The Strategic Isolation of the British Drug Field and the new Recovery Philosophy.

Introduction

In March 2008, a new 10 year national drugs strategy document was published: *Drugs: protecting families and communities.* This new drug strategy presents an agenda which strongly reinforces the main points of the last strategy with its emphasis on crime reduction and community safety. Like its predecessor, it says less about individual health and social outcomes.

In the same month the United Kingdom Drug Policy Commission, (UKDPC), an independent think tank, published a major report on the drugs strategy and its key focus criminal justice. The UKDPC[1] report, commenting upon the rapid expansion in UK treatment provision, argued that the recent focus on quantity should now be replaced by a focus on quality. "There is a concern that an emphasis on reducing offending may cloud the focus on the individual and their recovery, leading to simply the 'management of addiction' with a view to containing offending behaviour."

Moving from the provision of "quantity" to the provision of "quality" may not be easy or straightforward. Do we, as a field, know how to make this transition?

On October 13th of last year, the BBCs Home Affairs correspondent, Mark Easton, produced a report for the Radio 4 Today programme[2], *Payment for Addicts,* which asked some fundamental questions about the national drug strategy, the role of the government body responsible for delivering the strategy, the National Treatment Agency (NTA) and the value of the main 'technology' used in medical treatment interventions: methadone. In the BBC Radio 4 programme, Analysis[3], broadcast on March 27th, another full frontal attack on methadone was launched by a wide ranging group of researchers, ex-users and treatment providers. One clearly identifiable factor that both broadcasts shared was a failure on the part of those advocating the therapeutic role of methadone to make a credible case for its very widespread use as a maintenance management tool.

Writing about this "PR retreat" in an important article published in January's edition of the Druglink magazine[4], Mike Ashton, an independent journalist and highly respected commentator, wrote that "Opiate substitution is as close as we get to a silver bullet in addiction treatment. But in PR terms in Britain, and worse, to a degree in practice, its potential has been squandered. …The oral methadone services left in the wake of this retreat have allowed themselves to concede the reintegration ground to drug-free services, allowed themselves not to be seen as potentially an effective platform for non-residential rehabilitation. This is partly because in reality they have failed to realise this potential. Nationally the ambition has been titrated down to keeping patients off the streets and out of the courts, a poverty of ambition now rightly being challenged."

It is perhaps coincidental that at the precise moment the expansion of drug treatment has reached its limit and is about to be go into reverse, the wave of informed and engaged criticism of the national drugs strategy and its main technological and therapeutic interventions is going from strength to strength.

Increasingly, the field is divided between those who believe that the strategy and its focus on methadone maintenance treatment is substantially correct and those who believe that the national drugs strategy needs a radical review in order that a new focus on abstinence can be achieved.

In March, 2008, a group of drug policy, research and treatment professionals came together as a Consensus Panel under the auspices of the UK Drug Policy Commission. The purpose of this group was to reach a Treatment Consensus. This consensus aims to reconcile, on the one hand, the harm reductionists, who believe that opiate substitution has an important role to play in promoting stability and wellbeing for many patients with drug dependency problems and, on the other hand, abstentionists who believe that recovery is essentially a journey whose destination involves the achievement of a drug free state. In effect, therefore, the UK Drug Policy Commission Treatment Consensus is aiming to define Recovery in such a way as to identify both pharmacologically assisted therapies and abstinence as two modalities that can be located on a single recovery spectrum.

This process reflected a similar approach which took place at the Betty Ford clinic in California in 2007. In order to learn from this exercise, the UKDPC treatment consensus group, decided to invite a noted American Addiction Specialist, Tom McLellan, professor at the Center for Studies of Addiction at the University of Pennsylvania School of Medicine in Philadelphia, to help facilitate the group. Tom McLellan had played a major role in the Betty Ford Consensus Panel and, in October 2007, had published an article in the Journal of Substance Abuse called: *What is Recovery?*[5]

Tom McLellan's insights were invaluable. He was able to describe the American treatment field in such a way as to shine a light on our current predicament in the UK. Talking about the US Treatment and Addictions field, McLellan stated at the outset that "We made a bad mistake becoming isolated".

