

2013

# The Reorientation towards Recovery in UK Drug Debate, Policy and Practice: Exploring Local Stakeholder Perspectives

## Emerging Drug Trends: Phase Four Report



**Professor Fiona Measham**

Durham University, UK

**Dr Karenza Moore**

Lancaster University, UK

**Zoë Welch**

Lancaster University, UK

Political dynamic .....	38
Drug service dynamics.....	40
‘Bottom up’ drivers for change .....	44
Charismatic leaders.....	45
Recovery in Principle.....	46
What is ‘recovery’? .....	46
‘But for me, I don’t drink, I don’t smoke, I don’t take any drugs’ .....	48
Recovery in Practice.....	50
The reorientation towards recovery: mutual aid provision .....	50
‘Don’t believe you, show me’ .....	54
The Lancashire recovery community .....	57
‘Job creation for people in recovery’ .....	62
Building Recovery in Communities (BRiC) workers.....	63
‘You’re defined by your addiction and you’re defined by your recovery’ .....	66
Differentiation and segmentation .....	67
Socio-economic inequalities .....	69
The Future .....	70
Outcomes .....	71
Deprofessionalisation and the rise of the Third Sector.....	72
The place of harm reduction in the future .....	74
Recovery and sustainability .....	75
Conclusions .....	78
References.....	81
Appendix One: Lancashire Adult Substance Misuse Service System 2012 .....	95
Appendix Two: Interview respondents.....	95
Appendix Three: Interview schedule .....	98
Appendix Four: Going Wild at the Zoo, 1992.....	101

# Contents

---

Acknowledgements .....	4
Introduction .....	5
Why ‘Recovery’ for Phase Four? .....	5
The Local Context .....	6
Literature Review .....	9
The Re-emergence of Recovery .....	9
25 Years of drug policy and practice in north west England .....	11
The 1980s .....	12
The 1990s .....	13
The ‘noughties’ .....	14
The 2010s .....	15
Evidence and policy-making .....	16
The Deprofessionalisation of Drugs Services? .....	17
Recovery Orientated Interventions .....	20
Recovery communities .....	20
Recovery capital .....	22
Recovery identities .....	23
Methods .....	25
The interview schedule .....	26
Sampling .....	27
Observations .....	27
Analysis .....	28
Findings and Discussion .....	30
Drivers for change .....	30
‘Bums on seats’ .....	31
‘Well, what are you going to do next?’ .....	34
Timeliness of change – the drugs gerontocracy .....	36

## **Acknowledgements**

This research is funded by Lancashire Drug and Alcohol Action Team (LDAAT). We would like to thank Tom Woodcock and Chris Lee for their invaluable support and unbounded enthusiasm for the LDAAT Emerging Drug Trends research programme over the years and Julia Palmer for her prompt and accurate transcribing. We are also hugely grateful to all those who gave up their time to be interviewed for Phase Four and those who invited us to attend or kindly welcomed our attendance at numerous relevant meetings, events and conferences around the county, the country and overseas.

\*\*\*\*\*

Front Cover:

The front cover photograph is of 'LUFstock' Lancashire User Forum summer festival 2013, reproduced with permission of the participants. Authors are in alphabetical order.

## Introduction

This Phase Four report is part of an ongoing programme of research on Emerging Drug Trends (hereafter EDT) from 2010 onwards, funded by Lancashire Drug and Alcohol Action Team (hereafter LDAAT). Phase One and Phase Three utilised *in-situ* self report surveys to capture alcohol, legal and illicit drug use across Lancashire's night time economy (hereafter NTE) (Measham et al 2011a; Measham et al 2012). Phase Two explored the contexts, meanings, motivations and consequences of alcohol, legal and illicit drug use through focus groups with a range of young adults (Moore et al 2011)<sup>1</sup>. In contrast to this focus on prevalence, patterns and motivations, Phase Four explores drug policy and service provision, concentrating on the re-emergence in recent years of 'recovery' as a (contested) guiding principle in United Kingdom drug policy, heralding significant changes to drug debate, policy and practice at national and local level (Berridge 2012; Duke 2013). After 25 years of harm reduction interventions (Stimson 2010), recovery is increasingly being placed at the core of official responses to drug and alcohol use (eg. HM Government 2010; Scottish Government 2008; ACMD 2012). This Phase Four study examines local stakeholder perspectives on and experiences of why these policy changes have come about and how an apparent reorientation towards recovery at the national level has been interpreted and implemented in policy and practice at the local level. Hence, our overarching research question asks, how is the reorientation towards recovery in national drug debate, policy and practice shaping local services (and vice versa)?

## Why 'Recovery' for Phase Four?

Alongside historical, sociological and criminological analyses of the recovery debate (see *Literature Review* below)<sup>2</sup>, there is a growing literature evaluating specific recovery-orientated interventions and their efficacy in terms of outcomes for individual and/or service user groups (Yates and Malloch 2010). This literature sits alongside more critical attempts to understand service user experiences of recovery-orientated aspects of contemporary criminal justice, health and social care systems (Neale et al 2013).

---

<sup>1</sup> The reports from Phase One, Phase Two and Phase Three can be downloaded at [www.ldaat.org](http://www.ldaat.org).

<sup>2</sup> There is considerable crossover between the literatures on recovery in the drug and alcohol field and the mental health field, in terms of discourse, policy and practice, most explicitly in relation to dual diagnosis (Bell and Roberts 2008; Davidson 2008).

Further, in recent years considerable critical attention has been paid in the UK context to the relationship between ‘evidence’ and drug policy making in the crime and public health arenas (eg. Monaghan 2008, 2011), with important implications for our understanding of how policy formation processes tend to ignore the social contexts of drug problems (Stevens 2011).

However despite this degree of academic interest in drug policy and practice, there remains surprisingly little data-driven academic research on how the national recovery debate and UK drug policy more generally shape local drugs services and vice versa, such as how, if at all, service users engage with services (Ti et al 2012) and what is understood and experienced as recovery ‘on the ground’. With this in mind we explore local stakeholder perspectives on the interpretation and implementation of contemporary UK drug policies and practices that have ‘recovery’ at their core.

## **The Local Context**

Any reorientation of drug policy takes place within a particular time and space and is likely to have both positive and negative consequences (Monaghan 2012), mediated by the political, socio-economic and cultural context to their introduction. It is crucial to note then that we conducted the Phase Four study during a prolonged global economic downturn. ‘Austerity measures’ have been introduced by many Western governments, including the UK, to reduce state borrowing, resulting in widespread and ongoing public sector budget cuts and staff losses including in the criminal justice system, health, welfare, social care and education sectors. This has resulted in social, economic and political difficulties including high rates of youth unemployment, growing inequality and community tensions.

This difficult climate is both the backdrop – and some would argue the catalyst (Duke 2013) – to emergent and significant changes in the structure and commissioning of drugs services across the UK (HM Government 2010). Drugs services in Lancashire have seen a period of ‘modernisation’ dating back to 2007/8 when a gradual process of change to the service provider commissioning process began. Lancashire is a large county in the north west of England with a population of 1.2 million of whom 90% are White British, with a mix of more sparsely populated rural areas to the north and ex-mill towns to the south, along with several towns including Lancaster, Preston, Blackburn and Burnley. LDAAT had

previously divided the area into localities matching those covered by the Primary Care Trusts (PCTs)<sup>3</sup> in east, central and north Lancashire, commissioning services in each of the three areas. From 2007/8 LDAAT began retendering services using a pioneering ‘whole system’ approach (Best 2010), integrating criminal justice, drugs and alcohol, prison, community and youth services, an approach that was later advocated in the UK coalition government drug strategy (HM Government 2010). In Lancashire this whole system approach uses a ‘prime provider’ model, commissioning a prime provider in each area to be the key point of contact with LDAAT, with subcontractors administering additional aspects of provision in turn managed by the aforementioned prime provider.

The Phase Four study was undertaken at a time when our funders were experiencing considerable professional upheaval. In April 2013 the LDAAT Delivery Unit and Joint Commissioning Groups were dissolved and responsibility for service commissioning was shifted to local authorities housed under public health in Lancashire County Council (hereafter LCC). The LDAAT Board has been retained as a strategic group and now works with organisations such as LCC and the NHS England National Commissioning Board to oversee integrated service systems across the county. These changes are captured in the outline of Lancashire’s Adult Misuse Substance Service System 2012 (See Appendix One).

It is worth noting how the historical experiences of the two largest urban regional centres in north west England – Manchester and Liverpool – shaped national and indeed international drug policy and practice (Stimson 2007), particularly given their position as the politicised hubs of the harm reduction ‘movement’ from the 1980s onwards. Lancashire – without the significant urban centres of drug use and associated legacy of drug user radicalism of Manchester and Liverpool – had greater room to manoeuvre in terms of service redesign. A focus on Lancashire and its early implementation of a recovery oriented system provides a point of comparison to the metropolitan north west. In retendering services across the county, it has gradually moved away from the tiered commissioning structure outlined in *Models of Care* (NTA 2002) to focus on a recovery oriented whole-system approach whereby recovery is embedded in all aspects of the treatment system as recommended in the coalition government drug strategy (HM Government 2010).

Having outlined the Phase Four study in this *Introduction* and highlighted the timeliness of our research, we now turn to our *Literature Review* of academic, policy and practitioner studies relevant to drug and

---

<sup>3</sup> Clinical Commissioning Groups (hereafter CCGs) replaced PCTs in April 2013. They are now responsible for commissioning clinical services, with local authorities providing guidance to CCGs on commissioning public health services including smoking cessation, sexual health and drugs services (NHS 2012).

alcohol-related recovery. We then present the *Methods* used to access the perspectives and experiences of local stakeholders before moving on to the *Findings and Discussion* and finally *Conclusions*.



## Literature Review

In this chapter we offer a broad review of relevant academic, policy and practitioner literature on recovery in the drug and alcohol field. Given the considerable literature on recovery in the UK, not to mention longstanding work in this area from US academics and recovery campaigners, we concentrate on literature which (a) analyses the context and drivers of recent changes in UK drug debate, practice and policy; (b) best relates to our overarching Phase Four research question regarding interactions between policy and practice changes at local and national level; and (c) illuminates the themes identified in the stakeholder interviews, notably the place of harm reduction in the ‘recovery age’ (Measham and Moore 2013).

### The Re-emergence of Recovery

After 25 years of harm reduction interventions (Stimson 2010) and in the context of a perceived ‘criminalisation’ of UK drug policy (Seddon et al 2008, 2012) and the enduring role of medical and public health responses (Shiner 2013), recovery is increasingly being placed at the core of official responses to drug and alcohol use (HM Government 2010; Scottish Government 2008). Some have argued that this ‘recovery revolution’ (White 2007) – with abstinence at its core – is a direct challenge to harm reductionism (McKeganey 2012). Bolstered by a well-publicised report by the right wing think tank the Centre for Social Justice in 2007, the ‘new abstentionists’ (Ashton 2008), who support abstinence as the over-arching goal of recovery, have attracted considerable attention in political and media debate about UK drug policy. However whilst abstinence continues to feature explicitly in US-based organisations’ definitions of recovery and appeared as the core treatment goal in aforementioned early UK policy directives (Home Office 2008; Scottish Government 2008), following the launch of the coalition government drug strategy (HM Government 2010), abstinence has been somewhat underplayed in more recent UK definitions (ACMD 2012)<sup>4</sup>.

It has been suggested that what we are witnessing is a *re*-emergence of recovery in the UK drug and alcohol field rather than an emergence. Berridge (2012) notes for example that recovery has a long

---

<sup>4</sup> Although see Home Office (2012).

history in relation to drug and alcohol ‘addiction’, with its dominance as a model of understanding varying in accordance with shifts in political, socio-economic and cultural fortunes, as apparent in the divergent history of recovery in the US and the UK. Further, recovery from drug and alcohol use and dependence has long been the focus of voluntary action and mutual aid/peer support debates and practices (Mold and Berridge 2010), worth remembering in the current climate of upheaval and change in UK drugs services. (Mutual aid is discussed further below.)

What is meant by recovery continues to be widely debated. White, a key writer on recovery in the alcohol and drug field, has consistently argued that the addiction field’s “failure to achieve consensus on a definition...undermines clinical research, compromises clinical research and muddles the field’s communications to service constituents, allied service professionals, the public and policy makers” (2007:229). In a widely cited paper exploring the definition of ‘addiction recovery’, White highlights how *sustained abstinence* is central to many clinicians’ and recovery advocacy groups’ understandings of recovery particularly in the US (White 2007). In the US literature, the lack of a solid definition of recovery is often framed as inherently problematic for those working with dependent drug users, in terms of diagnostics, designing services, working with clients and measuring ‘success’. In the UK policy arena, the notion of ‘full recovery’ (Home Office 2012) emerges as being particularly confusing and contentious (Daddow 2012). Hence recourse to the apparent solidity of (sustained) abstinence as a (relatively) simple measurable outcome of engagement with drug treatment is perhaps understandable but damaging and potentially unworkable to (some) service users (see *Findings and Discussion*).

Further this opens up a definitional ‘can of worms’ in relation to what we might actually mean by abstinence, such as whether an individual is required to desist from *all* use of *all* psychoactive drugs or only from their primary (problem) drug, what time frame of abstinence is required eg. “complete and enduring” and crucially whether “sustained deceleration of the frequency and intensity of AOD use” (White 2007:232) counts as recovery.<sup>5</sup> For others recovery is an inherently fluid concept referring to qualitative outcomes such as an individual’s (re)integration into society (Roberts 2009). The ACMD Recovery Committee, in exploring key definitions of recovery, acknowledged the difficulty of defining (and achieving) recovery and concluded that recovery can best be conceptualised as a process which involves overcoming drug and/or alcohol dependence as well as improving social integration (eg. through employment) and better health and wellbeing (ACMD 2012). However, unlike the focus on the (long term) process typical of many recovery definitions, White argues that ‘addiction recovery’ may also

---

<sup>5</sup> Alcohol and Other Drug (AOD) problems.

be time limited in that it is the product of a “sudden event that is unplanned, positive and permanent” involving “profound religious, spiritual, or secular experiences that radically redefine interpersonal relationships and suddenly and completely alter one’s prior patterns of AOD use” (White 2007:234).

Securing a dominant definition can have very tangible consequences (Hacking 1999), with what recovery is understood to *be* in turn shaping which interventions are deemed appropriate and crucially effective. Clearly different stakeholders hold inequitable power in terms of defining and addressing drug problems, with the voices of people who use drugs (hereafter PWUDs) often ignored. As Ti et al (2012) note “PWUD face many challenges that restrict their ability to engage with public health professionals and policy makers, including the high levels of stigma and discrimination that persist among this population” (2012:7). As expanded on below, the prioritisation of certain forms of ‘efficacy evidence’ (sometimes driven by ideological positions and power relations) implies the marginalisation of other forms of evidence such as experiential accounts of those subject to interventions.

Further, even longstanding empirical evidence of reduced harm from interventions may not be enough to secure the acceptance amongst policy makers needed to elicit funding. In the drugs field harm reduction advocates continue to raise concerns over policy makers’ apparent lack of understanding regarding the efficacy of substitute prescribing, the achievability of abstinence and the increased risk of overdose associated with abstinence based programmes, as seen for example in Sweden (Druid et al 2007; Martin 2005; Roberts 2009). However the recognition (by some) of the role of prescribing in recovery has progressed debate in the UK from polarised standpoints towards the co-development of a more integrated approach to drug use and dependence via for example recovery oriented treatment systems (McLellan and White 2012).

## **25 Years of drug policy and practice in north west England**

Having explored debates in the field surrounding definitions of recovery and related concepts, the following section of the literature review seeks to review work on the specifics of north west England’s experience of and responses to drug use and dependence alongside its relationship with national drug policy in light of the reorientation towards recovery in the UK.

### *The 1980s*

Harm reduction recognises that individuals are not necessarily ready, willing or able to stop using drugs and that there should be a commitment, not least on public health grounds, to minimising the harm caused to individuals and society from drug use (Riley and O'Hare 2000). Since the late 1980s, initially in response to concerns about the spread of HIV/AIDS through the sharing of needles by injecting drug users (hereafter IDUs), a consensus (albeit tentative) developed amongst UK politicians, policy makers and practitioners in favour of a harm reduction approach (Berridge 1994; Wardle 2012). One of the many catalysts for this was a "highly significant and influential document" (Yates 2002) by the Advisory Council on the Misuse of Drugs (hereafter ACMD) published in 1988 whose recommendations were accepted by the Conservative government at the time. The recommendations in part rested on the findings of a harm reduction pilot in Merseyside in north west England (Stimson 1988; O'Hare 1992). As argued by Yates (2002), this reorientation towards harm reduction did not necessarily represent a seismic shift in UK drug policy but rather could be seen as a continuation of the twentieth century UK tradition of low threshold opiate maintenance prescribing as an accepted element of drug treatment which could be traced back to the 'British system' initiated by the Rolleston Report of 1926 (see also Strang and Gossop 2005).

Significantly for the Phase Four study (see *Findings and Discussion*), this influential ACMD report positioned harm reduction as working alongside abstinence in drug treatment, stating that whilst "HIV is a greater threat to public and individual health than drug misuse" and that the first goal of drug workers should be to prevent acquisition and transmission of the HIV virus, "abstinence remains the ultimate goal" (ACMD 1988). However, the consensus on harm reduction at the time obscured the tensions inherent in the formulation of national drug policy and its translation and implementation by local drug treatment services, along with public perceptions of the 'drug problem', political desirability and professional acceptance (Raistrick et al 1994), tensions that are still apparent in the contemporary context (Lenton and Allsop 2010).

The origins of the harm reduction movement can be traced to north west England and specifically the pilot project carried out in Merseyside in the mid-1980s. This was because the early 1980s had seen a massive increase in the use of heroin in northern cities, including Liverpool and Manchester, which led to concern over the spread of HIV among injectors, alongside issues such as poor health and social exclusion (Ashton and Seymour 2010). The pilot project was a population based public health strategy aimed at the whole population of IDUs, not just those seeking support to stop using. It worked on the

principle that if clean injecting equipment was provided to a sufficiently large proportion of the population, there would be a decrease in the spread of HIV. The evidence suggests that reaching thirty percent of injectors can be enough to prevent an HIV epidemic (NTA and Exchange Supplies 2008). In addition to the public health motivation, the Merseyside pilot offered maintenance prescribing through the Drug Dependency Unit in Liverpool. In the late 1980s, a third of all methadone prescribed in the UK was prescribed in Merseyside (Ashton and Seymour 2010). Complementing the Merseyside harm reduction pilot was the production of pioneering health education materials aimed at drug users by Lifeline Project based in Manchester. These materials, initially for HIV prevention amongst IDUs, became the accepted standard for advising drug users on minimising harm<sup>6</sup>.

A government funded evaluation deemed the Merseyside pilot a success (Stimson 1988). The evaluation not only found a decrease in the use of street drugs and in the incidence of sharing injecting equipment, but also found that acquisitive crime, a major issue at the time, had significantly reduced in Liverpool.

### *The 1990s*

By the mid-1990s the public health and educational aspects of harm reduction were well established and seemingly secure. The mid 1990s saw a shift from reducing harms in relation to the health of drug users to using harm reduction strategies to reduce societal harm (Wardle 2012). In 1995 Drug Action Teams (hereafter DATs) were created as dedicated commissioning bodies for drugs services. Alongside exploration of the causal links between drugs and crime, a 1996 Home Office evaluation concluded that widespread methadone prescribing had the potential to reduce rates of acquisitive crime such as burglary, theft, fraud and shoplifting, with crime reduction in Liverpool at the time directly attributed to methadone prescribing (Parker and Kirkby 1996). Following this evaluation the ACMD advised that what became known as the Mersey Model of Harm Reduction be rolled out nationwide (Ashton and Seymour 2010).) Thus the perceived causal link between drug dependence and acquisitive crime became received wisdom and was a central element of the Labour government's 10 year drug strategy (1998 to 2008) *Tackling Drugs to Build a Better Britain* (Cabinet Office 1998) which explicitly aimed to "increase

---

<sup>6</sup> In 1987, Lifeline, funded by the North West Regional Health Authority, produced an adult comic book called *Smack in the Eye*. As an antidote to 'dry' health education warnings which lacked resonance for drug users, *Smack in the Eye* aimed to educate users about safer injecting, safer sex practices and safer drug use in general, through the use of humour and clear harm reduction messaging. The success of *Smack in the Eye* launched a raft of further harm reduction publications and the advice given was taken up by agencies nationwide.

participation of problem drug misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime” (Cabinet Office 1998; Seddon 2000). An expansion of drugs services within the criminal justice system followed, with efforts made to move drug using offenders into treatment at every stage from arrest through to sentence (NTA 2009). This was not without controversy. As Hodgson et al (2006) note the focus on links between drugs and crime led to increased funding for drug treatment justified largely by its potential for crime reduction rather than its health benefits or a holistic concern for the wellbeing of PWUDs. Later research questioned the received wisdom underpinning criminal justice-focused drug policy, identifying a lack of empirical evidence for a linear cause and effect link between drugs and acquisitive crime and arguing that policy should consider other, broader factors associated with offending, drug dependence and social exclusion (Seddon 2000, 2006; Stevens 2011).

Harm reduction models were given further impetus in the early 1990s, again in north west England, following the expansion of formerly ‘underground’ and unlicensed acid house and rave dance parties and the apparent ‘normalisation’ of recreational drug use amongst young people (Measham et al 1994; Parker et al 1998). In response to this, the principles of harm reduction were adapted to provide, at the time, radical ‘safer dancing’ information specifically targeted at young recreational drug users (Newcombe 1994; Smith et al 2009). This application of harm reduction to recreational drug use then spread out from north west England across the UK and overseas.

