Recovery and the UK Drug Treatment System: key dimensions of change.

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1 The Scope and Purpose of this Discussion

This discussion aims to develop the ongoing debate about the future of the Drug Treatment field in the United Kingdom. It takes up certain themes from the current debates and discussions about the Recovery Orientation in drug treatment and seeks to locate these discussions historically in terms of a paradigm analysis, but also contemporaneously in terms of other key dimensions of current change.

In addition, therefore, to the dimension of change described by William L.White, (a transition from an acute care paradigm to a solution-focused recovery paradigm), I seek to contextualise some elements of the current recovery discussions within the following transformations as described by various authors and bodies.

Firstly, (key dimension of change 1) I examine the transformation in Social Care called for in the Putting People First Concordat. I describe the aspirations in the words of the signatories of the Concordat and then compare them to some of the viewpoints expressed in the current work of David Best *et al.* I also examine the impact of the direction of travel needed in order to fulfill the expectations of the Concordat and Best *et al,* and in this context I look at the role and significance of organisational learning both in periods of stability and also in periods of change and uncertainty and describe some of the key characteristics of the UK Drug Treatment workforce at this current time.

Secondly, (key dimension of change 2), I discuss the current work of Peter Adams and Jim Orford. This section is called *From the Particle Paradigm to the Social Paradigm.* The work of these two psychologists is critical of much clinical psychology, particularly in respect of its methodological individualism. In my brief and limited discussion of their work, I look in particular at Orford's epistemological contribution and also at Adams paradigmatic analysis of change in the field of psychology. This dimension of change is important in terms of a broader community and social perspective in the development of self-directed support, personalisation and recovery.

Thirdly, (key dimension of change 3), I examine the move from reductionist thinking to systems thinking. This fashionable new way of describing desired change and mapping key elements of change is a direct response to the divisive and silo-driven thrust of much recent public service reform. One important development in systems thinking has been in the drug and alcohol field in

Scotland where the Scotland Futures Forum (2007) has produced a systems architecture designed in order to help outline how the damage caused by drugs and alcohol can be halved by 2025. I believe that the architecture so described and the priorities that are recommended are firmly within an overall Recovery Orientation and moreover, at population level.

Fourthly, (key dimension of change 4) I describe the new UK 2008 Drug Strategy as an attempt to considerably reinforce the weakly responsibilising elements of the first UK National Drug Strategy. I examine the Welfare Reform Bill, with the help of important reports from DrugScope and the UK Drug Policy Commission, and describe the current drug strategy and its regime of personalised conditionality as an attempt to re-responsibilise drug use by requiring unemployed drug users to seek employment and thereby relinquish their entitlement to Incapacity Benefit.

I note the public support for this new regime of expectations and sanctions, but express concerns about the integrity of our profession if we allow the 'treatment' goals of the current drug strategy to cloud our own clinical judgments about the stabilisation and recovery of drug users caught up in this system. I conclude firstly, by looking at an example of a Recovery Focused System Transformation in an integrated mental health and addiction service in Philadelphia, and secondly, by offering some final thoughts on my discussion. I identify my own preferences as being for a Recovery Orientation strongly aligned with a Social Paradigm and set within a systems-based, community-driven approach and delivered by a profession strongly committed to Putting People First in an unconditional way.

2 Introduction: Paradigms, a popular way of describing and understanding change

One of the major characteristics of any period of profound change is the uncertainty that surrounds the role and significance of learning. In times of stability and growth one can, without wanting to sound too cynical, simply learn what one needs to learn in order to grow and develop and, thereby, fulfill, one's role. In the current period, however, we are faced with the prospect of both financial constraints, on the one hand, and on the other an uncertainty about the future direction of the drug treatment field. This uncertainty, most fundamentally concerns whether the drug treatment field needs merely to improve in an incremental sense or whether, on the other hand, it needs fundamentally to transform itself.

At times like this, the kind of learning that our field commits to will impact on our understanding and practice far more completely and fundamentally than the kind of organizational learning that we required when we were more sure about our overall direction of travel.

It may not be given to us to understand the times in which we live, although it is certainly understandable and forgivable that we should try. There is no map, however, that will enable us to grasp intuitively and straightforwardly the kind of changes that are going to impact on the drug treatment sector over the course of the next ten years. It is important, therefore, to examine the way in which we look at and describe change in this period of uncertainty and retrenchment.