The Isolation of the Drug Treatment and Policy Field

The drugs treatment and policy field has emerged and matured under conditions, relatively speaking, of professional, philosophical, strategic and institutional isolation.

In this country, over the course of the past 20 years, the perceived society-wide risks of drug use have governed the development and growth of the drug treatment and policy field. The drugs treatment and policy field has carved out an enviable position for itself within a unique boundaried space that straddles the health, social care and criminal justice sectors. The specific fears that drug use has engendered, at various stages over the course of this period, have promoted a public climate that has encouraged successive governments to invest in the

kind of treatment services that have sought, in one way or another, to quarantine drug users from mainstream society.

The public have been successively and successfully alarmed by the spectre of mass addiction (1981-1987) the threat of the AIDs pandemic (1987-1995) and most latterly, the fear of drug related crime and disorder (1995-2008). The chronology thus outlined has promoted successive waves of dedicated, ('ring-fenced') funding.

This quarantining has not been without benefits for those whose drug use has brought them into contact with treatment services. As a result of these benefits, however, drug users, particularly, regular users of 'hard' drugs like heroin and crack cocaine, have been effectively marginalised from mainstream services. The social marginalisation of the problem drug user has been mirrored, in some senses engineered, by these strategies of isolation that governments have preferred for this group of citizens.

Drug policy has evolved and developed within the well-protected and well-funded confines of a national policy framework. This framework has been further strengthened since 2001 by the creation of a Special Health Authority, the National Treatment Agency, (NTA), which has been charged with ensuring that the strategy and it targets are achieved.

Despite the leading role of the National Treatment Agency, the focal point of treatment interventions have been designed in such a way as to meet the priority objectives of the Home Office. To this end treatment and criminal justice have become very closely intertwined in our national strategy.

The growing importance of criminal justice targets has had a profound influence on the strategy. The distinct non statutory bodies initially charged with delivering the strategy at local level, Drug Action Teams, (DATs), have tended to become absorbed into local statutory partnerships charged with the reduction of crime and disorder, including drug related crime and disorder.

The recent report from the UK Drug Policy Commission, (UKDPC), *Reducing Drug Use, Reducing Reoffending* identifies a current annual spend for specific drug interventions within the adult Criminal Justice System (CJS) of over £330 million. (2006/2007).

Many employed within the UK drug treatment and policy field have strong apprehensions about the ever closer alignment of what we used to call 'drugs work' with the Criminal Justice System.

Far from lessening the isolation of the drugs strategy, it is felt that the growing alignment with criminal justice has actually only served to further isolate the drug treatment field from other related health and social care sectors delivering care and support to socially excluded people in the United Kingdom.

We have grown adjacent to, but in relative isolation, from other key health and social care sectors. Responding faithfully to a strong national lead, our centre of gravity has moved steadily and ever closer towards the Criminal Justice Sector. This movement has enabled the field to grow and prosper, but it has also served both to isolate us strategically and

programmatically from key transformations at local level and also to isolate our thinking from that taking place in key adjacent health and social care sectors. (This is not to deny or seek to escape our field's historical links with a tradition of radical penal welfare. Indeed, projects like Lifeline have their roots in this honourable tradition)

We are in danger of becoming permanently cut off from a new and exciting set of aspirations for communities and individuals and from the transformational thinking that is inspiring these changes.

Our Isolation and its key dimensions

Our isolation can be identified in the following four ways:

1. We are becoming isolated from each other: the first recovery debate.
2. We are becoming isolated from the public: the second recovery debate.
3. We are isolated from the new personalisation and recovery oriented philosophies of care that are inspiring colleagues in other sectors such as mental health and social care: the third recovery debate.
4. We are isolated from the neighbourhood based transformations taking place at local level through the new commissioning for health and well being. We have no clear place in the sustainable communities that local partners are seeking to build.