### *The ‘noughties’*

In 2001 the National Treatment Agency for Substance Misuse (hereafter NTA) was established as a Special Health Authority within the NHS. The NTA was charged with improving accessibility of services, building workforce capacity, monitoring the effectiveness of drugs services across England and – in line with the available evidence – producing and disseminating best practice guidance (NTA 2009, 2013). The NTA marked a more active approach by the UK government regarding the development and monitoring of drug treatment services. In 2002 the NTA produced a commissioning framework for all DATs laid out in the *Models of Care for the Treatment of Adult Drug Misusers* (known as Models of Care) (NTA 2002). Models of Care delineated commissioning according to four tiers of service provision from open access, low threshold services through to intensive specialist services with the aim of producing a minimum standard of provision in a given locality. In 2004 the National Drug Treatment Monitoring System

(hereafter NDTMS) was established to gather performance monitoring data from treatment services. Data was gathered on key performance indicators including access to treatment, reduction in waiting times, retention in treatment for twelve weeks and ‘successful’ completions (NTA 2006). It is important to note that in the Treatment Effectiveness Strategy 2004-5 there had been greater emphasis on care planning and increasing successful completions but the targets for discharge were unconnected to key performance indicators and so tended to be low priority at the point of strategy implementation. The main emphasis hence came to be on access to and retention in treatment. Furthermore as previously outlined, criminal justice interventions were increasingly prioritised given the enduring focus on the link between drugs, offending and crime reduction (Seddon 2010; Seddon et al 2012). Given these factors it is perhaps unsurprising that by 2005 almost half of the annual UK drug treatment budget was used to fund initiatives and interventions designed to prescribe methadone, in order to reduce or end users’ reliance on illicit drugs (Wardle 2013). As investment in such interventions increased, so their efficacy began to be more widely questioned (Album 2010; Roberts 2009).

### *The 2010s*

Although media, political and public debate around official responses to drug use and dependence in the UK intensified in 2007/8, there had been growing recognition by those working in the drug and alcohol field (particularly amongst those ‘at the sharp end’) of the need to explore alternative drug interventions, evident from as early as 2005 (Wardle 2012) (see above). This recognition in part led to an NTA pilot of ‘recovery oriented’ approaches to drug treatment (NTA 2008). Manchester and Birmingham were at the forefront of piloting recovery oriented provision from 2005-2008 through the Recovery Oriented Integrated System (hereafter ROIS). In terms of NDTMS performance measures, north west England was ahead of NTA targets for access, waiting times and twelve week retention in treatment. Supported by the then NTA regional manager, the recovery pilot known as the International Treatment Effectiveness Project (hereafter ITEP) involved collaboration between the NTA and the Texas Institute of Behavioural Research (NTA 2007a). It was piloted across 24 sites in Greater Manchester, using evaluated psychosocial intervention tools to attempt to improve provision and service effectiveness (NTA 2008). From 2008, following the ITEP pilot and further exploration of US drug treatment, there was a clear shift in focus within the NTA signalled by the publication of *Routes to Recovery* (NTA 2008a). *Routes to Recovery* was endorsed by the Conservative party, with recovery becoming a central theme of the 2010 coalition government drug strategy ‘*Reducing Demand, Restricting Supply, Building Recovery*’ (HM

Government 2010) with recovery becoming the “new national orthodoxy” in UK drug policy (Wardle 2013).

### *Evidence and policy-making*

As the ACMD Recovery Committee report (2012) notes, definitions of recovery are varied and contentious and overcoming dependence is a complex, personal and nonlinear process, which renders the scientific measurement of recovery outcomes problematic and triggers debate around what counts as ‘evidence’. The Cochrane Collaboration has established a standardised system to appraise evidence in the field of medicine (Pawson 2006) but its exclusive stress on objective scientific methods and notably Randomised Controlled Trials (RCTs) – termed ‘strong research evidence’ by ACMD (2012) – and the lack of nuanced understanding of alternative research paradigms risks excluding potentially more appropriate methodologies for assessing interventions, such as explorations of user experiences through qualitative social research methods (Amann 2000; Best et al 2012). In relation to recovery, ACMD acknowledges the need to consider factors not considered in the Cochrane reviews including contextual features of treatment programmes and expert accounts from ‘lived experience’, whilst highlighting that further research is required to explore what the available evidence can and cannot convey (ACMD 2013).

Stevens (2011) explores the production of UK drug policy, demonstrating how ‘evidence’ is but one element in the forming of a ‘climate of opinion’ in which policy makers act. Further, he argues that sometimes disparate and conflicting elements are used to construct seemingly coherent policy narratives which enable certain interventions to be presented as rational and indeed desirable to the exclusion of alternatives (Stevens 2011). The vagaries of the production of rational policy narratives can be illustrated by the contemporary debate regarding the provision of foil to encourage a shift in route of transmission from injecting to smoking drugs such as heroin and crack cocaine. Foil is understood to be a harm reduction measure because the harms from smoking are significantly lower than the harms from injecting (Pizzey and Hunt 2008). ACMD recommended that foil should be exempt from Section 9A of the Misuse of Drugs Act 1971 which criminalises the supply of drug taking paraphernalia (ACMD 2010). This recommendation – in the form of a letter to the Home Secretary in 2009, a full report reviewing the evidence (ACMD 2010), further advice in response to Department of Health queries (ACMD 2011) and further advice in response to Home Office queries (ACMD 2013) – finally received government approval in summer 2013. However in the exchanges between government ministers and ACMD on the issue of



foil, the Home Secretary rationalised a reorientation towards abstinence-based recovery – and away from harm reduction – by claiming that the government “aims to help addicts to achieve recovery free from dependence” and requesting that ACMD advise her regarding “what evidence there is that provision of foil would *get people off drugs*” (Home Office 2012, our emphasis).

From this it would seem that contemporary ministerial debate and preferred policy options foreground recovery to the detriment of pragmatic harm reduction interventions and deploy a diminished version of recovery that undermines a broader concern for the health and wellbeing of drug users. The advocacy of recovery in recent years in national drug policy seems to threaten the consensus on harm reduction, with funding for harm reduction focused organisations being cut (for example, the International Harm Reduction Association). The extent to which recovery is compatible with harm reduction in practice at the local level is explored in the *Findings and Discussion* chapter. We now outline another issue raised in the UK literature on the re-emergence of recovery and the reorientation of UK drugs services in recent years.

### The Deprofessionalisation of Drugs Services?

The re-emergence of and reorientation towards recovery has wrought a change in the role of both volunteer and paid peer mentors and ‘recovery champions’ within treatment services (NTA 2010)<sup>7</sup>. Central to any recovery oriented system is the use of community based, peer led support for drug users (Best et al 2010). These roles provide ex-service users with an opportunity to ‘give something back’, using their knowledge and experience to support others in their recovery, assisting service users to engage in all aspects of treatment (NTA 2010) and offering inspiring, visible examples of recovery (Strang et al 2010). Such roles can potentially challenge the existing paid workforce (Best et al 2010). Furthermore, cuts in government public sector spending have resulted in a reduction in paid, skilled staff and an increase in lower paid and volunteer workers alongside significant cuts in funding to organisations that support low paid workers (e.g. closure of the Greater Manchester Low Pay Unit, part of the Greater Manchester Pay and Employment Rights Advice Service). In a climate of budget cuts and job insecurities it is easy to see why the rise of a (formally) unskilled or inappropriately skilled low paid or unpaid workforce might be a source of anxiety to service staff. Furthermore, concern has been expressed over the suitability of some roles for service users recently exiting treatment. On one hand the

---

<sup>7</sup> ‘Recovery Champions’ are discussed in more detail in the final section of this *Literature Review*.

benefits of harnessing the enthusiasm of those recently 'clean' or 'in recovery' to motivate others can be positive, but the pressure of these roles could also have a negative impact on an individual's own recovery (Shapiro 2012).

Wardle (2013) outlines the evolution of the workforce in line with the development of drug treatment over the past fifteen years. He identifies several discrete stages of development since the creation of the NTA in 2001, arguing that rather than a paradigm shift from harm reduction to recovery, developments should be viewed as incremental steps. The stages he identifies are firstly, the expansion and training of a previously under skilled workforce to meet the rapid expansion of harm reduction focused drugs services and deliver clinically driven, one-to-one casework. Secondly, there was the training and development of the workforce to meet the NTA's increasing demand for effectiveness targets, along with the delivery of psychosocial interventions in line with the evolving evidence base (NICE 2007). Thirdly came the current phase of a recovery oriented workforce utilising community assets and peer support, in which workers 'evolved' from one-to-one focused key workers to recovery workers and recovery coordinators.

Linked to the themes of spontaneous recovery and the importance of contextual factors in recovery outcomes, Best et al's (2010) review of the evidence base for recovery challenges orthodox working methods. They suggest that professionals should be aware of the limits to their role in an individual's recovery journey and highlight that orthodox practices, including maintenance prescribing, may act as a barrier to recovery. They argue that there is a need for deprofessionalisation in the drug and alcohol field and highlight the significant roles peer and community support have the potential to play in the 'recovery age'.

The deprofessionalisation of public sector roles is not a new phenomenon but one central to Conservative thinking and neoliberal welfare reform (Cloke et al 2007). For example Hallett (1983) in her review of the 1982 Barclay Report on social workers details how in the early 1980s there were government concerns about the cost of public sector departments, including social work, and that it was argued by ministers and others that the role of social workers could be fulfilled by volunteers and informal caring networks. In the event the Barclay Committee clearly stated in their report that the voluntary sector could not and should not replace the specialist roles that statutory services undertook, despite the government's hope that it would provide authoritative support for cuts in social work services (Hallett 1983).

There has been an expansion of the voluntary sector in public services more broadly over the last 20 years (Clope et al 2006), alongside the rapid growth in low paid, less well qualified roles and the increased use of volunteers across public services for example, teaching assistants in schools (Bach et al 2006). In addition to these ‘assistants’ is an expanding unpaid workforce of volunteers, central to the Conservative vision of the ‘Big Society’, whereby the general public is encouraged to participate in local communities through volunteering activities (Cabinet Office 2011). This has been greeted with public suspicion that the use of volunteers is merely a means of cutting costs (RSA 2012). During the coalition government’s time in office, there have been widespread reductions in professional staffing levels and increased workloads across public services in order to manage budget reductions, with a significant increase in the low paid and volunteer workforce (Bach 2012).

Particularly relevant to the drugs field is the question of whether deprofessionalisation provides opportunities to those for whom professional training might not have been an option, as is the case for some problem drug users (hereafter PDUs), or whether it devalues professional roles and undermines the skills required to support drug users. In addition, concerns have been raised within health and social care services over unqualified staff working with vulnerable people. These concerns were given greater weight with the findings from the inquiry into patient care provided by mid Staffordshire NHS Foundation Trust from 2005-2009, which found that a high proportion of unqualified staff had been culpable in the poor overall care of patients (House of Commons 2010).

On the other hand, there is evidence to support the use of unqualified staff within social care services, particularly those with ‘lived experience’ of the problems they are working with. For ex-drug users, their experience potentially plays a crucial role in the relationship they might build with a service user. This experience is part of their individual recovery capital (Best and Laudet 2010) and with adequate support and training it could play a valuable role in an individual’s recovery. The idea of ‘giving something back’, using the experience of addiction to support others, is central to the philosophy of 12-Step. Indeed the so-called ‘paraprofessional’ has been central to the recovery movement in the United States (White 2000b) and has been present in alcohol and mental health services in the UK for decades.

## **Recovery Orientated Interventions**

Having presented literature which outlines key debates around ‘recovery’ in the drugs field and the chronology of national and local responses to drug use and dependence in the context of the recent reorientation towards recovery in UK drug debate, policy and practice, we now examine literature on key features of recovery orientated interventions.

### ***Recovery communities***

In the past five years in the UK, one of the principal features of the reorientation towards recovery has been the integration of the recovery community - notably self help and mutual aid<sup>8</sup> - into existing treatment services. Such integration is central to ROIS, as developed by George de Leon from his numerous studies of Therapeutic Communities (De Leon 2010) and embraced by the NTA (Best et al 2010; Gilman and Yates 2010). The NTA argue that ROIS place greater emphasis on treatment and aftercare (Gilman and Yates 2010) than previous systems which were overly concerned with retention in treatment (NTA 2007b). Following a pilot in Manchester and Birmingham, ROIS was gradually implemented in Lancashire from 2008/9 utilising existing community based support including mutual aid, with the aim of integrating ROIS into existing treatment provision to ensure access to all necessary elements for a successful recovery ‘journey’ (Strang et al 2010).

It should be noted that self help and mutual aid networks supporting recovery are not a new phenomenon (Mold and Berridge 2010). There is evidence of peer support networks for addiction in the UK as early as the 1890s (Berridge 2012). 12-Step Fellowships such as Alcoholics Anonymous and Narcotics Anonymous have been active in the UK for over seventy years (Yates and Malloch 2010). However they have tended to run in parallel with more ‘mainstream’ treatment services rather than be fully or even partially integrated with them. Peer led support has been associated with aftercare services within the mainstream treatment system but these have not necessarily been formalised, widespread or framed as mutual aid (Home Office 2005). Traditionally there was a greater degree of uptake and engagement with mutual aid from alcohol clients, often attributed to the lack of substitute prescribing for drinkers (NICE 2011).

---

<sup>8</sup> Mutual aid usually refers to spiritually based 12-Step Fellowships such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous and what is often considered to be their ‘secular alternative’ namely SMART Recovery (Self Management and Recovery Training).

The use of the recovery community can be challenging for mainstream treatment providers for a number of reasons. There can be a mistrust of the perceived ‘cultish’ doctrinaire and religious basis of the 12-Step model (Denzin 1987) which is seemingly at odds with a medically assisted and person centred approach to treatment (Raistrick et al 2006). Other criticisms are based on the lack of evidence of the effectiveness of mutual aid as discussed in more detail below. Studies to support the effectiveness of mutual aid in terms of positive long term outcomes have been criticised in the past for lacking scope and the necessary methodological rigour (Best et al 2010). However in recent years better executed studies have identified positive long term personal and social benefits for those who engage with mutual aid (Best et al 2010). Findings indicate that, as with other forms of intervention, the effectiveness of mutual aid is strongly dependent on timing, frequency and length of engagement, as well as individual tailoring of suitable treatment packages to potential clients (ACMD 2012). For those accessing mutual aid alongside other interventions, the degree of engagement and reported benefits are directly influenced by the attitudes towards mutual aid of their key worker (Best et al 2010), highlighting a need for a shared belief in and commitment to the benefits of mutual aid across the service system.

The reorientation towards recovery has seen a rise in prominence of recovery communities in various secular, religious and spiritual forms (White 2009). The language of recovery in these communities tends to be synonymous with that of the 12-Step movement most often associated with the US (Denzin 1987). The use of such recovery ‘talk’ and the increasing inclusion of US style 12-Step movement debates in UK drug policy and practice has presented both ideological and practical challenges to some UK drug and alcohol service providers and some long term service users (Wardle 2012). In part these challenges relate to the exclusion of certain current and potential service user groups from recovery communities and indeed the meaninglessness of recovery talk and recovery services for some drug users. As ACMD notes, recovery goals and outcomes are likely to restrict the available options for non-dependent and ‘recreational’ users (ACMD 2012), groups about which some drugs services remain concerned (eg. LDAAT’s work with young adults in the night-time economy; Measham et al 2010, 2012). The challenges of designing recovery orientated services for a range of drug and alcohol users are explored in more detail in the *Findings and Discussion*.

### **Recovery capital**

A recovery oriented approach seeks to build what has been termed ‘recovery capital’ (Roch and Best 2013). In the context of drug treatment, recovery capital is taken to mean those resources (already) available to the user which might be harnessed to support that individual’s personalised treatment journey (Best and Laudet 2010; Granfield and Cloud 2001; Groshkova et al 2013). Cloud and Granfield (2009) break down recovery capital into four component parts: social capital (personal relationships and support and obligations to social life); physical capital (financial resources that could increase recovery options); human capital (personal resources such as education and skills, but also aspirations and hope); and cultural capital (personal beliefs and principles that inform behaviour in social life).

Recovery capital has been found to be a key factor in ‘natural’ recovery, that is stopping using drugs without any formal intervention. Studies have found that those with low levels of dependency, short using careers and high recovery capital are more likely to recovery ‘naturally’ or spontaneously; conversely, those who are heavily dependent with low recovery capital are more likely to benefit from assistance from support services (ACMD 2012). Some researchers (eg. Carnwath and Smith 2002) have concluded that heroin users are more likely to achieve long term abstinence spontaneously, because of fundamental changes in self perception or social circumstances, than as a result of any form of social or psychological treatment. Again these changes are linked to aspects of recovery capital, with Best et al’s (2010) review of the effectiveness evidence suggesting that medical and quasi medical interventions can prolong a using career, unlike interventions which mobilise social support and build recovery capital. The concept of recovery capital has been adopted by the government and become widely accepted within the field (ACMD 2012).

Central to the recovery approach is the aim of providing treatment based on users’ strengths rather than their deficits or difficulties, with an emphasis on mobilising community resources and harnessing individual skills through asset based assessments (Best et al 2010; Foot and Hopkins 2010). The government report *Fair Society, Healthy Lives – The Marmot Review* (2010) outlined ways to address growing health inequalities in England. One of the key recommendations of the review was encouragement of individual participation and utilisation of community resources (or ‘capital’) to facilitate local decision making and more effective local service delivery (Foot and Hopkins 2010). Central to this approach is Asset Based Community Development, a concept developed in the US, which identifies, utilises and builds on existing assets within communities to achieve a variety of collective and

sustainable goals such as neighbourhood regeneration (Kretzmann and McKnight 1993). The mobilisation and utilisation of community assets in service delivery feeds into the coalition government's localism agenda, with the concept of asset based approaches to service delivery gaining popularity in the public sector, including in health and wellbeing services.

This development is not without its critics. The government's localism agenda supports the notion of accessing and building recovery capital amongst some of the most disadvantaged groups in society who have limited access to financial support and who are likely to face daily discrimination and stigma (Lloyd 2010, 2013). Recovery capital has been criticised by academics for feeding in to the broader agenda of 'responsibilisation' of individuals by the public, private and third sectors whereby the responsibility for the health and wellbeing of citizen-consumers shifts on to the individual and the 'community' in order to disabuse the public, private and third sectors of the burden of caring for and supporting those typically at the margins of society (eg. PDUs). This demonstrates the way in which apparently benevolent drug policy change may have a stigmatising and debilitating effect on some of the most vulnerable people in our society (Stevens 2011).

### ***Recovery identities***

A recurrent theme in current understandings of mutual aid – where one's self identity is a project to be worked on – is the extent of personal identification with the status of being 'in recovery' or having 'recovered'. White and Kurtz (2006) write somewhat simplistically of either/or identities, that is 'recovery positive' and 'recovery negative' identities. They argue that 12-Step interventions require members to have a 'recovery positive' identity that openly acknowledges their lifelong status as being 'in recovery' (White and Kurtz 2006), whilst a 'recovery negative' identity involves the private acknowledgement of recovery status, which as a result of a sense of shame is not shared with others. Problematically, a 'positive identity' relies on the continued identification with a problematic experience and may prevent the individual from moving beyond their difficult past (Koski-Jännes 2002). This may lead to the adoption of the identity of 'saved sinner' or for those who become involved in providing support to other users, that of 'wounded healer' (White 2000a). In either case the individual defines their 'essential' self by their 'addiction', preventing the potential development of more positive identities and greater (re)integration into society, if that is assumed to be the goal of the recovery process (for a critique of this see Fraser and valentine 2008). Yet the principles and practices of mutual aid and peer

support depend on the activism of recovery community members (essentially ex-service users) who continue to self-define via their (previous) 'illness status' and recovery experiences, boosting their credentials as 'healers'. Such a self-identity risks putting individuals into difficult positions of responsibility either too quickly or at a level beyond their skill set (Shapiro 2012). White (2000b) likens this phenomenon to the mythological curse of Icarus and urges recovery communities to guard against this curse through adequate support systems, the rotation of leaders and careful succession planning (White 2000b).

Here we can see some of the more controversial aspects of the recovery revolution in the US and more recently in the UK, whereby much debate around drug use and dependence rests on the notion of achievement and its inevitable corollary, failure. We see this achievement/failure binary playing out in recent debates concerning dependent drug users. Recovery is located largely in the will of the individual, albeit supported by his or her recovery community; this makes sense given the residues of moralism in official responses to drug and alcohol use (such as the 'drink responsibly' public health campaigns advocating individual responsibility in alcohol consumption). The individualisation of recovery from drug and alcohol dependence links with the aforementioned critique of the responsibilisation of the individual citizen-consumer and the obscuring of structural factors that limit the choices available to some (Stevens 2011).