There are many different ways of characterising the present and the changing times through which we are passing. It is always tempting to try and bundle up the present in a way which is coherent and comprehensible. It is certainly tempting to try to treat the present as if it was already a discrete 'period' in the sense that one talks about different periods of history. We are very accustomed to talking about paradigm shifts and new paradigms and we rarely shrink from broad summations, which seek in a single generalising sweep to describe the key features of a particular period. This trend is certainly not confined to the drug treatment sector. Our relative isolation in the drug treatment field, however, has served to encourage a way of understanding our history that does not immediately connect with broader strategic governmental and policy trends. In order to make these connections and also to connect with the key dimensions of change both current and future, it is advisable briefly to revisit our own understanding our recent past and then, whilst retaining what useful insights it affords, to move on.

Recent Paradigm formation in the UK drug treatment sector has functioned as a way of organising our own history according to a periodising model based on public fears about drug misuse.

In the UK drug treatment field we have our own debates and discussions, our own controversies, our own ways of looking at things and our own ways of describing our history. In respect of our history, we have become accustomed to breaking it down into chunks of time and identifying the key features of these periods. In our case the underlying principles underpinning our attempts at historical periodisation have been based on the particular fears concerning the harms attached to drug misuse that have driven public fears at the particular time in question. Our sector has described the policy and practice responses that emerged as a result of these public fears specific to particular periods as paradigms.[1]

We have been adept at responding to public fears and shaping answers to the questions that grow out of these fears into a series of policy, programme and practice responses attractive to both established and incoming government administrations. Without this facility we would not be here. These exercises in bundling up fears and motivating responses do not necessarily get to grips with more profound underlying social processes, however.

In this process of historical periodising, we are able to date, approximately, the beginning and end of two such recent periods. What we call the Public Health paradigm was dominant in the period between 1986 and 1995 and the Criminal Justice paradigm was dominant in the period from 1996 up till and including the present.[2] In engaging in this sort of periodisation, we, as a field, have managed, by and large, not to look too closely at what has been taking place around us. In the drug treatment sector we have rarely looked closely at parallel developments in social care, or mental health; we haven't even been minded to pay very close attention to the debates, discussions and changes affected the alcohol treatment field.

Both the Public Health paradigm and the Criminal Justice paradigm, as we have come to refer to them in the UK drugs field, may themselves be properly described as sub-types of the an overarching and structurally more fundamental risk reduction paradigm. Seddon et al (2008) make this point very clearly "this pendulum swing from health to crime, or from welfarism to punitiveness, the shift in British drug policy is much better understood as a transition from the early 1980s onwards to a new risk-based strategy for the governance of the ' drug problem. In this emphasis on managing drug-related risks, there is in fact *continuity* in the policy approach that runs throughout this period from the 1980s. We might note, for example, that the policy interest in drug-related crime can be traced back long before the election of New Labour in 1997."[3]

Despite substantial differences in approach, The Public Health Paradigm and the Crime Paradigm were, at heart, examples of a government strategy designed to contain the major perceived threats and harms associated with drug misuse and to reduce the attendant risks to the public, to communities and to drug misusers.[4] In this sense, the risk reduction (harm reduction) approach has dominated strategic thinking about drug policy and treatment at government level for the last twenty-five years.[5]

A very clear statement of this paradigm and its direct application to drug treatment policy is provided by Pat O'Malley (2008). "Harm minimizing programs for governing illicit drugs begin with the assumption that all drug-related harms are understood as risks--as identifiable probabilistically, and as preventable or capable of being minimized--while all interventions optimally are directed at reducing risks. It is important to stress that in these programs risks are taken to include both risks to drug using individuals as well as risks to other individuals and risks more broadly to society."[6]

O'Malley situates 'therapeutics' in the context of the overarching purpose of policy: "Therapeutics are abandoned or become subordinate to a regimen of crime risk reduction in which the distribution of services, privileges and treatment is conditional upon statistically demonstrable crime risk reduction."[7]
Certainly, the social exigencies and public fears that at a particular time call forth

a specific government response of an identifiable kind (*e.g.*, public health, criminal justice) do not necessarily specify, in precise correspondence, a discrete and specific form of clinical and psychosocial therapeutics. The broad therapeutics of the Criminal Justice paradigm that dominated under New Labour, *e.g.* the prescribing practices, the psychosocial offerings, the harm minimisation programmes were, notwithstanding incremental changes and improvements, substantially the same as they were for the Public Health paradigm that preceded it. These interventions have sought to balance the wellbeing of drug users with the risks and harms that drug use brings to families and carers, to communities and to the population at large. This balancing act and its attempts to deal satisfactorily with these key constituencies was a key characteristic of our common commitment to risk reduction. As a community safety policy it promoted cohesion, as a treatment measure it was supportive of drug users needing help and as a crime reduction measure it was popular with the public and critically, in respect of the latter point, brought measurable gains. Over the past quarter century, as a result of this successful balancing act, there has been a broad and effective consensus between government, the public, professionals and the recipients of drug treatment services.