1. We are becoming isolated from each other: the first recovery debate

For several years our field has seen growing divisions between abstentionists, on the one hand and an often unexplored 'harm reduction' alliance of clinicians, practitioners and policy specialists on the other. The latter group have been seen to advocate the importance of opiate substitution as the main technology of intervention in the management of problem drug use. This division has been quite pronounced in Scotland and the North West of England and has promoted a series of vigorous and occasionally negative debates. These debates reflect similar disagreements in other countries.

In the United States, for instance, writers and specialists in the addiction field have been concerned to develop a philosophy of care that will bring together these rival camps under a common philosophy.

This philosophy of care aims to identify pharmacological therapies, such as opiate substitute prescribing on the one hand and abstinence based models on the other as being two modalities capable of being located on the same spectrum. This single spectrum, according to writers like William L. Whyte and Tom McLellan is the spectrum of recovery. We are thus, potentially on the threshold of a new philosophy of care which may well unite the hitherto irreconcilably divided camps and develop a new style of recovery-oriented practice.

William L. Whyte, writing in the Journal of Substance Abuse Treatment[6], says, "There is growing evidence that the alcohol and other drug (AOD) problems arena is on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused

recovery paradigm." Whyte identifies a new recovery advocacy movement and notes "calls to shift the design of addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management."

Whyte doesn't underestimate the difficulties of bringing together people of widely different and often clearly conflicting views: "There will be multiple efforts to define recovery, and complete consensus on recovery definition between all stakeholders in the AOD problems arena is unlikely." Notwithstanding the scale of the challenge, however, Whyte has grounds for cautious optimism: "[it] may be possible to assure diverse representation in these efforts and to assure that the most critical questions are addressed within these deliberations." Whyte puts his own cards firmly on the table when he states: "An ideal definition of recovery would be broad enough to embrace both incremental and transformative styles of recovery initiation and consolidation."

Whyte says: "The question for the field is whether the moderated resolution of AOD problems will be embraced within the conceptual rubric of recovery." "Groups like Narcotics Anonymous (NA) have defined recovery in terms of abstinence from drug use, but addiction scientists have generally defined recovery from illicit drug dependence in terms of problem resolution rather than absence of drug use." Whyte is clearly worried that people using methadone and other socially stabilizing opiate substitution drugs will be denied membership of the Recovery movement: ***"How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence."***

It would be the ultimate indictment of our field if, in its haste to embrace a new and exciting philosophy of care, it inadvertently consigned tens of thousands of drug users in treatment to an even more stigmatised position in society than the one that they currently hold.

This debate, the first recovery debate, was for some time confined to ourselves in the drugs field. Increasingly, however, our divisions are attracting the attention of journalists and policy communities. Their interests extend beyond a curiosity with the internal politics of the UK drugs field. Their main concern is with the role that drug strategy, policy and treatment practice play within the national political arena. This is the second recovery debate.

2. We are becoming isolated from the public: the second recovery debate.

Our attempts to explain our broad harm reduction philosophy of care have begun to falter badly. There are occasions in broadcast interviews where spokespersons for our strategy seem unclear about its full range of key benefits. It feels as if key sectors including our own workforce and the policy community are ceasing to believe in what we are doing.

Our previous harm reduction philosophy and practice are seen by researchers like Dr. David Best to have produced disillusion and instrumentalism among staff, low expectations of clients, low expectations by clients and, overall, to have the effect of stigmatising treatment. Best and colleagues point to a clash of objectives; an incompatibility of goals in our national strategy between public health and safety, on the one hand, and individual wellbeing on the

other. In their view the adverse effects of a dominating maintenance regime are pervasive and contribute to the stigma around entering substitution treatment. Best also believes that such a regime contributes to a workforce ravaged by the effects of 'learned helplessness'[7]

Our own self-questioning has not gone unnoticed. Neither has the increasingly persistent questioning on the part of journalists regarding the effectiveness of our current forms of treatment. The attacks on treatment effectiveness have become very apparent through Radio 4s Today and Analysis programmes. In addition, the public is increasingly exposed to reports about the burden to the taxpayer of drug and alcohol users claiming benefits. A national drug strategy that champions treatment as the key driver both in reducing crime and also in reducing the benefit burden on the taxpayer will quickly unravel if the publics' perceptions are that treatment itself is not effective.

