NEW MODEL ARMY

The very concepts that glue together our drug treatment system are under attack for being too entrenched in medicine. **Ian Wardle** looks at the emerging challengers to a status quo that has dominated policy and practice for more than two decades.

In the drug treatment field we work with a group who are definitely not popular and whose drug-taking activities are against the law. The illegality of controlled drug use, its dangerous and disruptive marketplaces, its negative impact on communities and the health risks it poses to the wider, non-drug using population all make working with this group complex and challenging.

Therefore any drug treatment method capable of commanding government and public support must ensure that the general population can be protected against the broad range of negative health, crime and security impacts associated with illegal drug use. In recent history, methods of drug treatment have been designed in such a way as to fit comfortably within this dominant 'risk management' paradigm.

For over 20 years this harm reduction paradigm – with its mixture of biological, psychological and social ('biopsychosocial') underpinnings – has been the dominant form of therapeutic philosophy and practice in the UK drug treatment field. When, in 1988, the ACMD stated that henceforth HIV/AIDS was to be considered a greater threat to public health than drug misuse, the pathway was cleared for a range of new therapeutic interventions far more radical and flexible than anything that had gone before.

During the course of the mid to late 1990s, with the incoming New Labour administration, the threat of AIDS was seen to diminish and public attention – primed by politicians – switched to the threat of drug-related disorder and crime. Accordingly, the practical focus of our field switched to criminal justice interventions. With the ever-greater emphasis on crime, many of the harm reduction radicals who had come into the field in the 80s and early 90s felt betrayed. Notwithstanding this sense of betrayal, however, throughout the period from 1987 to the present day, both the dominant 'therapeutic' and risk management paradigms within which these harm reduction therapies sit, have remained unchanged.

Harm reduction therapeutics have always been characterised by a strongly palliative approach, such as preventing the spread of blood borne viruses, overdoses and death; to stabilize chaotic patterns of use and to reduce the incidence of injecting. All have a strong emphasis upon the drug users' safety. At the same time, each of these interventions seeks to protect the broader, non drug-using population. In addition to protecting drug users, needle exchanges cut down the risk of the transmission of blood borne viruses, while methadone prescribing reduces the need for dependent drug users to commit acquisitive crime.

We can see, therefore, how the harm minimisation, therapeutic paradigm nests comfortably and, at times, almost invisibly, within the overarching principles and policies of population-wide risk management. These policies aim, on a scientific and actuarial basis, to measure and reduce harms to all sections of society. In this way, the therapeutics of the drug treatment industry have been an integral part of this larger politically driven, population-wide management of risk.

However, this accepted wisdom on drug treatment is now facing a strong challenge, on a number of fronts, by an emerging group of thinkers.

In his 2008 book on addiction, *Fragmented Intimacy*, Peter Adams describes how the medical profession, and more latterly, the profession of psychology have, over the course of the past century, defined and dominated orthodox drug treatment. For Adams, this biopsychosocial (or as he calls it, 'partical', paradigm) is an example of an approach which places undue emphasis on individuals and insufficient attention on the social aspects of addiction. Adams says we need to move towards a 'social paradigm', which he says "shifts the focus of attention away from people as discrete individuals and towards people in terms of their relationships".

Like Adams, William White is also a paradigmatic thinker. In his paper, *Addiction recovery: Its definition and conceptual boundaries* (2007), he describes us as being "on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm". White describes how this new paradigm involves "calls to shift the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management".

White does not shrink from a clear reference to vested interest: "Recovery as an organizing concept that poses financial and ideological threats to existing social institutions and professional roles that have been granted cultural authority to manage [drug and alcohol] problems."

He makes clear that existing drug treatment providers may well feel threatened by the 'recovery' movement: "The recovery paradigm is spawning alternative institutions (eg recovery advocacy organizations, peer-based recovery support centers) and roles (eg recovery coaches, personal recovery assistants, recovery support specialists) that are challenging treatment institutions and competing with them for status and financial resources."

Both Adams and White identify a shift away from the biopsychosocial paradigm. Adams states that his book has been written with the "paradigm switcher in mind". In moving from

the 'particle paradigm' to the 'social paradigm', Adams urges us to change our vocabulary in order to reinforce the relational nature of addiction. Unlike White, Peter Adams wants to avoid the concept of 'recovery'. Adams states: "Words such as relapse and recovery are embedded in particle thinking and tend to focus attention onto qualities attached to the person and thereby convey little of a relational view of addiction. They will be replaced with relational words such as reversion and reintegration."