Critics of the US recovery revolution and the UK reorientation towards recovery highlight the continuity of 19<sup>th</sup> century moralising involving predominantly middle class concerns with the control and containment of the dangerous classes (the poor, the diseased, youth). When those at the bottom of the social strata consume psychoactive substances to excess in ways that are deemed socially unacceptable, they are stigmatised and 'othered' (Lloyd 2010, 2013). The 'othering' of these "revolting subjects" (Tyler 2013) is encouraged by politicians and many UK media outlets who recount stories of 'junkies' and 'benefit scroungers' existing in 'broken communities' (Tyler 2013), that is those who do not conform to the citizen-consumer ideal-type identity required in today's consumer capitalist society (Young 2007). As Manning (2007) notes in relation to the disproportionate press coverage of ecstasy related deaths compared to more widespread volatile substance abuse deaths in the 1990s, drugs and PWUDs tend to be framed in the media and in policy terms according to the class and social grouping of users (see also Moore and Measham 2012). Being sensitive to such processes is crucial when considering the production, interpretation and implementation of national and local drug policy and practice.



## **Methods**

As outlined above, the re-emergence of recovery as a contested guiding principle in the nation's responses to drug use and dependence (Berridge 2012) has shaped UK drug and alcohol policy in recent years (Duke 2013). Hence Phase Four focuses on the reorientation towards recovery in the drugs field and asks how this reorientation has been interpreted and implemented locally, drawing on the perspectives and experiences of a range of stakeholders at strategic, commissioning, service provider and service user/carer levels. In order to provide a critical reflection of the reorientation to recovery as it is being played out in a specific locality, the research team decided to undertake in-depth, semi structured qualitative interviews with key figures across Lancashire and further afield. A list of respondents can be found in Appendix Two.

Between October 2012 and March 2013 28 stakeholder interviews were conducted by the authors, with respondents chosen to represent the four levels of services discussed above. Semi structured qualitative interviews in social research typically aim to facilitate discussion and debate (Denzin and Lincoln 2012) whilst retaining sufficient structure to allow for comparability of data (May 1997). The Phase Four interview schedule (see Appendix Three) was designed to facilitate this form of structured dialogue with questions/themes accompanied by follow-up probes to encourage clarification and elaboration. Additional questions tailored to individual respondents were incorporated into the interview schedule where appropriate, for example practice related questions were added for service providers and service users.

With signed consent from respondents, interviews were recorded and notes were taken concurrently, with recordings then transcribed for analysis by a professional transcriber. Interviews lasted from 30 minutes to over two hours, with the majority lasting around an hour in length. Respondents are given a reference code throughout this report in order to maintain anonymity. In most cases the interviews were the sole point of contact between interviewer and respondent outside of the interview recruitment process.

### *The interview schedule*

As previously noted in the *Introduction*, the Phase Four research team produced an overarching research question formulated at the project planning stage with support from our funders LDAAT and drawing on our knowledge of recovery debates in the drug and alcohol as well as mental health fields, namely how is the reorientation towards recovery in national drug debate, policy and practice shaping local services and vice versa?

This research question shaped our draft interview schedule. Given that one of the key aims of the research was to explore the apparent disconnect between recovery discourse at national level (in policy documents, for example) and local professional understandings and practice, we initially set out to explore definitions of recovery at the start of each interview, organising the interview schedule into three sections: defining recovery; the shift to the recovery agenda; and evaluating recovery networks (such as peer support). However, following pilot interviews, we had concerns that this would produce rehearsed or ‘pat’ responses in line with respondents’ host organisational ‘message’, rather than encourage open reflection on the issues at hand.

With this in mind we amended the interview schedule and reorganised the questions under three headings: Practice, Expectations and Thinking (hereafter PET). This was designed to elicit more thoughtful responses with a focus on respondents providing practical examples to illustrate their points. The PET structure allowed respondents to discuss their current activities, their understanding of the drivers and expectations for the future and then finally, discussion of their definition of recovery, allowing them to think about their definition in relation to their earlier discussions of their practice and expectations. The revised structure was piloted with colleagues at Lifeline Project and proved to be a successful formula.

Phase Four was complemented by research undertaken by the University of Central Lancashire (hereafter UCLan) examining organisational change and how recovery works in practice at service level through a case study of the Inspire partnership in East Lancashire. We met with researchers from UCLan at the outset of the project to establish the parameters of each of the research projects and to ensure that the studies would dovetail rather than duplicate research themes.<sup>9</sup>

---

<sup>9</sup> The UCLan project ‘Developing an evidence base around recovery based drug and alcohol treatment’ is a Knowledge Transfer Project (2012-2015) funded by the Economic and Social Research Council, Technology Strategy Board, Lancashire Drug and Alcohol Action Team and CRI. For information contact Dr Alastair Roy: [anroy@uclan.ac.uk](mailto:anroy@uclan.ac.uk)

## **Sampling**

Interview respondents were identified through a process of purposive sampling, whereby key respondents were selected based on their roles in relation to our research parameters (Silverman 2000). An initial list of contacts from strategic advisers to service users and carers was drawn up in collaboration with LDAAT and through the authors' pre-existing knowledge of experts in the field. This provided a starting point for recruitment. The research team then met key contacts and spoke at local service user events to introduce the research and to generate interest in participation. Potential respondents were briefed about what participation would entail – a confidential in-depth interview exploring perceptions of recovery – and all of those approached agreed to participate in the research.

From the initial round of interviews we were able to 'snowball' the sample further, using existing respondents to suggest other potential respondents to approach. This was particularly useful for gaining access to service users and carers, but also for key figures who were involved in the recovery movement or debate at the time. In order to counter some of the inherent problems with snowball sampling such as overlooking individuals or groups who are not part of a specific network (May 1997), efforts were made to ensure that we 'snowballed' from contacts across the county and from all levels of service delivery.

Of the twenty eight interviews, two were with strategic leads (one at national level and one at county level); six with commissioners; six with providers (chief executives, managers and front line staff); six with paid peer support workers (ex-users and carers); six with volunteer peer support workers (ex-users and carers) and two with current service users (see Appendix Two). Where possible in the time frame, respondents at each level of the service system were recruited from each of the three LDAAT localities, with seven respondents from the north, five from the central and six from the east regions. A further five respondents had countywide responsibilities: two with north west regional responsibilities and three whose responsibilities were nationwide.

## **Observations**

In addition to the interviews, four stakeholder meetings (three service user network meetings and a social enterprise committee meeting) were observed and six drug treatment/recovery services across

the county were visited to provide added context to the interview material. Field notes were made from these meetings and have been incorporated into the background discussion and the *Findings and Discussion* section of the report.

## Analysis

Interview transcripts were analysed using thematic analysis techniques, exploring common themes, issues and contradictions within the interviews (Boyatzis 1998; Guest et al 2012). Briefly, thematic analysis involves moving beyond counting explicit words or phrases and focuses instead on identifying explicit and implicit ideas and related practices, or themes within the data. These themes (such as organisational change) are then assigned codes which are linked to the 'raw' data (such as an interview transcript) in an iterative process. Analysis of these codes is then undertaken, which may take several forms as appropriate, such as the comparison of code frequency, the identification of code reoccurrence, and identifying links across codes. There are precedents to our approach to recovery here: thematic analysis has recently been used to engage with national recovery orientated practice guidance documents to identify dominant themes in practice domains (Boutillier et al 2011)<sup>10</sup>.

From the initial round of analysis, common themes were identified in the transcripts and coded accordingly. In an iterative process typical of qualitative research methods, the codes were used to generate further questions and/or highlight 'intellectual puzzles' worthy of more detailed exploration (Mason 1996). Hence rather than reading through the Phase Four interview transcripts in a linear fashion, the data was revisited repeatedly according to the relevant sections of the interview schedule with a view to comparing and contrasting coded responses and answering our key research question (see *Introduction*). In the majority of interviews, conversations started before the official interview began and continued once the interview had finished and the recorder was switched off. This meant that there was a significant amount of data that was 'off the record'. Whilst this provided a deeper understanding of respondent perspectives it was not possible to include quotations or reference to these views in the analysis, for ethical reasons of confidentiality and more generally regarding accepted academic research protocols for interviews (ESRC 2012: 28).

---

<sup>10</sup> Although we recognise that this identification of the key characteristics of recovery orientated practice guidance is useful, our work differs in that we focus on what recovery means in practice in the words of those who commission, deliver and engage with drug services at the local level.

As discussed, the semi structured nature of the interview schedule required respondents to focus on particular issues the research team wished to explore whilst offering them space to give thought to their responses and to deviate from questions if the interviewer or respondent thought that a particular issue required elaboration. Some respondents also reflected on their answers after the interview had finished, be this over a coffee after the event, on leaving the building, or occasionally if we encountered our respondents later in the fieldwork period. This highlights how research respondents rarely have fully formulated responses readily to hand when interviewed (Booth Davies 1998; Silverman 1999) and so should be given time and space for reflection if possible. We have drawn on all 28 interviews to inform this report, but in selecting respondent quotes for inclusion we have concentrated on the material where the key themes were articulated most clearly.

Those respondents whose job roles were to be impacted upon by imminent changes in drug service commissioning tended to be the most candid in interview, which suggests that the interview process was a cathartic experience at least for some of them, in that it provided an opportunity for them to express views and voice concerns with the benefit of confidentiality. Hiller and Diluzio (2009) highlight how interviews may be cathartic when the researcher is “tapping into an experience that has not been deemed traumatic enough to warrant professional support or intervention and the respondent feels that no one has taken the time to really listen to her, [and] the interview provides the unexpected occasion to discuss these feelings” (2009:13). This is pertinent to the Phase Four study which as previously noted was undertaken at a time of considerable sector upheaval that sometimes took little account of the professional and personal consequences for those involved.

## Findings and Discussion

The following chapter presents the findings from the analysis of 28 in depth semi structured interviews and observations we undertook for the Phase Four study and as outlined in the *Methods* chapter. The findings are organised into four sections as detailed below:

- (a) *Drivers for change* presents our findings on stakeholder reflections on UK drug policy and their perspectives and experiences on why there has been a reorientation towards recovery in drug debate, policy and practice;
- (b) *Recovery in Principle* presents stakeholder perspectives on the concept of recovery in the drug and alcohol field;
- (c) *Recovery in Practice* considers stakeholder perspectives and experiences on how the reorientation towards recovery at the national level has shaped drug policy and practice at the local level and vice versa;
- (d) *The Future* explores stakeholder perspectives and experiences on what the reorientation towards recovery might mean for future drug service provision in the region given the perceived challenges ahead.

In each section of this chapter, key national drug debate, policy and practice developments relevant to the reorientation towards recovery are outlined and explored in light of our respondents' perspectives on how these operated at the local level.

### Drivers for change

This first section explores stakeholder reflections on UK drug policy and in particular their experiences and opinions on the reorientation towards recovery in drug debate, policy and practice.

### **‘Bums on seats’**

As outlined in the literature review, UK drug policy from the late 1980s onwards was centred on a response to public health concerns regarding an impending HIV/AIDS crisis amongst IDUs:

*‘There was the period in the eighties when people were constructing responses to the working class heroin epidemic, which had first been researched by Howard Parker on the Wirral in 1981, but harm reduction in its fully fledged form had to wait until the kind of apocalyptic threat of the AIDS crisis. So the two reports that Ruth Runciman had chaired for the ACMD in ‘87 and ‘88 were the decisive documents which, if you like, signalled in the famous words of the report that henceforth “HIV/AIDS is to be regarded as a greater threat to public health than drug use”. And that opened up what you might call a highly innovative period in UK harm reduction.’ (P1)*

The UK was at the forefront of harm reduction provision for IDUs with the widespread uptake of needle exchange schemes and safer injecting advice. As a result, it is recognised that UK drug policy in the 1980s was successful in averting the spread of HIV and other blood borne viruses (hereafter BBV) amongst IDUs, with only two per cent of those living with HIV in the UK being current or former IDUs compared to between 30 and 80% worldwide (National AIDS Trust 2013).

By the beginning of the 1990s, despite contact with services through needle exchange provision, there were low numbers of users engaged in treatment. Methadone had been prescribed from the late 1980s in areas such as Merseyside and Manchester as a means to encourage engagement but there was a perceived need for services more broadly to attract users into treatment. Evaluation of substitute prescribing indicated its effectiveness (O’Hare 1992; Stimson 1988), so methadone prescribing was in line with the existing evidence base:

*‘In the early 90s that’s what we were saying, is that yeah methadone, we never saw it as a miracle cure, but methadone puts bums on seats and at that time there weren’t people coming into services before we had methadone.’ (P2)*

Methadone was not only an effective tool to attract users into treatment. The monitoring of prescriptions was also an effective way of retaining users in treatment:

*'Giving them free drugs. So I didn't expect the Nobel Peace Prize 'cos give using addicts some free drugs and they'll come. Give them non directive volunteering and counselling and they won't bother.'* (S1)

Hence drug policy was primarily concerned with attracting users into treatment, carrying out assessments, prescribing accordingly and retaining users in treatment for a minimum of twelve weeks. The twelve week retention model worked on the principle that the longer someone was attending appointments, the more likely they were to reduce their drug use and improve engagement to address other needs. Engagement and retention in treatment took precedence over outcomes in terms of monitoring:

*'Retention targets were used as an indicator of the effectiveness of treatment. This became a key target and much success was achieved with this. They failed however, to identify the actual outcomes that are being strived for – successful discharges.'* (C6)

Within this framework came Shared Care. The idea of Shared Care is to provide an integrated treatment system involving primary and secondary (specialist) care. Shared Care arrangements offer stable users without overly complex needs the option to be treated in primary care settings. Shared Care arrangements are designed to increase access to and retention in treatment by seeing people within their own community. This is something that was taken up in Lancashire:

*'We'd had this view that treatment wouldn't just be delivered in a community drug team anymore, that it would be taken out. So we'd have more people being seen in the GP practices like the Shared Care model... And we had this sort of mantra at the time which was that people should fall into treatment, it should be that easy to get into, there shouldn't be 18 month waiting lists.'* (C5)

This system had a number of advantages. Firstly, it would help alleviate some of the pressures on specialist drugs services in terms of client load by seeing those with less complex needs in the community. Secondly, for users it would reduce the stigma associated with attending drugs services because users could be attending a GP surgery for any reason. Thirdly, some of the practical barriers to accessing treatment such as childcare could be overcome:



*'Taking treatment out to somewhere like a Sure Start centre. So if you've got parents going to Sure Start to support their family, well take treatment to them there. The kids are in a better place, you don't want kids in a treatment centre. So that sort of stuff was what we were trying to put in place, so treatment was integrated into the community.'* (C5)

Whilst in theory the Shared Care arrangements could have been effective in what they set out to achieve, provision was patchy and there were often issues with the primary care partnerships, not just in Lancashire but nationwide:

*'Some schemes might have been considered to be successful in terms of numbers attracted and we've known practices with huge numbers on their books. But when you look at these, few people progressed within the schemes. And who can blame them, there was a financial incentive for primary care to take on and continue managing clients in the practice. So one might ask what the incentive was for primary care to move them on. Commissioners were also culpable as retention in treatment was the key.'* (C6)

There was often little throughput from specialist drug treatment services into Shared Care with many users remaining in treatment services for long periods of time. Respondents highlighted that in practice Shared Care was not implemented as intended and functioned instead as a satellite service facilitating ever larger numbers to remain in treatment, at a time when drugs services were encouraged to recruit users into treatment and prescribing was increasing in prominence over other activities.

In the mid-1990s concerns about crime reduction came to the fore. The assumed drugs-crime link – characterised as a clear causal relationship – sparked a significant increase in investment in the drugs field and a commitment to tackling drug related crime, adopted by New Labour as a key policy prior to election. In 1995 DATs were created as dedicated commissioning bodies for drugs services and when Labour was elected to government in 1997, reducing drug related crime became one of its key objectives as evident in the ten year drug strategy *Tackling Drugs to Build a Better Britain* (1998). This saw a shift away from the public health harm reduction policies of the 1980s towards a focus on reducing the harm caused to society by drug related crime:

*'A period which like most of these periods of intensive innovation was time limited, but in a sense the HIV phase of harm reduction came to an end really in the mid 90s, and it was in the mid 90s*

*that the concerns about drugs, as the concerns about HIV diminished, the concerns about drugs and crime escalated.’ (P1)*

Methadone played a central role in attempts to reduce acquisitive crime. It was found that a significant proportion of users both in and out of treatment were ‘prolific offenders’ (repeat or persistent offenders) with offending seen as financially supporting their drug use. Prescribing methadone as an opiate substitute was seen as a key way to alleviate the financial pressures of using street drugs and consequently reduce levels of acquisitive crime:

*‘The crime driver transformed harm reduction whilst keeping the title. The content of harm reduction became very much more focused on methadone prescribing.’ (P1)*

From this came a raft of criminal justice interventions which recruited drug using offenders into treatment using voluntary, coercive and quasi coercive methods. Numbers in treatment increased as a result but it has been argued that as treatment penetration increased with this group so too did repeat attendance.

### ***‘Well, what are you going to do next?’***

Harm reduction, substitute prescribing, retention in treatment and criminal justice interventions experienced success within the parameters of what they set out to achieve, but it was felt that these were essentially focused on *‘the relatively straightforward alleviation of the symptoms of addiction’* (S1), namely treatment access, retention and a reduction in offending behaviour. Although the limitations of existing provision had been acknowledged in the field for a number of years, with this came a widespread recognition that there was a need to do something more:

*‘I think the point I... made in the early nineties...was that “well what are you going to do next?” Unless you’re honest, unless you say “actually what we’re going to do, we’re going to give up on this group of people and we’re just going to offer them a big bucket full of drugs and as long as they sit there and don’t do anything we’ll give them this bucket full of drugs”. Now that’s fine, provided you’re honest about that. They weren’t. They pretended that treatment was in some way...the first stage, and some people did give it up, but it was about bums on seats and the easiest way of getting bums on seats is giving people free drugs.’ (P2)*

Notably, from a strategic, commissioner and user perspective there was a sense that whilst the public health benefits of harm reduction were a given, there had been a lack of longer term positive outcomes in terms of cessation. It was felt that methadone prescribing had allowed people to become ‘locked’ in the treatment system rather than move on and reintegrate into society:

*‘If you look at pre-treatment, pre-treatment people are arrested, people that are catching and spreading blood borne viruses and they’re dying prematurely, that’s not good. So in treatment, that stops, they stay alive, they stay out of prison and they don’t contract, hopefully, or spread blood borne viruses particularly HIV, less so hepatitis C. So they’re the big wins and they’re the wins that we need to keep. They’re the big harm reduction wins. The question was in terms of the real... world, ask the man and woman in the street “what do you think the point of drug treatment is?” They’d say “well to get people off drugs so they can get on with their lives, a bridge to normal living”. Well it wasn’t a bridge to normal living, it was a bridge to an island somewhere where you didn’t commit crime, you didn’t spread blood borne viruses but you certainly don’t go to work and you still struggle to look after your kids because the vast majority are using [drugs] on top.’ (S1)*

*‘But I know back in Birkenhead, some of my friends... they were on North West Tonight in the eighties in their trackies [track suits] with their permed hair, “we’re going to St Helen’s, we’re going on this new methadone programme” and they’re still on 160 mil [millilitres] a day now thirty odd years later, so they don’t see any other way of life. Why would they want to? If they do reduce off their meth a little bit then they sell what they’ve got and it’s an extra giro.’ (PP1)*

*‘Bums on seats, retention, reduce crime. Great, we did all that but what we saw when we did the analysis of clients two to five years down the line, we’d label them ‘stuck but stable’. They came in very chaotic, they were scripted, stabilised but if you came back to those clients two years down the line nothing else had improved. Their housing hadn’t improved, their family hadn’t improved, they were still on tab.’ (C3)*

The perceived stagnation in treatment<sup>11</sup>, a lack of innovation and the sense of failure to achieve lasting change provoked the question of what do we do next?

---

<sup>11</sup> It is worth noting that this negative view of stagnation in drug treatment was absent from our interviews with service providers, particularly frontline workers.

*'We'd attracted all the people in and then the next question was well then "what are you going to do with them?"... So we went through that and you ended up with this industry that didn't have anywhere to go. So I think part of the driver was that. That people were sick of it, that all you get is you come into a drug service and you get given a script and that's it.'* (P2)

This debate was not just amongst professionals working within the drugs field. Drug treatment had received significant investment and questions started to be asked about the effectiveness of treatment from both inside and outside the field. North west England had been very successful in terms of numbers receiving prescriptions and retained in treatment according to the NDTMS performance targets, but the limitations of these measures in terms of outcomes were noted. In 2005 the Society of Local Authority Chief Executives asked the NTA:

*"So you've got 200,000 people in treatment, so what? Are they going to work? Are they looking after their kids? Or is it simply that they've been put in the methadone chorale and they're not committing crime anymore which is great, they're alive which is even better, and they're not spreading HIV which is superb... That's great but are they able to do anything more than that?" So that's where it came from... the "so what?" questions, by the local authority chief execs.'* (S1)

It was felt that the primary aim of drug treatment had been lost and there was a need to refocus attention on supporting people to stop using drugs. Therefore one of the initial drivers for change was the legacy of the previous 25 years' drug policy and practice and the resultant stagnation in treatment services. Another aspect of this evolution was the changing nature of the treatment population itself, discussed below.

### ***Timeliness of change – the drugs gerontocracy***

NDTMS data indicates that opiate users in treatment services across the UK are an ageing population and north west England is no exception. This changing profile of PWUDs in treatment was also a significant driver for change. The number of adults starting treatment for crack and heroin in the 18-24 and 25-29 age ranges significantly reduced in the 2000s, with those aged 40 and over being the only group increasing in numbers, making up over thirty per cent of the whole treatment population (NTA 2012a, 2012b). There had been a significant decrease in the number of new heroin users starting treatment for the first time since monitoring began (9,249 in 2011/12 compared to 47,709 in 2005/06), alongside a

decline in 16-24 year olds using drugs and accessing treatment (NTA 2012b). Figures also suggest a twelve per cent reduction in IDUs from previous years. Drug related deaths also reflect this trend with the highest numbers being amongst those aged 40 and over, about 60 per cent more than the figure for ten years previously (802 in 2011 compared with 504 in 2001) (NTA 2012b).