A vigourous recovery movement championing the virtues and value of abstention is to be entirely welcomed. It will form a critical part of the spectrum of recovery talked about by writers like William L. White and Tom McLellan.

However, Abstentionism as a punitive philosophy, a stick with which to beat this government, the drugs field, the NTA and, last but very definitely not least, dependent drug users, is absolutely not to be welcomed.

Abstentionism in the wrong hands is a very damaging tool indeed. The RSA think tank, in its commentary on the government's new strategy, states that "the current political climate on drugs is moralistic, at least partly because the Conservatives have adopted a stern stance in favour of abstinence…" This seems to be borne out by statements like the one from Tory MP David Davies,[8] "Taxpayers will be outraged that so much of their money is going to junkies and winos who will uses the money simply to feed their disgusting habits. Nobody forced them to get hooked on drink or drugs. It's their responsibility to get cleaned up and off benefits."

This latter point is emphasised in somewhat more modest language by Home Secretary Jacqui Smith in her foreword to the new national drug strategy.[9] She says: " [b]e clear that drug users **have a responsibility** (original emphasis) to engage in treatment in return for the help and support available." Speaking about treatment, she says, "we will clearly prioritise those who are causing the most harm to communities and families." The RSA[10] concludes that the tendency to set drug users apart from society is also detectible, though not necessarily deliberate, in the new drug strategy's title, *Drugs: protecting families and communities*

The first recovery debate remained within the confines of our field. The second recovery debate has already served to isolate people with drug problems from families, communities and the taxpayer. A new and politically punitive use of 'abstinence' is emerging and influencing, in its different ways, the pronouncements of both government and opposition politicians.

As a field, we still retain a degree of confidence that drug treatment has helped reduce crime. Our inability as a field to influence these important current debates, however, is largely as a

result of our own faltering confidence in what we have achieved in respect of other crucial health and social benefits on behalf of a large proportion those people who use our services.

3. We are isolated from the new personalisation and recovery oriented philosophies of care that are inspiring colleagues in other sectors of health and social care: the third recovery debate

The third recovery debate has had a profound influence on thinking in mental health and social care, but has not, until recently, had any real impact in the drugs field.

A recent joint position paper, *Common Purpose*,[11] from the Care Services Improvement Partnership (CSIP), the Royal College of Psychiatrists (RCPsych) and the Social Care Institute for Excellence (SCIE) states that the turn towards a recovery oriented care is "based on the core belief that adopting recovery as a guiding purpose for mental health services favours hope and creativity over hope and despair." The strikingly positive tone of this declaration would seem out of place in the strategies and policy positions of the drug treatment field, but it is by no means unusual in the most current mental health literature.

For all, its idealism, however, the concept of recovery is a broad concept and not a narrow one. It is pointed out that, "In ordinary speech, recovery is often equated with cure … However, for severe mental health problems, and in reality all long-term conditions, outcomes are more complex and are described both by resolution of symptoms, impacts on life domains affected by illness, and growth and development of other valued life experiences." The current concept of recovery "[i]s not limited by the presence or absence of symptoms, and disabilities, nor the ongoing use of services. The concept of personal recovery pivots around considerations of how to live and how to live well in the context of long-term mental health conditions." This breadth of definition clearly doesn't make treatment the major issue. Neither does it rely upon a simple criterion of recovery as cure.

This theme is taken up in another recent publication entitled *"Making Recovery a Reality"* from the Sainsbury Centre for Mental Health[12]. Here, the authors state "'Recovery' is an idea whose time has come. At its heart is a set of values about a person's right to build a meaningful life for themselves…" They go on to say: "A central tenet of recovery is that it does not necessarily mean cure ('clinical recovery')." Instead, it emphasises the unique journey of an individual living with mental health problems to build a life for themselves beyond illness ('social recovery'). Thus, a person can recover their life, without necessarily 'recovering from' their illness.