The challenge mounted to the dominant, professionally led biopsychosocial paradigm by both Adams' 'social paradigm' and by William White's 'recovery paradigm' is joined and extended by Bruce Alexander. In 2008's *The Globalisation of Addiction: a Study in the Poverty of the Spirit*, Alexander extends the critique of the dominant medical and psychological view of addiction: "For the present, mainstream psychology, like mainstream medicine, is inseparably wedded to the conventional wisdom on addiction. For this reason, it is not particularly useful on this topic."

Alexander, like Adams and White, is advocating switching paradigms. He has been led to this conclusion almost by accident: "Without meaning to…I kept coming across insights into addiction that were more powerful than those I had encountered in the professional literature on addiction."

Alexander has developed an historical perspective which he describes as the 'dislocation' theory of addiction, which forms the basis of his book. Like Adams he does not believe that addiction is an individual problem. In addition, from his historical perspective, he goes further in challenging the contention that drug addiction is the prototypical form of addiction.

"Switching to an historical perspective on addiction is not as easy as it may appear, because conventional wisdom stands in the way," he writes. Alexander provides wide-ranging evidence, however, that alcoholism and other addictions plague our modern cities because they are "unavoidable by-products of modernity itself".

Two of the key ideas in his paradigm are that firstly, drug addiction is merely a small corner of a larger addiction problem and secondly, the "large-scale dislocation, fostered by the continuing growth of free-market society, is the root cause of the current proliferation of addiction across the globalising world."

For Alexander, it is this global market place that undermines psychosocial integration: "Addiction is neither a disease nor a moral failure, but a narrowly focused lifestyle that functions as a meagre substitute for people who desperately lack psychosocial integration. Only chronically and severely dislocated people are vulnerable to addiction. Why would anybody who was not suffering from an agonising lack of psychosocial integration ever devote his or her life to a narrow, dangerous, offensive lifestyle?"

He adds: "Adopting a global, historical perspective on addiction does not mean turning away from the valiant, individual struggles of addicted men and women and their families. Nor does it mean turning against the addiction professionals who have served the conventional wisdom with such compassion. It could mean, however, re-organising the practices of addiction professionals within a larger social project."

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Yet another voice critical of the current role of professionals is Jim Orford. In his 2008 paper *Asking the right questions in the right way – the need for a shift in research on psychological treatments for addiction*, Orford develops the criticism of current psychological treatments for addiction which he calls the 'technology model'.

"The addiction field may be accused of lagging well behind some of the newer ideas in the health services and health sciences, where the involvement of service users in thinking about services, professionals sharing decision-making about choice of treatment, and the promotion of partnerships with members of disadvantaged communities in order to ensure service appropriateness and accessibility, are valued highly."

Like Adams, Alexander and White, Orford emphasises the spiritual dimension to change. Whereas for White, the onus is on 'recovery', for Orford the dominant organising concept is 'change'. Orford, like White, has long drawn attention to the role of organisations like Alcoholics Anonymous. "The continued prominence and growth of mutual-help organisations, particularly AA and other 12-step organisations…strengthens the argument that the change process is not to be understood most readily by accepting the supposed rationales of modern physical or psychological treatments, or by taking too seriously their techniques, but rather by an appreciation of the factors that are common to a variety of forms, whether religious, medical, psychological or unaided."

This is a time of uncertainty and change. It is also a very exciting time of challenge and fundamental review. We are examining the fundamentals of our field, our traditional patterns of professional dominance, our beliefs and our science at a time when the long steady growth in drug treatment may well be about to be reversed. One exciting change is the emergence in the north west of England and Scotland of a movement devoted to recovery. This movement is characterised by a sense of partnership, entrepreneurialism, optimism, critique and solidarity. The new, recently inaugurated Recovery Academy, led by David Best and Stephen Bamber and supported by the North West NTA, is seeking to build upon its successes in turning lives around by arming itself with a 'recovery science' so that it can argue its political and evidentiary case more broadly and more effectively.

In addition to the recovery paradigm, however, there are, as I have shown, a range of new, exciting and fundamental challenges to our traditional ways of thinking about addiction and to our current professional orthodoxies. We must enjoy and explore these challenges and, just as importantly, work through how these new perspectives can feed into and influence the broader social paradigms on illegal drug use and the risks and harms that attach to it. At the same time as challenging and amending our field's therapeutic paradigms, we must never ignore the struggle to change the broader political paradigms within which they sit and without which they cannot operate.

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Ian Wardle and David Best will be speaking at DrugScope's Annual Conference in October 2009.