Given this context, there was a timeliness to the change in treatment focus. Benyon et al's (2007) study of older drug users in north west England highlighted the considerable future costs of addressing the physical and psychological needs of older users, calling for more research to examine the health needs of the ageing population. The potential for compromised health and more expensive treatment for older users, a general lack of new treatment options for those with entrenched drug use and a fall in the number of new presentations are all elements of the context in which a shift to recovery oriented treatment emerged.

Alongside the fall in new opiate users presenting to treatment were changing trends in drug use, suggesting that drugs services needed to respond to emergent problems:

*'Most of the people presenting who are still on methadone are in their forties and fifties. It's not about teenagers being on it, it's all 'Bubble'<sup>12</sup> and 'legal highs', so the whole culture changes all the time anyway.'* (PP1)

*'The evidence and the stats... say it's an ageing population but it's only being replaced by other drugs. It's just different drugs isn't it?'* (SU2)

Therefore changing drug trends and an ageing user population contributed to the timeliness of a change in treatment direction, along with the impact of prolonged drug use and the associated lifestyle on the health and personal circumstances of users. With age, crime became a less viable option for many users and along with a general narrowing of options, resulted in individual users being increasingly receptive to change:

*'Our lot are getting so old now, they're not committing that much crime anyway. You're knackered. They're not like they were. They're not that prolific anymore. If you look at something like domestic burglary there's not a lot that are doing it... Ours are more likely to be drinking*

---

<sup>12</sup> Bubble is a generic term given to synthetic stimulants of unknown composition – 'unidentified white powders' (Measham et al 2011b) – particularly mephedrone and other new psychoactive substances, in north west England.

*white cider and just about getting round to nicking a big packet of cheese from Tesco or a slab of meat from somewhere, and then they get caught all the time, then they don't pay their fines. So they're an old, old bunch. I mean never was it more true Fred Wild at the Zoo<sup>13</sup>, and it's come true. That frenzied vision some years ago is actually real now.'* (S1)

*'They've matured, they've fared ill or prospered, they've gone their own ways often involving stops in jail. As they've grown older they've grown iller, they've had mental health problems, they've been on disability allowance, they've lived and they've had children, the children haven't had it and intergenerational factors have gotten hold, but that lot are getting old now. And we're getting old with them. And the whole thing's becoming a gerontocracy.'* (P1)

It was also noted that it was not only those in treatment who were ageing, but also the key figures who had shaped drug policy and practice over the previous 25 years, at local and national level. It is the political dynamic to these drivers for change that are discussed in the next section.

### **Political dynamic**

At national level in the run up to the 2010 general election the Conservative party began to question the effectiveness of New Labour drug policy and turned its attention to drug treatment and the neglected role of residential rehabilitation. Within existing provision, residential rehabilitation had not received the same financial input as other aspects of the treatment system (including inpatient detoxification). Access to residential rehabilitation was through local authorities and funding was limited. For those promoting abstinence based recovery who saw residential rehabilitation as a central part of the 'road to recovery', the general election was an opportunity to obtain political support for investment in residential rehabilitation:

*'To be honest, recovery brought together a kind of rogues' gallery of discontent, some of whom were at the very heart of the drugs establishment, some of whose main issue was the fact that they'd been marginalised. I mean the rehab industry is the perfect example here, people who were, if you like, working in a variety of residential establishments, some successful, many not,*

---

<sup>13</sup> See Appendix 3 for Lifeline Publications' *Wild at the Zoo* (Reproduced with permission)

*who felt that the drugs strategy had marginalised residential rehab as a potentially successful and decisive modality and were upset about it. So it mobilised them.’ (P1)*

The Conservatives embraced the rehabilitation movement and mobilised support through their commitment to residential rehabilitation. This political dynamic created further splits in the field around treatment philosophies:

*‘I think that a lot of the abstinence versus harm reduction debate has been generated by self interest amongst different provider organisations because of their particular specialisms, and I think that the residential rehab sector, which for historical reasons has always been politically well connected, they’ve felt that they’ve really, really missed out on the money.’ (C2)*

*‘You’ve got the rehab gang for example promoting abstinence and that the only way to get recovery is to go into residential rehabilitation. There’s a big strong lobbying movement there that – from what I understand and from the connections that I’ve got – seem to have a really good link right into the heart of government. And you think fair enough they’ve got a point, rehab’s a really important part of the treatment journey for some people. But for some people. It’s not necessarily what everybody needs.’ (C5)*

Thus the dichotomy between harm reduction and recovery was seen by some respondents as having been artificially created by conflicting political factions and vested interests:

*‘So drug treatment again became a political football around recovery, recovery versus harm reduction. They’re artificial really but you know politics.’ (S1)*

Nevertheless, the harm reduction versus recovery dichotomy became a politically effective tool in the run up to the general election with outcomes for harm reduction being limited to public health gains and crime reduction as opposed to users ‘getting better’:

*‘Goes to the election, I mean you couldn’t blame them really... ‘cos they could just say to the harm reduction crowd “right show us all these people who are doing well then, you line them all up, bring all these people who are doing well, bring us half a dozen who can chew chewing gum and walk in a straight line and we’ll show you ours”. And of course they could bring a legion of people. We couldn’t, and I still regard myself as a harm reductionist. Fact of the matter is we couldn’t because it’s not pretty. What we do, it keeps people alive which is fantastic, stops them*

*getting blood borne viruses, keeps them out of jail, but it isn't pretty. We haven't got many poster boys and girls for harm reduction. It sounds cruel but it's true. Whereas on the recovery side there's any number of modern tales of salvation and redemption, bright shiny people who've been and personally shook hands with the devil himself and have come back with a story to tell.'*  
(S1)

The 'harm reduction versus recovery' dichotomy gained political traction despite its reliance on hazy definitions of both harm reduction and recovery, with methadone maintenance used as a proxy for all harm reduction rather than disaggregating various aspects such as safer injecting, reduction of BBVs or overdose prevention and abstinence used as a proxy for recovery. The research discussed in the literature review above, by contrast, highlights how recovery is potentially an all-encompassing term which can include aspects of harm reduction as well as abstinence. The backlash could be characterised therefore, as a backlash against methadone in particular (particularly long term methadone maintenance) rather than harm reduction in general:

*'We got stuck with methadone, and it was methadone that the arguments were about. It wasn't about harm reduction and people say there was this big argument between harm reductionists and the recovery movement. There wasn't. The argument was about methadone, it wasn't about harm reduction per se.'* (P2)

The outcome of these debates was that harm reduction (ie methadone) was characterised as bad and recovery (ie residential rehabilitation and abstinence) was characterised as good, with a resulting shift in resources. In summary, the political drivers for change are contentious but for a great many individuals across the system including senior figures in strategic and commissioning roles, leading figures in service provision and within service user groups, the introduction of a recovery focused approach came as a welcome change to the existing provision.

### **Drug service dynamics**

Reshaping drug policy and reorienting towards recovery became a Conservative party priority in the late 2000s, gaining momentum from the start of election campaigning in 2008 up to the publication of the coalition government drug strategy in 2010, by which time *'the game was over... recovery became the new orthodoxy'* (P1). Following the general election, the coalition government had further economic and



political incentives to reshape drug policy. There was a need for cost savings across the board and the coalition government was vehemently committed to cutting public sector spending; therefore a reduction in drug treatment budgets seemed inevitable. A commitment to moving people out of costly specialist drug treatment and into community based mutual aid services had obvious financial advantages:

*‘The thing about the 12-Steps is you can’t commission it. They don’t want your money.’ (S1)*

In this climate public sector spending demanded better outcomes for investment, facilitating a shift to a more outcomes focused treatment system and relatedly, more commercial influence such as allocating resources through Payment by Results (hereafter PbR):

*‘They [the coalition government] want to see more attention paid to outcomes in general across the board, and they see a commercial incentive as a means of making this happen.’ (C6)*

The need for cost savings and efficiency within treatment services was transferred to commissioners with an expectation that Drug and Alcohol Action Teams should be recommissioning services to save money and reorient towards a recovery focus:

*‘One of the things we can’t get away from is we’ve had to make savings. You can’t continue to do the same thing with less money.’ (C6)*

Having met NDTMS targets, north west England was at the forefront of recovery oriented innovations:

*‘The north west was way ahead of its trajectory under the previous administration, so we were doing too well quite frankly... we were hitting access, got rid of the waiting times, and retention, the two parts of the public service agreement. Get people into treatment and keep them there for twelve weeks. Well we’d done that embarrassingly early really.’ (S1)*

In commissioning recovery oriented services, not just north west England but Lancashire<sup>14</sup> in particular had been ahead of the game in commissioning a whole system approach in 2009, prior to the launch of the 2010 drug strategy:

---

<sup>14</sup> There were recovery initiatives elsewhere at the time, for example, the peer designed recovery services implemented by the Service User Drug Reference Group funded by the Royal Borough of Kensington and Chelsea DAAT. Nonetheless, Lancashire can claim pioneering status for the north west.

*‘Well that 2010 strategy was right on the money for us. It couldn’t have been better as far as I’m concerned because it confirmed lots of the things we’d already done. I mean we put a big consultation response in around the strategy but it gave us the flexibility around alcohol, it talked about whole systems approaches, it talked about outcomes, it talked about recovery, families. That’s what we’d done.’ (C2)*

There was an acknowledgement amongst commissioners that recovery should have been the ultimate aim of treatment services but that hitting NDTMS targets had overshadowed the end goal:

*‘And the whole point of doing treatment was to address people’s addictive behaviours and stuff like that. So theoretically we should have always been in a recovery framework but it wasn’t framed like that was it? And everybody got bogged down in numbers in treatment and expanding numbers in treatment rather than improving the quality’. (C5)*

Respondents reported to us that through their whole system commissioning model Lancashire DAAT had managed to side step the ‘harm reduction versus recovery’ debate, illustrating their commitment to both harm reduction and recovery:

*‘We used to pride ourselves, whenever people said “harm reduction or recovery”, we’d just say “look recovery is central to our whole system from the word go” and we’ve always said that.’ (C2)*

*‘At that point in time there was the huge debate raging between harm reduction versus abstentionists and all that, and we just didn’t buy into it. So at that stage we didn’t use the term recovery a lot. But actually I’ve been back over that specification recently for the new re-commissioning process and it’s fully recovery orientated. We didn’t use the language deliberately because at that time it was so politicised and we didn’t want to get dragged either side because we don’t believe in that polarisation.’ (C5)*

Within their commissioning structure was also the commitment to a person centred approach and the use of volunteers and peer mentors within treatment services and encouraging participation for those leaving treatment:

*‘So that was the watershed moment for me because that’s where we contractually demanded that our provider started to use volunteers, peer mentors, started to look at the person in the round, the whole person really.’ (C5)*

The LDAAT team's commitment to harm reduction's integral role in the recovery journey was reflected in their views on the public health benefits of harm reduction. Such harm reduction measures were seen not only as vital to improving health but also as a means to enter treatment:

*'Needle exchange needs to be a needle exchange but it needs to be really really clear that it's also a gateway. It's not just a one door in and out, you can come in, get your needles and go out again. It needs to be that this door also opens another world for you really.'* (C5)

*'I'd resign tomorrow if people couldn't get needles in Lancashire or couldn't get safer injecting advice, it's part of the spec, it's a system, it's an overall system. A recovery outcome for me is if somebody starts using a needle exchange and doesn't share. That for me is a step on the recovery journey and that's how we all see it in our team. We don't get drawn into all this false stuff about recovery is abstinence and harm reduction is wrong because you're trapping people in a cycle of addiction. It's nonsense to me, it's a continuum.'* (C2)

As discussed, Lancashire retendered services in 2008/9 using a whole system commissioning model with a strong recovery focus throughout the system. It was hoped that this approach would lead to greater efficiency and integration of all aspects of treatment to better focus on long term outcomes. The innovation and creativity within this Lancashire approach was noted by our non Lancashire-based respondents too; firstly in terms of being 'ahead of the game' in whole system commissioning and secondly in terms of the commitment to utilising current and ex-service users:

*'He's... a strong believer in what you might call the impact and import of people in recovery in terms of not only self-organisation but also in terms of helping shape services. And Red Rose Recovery is probably one of the most clear cut projects of its kind in terms of championing the rights of service users, but also championing the insight that service users need to be able to organise in order to better their own economic predicament through the creation of social enterprises.'* (P1)

The benefits of a whole system approach were explained in terms of highlighting the greater level of integration and efficiency compared to the tiered systems outlined in Models of Care (NTA 2002):

*'What we've got is an integrated system, a whole system approach, so when you look at the contracts in Lancashire our providers are required to deliver harm reduction alongside clinical*

*services alongside abstinence services. Now when you have a design like that you take out the competition between the agency that's commissioned to do abstinence versus the clinical service versus the harm reduction services... I have serious reservations about the value for money that you get from a multi-provider system, and this is I think the norm and I think a lot of it can be laid at the door of Models of Care which chunked everything up. It was the antithesis of an integrated system even though probably they set out to try and describe an integrated system. What they actually did was chopped it up, butchered a whole system approach.'* (C2)

Lancashire could be seen as an ideal region for modernisation. Historically, drug treatment had been underdeveloped in the county. There was huge demographic and socio-economic diversity as well as a wide range of contrasting needs. In the past provision had been patchy in terms of availability and effectiveness, so it presented itself as a blank canvas for innovative commissioning:

*'I think they were pretty desperate in Lancashire... it was a big canvas to work on and there were two or three people who locally were saying "well what's he on about? We know how to do it". But they weren't really listened to because people knew that those people had had their chance and not been able to do it. So yeah I had a pretty free rein most of the time.'* (C2)

### ***'Bottom up' drivers for change***

The recovery network in Lancashire has been successful in recruiting a range of service users who had been in treatment for a number of years. In discussing their experiences, many reported that changes in service delivery and the opportunities offered to them through the recovery community had been welcome:

*'I think it's come from nothing was changing. Numbers just the same, crime just the same if not worse, methadone was probably costing a lot more. Originally the idea yes harm min great, keeping people stuck on scripts is not the way to go, it's killing people. People I've used with and my generation are dead or dying literally. People I've used with that are 37-43, if they've made it past their forties, they're dropping like flies.'* (VP5)

Service user respondents reported that participating in the recovery community had been an empowering experience. Effective communication channels with LDAAT resulted in respondents feeling that they had an understanding of, and input into, the redesign of local drugs services:

*‘What they’ve done is they’ve brought us along on that journey. They’ve not just said “this is what we’re going to commission”, they’ve said “this is why we’re going to commission it”. So we can see why it’s happening... It’s a two way street and we kind of get an opportunity to influence the policy and say what’s good and what’s bad about treatment provision. But then in return they give us an understanding of the bigger picture and play that part in it.’ (PP4)*

The sense across the recovery network that voices had been heard was key to the enthusiasm, commitment and self belief that formed the basis of much recovery community activity discussed in later sections of this chapter.

### **Charismatic leaders**

One of the key features of organisations that innovate and shape the landscape is strong leadership, that is a visionary character with the ability to inspire others and the energy, insight and enthusiasm to generate and carry forward ideas. In a climate of organisational and policy change there is an important role for strong leadership to drive change. Throughout the system in Lancashire there were examples of ‘charismatic leaders’ - inspiring people in positions of power at each level of the system who provided guidance to others.

Most important for our purposes is how a version of Weber’s ‘charismatic authority’ termed ‘charismatic leadership’ or sometimes ‘transformational leadership’ has been understood by researchers of organisations and organisational change (Conger and Kanungo 1998; see Yukl 1999 for a critique). This work focuses on how often highly personal or what Weber called ‘unique and idiosyncratic’ forms of leadership interventions shape the culture of an organisation and in particular how the people involved (employees, service users) respond to change and innovation (Conger and Kanungo 1987; Kavanagh and Ashkanasy 2006).

The characteristics identified as essential to successful charismatic leadership during periods of organisational change include (1) energy and determination, (2) vision, (3) challenge and

encouragement, and (4) risk taking (Javidan and Waldman 2003). This is salient because this study was undertaken during a period of considerable upheaval in drug and alcohol services specifically and within the public sector more generally. We suggest that certain individuals in Lancashire, through their charismatic and/or transformational leadership styles combined with sheer hard work, were instrumental in successfully managing the change that the national reorientation towards recovery entailed:

*‘He’s an instrumental figure in that respect and he’s pretty much a mentor for me. I look up to [name] if I’m honest, ‘cos without meeting [name] I don’t think I’d have found recovery in general ‘cos I didn’t know what it was about.’ (VP3)*

There was an awareness amongst stakeholders of the role that these individual ‘charismatic leaders’ played in each aspect of the system and with that came an understanding of the necessary balance between the benefits of influential leadership and a need to guard against depending on personalities, using strategies such as planning for sustainability and making contingency plans. However, in the context of public sector job cuts, there is an enhanced risk of losing years of experience, skills and knowledge which cannot be easily replaced.

## Recovery in Principle

This second section of our *Findings and Discussion* chapter presents stakeholder perspectives on the concept of recovery in the drug and alcohol field. All stakeholders were asked ‘What would you say your concept of recovery is?’ (See Appendix Three).

### What is ‘recovery’?

The 2010 coalition government drug strategy *‘Reducing Demand, Restricting Supply, Building Recovery’* (HM Government 2010) states that ‘recovery is an individual person-centred journey’. This is echoed across the service system in Lancashire where almost all respondents spoke of recovery in terms of a personal process and/or journey involving incremental life improvements:

*‘My concept of recovery is as simple as people starting to feel optimistic about things going on in their lives, people feeling the confidence to make positive changes in their life.’ (C2)*

*‘What is recovery? God, that’s a big question. What is recovery? I think recovery’s an adventure. It’s about getting to know yourself. Recovery is about actually getting to know the person that you are, what you like, what you don’t like, what your values are, what’s important to you. I think that’s what recovery is, about wanting to move forward and achieve things that you’ve never achieved in your life.’ (PP5)*

*‘It’s very much an individual journey for everybody. It’s about enabling people to find out who they are, not encouraging relapses and stuff like that. But a lot of people do need to have a relapse to realise that they are powerless over it. So it’s just being open minded and supportive and helping people.’ (PP1)*

Almost all respondents stated in one way or another that the ultimate goal was to be part of ‘normal’ society’:

*‘Well I remember talking to me mate and he said “what’s recovery to you?” And I said “well I’m living in me house now, I’ve got a partner, I’ve got a kid, and I go out and I say hello to the neighbours and I get in me car and go to work. I come home and I look back on to the neighbours alright, and go in the house and watch a film” And that for me is recovery. It’s normality, just being a normal member, just being.’ (VP1)*

Echoing the commissioner quoted above, many respondents saw the recovery journey beginning with the first presentation to services:

*‘So as soon as you step through the door of a treatment provider or to say “I need help”, just by getting a script, that is when recovery starts.’ (PP1)*

*‘I don’t see recovery as just abstinence and I know people say they’re in recovery and they’re abstinent, but I see recovery as when they walk through the door and how they are then, that being the start of the journey.’ (P5)*

The looseness and flexibility of respondents’ answers highlighted the difficulty in applying a single definition to such a multifaceted concept. This challenge is reflected in the academic debates

surrounding the concept of recovery, as discussed in the literature review. In Lancashire it was the utilisation of a fluid definition of recovery that enabled a convergence of different perspectives and philosophies, thus side stepping some of the high profile political debates discussed above, that conflate harm reduction with methadone prescribing and claim abstinence is a necessary condition to engagement with drug treatment as well as the only viable goal of interventions (see *Conclusions*).

***‘But for me, I don’t drink, I don’t smoke, I don’t take any drugs’***

Whilst many respondents’ concepts of recovery were centred on the recovery journey and integration into society, closer analysis of the interview transcripts highlighted tensions between the attitudes to recovery that ran through respondents’ narratives and the explicit definition of recovery given at the end of the interview in response to the direct question. Some respondents recognised these tensions in the interview, acknowledging that they had given a ‘standard’ definition that did not necessarily relate to their personal experience. These tensions typically revealed that for many respondents (and almost all ex-users) in our sample the ultimate goal of recovery was abstinence:

*‘But for me, I don’t drink, I don’t smoke, I don’t take any drugs, I like to live an honest life, and I’ve given me life to God as well, and I want to keep a level of honesty, open mindedness, integrity.’ (VP1)*

*‘I know people who can drink successfully but I don’t... I live and breathe my programme and my programme is all about me being a better person.’ (VP5)*

*‘Right here right now I’m abstinent and I’m alright with that. I choose to be that... it’s to do with the mind and how I want to keep a level of peace, clarity. If I put a substance in that that’s going to knock it, if I stop linking up with other people in recovery, that’s going to take me away from it. If I stop reflecting and just start going “whatever”, that’s going to take me away from it. So recovery to me is just maintaining the level of peace and honesty in my life really. And that’s recovery. Internal recovery. It’s not about drugs.’ (VP1)*

*‘The goal is abstinence but whatever your substance was, the goal is abstinence from that substance, whatever your problematic substance was.’ (PP1)*

This was echoed by professionals:



*'Let's reduce harm and keep people safe and help them develop and move towards what we'd all like is abstinence.'* (P5)

*'I mean if we're honest, that's got to be what you're after really, if you want outcomes, ultimately you want people to stop using... be that abstinence from your primary drug or all drugs but that's what you want.'* (C6)

Even when abstinence was not explicit or essential for an individual, the underlying meaning still pointed towards abstinence given the potential risks of continued use of other substances:

*'How do you define recovery? Is somebody recovered from let's say heroin addiction, yet they smoke weed, or they go out of a weekend or something like that? Are they recovered? Well they're recovered from their heroin addiction, but it's a very risky lifestyle. Also, is somebody recovered from let's say a heroin addiction if they smoke it once a month?'* (VP6)

*'I have a drink now and then and I'd say I was in recovery but I wasn't an alcoholic so I can. But I get called an addict of a different breed apparently 'cos some people can't take any substance. A lot of people have a gateway drug or substance: alcohol isn't my gateway, cannabis is. If I smoke a spliff then I want to go and get proper high even though I haven't smoked pot since I was fifteen but I did it a couple of years ago and that was it. I didn't use gear but I was smoking crack and drinking loads of whisky to come down because I'd had a few spliffs.'* (PP1)

Most of our respondents saw abstinence as the goal of recovery but accepted that people who were far from abstinent could still be members of the recovery community. In this sense the conceptualisation and application of 'recovery' at local level was more fluid than presented in high profile national drug policy debates, with the broadest and most nuanced definitions coming from commissioners and practitioners. This indicated an awareness of the inherent problems of abstinence in terms of both general principles and achievability/viability in light of their professional experience and local knowledge. Service users, particularly those who were abstinent, did not tend to be concerned with such complexities since they were speaking from personal experience.