The Sainsbury report also make clear that these ideas "[c]an also be applied in specialist areas such as forensic mental health services, brain disorders and drug and alcohol problems."

But can we in the drugs field really embrace this radical-sounding new philosophy of care? To quote a *Common Purpose* " [e]ngagement with a recovery orientation is a matter of open and continuing debate for professions and services." The report also points out that this "emphasis on recovery is fully consistent with current government policies in health and social care in England and Wales, citing amongst other papers, the White Paper, *'Our health, our*

care, our say (DH, 2006) and the *'Commissioning framework for health and well-being* (DH, 2007).

Are we in the drugs field really ready for recovery debate number 3? Are we not too busy attempting to reconcile the differences in our own field (recovery debate number one) and warding off and, hopefully countering, the kind of punitive notions of recovery being advanced by certain policy communities (recovery debate number 2). Are we really ready to take on and absorb a set of radical ideas that seem, at first sight, to be at such odds with our current emphasis on quantity over quality, our top-down models of governance and our increasingly coercive policies with their clear prioritisation of "those who are causing the most harm to communities and families" (*Drugs: protecting families and communities*, Home Office 2008).

The Scottish Advisory Committee on Drug Misuse (SACDM)[13] clearly thinks that the drugs field is ready to join recovery debate number 3. In fact, in their view, internal divisions and external political manoeuvring can only be adequately dealt with if the drugs field is ready to learn from other sectors by taking on fresh perspectives about recovery.

In March, 2008 the Scottish Government published a report from SACDM entitled, *Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland*. The Committee addresses the key issue at the heart of recovery debate 1 by stating in its Executive Summary that "recovery may not involve abstinence -- all services and commissioning partners must put service users at the heart of their activities."

Essential Care was written before the paper from the Centre for Policy Studies, entitled *The 2008 Drug Strategy -- The continuing nationalisation of addiction.* The paper, by Kathy Gyngell, Chair of the Centre's Prison and Addiction Policy Forum[14], states that "The necessity of abstinence, which in other European countries is recognised as the key step on the road to recovery, is absent from UK treatment policy. The revised strategy pays lip service to it -- possibly in response to recent criticism of poor policy outcomes -- but mentions it is only as an optional add on, not as a fundamental."

Despite its earlier publication date, the Scottish Advisory Committee on Drug Misuse could have been writing about the Centre for Policy Studies when they argued that "…recovery must become a key focus of the care available for problem substance use rather than an ideology which advocates any particular type of treatment." In the introduction to section 1 of the report, the Committee states: "We must create a continuum of care which balances the undisputed need to reduce the harm associated with problem substance use while maximising the opportunity to return to normal lifestyles and activities whenever this is realistic."

The introduction also states that "Services may not be emphasising recovery -- instead engendering a culture of dependency on the services themselves." In other words, it is not acceptable to reduce harm if, at the same time, one is limiting recovery? "In response to the perceived nature of problem substance users, many services have developed approaches which fail to maximise potential. These services can make service users into passive recipients of interventions which are organised, not around their hopes, wishes and aspirations, but around the needs of services to develop systems which meet high levels of demand and manage risk."

4. We are isolated from the transformations taking place at local level through the new commissioning for health and well being. We have no clear place in the sustainable communities that local partners are seeking to build.

The drug specific PSAs (Public Service Agreements) represent the highest level of the government's strategy objectives for our sector. PSA 25 is entitled: Reducing the harm caused by alcohol and drugs. The targets that PSA 25 identifies are 1) the number of drug users recorded as being in effective treatment; 2) the rate of drug-related offending and 3) the percentage of the public who perceive drug use or dealing to be a problem in their area.

These targets reflect a social group that is identified almost exclusively in terms of the harms with which it is most readily associated.

In speaking of the new 'personalisation agenda' in social care, Cabinet Secretary, Ed Milliband speaks positively and passionately about the need to move beyond traditional welfare solutions for those who are poor, excluded and in need. The personalisation agenda speaks to two key contemporary political priorities: firstly, the need to put individuals in control of their own care and support and secondly, the need to match this new form of effective demand with a new market place of effective supply. The creation of the new one-to-one, directly-accessed (online) social care markets is key to providing appropriate breadth of choice for the newly enabled budget-holding citizens as they seek to take control of their lives.

