then logical and evidential flaws might be forgiven. The issue boils down to a simple question: if we want more patients to exit treatment, how are we going to keep them safe? Will the supports be there to help them create a life satisfying and stable enough to avoid rapid and risky relapse?

Here's another circle to square: not only is treatment more and more squeezed, but beyond the clinic, recovery resources are likely to get scarcer as the economy falters, housing becomes even harder to find, and socially excluding stigma restricts access to such resources as there are. A society tightening its belt in the face of unemployment and major housing problems is less, not more likely, to find the generosity needed to offer welcome, shelter and employment to a constituency they have been taught to fear and at best pity, at worst, despise.

Ramping up treatment exits is seen as a way to save money, but keeping ex-patients safe will probably cost much more than keeping them in treatment. Overcoming the kinds of deficits patients have typically accumulated, and the resistance of a less than accommodating society, does not come easily or cheaply. If the money isn't these to sustain treatment, where will it come from to prevent relapse after treatment?

What will *really* change?

Despite words and policies, how far services will actually change is debatable. Services and (especially with increased local autonomy) drug action teams don't have to follow central policy leads, but the reality on the ground, shaped by the indicators through which they are held accountable, may force them to.

The sole national indicator dedicated to judging the success of the treatment system also largely determines how much national treatment funding is allocated to an area; it *matters*. Optimistically termed numbers in "effective treatment", to the existing 12-week retention yardstick has been added "planned discharge" after whatever time.

Areas can do well on this indicator by retaining patients, but without extra resources, that blocks spaces, threatening performance on waiting list and patient recruitment measures. The temptation will be to ramp up the number and rapidity of "planned discharges", and/or to discharge as soon as possible after 12 weeks, and/or to cut treatment even closer to the bone,[10] or, as has already happened, to return to inherently shorter-term treatments such as time-limited detoxification.[11] Whichever solution is chosen risks increasing relapse rates and *diminishing* effectiveness in the name of increased efficiency.

If repeated relapse rather than recovery is the outcome, at a national level, no one need know. Such failures are not just hidden from the treatment indicator, but could be recorded as successes. Only the final discharge status within a year is counted, closing the indicator's eyes to relapses within the year, and relapses and returns to treatment across years are yet another successful patient recruitment, which can once again be followed by a successful planned discharge.[12]

Another end for client-centred services?

Interviewed in 1995, the civil servant responsible for Britain's very first national

drug strategy said, "You realise this means the end of client-centred services."[13] Her prescience continues to be confirmed. What we want out of treatment has morphed from keeping out the Mafia and the Triads, penning AIDS within 'not-us' groups, saving 'us' from crime, and now contributing to 'our' economic survival strategy. In each case, the patient's needs and aspirations are subjugated.

But now there is an important difference. Where before our social objectives meant keeping people *in* treatment, the new one means getting them *out*. Unless resources and societal change are sufficient to prevent this, rather than recovery, disease, relapse, overdose due to eliminated tolerance, and further criminalisation and social deterioration, may lay at the end of this particular road to recovery.

Note: This is the manuscript of an article published by DrugScope in *Druglink* in July 2008 and available in manuscript form at http://www.lifeline.org.uk/feature.php?IDnum=56. Many of the issues raised in this article were expanded on in the fully referenced papers *The New Abstentionist*s (http://www.drugscope.org.uk/Documents/PDF/Good%20Practice/Ashton_M_30.pdf) and *A flag in the breeze* (http://www.smmgp.org.uk/html/news.php#020608). Only new and essential citations are referenced here. *A flag in the breeze* and the current document emerged from the thinking developed over a series of four debates on *The New Abstentionist*s organised by the Conference Consortium (http://www.conferenceconsortium.org) and DrugScope (http://www.drugscope.org.uk). Check their web sites for documents arising from the debates.

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[1] Today's resurgence of interest in recovery in the UK owes more to contemporary thinking in mental health and disability and social inclusion than to the 12-step tradition which has of course for decades used this term for the reconstruction of an abstinence-based life after addiction.

[2] http://www.wellscotland.info/mentalhealth/national-programme.html

[3] http://www.wellscotland.info/mentalhealth/campaigns/scottish-recovery-network.html

[4] How it will end up is unclear; several versions have been circulated. At the time of writing, this is based on the last publicly presented version seen by me on 6 June 2008 when it was presented by the UKDPC CEO Roger Howard.

[5] Personal communication from working group chair John Strang, 14 June 2008.

[6] I am grateful to David Best for this insight.

[7] An insight for which I am grateful to Marcus Roberts of DrugScope.

[8]In respect of mental health see for example: *Breaking down barriers – the clinical case for change*. Department of Health; 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074579

[9] Paolo Lewkowicz, http://davidclarkwired.blogspot.com/2008/05/on-isolation-and-recovery-excellent.html

10 Best D. "Why would anyone claim to be a 'new abstentionist'?" *Druglink*: 2007.

[11] Day E. *et al*. "The role of detoxification using methadone reduction in a drug treatment service." *Journal of Substance Use*: 2003, 8(4), p. 252–259.

[12] The relevant national indicator is in PSA Delivery Agreement 25. National indicators in PSA Delivery Agreement 16 do measure housing and employment of mental health service patients, but now only of the minority of complex and severe cases subject to a formal Care Programme Approach. The new TOP form too may make reintegration data available nationally but normally only at treatment discharge when no-one really expects major changes such as employment and rehousing to have been embedded in the patient's life.

[13]Alluded to in: Ashton, M, (1995) "English national strategy goes live." *Druglink*, 10(4), 6.