## Recovery in Practice

### *The reorientation towards recovery: mutual aid provision*

This third section of our *Findings and Discussion* chapter presents stakeholder perspectives on how national drug policy is shaping local policy and practice. At a national strategic level, mutual aid provision (12-Step Fellowship and SMART recovery) has been central to what has been promoted in recovery oriented treatment, particularly by the NTA. While the language of recovery is central to 12-Step thinking, for many Phase Four respondents the term did not have the direct association with 12-Step and therefore was accepted, often being perceived as something new and welcome. This created a recovery rhetoric that was progressive and largely palatable.

As discussed in the literature review, drug users may stop using drugs after a period of occasional or sometimes prolonged use, whether on their own or with the help of treatment or other support services (Strang 2012). Given that PDUs who stop drugs tend to disappear from the treatment system, examples of successful recovery tend to be in short supply. Following an exploration of the recovery movement in the US, the NTA looked to existing mutual aid networks across the country for examples of recovery. Despite the evidence base for recovery oriented policy being less robust than some of its advocates have claimed (NTA 2010), the evident success of these groups with some drug users combined with the current political and economic context led the NTA to recommend that mutual aid should be an integral part of a recovery oriented treatment system (NTA 2010). This ideological shift towards mutual aid was a significant move in the field:

*'I mean there was a time and it's not that long ago when the 12-Step Fellowship was little short of a taboo in the drug treatment industry. Never in the alcohol treatment industry where, if you like, it was accepted and valued from very early on. But in the drug treatment industry that absolutely was not the case.'* (P1)

The drive towards directing users into mutual aid also presented challenges to existing mutual aid services in accepting a new 'type' of member:

*'I spend as much time now with the 12-Step Fellowships explaining what on earth's going on when all these people turn up in a minibus who do not have the gift of desperation, who haven't bottomed out, who haven't got anywhere else to go. They're being bussed in by a treatment centre and it causes friction with the old school.'* (S1)

*'This is an AA meeting that's been going on for years with the same group of people going for ten years more. Next thing seven scallies in tracksuits turn up with Adidas trainers on and they're saying "what's going on here? Who the fuck are these?" And then next thing they know they start talking about drugs. "Ooh hang on a minute you've got your own fellowship for that, we don't do that here". And that causes tension.'* (S1)

Drugs services nationally began to be retendered with a recovery focus, with services being rebranded as 'recovery services' staffed by 'recovery workers'. As with the UK public sector more generally, the field was increasingly forced to become more commercially minded with the coalition government emphasising competition as a way to improve efficiency and 'drive up' standards as part of a broader trend of marketisation. In a drive to demonstrate a greater return for investment PbR was piloted across the country:

*'So services are increasingly being commissioned and reorientated to become more recovery focused. To drive this, in some areas PbR is being implemented in various guises... My concern is that commissioning for outcomes in this way can be a blunt tool, a tool this country has little experience of in this arena. It could blow up in our face if success is not forthcoming in the medium term. We can only say it's too early to tell for so long... what is encouraging is that we are examining as a core component the potential of people to progress, to recover and hopefully designing systems more to achieve this.'* (C6)

Following the gradual LDAAT system redesign from 2008 onwards, recovery oriented services were better established in Lancashire than elsewhere in the region, with individual services developing their own responses to recovery to meet their clients' needs as well as facilitating access to mutual aid in the community:

*'I would hope that the sort of areas like NA, AA, SMART and all of the other things that are emerging, I hope that all those are just in a sense become different routes, different flavours, different support packages to suit different people's needs, and they're all part of a bigger recovery community. I would hate to see that you start getting divisions down those sorts of lines, because that wouldn't help anybody... We all need different support, we all have different allegiances and all the rest of it but we can still all be members of the same thing.'* (C5)

Government policy and local service redesign aimed to respond to the needs of the majority of service users. As discussed earlier, the majority of those in treatment were an ageing population of opiate users, often ex-offenders who had been in treatment for a number of years. From a strategic perspective, mutual aid had the benefit of being a sustainable and cost effective intervention. It was also considered to fit well with the 'mindset' of the majority of the treatment population in that the straightforward, no nonsense philosophy underpinning mutual aid was suited to the 'all or nothing' thinking of many PDUs:

*'So because there's something about the binary nature of the criminogenic type, make it 0/1, black/white, we don't do grey. Give a criminal the option for grey and they'll go for grey every time and they'll run some middle class liberal ragged. It's in their DNA. They'll tell lies even when the truth would serve them better. Just because they're hard wired. I mean I am.'* (S1)

In relation to 12-Step, it had been found that the *removal* of decision making opportunities (in contrast to more person-centred therapies) could be effective, when contextualised in the poor decision making of some users:

*'Yeah well if you think about it, "what do you think?" "What do you mean what the fuck do I think? My best thinking got me here. My best thinking told me that shoving seventy pounds worth of heroin and crack cocaine in a 20 mil barrel, put in a green needle and shove it in my groin told me that were a good idea. What on earth are you asking me for?" My best thinking got me here, I'm not Einstein. And what did Einstein say? The definition of insanity, doing the same thing expecting a different result or trying to create something new using the same energy that created it. Preposterous.'* (S1)

This receptiveness to the 'all or nothing' aspects of 12-Step was confirmed by service users:

*'It took me to go on a 12-Step programme, introduced to the Steps then to get a sponsor and I've gone through the big book with Alcoholics Anonymous me, so I'm DAA [Drug Addicts Anonymous]. Some people think we're a bit hardcore but I fucking need hardcore me... I needed someone to say "shut up and listen, your way sucks, hand it over". I needed that.'* (VP5)

SMART Recovery was considered to be a viable secular alternative to 12-Step for some users which allowed flexibility and the option to disengage with their recovery identity if they desired:

*'If I was in the fellowships I'd be told that I have to do this programme for the rest of my life. And that scares the hell out of me, I don't wanna be defined as an addict for the rest of my life because that will keep me there. And in SMART we don't put ourselves in a box, like at the fellowships you say "my name's [name], I'm an addict". I've had a problem with that from day one 'cos if I say it every time I go to a meeting, it's ok I'm an addict, let's go and use. But that's my off key sense of thinking. But that's why I like SMART 'cos you don't put yourself in a box, it's not a long term, it can be a lifetime programme if you want it to be, but it's there for as and when you need it. So you're not reliant on something for the rest of your life.'* (PP1)

By contrast, some respondents highlighted how SMART Recovery and 12-Step could work together. A theme emerged that SMART was an effective programme for the early stages of recovery, focussing on the recognition of negative thought patterns and behaviours, similar to Cognitive Behavioural Therapy:

*'It's good 'cos SMART's brilliant early days because it's a four point programme, building and maintaining motivation to change which is a big part of it, especially when you're first thinking about getting clean, 'cos that contemplation, pre-contemplation, all that kind of stuff. And then coping with urges and cravings which is another key point to it because when you have a thought of using having a bit of armour to be "right no, I'm not going to use", instead of just white knuckling it. Techniques of how you can flip your thinking.'* (PP1)

*'And then a lot of people say "oh 12-Step and SMART's totally different". It's not. They work perfectly together. And what I've found for a lot of people who've spent a lot of years in addiction, myself included, and also people who've suffered from PTSD and stuff like that, that's brilliant for stuff like that, and then it also ties in with managing thoughts, feelings and behaviours. If you asked someone to do a 12-Step programme and they can't manage their thoughts, feelings and behaviours then they're gonna relapse, some of them, because you're just going to open a can of worms. Whereas SMART it's nice and steady until they get to that stage where they think "oh right" and then they move on to 12-Step. So a lot of them link in brilliant with each other.'* (VP4)

There was a good deal of evidence of the positive impact mutual aid and peer support had had on individuals and the on going positive experience it provided. One of the key features was the common bond of shared experience and the credibility this produced:

*'I think people just see the common bond being that they had once. It's kind of like the sinking of the Titanic, that you could have two very different, you know an aristocrat on the... top of the ship down to like the deck servants below, but when they were faced with the peril of subsequent death they had that common bond, they saved one another. And I feel it's exactly the same with the people that have experienced substance misuse issues. It doesn't matter where you've been but it's where you're going and it's that common bond I guess that they have in common rather than how they're actually recovering. That's irrelevant.'* (PP6)

*'I believe in what I do and I believe people get well... I was 12-Step, and I don't think I've ever been a 12-Step friggin army guy, 'cos although I do it, I don't think going to an NA meeting is the be all and end all... I think regardless of whatever model it is, the thing that runs through it all is the therapeutic value of one person helping another, and kinship. So that is what sustains long term recovery.'* (VP1)

At the heart of mutual aid is the idea of a recovery community, providing mutual or peer support, as described by one stakeholder:

*'I think it was the way it was delivered, from an ex addict. And I remember, this is four years ago, you didn't really get ex addicts recovered going into detoxes as like these days. What I do out there is beneficial, it's effective, it's never been done before on a level like I'm on, probation I mean. There's talk of the jails and that... 'cos I think people are seeing the effectiveness of one addict helping another.'* (VP5)

Also crucial is 'visible recovery', that is seeing people in recovery who have made positive changes to their lives. Whilst recovery oriented activity within services was evident, the most prominent feature of the fieldwork was the active recovery network, and central to this was the idea of visible, or infectious, recovery. Visible recovery can be seen to underpin much of the activity across Lancashire as discussed below.

### ***'Don't believe you, show me'***

A common theme emerging from the fieldwork was that whilst they were using drugs, the majority of current and ex-users interviewed had never known a problem user stop using drugs (or alcohol):

*'I did most of my using all on Merseyside, London and Manchester and I didn't see any visible recovery, I didn't see people get clean... All I knew was addicts and I didn't see anybody getting clean and doing anything with their lives. So I didn't know it was possible basically.'* (PP1)

As such, they had not considered it to be an option:

*'Well fucking hell, I've been in and out, well I've never been out, I've been in for 25 years and never could ever stay clean on me own. The idea was fantastic... the reality was so different. I was on, I either ended up in jail and if I was in jail I was still milling around for drugs, or in detox in Prestwich which when I was doing it was Kenyon House, and I'd do a five, six week detox off 150 mil of meth, my benzos and alcohol, and always managed. Even though I desired sobriety, I desired to be abstinent, the reality was very different. As soon as I left detox I'd treat meself. And I'd never seen anyone recovered. All I heard about was NA meetings but didn't ever feel to go to one.'* (VP5)

Those who did recover would not be seen:

*'People just disappeared from your community. They went to rehab and never came back so you never thought "well are they doing alright or are they not?" They just weren't there anymore.'* (PP5)

For many users, the idea that abstinence - stopping using drugs and alcohol altogether - could be their treatment goal had been thought impossible:

*'For me the goal was to get some kind of substance into my world that would stop me offending. The goal was to stabilise me. For me the goal was never abstinence, I'd never seen anybody who'd got clean. That wasn't a reality for me, nobody had told me that was even possible, hence twenty years in addiction. And that's something what has changed and I think people are starting to realise for the first time that it's possible, it can be done.'* (PP4)

However, when they did see someone who had stopped using drugs it had a powerful effect:

*'I never knew anybody get clean no, not until rehab was the first introduction I had to people who weren't using. Clean to me ten years ago was somebody on a hundred mil of methadone, drinking alcohol on top of it but not using street heroin. That to me was clean and "wow how do*

*you do that?" 'Cos I just couldn't even see that as feasible and then through rehab and involvement through mutual aid, coming across people who were clean it was like "oh my God".'*  
(PP6)

Seeing and being supported by peers within a recovery community had a profound and inspiring effect for a significant number of respondents who talked about how being in contact with others in recovery helped them on their own recovery journey. The positive impact of visible recovery was captured by one respondent who spoke passionately about her experience:

*"Show me anything, just show me. Don't believe you, show me"... If you can identify with somebody and you can relate to somebody, connect with somebody, you're fucking half way there. Because we all aspire to be something. We all have a mentor in our life, whether it's your mum, your dad, your grandma, someone on telly. And if you can see somebody used to be in jail, used to be on copious amounts of fucking whatever it is, prescribed or not prescribed, and they're living in a recovered state, their lights are on in their eyes, they're living it, they're happy, they've got their family. How can you not want that? I mean they're genuinely energetic, motivated, because they're recovered... It's like "yeah do you know what, I can do this". And that's massive that.'* (VP5)

Visible recovery and engagement in the recovery community worked on the principle that individuals could take an active role in their own recovery. This active role in recovery was central to much of the activity observed across Lancashire for this study. As discussed, some respondents perceived that users were 'locked' in treatment and that existing prescribing practices did not encourage people to move on and take responsibility for their own recovery. In other words, users were passive in their treatment experience rather than being encouraged to take an active role in shaping their own future:

*'So people can be quite passive in orthodox treatment, they can't be passive in recovery, they have to do something.'* (S1)

Counter to this, it could be argued that substitute prescribing required some level of activity through the presentation at services for prescriptions and key work sessions. Whilst recovery requires participation by the user, aspects of mutual aid, 12-Step in particular, are passive in their requirement to surrender autonomy to a 'higher power'.



A range of recovery oriented activities were evident across the county which included a growing number of SMART Recovery and 12-Step Fellowships running both within service settings and out in the community, with additional, less intensive group programmes within services. Even prior to the new recovery directives, Lancashire had embraced the idea of visible recovery and mapped it on to all elements of the service system, with recovery workers encouraged to work with clients to reduce their prescription doses and get them involved in group programmes. This was particularly notable in the context of the Lancashire User Forum (hereafter LUF).

### *The Lancashire recovery community*

The LUF was established in 2006 as a service user group, much like many others around the UK to facilitate service users providing feedback on service delivery to providers and commissioners, as outlined in Models of Care (NTA 2002). Prior to the 2009 service redesign, the LUF group had not been a particularly effective or positive forum for service users, providers or commissioners:

*‘For a long time Lancashire User Forum used to be a massive ‘wingeathon’ because people would have a negative experience of treatment and they’d come to the Lancashire User Forum and they’d voice it and it must have been very hard for professionals to attend that forum and hear that they’re being criticised for doing their job. And these guys who was criticising them had no comprehension that it was a commissioned service delivery, they just knew that it wasn’t working and that’s what they was complaining about. But in turn that demoralised the staff and it became very negative so they commissioned a new way of working borne out of this negativity.’*  
(PP4)

The whole service system commissioning model gave the LUF new impetus:

*‘It never really took off until we’d done the modernisation, the restructure of the more formal clinical treatment system, because that opened the gates to allow for people to come through and that connected different parts of the system.’* (C2)

From here the user forum grew. In order to maximise the potential power of visible recovery, one of the key elements that the LUF promoted was its accessibility to all users at any stage of recovery. However, while it was open to all, there were commonalities between the most active members which reflected

the broader treatment population. Treatment clients can be characterised as disproportionately white British (former) problematic drug or alcohol users with significant prior offending and from socially disadvantaged backgrounds:

*'But what we're finding is that if you like, the core leadership group that's emerging, you know there are consistent themes: being in prison, Class A addiction over many years. They're survivors if you like. Good mix around genders, you've got the LUF ladies and the LUF lads. They're not soft touches any of them, these are people who've been through the mill big time. But yeah there's nothing namby pamby if you like around, I don't know what I'm trying to say but it's not sort of like a knitting circle.'* (C2)

In addition to those who had been through treatment, the user forum had reportedly been successful in attracting families, carers and professionals in the field:

*'Lancashire User Forum is made up from families, carers, service users, people in addiction, people who are abstinent, people who are stable on a prescription, professionals, commissioners, just community really, it's made up of everybody... [but] I'd say it's a service user led group, the majority of our members have come through or are in treatment.'* (PP4)

The LUF grew quickly and began to attract large numbers of people to each of the meetings:

*'We're big, we're probably the biggest service user group in the UK. I don't know if that's true but I've not come across one that meets every six weeks with maybe 250 people now.'* (PP4)

Making the group accessible to all was also a reaction to some of the criticisms of the 12-Step Fellowships where membership relied on abstinence:

*'Far too much of the recovery world and the fellowship world is built around how long people have been in recovery... The fact of the matter is the most important people are the people who are there for the first time. [Former chair's name] is not chair anymore, he's handed it over. But that's something that he talks about, he says at the opening gambit of every LUF meeting "who's here for the first time 'cos you're the most important people in this room". It's to undermine the kings and queens of recovery, you know, you can't do anything until you've got so many years under your belt.'* (C2)

In order to further improve access, during our fieldwork LUF was in the process of being devolved into three separate six weekly meetings in each of the localities, with one county wide meeting to be held every quarter. This was in response to the expansion of the group and the need to ensure that the group was engaging with people from across the county and that the agenda remained as relevant as possible to local needs:

*‘The vision is just to get everybody who’s out there in rural areas who don’t get reached or are afraid to come forward to the surface and get them to engage and have a voice in their locality meetings.’ (VP3)*

*‘I believe each locality can grow their forum as big as the county wide one. I believe there’s enough people out there to do that... It’s not just about people in addiction, what about the people who are affected by it? And then you go a bit bigger then.’ (PP4)*

At the core of the LUF was their constitution which was developed in collaboration with LDAAT and was centred on the New Economics Foundation’s *Five Ways to Wellbeing*<sup>15</sup>. The LUF motto is ‘Working together, moving forward’:

*‘We are now visible inside the CDTs, Lifeline are, I am, and it’s about working together and moving forward, it really is, which is a LUF strap line. It really is about that, that’s as simple as it is, work together.’ (VP5)*

Central to LUF activity was a ‘strengths based’ assessment process focussed on building on individual assets and building links with the community for Asset Based Community Development (ABCD). The mutual value of these partnerships was noted:

*‘The very fact that we can mobilise seventy volunteers to descend on any one spot, anywhere in the county within a couple of weeks is a strong selling point ‘cos we can say to the universities and the colleges “Alright what kind of qualifications? What’s this about a few credits for volunteering? How much do you get paid to get one person through that?” And they get paid a thousand pound per person to get through and we’ve had sixty people through it so we’ve*

---

<sup>15</sup> The *Five Ways to Wellbeing* is a set of key messages aimed at improving the health and wellbeing of the general population. They have been adapted and adopted by a wide range of organisations. The messages are: ‘connect’ (with the people around you); ‘be active’ (physical activity); ‘take notice’ (awareness of the world), ‘keep learning’ ((re)discovering interests) and ‘give’ (doing something for those around you, volunteering). The messages were developed in 2008 as part of the Think Tank, Foresight’s project on *Mental Capital and Wellbeing*.