Milliband and others, within CSIP (The Care Services Improvement Partnership), the RSA, Demos and other policy communities are pointing the way ever more clearly towards the creation of a range of new public goods supplied through new outcome-based, locally driven systems. Where is the drug treatment field in this new world? According to Demos, "Self-directed support plans would make sense for ex-offenders and drug users committed to finding work and improving the quality of their lives."[15]

Will we, as a field, be able to make the breakthrough into this new world of recovery and personalised services or will we continue to be isolated in a world of narrow treatment and enforcement perspectives? Too much of our current model of harm reduction equates to minimising the harm to society by consigning our service users to helplessness and hopelessness.

Part of the explanation for this state of affairs lies with the unpopularity of our client group. ***The more unpopular the client group, the more difficult it is to see the service user, to respect the service user and to empower the service user.***

We work with the " 'undeserving' very socially excluded".

We work with a group of citizens who aren't just socially excluded, they are very socially excluded. In addition, they are regarded by the public as a very undeserving group. One might, therefore, describe our client group of problem drug users as the "'undeserving', very socially excluded". In the main, local communities as well as the public at large does not

identify the treatment and rehabilitation of drug users as one of Ed Milliband's new Public Goods. On the contrary they regard drug use and drug users as a clear example of a Public Bad! So often community empowerment has involved communities exhibiting powerful self-organisation in order to slow-down and discourage the provision of drug services. At local level we are a long way from demonstrating that we are not a public bad, but an essential part of a successful and sustainable local strategy

This has had a negative effect on some of our treatment services. Many of our clients are not faring well. "Some services may even resist service users' requests to explore other approaches to recovery such as detoxification or residential rehabilitation, reducing opportunities to progress. In some services staff can find themselves dispirited and may lower their expectations of service users." (*Essential Care*, March 2008)

Another explanation for our poor performance lies in our inability to address the complex range of needs that most problem drug users have. The shift to a recovery-oriented paradigm will require a much greater focus on the broader determinants of health and well-being, such as employment, housing and, critically, the restoration of social networks. "A genuinely person-centred approach must look at every facet of a person's life--as well as their drug habits." (*Making it Personal*, Demos, 2008) Nevertheless, as the Scottish Committee makes plain, "The complexity of substance users' problems should not be accepted as an excuse not to pursue recovery." (Essential Care, Scottish Advisory Committee on Drug Misuse, March 2008: p 7)

Our current models of treatment are unlikely to capture the imaginations of local partnerships. Our national strategy has promoted and endorsed a sector that has developed in isolation and as a consequence is not well positioned in many local partnerships. Our inability to point to positive, community-enhancing outcomes is telling against us as local level. We need to focus far more clearly upon what we can contribute to the new commissioning environment.

The new commissioning frameworks at local level do have a difficult balancing act to maintain. On the one hand, they have to learn how to speak up for the Community, whilst at the same time they must ensure that excluded groups are not left out. The Department of Health's *Commissioning framework for health and wellbeing* sets out the direction of travel very clearly: "[we] need to look further than just physical health problems, to promote well-being, which includes social care, work, housing and all the other elements that build a sustainable community."[16]

This is the key to the future of our field: to build a firm foundation for our services within the sustainable community planning frameworks of local partnerships. The new framework is an enabling framework for our field in so far as it demonstrates a clear need to include the excluded: "Commissioners should also focus on those whose voice is not often heard (such as children and young people, socially excluded people, asylum-seekers) and use a variety of engagement, equity audit or social marketing approaches to ensure that they are able to have their views and needs recognised."

Conclusion

We are charged with nothing less than enabling our clients to speak with the newly enabled voice of recovery. By working more closely with providers and commissioners at local level and by addressing the full range of our clients needs together we will develop a solution focused strategy in relation to problem drug use. We will develop packages of person-centred care that tackle the needs of our clients and go beyond just the clinical stabilisation of physical symptoms.