*brought sixty thousand pound in revenue to the college. So let's have a bit of co-operation here... education is the way forward, but co-operation is very big... And that's a process so it comes from building up them connections.'* (PP4)

The value of the Lancashire recovery network in building these links was acknowledged by senior strategists:

*'What they're doing is building community assets and that's a really exciting development.'* (S2)

*'[Name of strategic lead] describing us [the Lancashire recovery network] as an "asset churning machine" then the idea is to pump them out and get them out into the community, get on with your life and be good and be good at it, in the words of Lil Wayne [US rapper]. I think we're doing alright.'* (PP4)

One of the key features of the LUF was its close links with LDAAT, with the chairperson of the LUF sitting on the DAAT board. The close links were considered to be crucial to ensuring that the LUF was able to play an integral part in the treatment system by positively encouraging people to access support and engage with services. In the past it was felt that user groups had distanced themselves from commissioners and providers due to negative perceptions of treatment provision. The LUF's relationship with LDAAT was indicative of a recognition of the value of user feedback to commissioners on provision and a genuine sense from the user forum that commissioners were committed to their recovery and developing a service system in line with their needs:

*'We were talking about building an independent service user peer-led organisation ... One of the things we found was that there are organisations that are independent, but they're independent and they're fiercely independent. If you mention a provider to them they just won't know, because these independent organisations in my opinion have been borne out of negativity.... Now what we've got in Lancashire is a positive experience of treatment. We've got lots of people who are accessing it and having a positive experience and from that we want to build a positive forum, that is independent but looks to work with and build on the strengths of the providers... That connection, that bridge, is what we're trying to build.'* (PP4)

The majority of interview respondents involved in volunteering and peer mentor roles were also involved in the LUF. The sense of community, the peer support and the commitment and involvement of commissioners in meetings were all seen as central to the success of the LUF:

*'And I think LUF is fantastic and it's once every six weeks and there's so much going on in that day. It's just mind blowing how far we have come in services, working together to all sit in one room, when it was never like that, it was always us and them. You feel like a unity, you do feel a part of [it].'* (VP5)

*'Yeah it's one of my favourite dates in the calendar. I do it in me own time as well, I don't count it as work, and I've got to know loads of guys. But a lot of that's down to the fact I'm not technically a real 'suit'... No, I mean most of my career personally I've not been a suit if you like, so I'm pretending to be a suit as opposed to the other way around.'* (C2)

*'It's opened doors in other places for me in my life, introduced me to people I didn't think I'd ever rub shoulders with. It gets me out the house, my self esteem, confidence. 'Cos I was low on confidence for a long time, 'cos I put the drugs down which used to suppress me feelings. When I take away the drugs I've got issues underlying [that] I need to deal with and confidence was one of them. So I've been able to build up my confidence in respect to that. And getting to meet more good people as well, which I really needed in my life, put me back in order to keep me on the straight and narrow.'* (VP3)

There was a strong commitment to inclusivity in the LUF. Those still using and at the beginning of their 'recovery journey' were actively encouraged to participate, the value of which is illustrated by one respondent:

*'So I remember it was about nine months ago and a lad came and I know personally this lad, he'd been in addiction for twenty years in a bedsit handcuffed to a chemist every day. And he came and he said "today's my first day clean in twenty years". And the room erupted and I just have watched that guy's journey over social media and over meetings and connecting him with the community. And slowly he's emerged as someone who's got an opinion but someone who's confident enough to express that without the fear of being ridiculed for saying "you don't matter you're just a junkie, you can't possibly have anything to contribute". And now these people are coming up and they're saying "well I have got something to contribute". And that's the strength*

*what we're building on. And for me that's what it's always been about, empowering people to live their own life.'* (PP4)

The inspiring effect of visible recovery was at the heart of what the LUF set out to achieve. Also within this was the desire to create an open and mutually supportive community where people could not only celebrate their successes but also share their problems, particularly around any vulnerability to or signs of potential relapse.

### ***'Job creation for people in recovery'***

Alongside the links with mutual aid and group activity within services, another key component of recovery oriented provision was the creation and development of volunteering opportunities for peer mentors within services. This volunteering was designed to provide opportunities for those who had left treatment, either recently, in order to harness their burgeoning energy and enthusiasm; or for those who had stopped using for a number of years, to 'give something back' to other users in treatment. However the primary role of these peer mentors was to provide visible and inspirational examples of recovery throughout the service system and support recovery workers in facilitating users into groups, mutual aid and other sources of support and opportunity in the community:

*'They are encouraged to attend groups and if they do attend groups then they'll meet me, then they'll get introduced to LUF, "what do you want to do, what are your skills, what are your assets, what do you like? Let's find it. I'll introduce you to these guys, they're all recovered." It's inspirational.'* (VP5)

*'And if we can put systems in place, be it clinical services or be it peer support services or be it needle exchange services, if we can create opportunities for people who are in chaos to bump into positivity and if we can create an environment where people actually see that there is a way forward, that's recovery.'* (C2)

This volunteering linked in with the ethos of the LUF, SMART and 12-Step mutual aid networks, whereby 'giving something back' was an essential component of the recovery process. In addition to the voluntary roles there were also a number of paid opportunities for ex service users. These roles were funded by LDAAT and a Building Recovery in Communities (hereafter BRiC) fund managed by LDAAT. Roles included

‘recovery champions’ based within services who provide help to service users in terms of accessing community based support for their recovery.

### **Building Recovery in Communities (BRiC) workers**

In 2011 the BRiC fund was established and managed by LDAAT with the aim of providing a co-ordinator in each of the localities based in each of the three treatment provider organisations. Co-ordinators build links with community resources to widen the opportunities available to services users, with a view to improving ‘recovery’ outcomes, as described by one respondent:

*‘I see my role as is making visible recovery within the communities, so that there are role models there, so people can actually see it as achievable. It’s also my role to get people engaged in employment, education, volunteering. My role is to engage peer mentors and volunteers, especially peer mentors that have been through services and are coming back as peer mentors, to start taking on lead roles in things like bike rides, cycle rides, you know, visible things that other service users can get involved in. Pretty much it’s bridging the gap between when someone comes into treatment services [and] when they get signed out of services, they’ve actually still got a pathway that they can follow, which reintegrates them back into society rather than feeling like they’re being dropped off a cliff.’ (PP5)*

The three BRiC coordinators based in each locality worked alongside the Red Rose Recovery workers based in the Community Voluntary Services (herein CVS). At the time of the Phase Four research Red Rose Recovery had just been rebranded and re-launched. Red Rose Recovery is a social enterprise scheme which aims to identify and provide opportunities for those in recovery, to build on individual assets and to develop the skills and experience to work outside of the treatment system in the ‘real world.’ This venture came out of development and modernisation ideas from LDAAT, demonstrating the strong commitment to recovery and (re)integration from the commissioners:

*‘Red Rose Recovery is probably one of the most clear cut projects of its kind in terms of championing the rights of service users, but also championing the insight that service users need to be able to organise in order to better their own economic predicament through the creation of social enterprises.’ (P1)*

Whilst funded by LDAAT, it was administered by CVS who were tasked with formally establishing and constituting the organisation and managing the day-to-day activities. A Red Rose Recovery worker was appointed in each locality and was overseen by a team leader, the former chair of the LUF. This structure of having Red Rose Recovery managed by the CVS was an active decision to encourage integration:

*‘One of the things Red Rose Recovery’s looked at is taking it a step further into the community to facilitate volunteering, where we’re in the CVS.’ (PP4)*

Red Rose Recovery has close links with the LUF and the aim was for the two to work in partnership:

*‘The model is that they’ve got a symbiotic relationship. They’re very different but they rely on each other because the LUF brings the numbers in, but the LUF meets every six weeks... Red Rose Recovery is a day to day business, it gives Monday to Friday opportunities for people who are on the recovery journey... to do volunteering, to do different activities, to learn skills, to get support. And then the LUF brings it together.’ (C2)*

The majority of respondents who had taken on volunteering and peer mentor roles within the system were hugely positive about the experience. They were passionate about the profound effect visible examples of recovery could offer:

*‘I’m a volunteer. But I like being a volunteer ‘cos I get everywhere. I can get around and I don’t have to do anything. I do it with a desire to help because I see, and I don’t run around screaming and shouting what I’m doing either. I see results from what I do, people are wanting what I’ve got, which is recovery. This is recovery.’ (VP5)*

Those involved in the recovery community recounted how there was also a need to establish credibility with key policy makers and commissioners:

*‘It’s credibility innit? We’re relevant because we’ve recovered but we’ve recovered from a lifestyle of deviance, so we haven’t got that credibility [in broader society], which is why we need the directors to buy into it. This is why we need it from the top, to say this is good, this is what we believe in, and these guys are the real deal... It’s like some of our guys are absolutely the right people that should be going into the schools to talk to the youth about the dangers of drugs and where a life of crime can lead, but they haven’t got the credibility because they’ve got a criminal record, the very thing what qualifies them to speak on that subject. So that’s what we’ve tried to*



*develop, that credibility. And we've had to develop skills and professionalism, hence the committee and that's been a process.'* (PP4)

Interviews with strategists and policy leads suggested that ex users were increasingly seen as not only credible but essential to future service development:

*'The work going on around the Lancashire User Forum and Red Rose Recovery some of the innovative nature of that, I think that's something we can really build on. So I think there is so much more we can do with the LUF in lots of other ways, not just with Red Rose Recovery but with building assets within communities and linking it to other agendas like domestic violence for instance. You know because talking to many of the people in the User Forum you know many of them have been victims or have been perpetrators of domestic violence.'* (S2)

Communicating the possibility of recovery to those people continuing their drug use was at the heart of respondents' accounts of their commitment to the recovery community in the region:

*'Like spreading the word and one of the most important things is that we have to expose people to positive role models and to exemplars of change and recovery. And that's where our Lancashire User Forum comes into its own because one of the most important things that I feel about the Lancashire User Forum is it's got to be accessible to people who are still bang at it.'* (C2)

There was recognition, however, that the passion, commitment and enthusiasm of those involved was potentially unsustainable and even divisive:

*'I love it me on a humorous level because I think the recovery movement is like the reformation church, you get no end of splinter groups and Quakers and Shakers and doo da. It's the people's church of recovery or the unreformed church of recovery, it's great. That's being obviously facetious but I think that that is one of the problems that I try to down play, some of the evangelism if you like around recovery.'* (C2)

*'It has caused me to think about who am I seeing here? Is it a true representation of people with substance misuse problems, mental health problems, etc etc? Is it truly representative and what support is being given to the others who sit with this? Irrespective of that, this is doing something*

*very good and some people might not buy into it... but I'm really struggling to see what else would be on offer.'* (S2)

There was also evidence that such “evangelism” (C2 above; SU2 below) might not sit well with some service users who had a sense that those involved in the recovery community were fragile. This was discussed as particularly apparent in relation to mutual aid, when individual needs and vulnerabilities could overwhelm collective commitment:

*'What happens is the evangelicals quickly pick up on the fact that they're talking to a wall and they don't get the response they want and they will come back at you and say "come on, come along". If you ask them about it, they get quite prickly, you know what I mean, cos it's fucking with their recovery and "you're fucking with my recovery, man". Boom, dropped you, end of.'* (SU2)

### ***'You're defined by your addiction and you're defined by your recovery'***

A key feature of the LUF and central to the wider recovery community is the obvious common bond of having been dependent on or affected by drugs or alcohol. By its very nature, being part of the recovery community requires self identification as a drug (and drug service) user or ex user. Whilst participation in the LUF and other recovery activities was an invaluable source of support and inspiration for the majority, not all service users wanted to be part of this community. For some, the notion of being defined by their drug use – albeit as an ex user – was something that they rejected:

*'And it's always "ex" you know, ex users and they seem, this is my, they seem to have the two groups you know, and they never, it's not like a community... For me, I've been defined by my drug addiction all my life. So it's now that I'm going to be defined by my recovery for the rest of my life. That's what it feels like. I have to define myself as an ex user who's done so well, you know.'* (SU2)

And for those who were more critical of the recovery community, involvement in the community did not necessarily help people to ‘move on’:

*'Fucking they don't want to [move on] yeah. So it is like you're defined by your addiction and you're defined by your recovery and that's the way it is for a certain group of people.'* (SU2)

A further challenge to the recovery community was the potential (particularly in smaller towns with less transitory populations) for resentment to develop towards those who have ‘recovered’ and started to experience success in their lives. Recovery tended to have both the greatest and the least resonance amongst long term service users with the key difference being their apparent willingness to identify as ex users and to be involved in a scene populated by people in recovery. A related issue raised by respondents was that community membership undermined confidentiality:

*‘And you probably know them anyway. And again I am not fucking sitting in a group saying “I wanted to use last week, me girlfriend went out” with my girlfriend’s fucking friend sat there. “Oh it’s confidential”. No it’s fucking not.’ (SU2)*

For ex users who continue to live in the same area there are added pressures, therefore, of being known in that community:

*‘Massive [pressures] yeah of course. Cos a lot of people look up to me, and then also as well because not everyone’s saying “yeah he’s in recovery and great”, some people are just waiting for it all to go wrong and that’s reality. Because I was not an angel before, I was an asshole. So now I’ve turned the coin round, winning people over, some people forgive and forget or say “nice one”... [of being known in the community] Yeah for all the wrong reasons but now because I’m getting known for the right reasons some people are a little uneasy with that.’ (VP4)*

### **Differentiation and segmentation**

In our discussions with respondents about recovery in practice in Lancashire, differentiation and segmentation of recovery orientated interventions, and drugs services more generally, was a recurrent topic. Commissioners spoke of the treatment system in terms of a ‘broad church’ where everyone was welcome:

*‘I take a small ‘c’ catholic view of substance misuse treatment. It’s got to be a broad church, it welcomes lots, it has to have lots of different options in it.’ (C2)*

However in some areas, particularly smaller towns and where recovery activity was less well established, a barrier to engagement was the dearth of options available. Limited options resulted in a lack of differentiation and segmentation of what was on offer to meet the needs of individuals:

*'In the groups, if you're in a group with twelve people and some are like meself, talks you know, I said this to me girlfriend, I said "I've dumbbed it down". And she was like "fucking what?" I said "I've dumbbed me conversation". And she went "that's really insulting to 'em". And I was like "I'm trying, 'cos I know I'll start and it'll intimidate them".'* (SU2)

This respondent's experience suggests that what was on offer, at least in some areas, lacked the necessary inspiration to engage with the whole group and offer all individuals the opportunity to 'move on' and (re)integrate. Furthermore, respondents noted the challenge of attempting to grow a recovery community or mutual aid network that could fully address the range of user needs in areas with small populations of users:

*'What I'm finding is what works in big cities for [service names] and these organisations, does not work in the sticks... [Lancashire town] doesn't have that many clients using [service name], and they're wanting to push family mutual aid partnership, women's groups, men's groups, mixed groups, people who are abstaining groups, there's just not enough, there's not enough of a client base in [Lancashire town] to support it.'* (VP6)

This highlights the limited capacity in smaller areas to provide a choice of options. Yet concerns raised by respondents about lack of choice or the need for a critical mass for development by no means amounted to a wholesale rejection of recovery communities or indeed the reorientation towards recovery as played out across Lancashire. Rather there was a recognition that participating in a recovery community was not appropriate for everyone:

*'Well people have took drugs since the Egyptians or before and they're still going to take drugs. Just because they're saying "recovery" everyone's not going to say "yes we want that" and be all tip-toeing through the tulips singing "recovery". It's not going to happen.'* (VP4)

In terms of differentiation of service user groups, there was recognition that mutual aid (here 12-Step) in particular was not suitable for everyone:

*'This is not for people who are just heavy drinkers. This is not for people who can manage to use drugs recreationally. This is for people, as Carl Jung said in 1929, it's a rolling hazard, this programme, this 12-Step programme is for people who've got no 'off' switch, who do have a spiritual malady because their spirit, as in God's spirit, is in vodka.'* (S1)

The fact that ‘recreational’ drug users typically differ from ‘traditional’ service user populations is widely recognised (Aldridge et al 2011; NTA 2013). Concurring with this, the respondents in this study discussed how ‘recreational’ and non dependent drug use did not fit well with recovery oriented services:

*‘It don’t necessarily fit... most recreational users have never really been suitable for those methods anyway... For the vast majority of recreational users the recovery is meaningless, it’s not a service of any use to them whatsoever. Advice and information services are, those sorts of things, low level entry counselling services are. ‘Crew’ [Edinburgh based drugs advice service] have got a cannabis service there, it’s been really, really popular at the moment. What seems to be coming across is quite an increase in the number of cannabis users they’re seeing with quite serious problems. But they’re not going to come along to traditional drugs services.’ (P2)*

Alongside the longstanding concerns about the ‘fit’ between traditional opiate-dominated treatment services and users who may experience problems with steroids, alcohol or stimulants, the more recent focus on recovery and the move to mutual aid-type support raised further questions about the ability of drugs services to meet a range of needs.

### **Socio-economic inequalities**

Like any form of therapy or support for individuals, drugs services are open to the criticism that efficacy is inevitably constrained by the wider context of socio-economic inequality, exclusion and disadvantage which remains unchanged or indeed may have worsened in recent years:

*‘The kind of problems, the kind of people that we see and we always see, the common denominator’s always poverty in any of this, are still going to be there.’ (P2)*

Respondents were also aware that personal financial restrictions could limit both ‘choice’ of treatment services and choice of options when ‘moving on’ after treatment:

*‘And the drugs are a symptom aren’t they? If I was obese, shopaholics, workaholics, fucking chocoholics, I don’t know, you can’t walk past a bookies without having a bet you know. But the drugs has become like this industry man, and it just, and ‘cos it’s you know the world we live in, you’ve got two tiers haven’t you? If you’ve got the money you’re going to be able to buy the*

*service that you need. If you haven't got any money you're going to get the fucking service you're given.'* (SU2)

*'It's a two tier system... It drives me mad. There's some people who I know that have got money, fucking clean now, they've been clean for years. One of them's in south fucking America.'* (SU2)

Respondents' perceptions and experiences of drug use, dependence and service engagement echo social science critiques of the coalition government's framing of 'recovery capital' which tends to detach the individual and indeed the community from wider consumer capitalist society:

*'It's from the university of stating the bleeding obvious. If you're a middle class young man with good qualifications and you've got some work experience and you've got a well to do family who's willing to back you up and all well educated and the rest of it, and you come along and you've got a heroin problem and you come along to me and you're not from a good family, you can't read and write, you've spent half your life in jail, your parents may have been drug users, there may be mental health problems there and the rest of it, you're living rough on the streets, you haven't got any social networks outside of people using drugs. And you get the two of them coming along, I mean which one's going to have the better success rate? It's not rocket science and we've always known that. And social capital's great if you've got it, but unfortunately in something like a needle exchange in Manchester you were dealing with, certainly when we were doing it, eighty per cent of the population homeless, they didn't have any social capital to go back to.'* (P2)

## The Future

The previous sections of this chapter have sought to outline the process by which the current focus on 'recovery' has come about, to describe what recovery orientated activities are being undertaken in Lancashire, and to provide a critical discussion of current practice as viewed from the perspectives of different stakeholders. We now consider how respondents conceptualised the future of recovery and articulated their own hopes and fears, contextualised within a fieldwork period which could be characterised by change, uncertainty and economic instability.

## Outcomes

There was a consensus amongst respondents that whatever happened to the commissioning of services in the future, the one certainty was that all activity would become increasingly outcomes-driven. The ability to demonstrate outcomes would be central to future commissioning decisions:

*'It's not just substance misuse, it's everything that we need to be commissioning for. We need to be commissioning for outcomes, so it's very important to identify what those outcomes are right from the start and commission to those rather than just commissioning services. So there is a focus on commissioning for outcomes and that it's an accepted principle.'* (S2)

It was recognised that in order to demonstrate positive outcomes a range of measures and indicators would need to be employed and in doing so services would be able to justify continued financial support:

*'So I think all we can do in the commissioning world is keep showing the outcomes that it delivers ... showing that those that are involved in treatment move out of revolution quicker and off the cohort, that people are getting and maintaining tenancies, that we are skilling people up, that we've got more people in visible recovery, that we've got a growth in mutual aid groups. All those sorts of things are indicators that things are going in the right direction and all we can do is keep promoting that and pushing that and working on our core stats in treatment, to say that successful discharges continue to go up. TOPs compliances is where it needs to be, representation rates are below the cut off level that has been set. If we can keep doing that then we've got a legit argument to keep the money coming in.'* (C5)

The need to demonstrate effectiveness in commissioning and in practice was echoed at strategic level:

*'I'm not sure about drug and alcohol funding but the public health budget of which substance misuse is a significant contribution, is ring fenced until 2015. Two year focus and then the thing is to try and prove ourselves in public health, that we can deliver in those two years, then we can resist the possible threat of people pinching our resources to spend elsewhere.'* (S2)

However, it was felt that the reality of public sector funding decisions was sometimes driven by politics and personalities rather than by the merits of the case:

*'It's become a small industry and the industry will have to shrink and it won't, you would like to think that logically that it will be selected which bits, the most successful, we know it won't work*

*like that, it will be fucking chaos. Chaos and those that are good at shouting and getting money and filling in forms. It's always been the way.'* (P2)

From a strategic perspective, commissioning a recovery oriented system was not enough; the entire service system needed to be signed up to recovery before outcomes could be realised:

*'I applaud what Lancashire have done, I think it's as much as they could possibly do. Unfortunately it doesn't seem to be making that many recovery biscuits. Nowhere in the country that I'm aware of, and I've been doing this nationally now, can you show that retendering the system has led to long term sustainable performance improvement.'* (S1)

### **Deprofessionalisation and the rise of the Third Sector**

In order to deliver the outcomes and manage budgetary restraints, it was clear that from a strategic perspective the trend towards the increased role of the third and voluntary sectors in service delivery would continue. For Lancashire this meant a strategic vision of utilising the recovery community activity already in place:

*'Wouldn't it be great if the providers really embraced the User Forum and used them in a way to make their services more effective, less resource intensive, so there's more opportunities? Or you could say it's not about providers, it's about outcomes and you could take that approach... But I think we'd be heading for a utopian world if we didn't need any kind of provision because everything was being provided through volunteers or the Third Sector system.'* (S2)

From a workforce perspective, there was a sense that deprofessionalisation was the future and that this future was unlikely to be 'bright':

*'I think that drugs services will be decimated in the next ten years. My suspicion is the move to Public Health England, moving away from the NTA, having commissioners who are less skilled and experienced... I think they'll employ more and more volunteers and get rid of more and more experienced workers.'* (P5)

Whilst it was recognised that volunteers should not replace professionals, ex users were seen as having a vital role to play in drug and alcohol treatment, working in partnership with professionals:



*'I think there's space for both but I think one of the key principles is that we need to be developing the Third Sector. And particularly in this area where it's specialist but it's not, but it benefits from a, for many people, it benefits from first hand experience, you know there's a credibility element and I think that's where the LUF are becoming more successful.'* (S2)

Ultimately, the ability to delivery outcomes relative to investment was key:

*'We're not here to protect services or protect professionals, we're here to get outcomes for our local community. I think there is space there for everybody to exist. It may be that some professionals feel a bit vulnerable because of this growing Third Sector. I'm not bothered really. You know if we're looking at outcomes then that's what we should be going for.'* (S2)

As with other areas of the health and social care sectors, it was felt that there was the potential for volunteer led services to provide the more basic or generic levels of care, leaving professionals to carry out more specialist work:

*'I think that's the general trend. I mean if you look at health services there are too many providers trying to provide the same service and what we need to do is build up the core generic service and if that's through the Third Sector then that's fine but... there'll still be a need for that specialist level but maybe the threshold is wrapped up a bit. There's more issues that can be dealt with in the broader offer, does that make sense?'* (S2)

In terms of the future of drugs services, respondents recognised the need for specialist roles, be they provided by statutory services or through the purchase of specialist and clinical support from the Third and voluntary sectors. A hope was expressed for future provision of specialist psychological interventions, for medical interventions to better meet health needs and for a general shift away from an individualised therapeutic alliance between professional and client to group based social networking facilitated by a workforce of peer mentors and volunteers. However, whilst respondents hoped for increased provision of specialist 'high-end' services, NICE guidelines downplay psychological interventions and recommend instead mutual aid and where appropriate, behavioural therapy for couples, reserving cognitive behavioural therapies for those with underlying anxiety and depression (NICE 2007).

### *The place of harm reduction in the future*

The place of harm reduction was a recurring theme in stakeholder interviews in the context of recovery orientated commissioning in the future. The importance of the public health aspect of harm reduction (such as reducing BBV transmission) was widely accepted as a crucial part of ongoing delivery:

*‘Well I mean it’s there, it’s the jewel in the crown of the public health response to injecting drug use. There’s no question about that and the money’s safe, certainly safe in public health because obviously the public health protection unit, blood borne virus prevention transmission, the crime thing doesn’t work as well obviously in public health as it did in the previous administration. But the harm reduction gains are there and they’re locked in.’ (S1)*

The perceived political sensitivities of harm reduction were noted:

*‘I think it’s for us to present the case. Harm reduction is such an important element. It’s very political but it’s such a proven, evidence based component of any substance misuse strategy... I think it’s political because... needle exchanges for instance, on their patch... should they be supporting those things or should they be staying well away from them? Well I think the challenge for me is to make the case, but it marks the evidence based approach to substance misuse... and public health more broadly... That’s the test really, how we influence not only politicians but the people in the system to say “look, this is how it’s going to be”.’ (S2)*

There was recognition that there should be a continued commitment to harm reduction initiatives that can respond to a range of drug use:

*‘Yeah I would hope it continues not to apply that distinction. It shouldn’t matter what substance you’ve used. So likewise the delivery of harm reduction. There’s been a debate in partnerships and services that “ooh we shouldn’t give needles out to steroid users”. Well that’s ridiculous blatantly because if you’re injecting you’re at risk of BBV.’ (C5)*

### **Recovery and sustainability**

Those stakeholders committed to recovery indicated that they saw this commitment continuing into the future. There was a hope that changes in structure and commissioning would not impact negatively on the Lancashire recovery community and that recovery orientated activity would continue to grow:

*'I think the movement's much bigger now culturally and nationally that that argument will get scrapped out and I would hope that the sort of areas like NA, AA, SMART and all of the other things that are emerging, I hope that all those are just in a sense become different routes, different flavours, different support packages to suit different people's needs, and they're all part of a bigger recovery community... We all need different support, we all have different allegiances and all the rest of it but we can still all be members of the same thing.'* (C5)

There was also a recognition that the system needed to respond to growing numbers of people in recovery services:

*'I still think it's early days in terms of the ability of the drug treatment industry properly and sensitively and responsibly to manage large numbers of people who are in recovery, that you want to use to drive your engine forward and are happy to bring on board but who you don't necessarily fully understand how to nurture and develop.'* (P1)

From our stakeholder interviews there was a sense that those involved in the Lancashire recovery community were aware of its need to be self-sustaining, with many respondents reasonably confident that this was achievable:

*'So is it sustainable going forward? I hope it is sustainable because mutual aid has been sustainable over all these years with no core support. And if people are passionate advocates for visible recovery and we've got the critical mass I talked about earlier then there should always be somebody prepared to stand in the shoes and become the next leader'* (C5)

There were concerns that despite Lancashire having commissioned a recovery oriented system ahead of most areas, they were ultimately at the mercy of the changing tides of drug policy:

*'I hope that that recovery infection continues. But I don't think it's assured, I really don't, in that yes recovery is strong for us and embedded in our contracts, our values, our beliefs. That's not necessarily shared with quite a different organisation [such] as Lancashire County Council, which*

*has a breadth of strategies and focus and that seem to change on an annual basis depending on what bloody reports come out, what new strategies come out. So it's a threat.'* (C4)

Whilst there might be a commitment to retain the whole system approach, other partner agencies could ultimately withdraw resources:

*'I think there's a conflict in terms of because there are so many changing aspects to the work that we're doing and the movement, the transition, that it potentially gets lost in all of that and whether Lancashire County Council understand and adopt that recovery based, asset based, lived experience kind of agenda. I would hope that they would learn about the strengths of that and want to absorb that in the future and that's why we're recommissioning to try and bring all that together and keep that in one contract and keep that safe, so actually you can't take it apart. Although you could. If the police and crime commissioner wanted to stop the criminal justice element of that service and pull the funding then it's gone. So I would hope that at a local level the strength of it continues through the people. And that's what we've always wanted.'* (C4)

In a positive sense Lancashire recovery activity and services, with the necessary strategic support, were in a strong position to justify their continued activity:

*'I'm ever the optimist and providing we can make the rationale and the argument stick then there's no reason why we can't do innovative things and progress and maintain the momentum that LDAAT have succeeded in doing.'* (S2)

More broadly the new climate was seen as an opportunity for innovation which relates to the need for the space to take 'risky' decisions:

*'So recovery has to be thought about in a collective way, at the level of the municipality and at the level of the neighbourhood. And we have to contribute actively to providing services in that context, not just partnerships that enable local authorities to exploit their existing resource more fully than they otherwise would. I think we need to in that sense go beyond partnership and for a while I think the territory that [the service] operates in might be slightly lawless... There won't be anybody to send us a guideline document telling us how we need to behave. It's not about making up one's own rules and then trying to force them on other people but I think we'll have to take a whole series of really interesting decisions and decisions for which there's no real existing*

*benchmark of good practice. And I think that means taking much much bigger risks. So I mean it's really challenging and it's really interesting for everybody I hope.'* (P1)

The above quote provides a good summary of what could be characterised as a 'cautiously optimistic' view of recent change held by most respondents, despite recent uncertainties and upheaval. Much of the discussion about the future was concerned with the immediate future. Yet change takes time and investment as discussed in our literature review, and crucially is subject to a range of other influences outside the control of local stakeholders such as changes in drug use and treatment populations, political drivers and entrenched socio-economic inequalities.

## Conclusions

As noted in the *Introduction*, despite the burgeoning literature on recovery in the drug and alcohol field, there is a dearth of UK research exploring how the changing national policy agenda is shaping drugs services at the local level. In particular little is known about the reorientation towards recovery from the perspectives and experiences of local commissioners, providers, users and carers in a specific locale. To explore this we undertook stakeholder interviews across several months in late 2012 and early 2013, the findings of which we outlined in the previous chapter.

The reorientation towards recovery in UK drug debate, policy and practice documented here follows 25 years of consensus around harm reduction interventions, initially as a response to public health issues about BBVs and later as a crime reduction strategy addressing the political focus on the drugs-crime nexus (ie. methadone maintenance to cut acquisitive crime). At the macro level, the polarisation of harm reduction and recovery has obscured a longer term “strategic coherence” in the drug and alcohol field in terms of public health, medical, criminal justice and moralistic approaches to drug use, dependence and ‘addiction’ (Seddon 2010; Shiner 2013), with drug use long considered a social problem demanding a response from the state such as the “proactive prohibition” of psychoactive substances (Bancroft 2009; Measham and Moore 2008). The reorientation towards recovery is ultimately contained within a prohibitionist drug control system which is dominated by criminal justice responses (law enforcement) in terms of budget allocation, for example. However as this Phase Four study highlights, the reorientation towards recovery situates (at least some) drug users at the heart of service design through a whole system approach which attempts to deal holistically with the individual concerned. In this sense there are both positive and negative consequences that emerge from the reorientation towards recovery, at least at the local level.

Firstly, then we conclude that recovery is a fluid concept which has been utilised by people in divergent positions to highlight both positive and negative aspects to recent changes in UK drug policy and practice. In Lancashire the adoption of a ‘broad church’ definition of recovery enabled service design and delivery to adapt in the challenging and highly politicised drug and alcohol field. Those committed to ensuring the safety, health and wellbeing of drug users have broadly welcomed the reorientation towards recovery in contemporary UK drug policy but remain understandably cautious about abstinence advocacy (Best and Coomber forthcoming). If abstinence was explicitly defined as the ultimate treatment goal of recovery, then recovery would potentially be more controversial in terms of implementation as a

policy directive. In contrast, the fluidity of the concept of recovery as a person centred journey with (re)integration as a key goal has helped to bring together the service system across Lancashire and has reinforced the concept of a whole system approach. The distinction between the reorientation towards recovery and established treatment approaches (such as methadone prescribing) has been unhelpfully represented in some of the more politicised debates about how to “get people off drugs” (Home Office 2012). Concerns continue to exist about the outcomes measurements of recovery orientated interventions, with a danger that abstinence becomes an easily measurable but over simplistic proxy for ‘success’, with resultant (un)intended consequences for service design, delivery and the service user experience.

Secondly, we conclude that inclusion/exclusion is a crucial issue now and going forward; an issue about which those working at the local level are clearly mindful (see *Findings and Discussion* for examples). There remains continuity in UK drug policy in the recovery age in terms of the focus on PDUs and harm reduction through clean syringes, low threshold access to treatment, crime reduction measures to cut offending amongst this population and increasingly encouragement to engage with recovery orientated services including (now better recognised) recovery communities. Although the strengthening of recovery communities apparent in Lancashire hopefully means that the “recovery infection continues” (C4), such communities may be viewed by outsiders as being exclusive, as 12-Step Fellowships sometimes are (Roch and Best 2013). Furthermore, research exploring non engagement in recovery communities by some PDUs would be invaluable given this concern. An overemphasis on recovery and in particular an overemphasis on abstinence may eliminate certain policy/practice options for policy makers and practitioners, negatively impact on drugs services, exclude current and potential service users and ignore certain PWUDs, notably non-dependent and/or ‘recreational’ users. However in Lancashire it has long been recognised that drug and alcohol use – prevalence, patterns and types of drugs – are ever changing at local as well as national level (Home Office 2013). The problems these groups face may differ significantly from the ageing, predominantly opiate using PDU service user group and hence demand different drugs services incorporating a range of interventions which include harm reduction initiatives (Measham et al 2010, 2011a, 2011b, 2012; Moore et al 2011).

Throughout this Phase Four study we have highlighted how the reorientation towards recovery at local level relates to broader social trends best understood as a moment in a long history of UK drug policy. The contemporary recovery revolution is being shaped by wider forces such as the continuing economic crisis, public sector cuts, political ‘point scoring’ in a highly sensitive public policy arena, dissatisfaction

with treatment orthodoxies amongst commissioners, providers and service users and the changing nature of drug prevalence and patterns both nationally and locally.

Thirdly, then we conclude that the local legacy of a region profoundly shapes all stakeholders' perspectives and experiences at a specific time and place. Local legacies may include historical and contemporary drug prevalence, patterns and problems; incumbent service structures; workforce strengths and weaknesses; partnership working relationships; previous successes and failures in responding to drug use (eg. harm reduction in metropolitan north west England; the whole system approach in Lancashire) and the presence of charismatic individuals across the stakeholder groups. Understanding and documenting such local legacies is crucial to capturing how national drug policy is interpreted, implemented and experienced locally.

The pursuit of the "pragmatism, compromise and flexibility" in drug policy and practice as characterised by Duke (2013) continues in the sometimes fraught context of the politically sensitive drugs field. Given the changing structure of drug and alcohol commissioning, a reduction in staff numbers and resources, the piloting of PbR for treatment outcomes and somewhat frenetic activity around recovery from within government agencies (eg. Day 2013), how the reorientation towards recovery in UK drug policy debate, policy and practice evolves and how well it serves drug users/carers remains to be seen. In this sense 'recovery' is indeed a journey.

However, and to end on a positive note, we suggest that what we have documented here in the Phase Four study will surely be another 'moment' in the history of north west England's innovative approach to people who use drugs. A focus on Lancashire and its early implementation of a recovery oriented system provides a point of comparison to the north west of England more broadly and also to the rest of the country. Lancashire has a well developed recovery community with a significant amount of support, energy and enthusiasm. Ultimately the ability to demonstrate outcomes in relation to levels of investment will be central to determining the future of the Lancashire recovery system, but innovation in commissioning, commitment to recovery across the system, an active and embedded recovery community and awareness of challenges such as inclusion/exclusion in service delivery place Lancashire in a strong position to ride the recovery 'wave'.



## References

ACMD (2013) *ACMD further advice on foil*. London: HMSO.

ACMD (2012) *Recovery from drug and alcohol dependence: an overview of the evidence*. London: HMSO.

ACMD (2011) *ACMD: Consideration of the use of foil as an intervention to reduce the harms of heroin and cocaine*. London: HMSO.

ACMD (2010) *Consideration of the use of foil, as an intervention to reduce the harms of injecting heroin*. London: HMSO.

ACMD (1988) *AIDS and Drug Misuse Part 1*. London: HMSO.

Album, V. (2010) *Impact of developing criminal justice interventions relative to a cohort of substance misuse related offenders*. PhD Thesis. Lancaster: Lancaster University.

Adair-Totef, C. (2005) Max Weber's Charisma. *Journal of Classical Sociology*, 5(2): 189-204.

Aldridge, J., Measham, F. and Williams, L. (2011), *Illegal Leisure Revisited: Changing patterns of alcohol and drug use in adolescents and young adults*, London: Routledge

Amann, R. (2000) Foreword in S.M. Nutley, H.T.O. Davies and P. C. Smith (eds.) *What Works?: Evidence-based Policy and Practice in Public Services*. Bristol: The Policy Press

Ashton, M. (2008) The New Abstentionists. *Druglink* special insert, Dec/Jan 2008. London: Drugscope.

Ashton, M. and Seymour, H. (2010) Public Health and the origins of the Mersey Model of Harm Reduction. *International Journal of Drug Policy*, 21(2): 94-96.

Ashton, M. (2007) *Potholed Road to Recovery*, London: Drugscope.

Bach, S. (2012) Shrinking the State or the Big Society? Public service employment relations in an era of austerity. *Industrial Relations Journal*, 43: 399–415.

Bach, S. Kessler, I. and Heron, P. (2006) Changing job boundaries and workforce reform: the case of teaching assistants. *Industrial Relations Journal*, 37: 2–21.

Bancroft, A. (2009) *Drugs, Intoxication and Society*, Bristol: Polity.

Bell, A. and Roberts, M. (2013) Recovery in mental health and substance misuse services. *Advances in Dual Diagnosis*, 6(2): 4-4.

Berridge, V. (1994) 'Aids and British drug policy: history repeats itself...?' in R. Coomber (ed.) *Drugs and Drug Use in Society*, Greenwich: University Press.

Berridge, V. (2012) The rise, fall, and revival of recovery in drug policy. *The Lancet*. 379, Issue 9810, Pages 22 - 23, 7 January 2012.

Best, D. and Coomber, R. (forthcoming) Recovery and harm reduction – polar opposites or common cause? A review based on the UK experience, *Drug and Alcohol Review*, special edition on recovery.

Best, D. and Laudet, A.B. (2010) *The Potential of Recovery Capital*. London: RSA.

Best, D., Rome, A., Hanning, K. A., White, W., Gossop, M. Taylor, A. and Perkins, A. (2010) *Research For Recovery: A Review of the Drugs Evidence Base*. Edinburgh: Scottish Government.

Beynon, C. M., McVeigh, J and Roe, B. (2007) Problematic drug use, ageing and older people: trends in the age of drug users in northwest England. *Ageing and Society*, 27(06): 799-810.

Booth-Davies, J. (1998) *The Myth of Addiction* (2<sup>nd</sup> ed), London: Routledge.

Boutillier, C., Leamy, M. Bird, V., Davidson, L. Williams, J., and Slade, M. (2011) What Does Recovery Mean in Practice? A qualitative analysis of international recovery-orientated practice guidance, *Psychiatric Services*, 62(12): 1470-1476.

Boyatzis, R. (1998) *Transforming Qualitative Information: Thematic analysis and code development*, London: Sage.

Bryman, A. (1992) *Charisma and leadership in organizations*, London: Sage.

Cabinet Office (1998) *Tackling Drugs to Build a Better Britain*. London: Cabinet Office

Cabinet Office (2011) *Giving White Paper – making it easier to take part in a bigger, stronger society*. 23 May 2011. London: Cabinet Office.

Carnwath, T. and Smith, I. (2002) *Heroin Century*. Routledge, London.

Cloke, P., Johnsen, S. and May, J. (2007) Ethical citizenship? Volunteers and the ethics of providing services for homeless people. *Geoforum* 38(6): 1089–1101.

Cloud, W and Granfield, R. (2009) Conceptualizing recovery capital: expansion of a theoretical construct. *Substance Use Misuse*. 43(12-13): 1971-1986.

Conger, J.A. and Kanungo, R.N. (1998) *Charismatic Leadership in Organisations*. Thousand Oaks, Calif.: Sage.

Conger, J. A. (1993) Max Weber's Conceptualisation of Charismatic Authority: Its influence on organisational research. *Leadership Quarterly*, 43(3/4): 277-288.

Conger, J. and Kanugo, R. (1987) Toward a behavioural theory of charismatic leadership in organizational settings. *Academy of Management Review*, 12: 637–647.

- Daddow, R. (2012) *Putting 'Full Recovery' First*, Royal Society of Arts (RSA) blog, available at <http://www.rsablogs.org.uk/2012/recovery/putting-full-recovery/>, accessed 13<sup>th</sup> August 2013.
- Davidson, L. (2008) From "double trouble" to "dual recovery": integrating models of recovery in addiction and mental health. *Journal of Dual Diagnosis*, 4(3): 273-290.
- Day, E. (2013) *Routes to Recovery via the Community*. Public Health England, London.
- De Leon, G. (2010) 'The Therapeutic Community: A Recovery-Oriented Treatment Pathway and the Emergence of a Recovery-Oriented Integrated System', in Yates, R. (Ed) (2010) *Tackling Addiction: Pathways to Recovery*. London: Jessica Kingsley.
- Denzin, N. (1987) *The Recovering Alcoholic*. London: Sage.
- Denzin, N. and Lincoln, Y. (2012) *The Handbook of Qualitative Research* (4<sup>th</sup> ed). London: Sage.
- Druid H, Strandberg JJ, Alkass K, Nyström I, Kugelberg FC, Kronstrand R. (2007) Evaluation of the role of abstinence in heroin overdose deaths using segmental hair analysis. *Forensic Science International*, 168(2-3):223-226.
- Duke, K. (2013) From Crime to Recovery: The reframing of British drug policy? *Journal of Drug Issues*, 43(1):39-55.
- ESRC (2012) *Economic and Social Research Council Framework for Research Ethics 2010: Updated for September 2012*, London: ESRC, available at [http://www.esrc.ac.uk/images/Framework-for-Research-Ethics\\_tcm8-4586.pdf](http://www.esrc.ac.uk/images/Framework-for-Research-Ethics_tcm8-4586.pdf), accessed 13<sup>th</sup> August 2013.
- Ferri, M., Amato, L., and Davoli, M. (2006) Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews* 2006, 3: no page numbers.
- Foot, J. and Hopkins, T. (2010) *A glass half-full: how an asset approach can improve community health and well-being*. Improvement and Development Agency (IDeA).

Fraser, S. and Valentine, K. (2008) *Substitute and Substitution: Methadone subjects in liberal societies*, Basingstoke: Palgrave Macmillan.

Gilman, M. and Yates, R. (2010) 'NW ROIS: Recovery-Oriented Integrated Systems in North West England.' in Yates, R. (ed) (2010) *Tackling Addiction: Pathways to Recovery*. London: Jessica Kingsley.

Granfield, R. and Cloud, W (2001) Social Context and Natural Recovery: the Role of Social Capital in the Resolution of Drug-associated Problems, *Substance Use and Misuse*, 36:1543-1570

Groshkova, T., Best, D. and White, W. (2013) The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review* (March 2013) 32: 187-194

Guest, G., MacQueen, K.M. and Namey, E. (2012) *Applied Thematic Analysis*. London: Sage.

Hacking, I. (1999) *The Social Construction of What?* Cambridge, MA: Harvard University Press.

Hallett, C. (1983) Social Workers: Their Role and Tasks (1982) *British Journal of Social Work*. 13(1): 395-404.

Hiller, H. H. and DiLuzio, L (2009) The Interviewee and the Research Interview: Analyzing a neglected dimension in research. *Canadian Review of Sociology and Anthropology*, 41(1):1-26.

Hodgson, P. Parker, A. and Seddon, T (2006) Doing drugs research in the criminal justice system: Some notes from the field. *Addiction Research and Theory*, 14(3): 253-264.