Of course we must acknowledge that we are not alone in needing to develop and learn. The *Commissioning framework for health and wellbeing* looks closely at current commissioning capacity and acknowledges that: "Many commissioners (whether NHS or local authority) may find it hard to bring together the capacity, capability and leadership necessary to commission health and well-being." Commissioners in the drugs sector need to reach out to other commissioners in order to achieve more comprehensive and inclusive assessments of need for our clients. Those of us responsible for providing services have a right to expect commissioners to take, in the words of the *Commissioning framework* "a more proactive approach to market shaping".

At the same time, the onus is upon major providers of drug treatment services to develop an organisational capacity to deliver radical innovation. Here, transformation must mean more than just the joining up of IT systems and the sharing of back office functions. It means that providers in the drugs sector need to reach out to other providers, inlcuding providers of housing, education and health care, in order to achieve more comprehensive and inclusive service solutions for our clients. Our different organisations all too often serve the same customers. We need to begin to act on the whole 'system' and not just on separate service silos.

This is a very significant challenge and one that is being defined, described and undertaken as part of the devolution of control from Whitehall to local partnerships. Our recent experience in the Drug Treatment and Policy field is one of supporting a well-funded annually-expanding, target driven strategy. We are in the process of moving into a fundamentally different world. A world where our ability to form credible and lasting local partnerships will determine our effectiveness. A world where we can count on far less in the way of centrally guaranteed, ring-fenced funding. A world where the personal recovery journeys of our service users must shape the trajectory of our service plans and, crucially, win the support of local communities and not their hostility and mistrust.

In this world, we need as a sector to learn from each other and from our colleagues in other sectors and to work genuinely towards putting our service users at the centre of all that we do. This means all of our clients, not just those for whom abstinence is a chosen and preferred route.

In short, we must bring to an end our professional, strategic and institutional isolation.

[1] UK Drug Policy Commission: Reducing Drug Use, Reducing Reoffending. March 2008

[2] “Payment for Addicts”, Home Affairs Correspondent Mark Easton, BBC Radio 4 Today, October 13th 2007

[3], ‘Can we kick the habit?’ BBC Radio 4 Analysis, 27th March 2008

[4] Mike Ashton, The New Abstentionists, Druglink, Jan-Feb 2008

[5] The Betty Ford Institute Consensus Panel, “What is recovery?”, Journal of Substance Abuse Treatment 33, (2007)

[6] William L. White, Addiction recovery: Its definition and conceptual boundaries, Journal of Substance Abuse Treatment 33, (2007)

[7] David Best, Jessica Loaring, Safeena Ghufran and Ed Day, Different Roads, Drink and Drug News, 19th May 2008.

[8] David Davies MP, quoted in Daily Express article ‘Outrage at £8.5M a week for jobless junkies and winos, (Daily Express April 8th 2008).

[9] Jaqui Smith, Home Secretary’s Foreword: Drugs: protecting families and communities, (the 2008 drug strategy), HM Government, 2008

[10] RSA: Commentary on the 2008 drug strategy -- Drugs protecting families and communities, RSA, 2008

[11] Care Services Improvement Partnership (CSIP), Royal College of Psychiatrists (RCPsych), Social Care Institute for Excellence (SCIE): A common purpose: Recovery in future mental health services., Social Care Institute for Excellence, May 2007.

[12] Geoff Shepherd, Jed Boardman & Mike Slade ,Making Recovery a Reality, Sainsbury Centre for Mental Health, March 2008.

[13] Scottish Advisory Committee on Drug Misuse (SACDM), Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland, Scottish Government, March 2008

[14] Kathy Gyngell: The 2008 Drugs Strategy, The Continuing Nationalisation of the addiction, Centre for Policy Studies, March 2008.

[15] Charles Leadbeater, Jamie Bartlett and Niamh Gallagher, Making it Personal, Demos 2008.

[16] Department of Health, Commissioning framework for health and well-being, Department of Health, March 2007.