HM Government (2010) *Drug Strategy 2010: Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*. London: Home Office.

Home Office (2013) *Drug Misuse: Findings from the 2012/2013 Crime Survey for England and Wales*, London: Home Office.

Home Office (2012) *Putting Full Recovery First*. London: Home Office.

Home Office (2008) *Drugs: Protecting Families and Communities – The 2008 Drug Strategy*. London: Home Office.

Home Office (2005) *Developing peer-led support for individuals leaving substance misuse treatment*. April 2005. London: Home Office.

House of Commons (2010) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary*. London: The Stationary Office.

Humphreys, K. *et al* (2004) Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3): 151–158.

Javidan, M. and Waldman, D.A. (2004) Exploring Charismatic Leadership in the Public Sector. *Public Administration Review*. 63(2): 229-242.

Kavanagh, M.H. and Ashkanasy, N.M. (2006) The Impact of Leadership and Change Management Strategy on Organisational Culture and Individual Acceptance of Change during a Merger. *British Journal of Management*. 17(1):81-103.

Koski-Jännes, A. (2002) Social and Personal Identity Projects in the Recovery from Addictive Behaviours. *Addiction Research and Theory*. 10(2): 183-20.

Kretzmann, J. P. and McKnight, J. L. (1993) *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ABCD Institute.

Lenton, S. and Allsop, S. (2010) A Tale of CIN – The Cannabis Infringement Notice Scheme in Western Australia. *Addiction*, 105(5): 808-816.

Lloyd, C. (2013) The Stigmatisation of Problem Drug Users: A narrative literature review. *Drugs: Education, Prevention and Policy*, 20(2):85-95.

Lloyd, C. (2010) *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users*. London: UK Drug Policy Commission.

Available at: [http://www.ukdpc.org.uk/resources/Stigma\\_Expert\\_Commentary\\_final2.pdf](http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final2.pdf).

Manning, P. (2007) *Drugs and Popular Culture: Drugs, Media and Identity in Contemporary Society*. Cullompton: Willan.

Mattick, R.P., Breen, C., Kimber, J., and Davoli, M. (2009) Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews 2009*, 3: no page numbers.

Mason, J. (1996) *Qualitative Researching*. London: Sage.

May, T. (1997) *Social Research*. Buckingham: Open University Press.

Martin, P. (2005). Critique of 'What are drug users looking for when they contact drug services: Abstinence or harm reduction?' by Neil McKeganey, Zoë Morris, Joanne Neil and Michele Robertson, *Drugs: Education, Prevention and Policy*, 12 (4): 257–259.

McIntosh, J. and McKeganey, N. (2000) Addicts' narratives of recovery from drug use: constructing a non-addict identity. *Social Science & Medicine*, 50(10):1501-1510.

McLellen, T. and White, W. (2012) 'Come Together.' *Druglink*. July/August 2012.

McKeganey, N. (2012) Harm reduction at a crossroads and the rediscovery of drug user abstinence. *Drugs: Education, Prevention and Policy*, 19(4): 276-283.

McKeganey, N., Morris, Z., Neale, J., and Robertson, M. (2004) What are drug users looking for when they contact drug services: Abstinence or harm reduction? *Drugs: Education, Prevention and Policy*, 11(5): 423–435.

Measham, F. and Moore, K. (2008) The Criminalisation of Intoxication, in P. Squires (ed.) *ASBO Nation: The Criminalisation of Nuisance*, Bristol: Policy Press, pp.273-288.

Measham, F. and Moore, K. (2013) What place for harm reduction in the 'recovery age'? A qualitative study exploring user, service provider and commissioner perspectives on policy and practice in north west England, International Harm Reduction Association Conference 2013, 10-12<sup>th</sup> June, Vilnius, Lithuania.

Measham, F., Moore, K. and Østergaard, J. (2011a) *Emerging Drug Trends in Lancashire: Night Time Economy Surveys. Phase One Report*. Lancaster: Lancaster University / LDAAT.

Measham, F., Moore, K. and Østergaard, J. (2011b), Mephedrone, 'Bubble' and Unidentified White Powders: The contested identities of synthetic 'legal highs', *Drugs and Alcohol Today*, 11 (3): 137-147.

Measham, F., Newcombe, R. and Parker, H. (1994) The normalisation of recreational drug use amongst young people in North-West England. *British Journal of Sociology*, 45(2): 287-312.

Measham, F., Moore, K. and Welch, Z. (2012) *Emerging Drug Trends in Lancashire: Nightclub Surveys. Phase Three Report*. Lancaster: Lancaster University and LDAAT.

Measham, F., Moore, K., Newcombe, R. and Welch, Z. (2010) Tweaking, Bombing, Dabbing and Stockpiling: The emergence of mephedrone and the perversity of prohibition. *Drugs and Alcohol Today*, 10(1): 14-21.

Mold, A. and Berridge, V. (2010) *Voluntary Action and Illegal Drugs: Health and Society in Britain since the 1960s*. Basingstoke: Palgrave Macmillan.



Monaghan, M. (2012) The recent evolution of UK drug strategies: From maintenance to behaviour change? *People, Place and Policy Online*, 6(1): 29-40.

Monaghan, M. (2011) *Evidence versus politics: Exploiting research in UK drug policy making?* Bristol: Policy Press.

Monaghan, M. (2008) Appreciating Cannabis: The paradox of evidence in evidence-based policy-making. *Evidence and Policy: A Journal of Research, Debate and Practice*, 4:209-231.

Moore, K. and Measham, F. (2012) Impermissible Pleasures in UK Leisure: Exploring policy developments in alcohol and illicit drugs, in C. Jones, E. Barclay and R. Mawby (eds.) *The Problem of Pleasure: Leisure, Tourism and Crime*, Abingdon: Routledge, pp.62-76.

Moore, K., Measham, F., Østergaard, J., Fitzpatrick, C. and Bhardwa, B. (2011) *Emerging Drug Trends in Lancashire: Focussing on young adults' alcohol and drug use. Phase Two Report*. Lancaster: Lancaster University / LDAAT.

Neale, J., Nettledon, S., Pickering, L. (2013) Does Recovery-orientated treatment prompt heroin users prematurely into detoxification and abstinence programmes? A qualitative study. *Drug and Alcohol Dependence*, 127(1-3): 163-169.

New Economics Foundation (2011) *Five Ways to Wellbeing - new applications, new ways of thinking*. London: NEF.

Newcombe, R. (1994) *Safer Dancing: Guidelines for good practice at dance parties and nightclubs*. Liverpool: 3D.

NHS (2012) *Commissioning fact sheet for clinical commissioning groups*. Commissioning Board. July 2012.

NICE (2007) *NICE clinical guideline 51 Drug misuse: psychosocial interventions*. London: NHS.

NICE (2011) *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115*. London: National Institute for Health and Clinical Excellence.

NTA (2013) *Club Drugs: Emerging Trends and Risks*. London: NTA.

NTA (2012a) *Drug Treatment in England: The Road to Recovery*. London: NTA.

NTA (2012b) *Drug Treatment 2012: progress made, challenges ahead*. London: NTA

NTA (2010) *Commissioning for recovery*. London: NTA.

NTA (2009) *Breaking the Link, the role of drug treatment in tackling crime*. London: NTA.

NTA (2008) *Routes to Recovery*. London: NTA.

NTA (2007a) *The International Treatment Effectiveness Project: Implementing Psycho-social Interventions for Adult Drug Misusers*. London: NTA.

NTA (2007b) *The Treatment Outcomes Profile (TOP) An implementation guide for managers*. London: NTA.

NTA (2006) *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2004 - 31 March 2005*. London: NTA.

NTA (2002) *Models of Care for Treatment of Adult Drug Misusers*. London: NTA.

O'Hare, P. A. (1992) 'The Mersey Harm Reduction Model: Evaluation of a Local Strategy for Preventing the Spread of HIV Among and From IDU' in Paccaud, F, Vader, J. P and Gutzwiller, F. (eds) *Assessing AIDS Prevention*. pp 191-212. Basel: Birkhauser Basel.

Parker H, and Kirby P. (1996) Methadone maintenance and crime reduction on Merseyside. *Police Research Group, Crime Detection and Prevention Series*, Paper 72, 1996.

Parker, H., Aldridge, J and Measham, F. (1994) *Illegal Leisure: The normalization of adolescent recreational drug use*, London: Routledge.

Pawson, R. (2006) *Evidence-based Policy. A Realist Perspective*. London: Sage.

Pizzey, R. and Hunt, N. (2008) Distributing foil from needle and syringe programmes (NSPs) to promote transitions from heroin injecting to chasing: An evaluation, *Harm Reduction Journal*, 5 (24).

Raistrick, D., Bradshaw, J., Tober, G., et al (1994) Development of the Leeds Dependence Questionnaire. *Addiction*, 89, 563-572

Raistrick, D., Heather, N. and Godfrey, C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: NTA.

Riley, D. and O'Hare, P. (1999) 'Harm Reduction: History, Definition and Practice' in Inciardi, J. A. and Harrison, L. D. (Eds) (1999) *Harm Reduction: National and International Perspectives*. London: Sage.

Roberts, M. (2009) *Drug treatment at the crossroads: what it's for, where it's at and how to make it even better*. London: DrugScope.

Roch, J. D., and Best, D. (eds.) (2013) *Addiction and Recovery in the UK*. London: Routledge.

RSA (2012) *Beyond the Big Society. Psychological Foundations of Active Citizenship*. London: RSA.

Scottish Government (2008) *The Road to Recovery*. Edinburgh: Scottish Government.

Seddon, T. Williams, L. and Ralphs, R. (2012) *Tough Choices: Risk, Security and the Criminalization of Drug Policy* (Clarendon Studies in Criminology). Oxford: OUP.

Seddon, T., Ralphs, R., & Williams, L. (2008) Risk, security and the “criminalisation” of British drugs policy. *British Journal of Criminology*, 48(6): 818-834.

Seddon, T. (2006) *Drugs, Crime and Social Exclusion - Social Context and Social Theory in British Drugs–Crime Research*. *British Journal of Criminology*, 46(4): 680-703.

Seddon, T. (2000) Explaining the Drug–Crime Link: Theoretical, Policy and Research Issues. *Journal of Social Policy*, 29(1): 95-107.

Shapiro, H. (2012) ‘Walk the Line’ *Druglink*. July/August 2012. London: Drugscope.

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Shiner, M. (2013) British Drug Policy and the Modern State: Reconsidering the Criminalisation Thesis. *Journal of Social Policy*, 42:623-643.

Silverman, D. (2000) *Doing Qualitative Research*. London: Sage.

Smith, Z., Moore, K. and Measham, F. (2009) MDMA Powder, Pills and Crystal: The persistence of ecstasy and the poverty of policy. *Drugs and Alcohol Today*, 9(1):13-19.

Stevens, A. (2011) *Drugs, Crime and Public Health: The Political Economy of Drug Policy*. Abingdon: Routledge.

Stimson, G. V. (2010) *Harm reduction: evidence, impacts and challenges*. EMCDDA Monographs. April 2010. Lisbon: EMCDDA.

Stimson, G. V. (2007) Harm Reduction – Coming of Age: A local movement with global impact, *International Journal of Drug Policy*. 18(2): 67-69.

- Stimson, G. V. (1988) *Injecting Equipment Exchange Schemes in England and Scotland*. Final report. London: University of London Goldsmiths College.
- Strang, J. (2012) *Medications in recovery re-orientating drug dependence treatment*. London: NTA.
- Strang, J. and Gossop, M. (eds) (2005) *Heroin Addiction and 'The British System'*. London: Routledge.
- Ti, L., Tzemis, D. and Buxton, J. (2012) Engaging people who use drugs in policy and program development: A review of the literature. *Substance Abuse Treatment, Prevention and Policy*, 7:47-46.
- Tyler, I. (2013) *Revolting Subjects: Social Abjection and Resistance in Neoliberal Britain*. London: Zed Books.
- Wardle, I. (2013) *The Drug Treatment Workforce*. Manchester: Lifeline.
- Wardle, I. (2012) Five Years of Recovery: December 2005-2010 – From Challenge to Orthodoxy. *Drugs: Education, Prevention and Policy*, 19(4): 294-298.
- Wardle, I. (2012) *Recovery: From Challenge to Orthodoxy, 2005-2010*. Manchester: Lifeline.
- White, W. (2000a) The history of recovered people as wounded healers: I. From native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23.
- White, W. (2000b) Toward a New Recovery Movement: Historical Reflections on Recovery, Treatment and Advocacy. Prepared for the *Center for Substance Abuse Treatment Recovery Community Support Program Conference, "Working Together for Recovery"* April 3-5, 2000
- White, W. (2009) 'The Mobilization of Community Resources to Support Long-Term Addiction Recovery'. *Journal of Substance Abuse Treatment*, 36(2): 146-58.
- White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33: 229-241.

White, W. and Kurtz, E. (2006) The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates. *International Journal of Self Help and Self Care*, 3(1-2): 21-61.

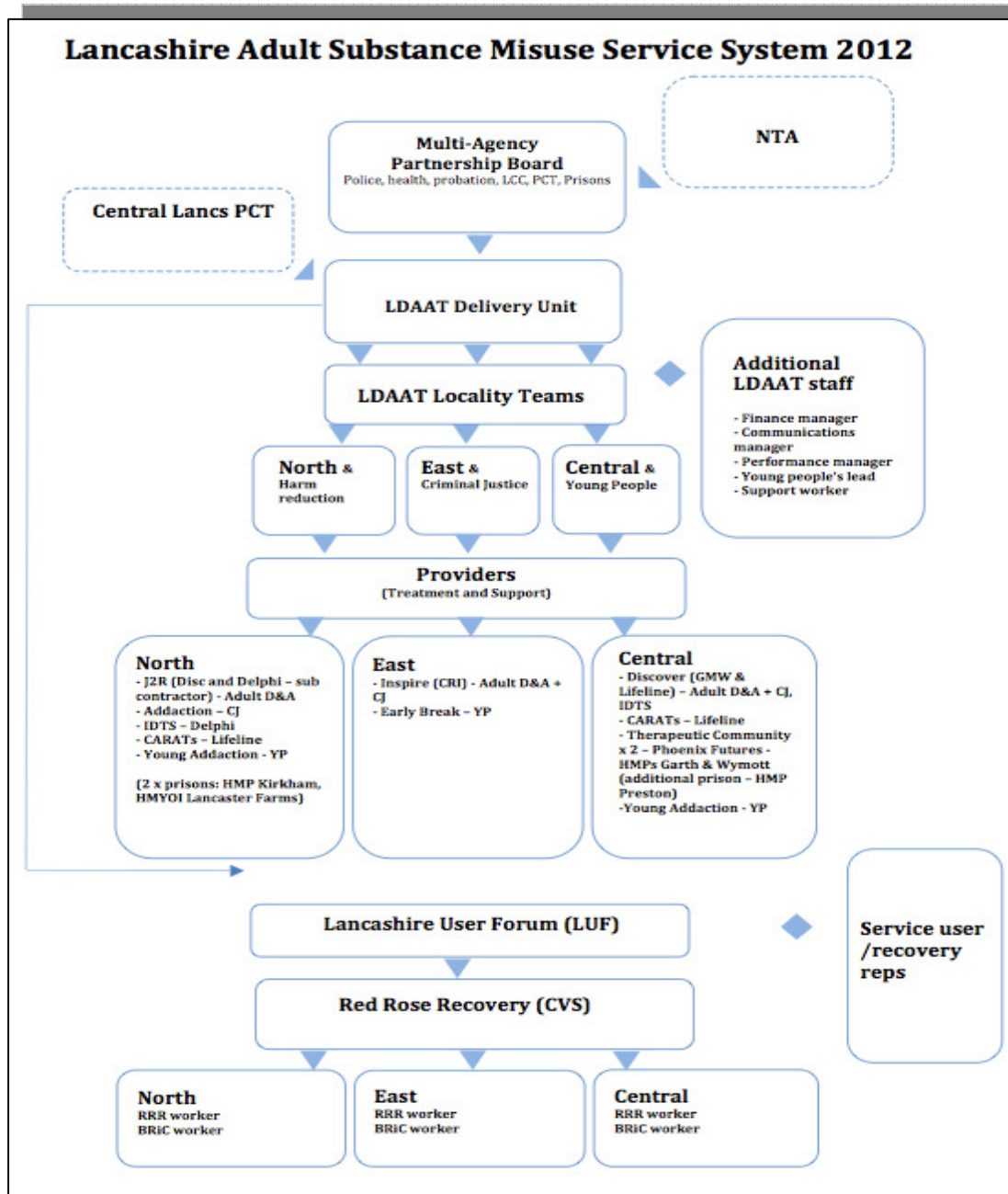
Yates, R. (2002) *A Brief History of British Drug Policy; 1950 – 2001*. Scottish Drugs Training Project. Stirling: University of Stirling.

Yates, R. and Malloch, M. (2010) (eds.) *Tackling Addiction: Pathways to Recovery*. London: Jessica Kingsley.

Young, J. (2007) *The Vertigo of Late Modernity*. London: Sage.

Yukl, G. (1999) An Evaluation of the Conceptual Weaknesses in Transformational and Charismatic Leadership. *The Leadership Quarterly*, 10(2):285-305.

## Appendix One: Lancashire Adult Substance Misuse Service System 2012



## Appendix Two: Interview respondents

	<b>Role</b>	<b>Locality</b>	<b>Code</b>
1	Strategic	National	S1
2	Strategic	County-wide	S2
3	Commissioner	County-wide	C1
4	Commissioner	County-wide	C2
5	Commissioner	East	C3
6	Commissioner	Central	C4
7	Commissioner	North	C5
8	Commissioner	Wigan and Leigh	C6
9	Provider	National	P1
10	Provider	North West	P2
11	Provider	Central	P3
12	Provider	National	P4
13	Provider	North	P5



14	Provider	East	P6
15	Provider / peer support	East	PP1
16	Provider / peer support	Central	PP2
17	Provider / peer support	East	PP3
18	Provider / peer support	County-wide	PP4
19	Provider / peer support	North	PP5
20	Provider / peer support	East	PP6
21	Volunteer / peer support	North	VP1
22	Volunteer / peer support	East	VP2
23	Volunteer / peer support	County-wide	VP3
24	Volunteer / peer support	North	VP4
25	Volunteer / peer support	Central	VP5
26	Volunteer / peer support	North	VP6
27	Service user	East	SU1
28	Service user	North	SU2

## Appendix Three: Interview schedule

<i>Phase Four Interview Schedule</i>	<i>Date and ID:.....</i>
<p>Note: All interviewees to read respondent information sheet, asked if they agree to the interview being digitally recorded and sign the consent form.</p>	
<p><i>Overview</i></p> <p>The key aim of Phase Four is to provide a critical reflection on how policy is interpreted in the context of the 'recovery' agenda from strategic, commissioning, provider, user and carer perspectives.</p> <p>In light of changes in service delivery and the shift towards more recovery-orientated provision we're looking for your views on what's different?</p> <p>So, to start with I'd like to talk about what's happening in practice....</p>	
<p><b>1. PRACTICE (Challenges and conflicts)</b></p>	
<p>1.1 What are workers / service users / mentors doing at the moment?</p> <p>(Can you give examples? – explore how this is different from before; explore views on activity and how it all works)</p>	
<p>1.2 In what ways do you think it fits with the old styles of practice? / Do you think there is any conflict?</p> <p>(NX, methadone maintenance, detox, stabilisation for drugs and alcohol...)</p>	
<p>1.3 How does 'harm reduction' fit with what you do?</p> <p>(Define harm reduction, does it still have a place...if so, give examples; if not, why not?)</p>	
<p>1.4 Which groups are you targeting (or attracting) in what you offer?</p> <p>(Can you give me examples? - e.g. traditional services user – 35-45 years old, white male heroin users; ex-offenders; drinkers in service for a long time?)</p>	

(Are you groups self-selecting by what you offer?)

1.4 (a) If you attract a particular group, why do you think that is, and where does that drive come from?

(by default or design? A drive from commissioners / policy makers?)

1.4 (b) Do you think there are any particular groups who don't use your service / activity?

(Who and why do you think this is?)

1.5 Does your practice consider individual service users' assets or strengths?

(What else is there for people – other options to peer support etc...?)

1.5 (a) How does this work in practice?

1.6 Is your practice / activity sustainable in the future?

(Funding, availability of free course and activities etc)

(LUF – explore some of the issues around 'recovery champions' – how sustainable are these roles / how do people move on? Burn out etc...)

## **2. EXPECTATION**

2.1 Where do you see you practice / response / commissioning decisions (etc) going?

(e.g. devolving of LUF / move towards outcome focussed monitoring – PbR etc /more assessments / formulaic clinical management etc...)

(LUF – explore the idea of Recovery Champions – how do they see things with the change of chair etc...)

2.2 Do you see your activity growing?

(In what ways? / Does it have its own impetus / financial stability / independence?)

(Again, with LUF explore – 'recovery champions' and how do people move on?)

## **3. THINKING (Debate into practice)**

3.1 What's driving this?

(Commissioners? Government policy? – What's your understanding of it all...?)

3.2 What would you say your concept of 'recovery' is?

(How would you define it?)

3.3 In what ways would you say this is matched to your practice?

(Are there any tensions / disconnect?)

3.4 Are there any other issues you would like to discuss before we finish?

Thank-you for taking the time to talk to us.

## Appendix Four: Going Wild at the Zoo, 1992.