The past thirty years of UK drug strategy has attempted the balancing act of managing risk at a number of levels.

As a field we have enjoyed steady growth over the course of the past thirty years, significant growth over the course of the past ten years and very significant growth over the course of the past five years. This growth has tended to insulate us from some of the concerns felt by those sectors and services that have not been as financially well endowed.[8]

As we have grown so what is expected of us has grown too. Over the course of the past ten years, the government has become progressively more demanding in terms of the targets they set our field. These targets have required a major expansion in the capacity of the drug treatment sector in England and Wales in order to be able to cut waiting lists, increase the numbers in treatment and keep people in treatment for long enough for them to gain a significant therapeutic benefit.[9]

Although these targets were demanding, they have been met. Fully three years before the end of the first national strategy, in 2005, it was already apparent that our field was on course to hit and surpass our key targets. The drug treatment field was probably uniquely successful in hitting its 'output' targets. In truth, we may have been uniquely fortunate in terms of having a series of achievable and comprehensible targets to hit and the support and investment to hit them. Perhaps the high water mark of the 1998-2008 National Drug Strategy was the 2005 National Treatment Conference organised by the National Treatment Agency. This was the conference where the strengths and the successes of the

National Strategy were celebrated; this was also the conference where, for the first time, the shortcomings of what we had achieved were frankly confronted.[10]

In 2005 it was recognised that the balance of our drug treatment strategy needed to shift.

In particular, this was the first national conference where the limitations of a strategy overly dominated by methadone maintenance were first spelled out. At this conference the field was introduced to the terms, ‘treatment effectiveness’ and ‘treatment journey’. It is well, in light of subsequent controversy, to remind ourselves that the shortcomings of our first national strategy were brought to our field by the National Treatment Agency. At this conference, we began to think beyond 'outputs' and 'numbers in treatment' and began to deal with 'outcomes' and the quality of the 'treatment journey'.

In the period of time that has passed since the 2005 conference, we have made steady progress in defining what the new drug treatment should look like. We have established more clearly than ever before an 'evidence base' for our clinical interventions. In addition we have re-discovered the role and potential impact of psychosocial interventions. As part of this latter discovery, we have set our sites ever more clearly on improving the core intervention of key-working upon which so much of the integrity of our reputation hangs. Key working is both the cornerstone of performance in respect of targets and also the setting where clinically effective interventions are delivered, supervised and appraised. Perhaps most importantly, it forms the basis of the initial engagement and subsequent journey that drug users undertake as part of the process of regaining control of their lives.

It is apparent, however, that the significant, incremental progress made since 2005 is insufficient in the eyes of many commentators within and without the drug treatment field. These criticisms have often focused on the failure of the National Strategy to go beyond the prescribing of substitute drugs like methadone. Advocates of a Recovery Orientation, in particular, have set out a fundamentally different philosophical and practical approach to drug treatment and have, in effect, challenged those of us working in the mainstream to examine our current practice and reorient our approach accordingly.

The Recovery Movement, if I may so refer to the significant and diverse groups of Recovery Advocates currently active in England, Wales and Scotland, is an important measure of just how seriously we are debating the quality and purpose of drug treatment in this country. For some, the Recovery Orientation represents a profound change in direction for our treatment system.

The significance of Recovery Advocacy is the subject of continuing keen debate at the time of writing this paper. There are, however, two sets of questions that

can be framed in respect of Recovery. Firstly, there are those questions that address what the current impact of a Recovery Oriented System should be on the existing drug treatment system. The second set of questions concerns where the recovery movement fits within that broad set of changes and transformations currently underway, which will inevitably have a major impact on drug treatment in the future.

In respect of the first set of questions regarding the impact of the Recovery Movement on the drug treatment field as it is now, one might start by asking whether Recovery will seek principally to be a modality that fits neatly into the existing system as a post-script to a period of treatment? On this view, Recovery may simply be about creating a range of abstinence oriented rehabilitative aftercare services, some in the community, some residential.

Alternatively, Recovery may imply a more thoroughgoing transformation our existing ways addressing problems of addiction and dependence involving a much greater empowerment of communities, users of services and families and carers? [11]

Understood this way, Recovery represents a much a more fundamental challenge to our drug treatment system. One that goes beyond our recent historical periodisations, beyond the risk-management model that underpinned those otherwise quite different models and beyond the therapeutic and clinical assumptions that have accompanied the risk management model in its various manifestations over the course of the past quarter century.

To restate the first set of questions: is Recovery a movement in name only and more accurately described as an advocacy network arguing for significant but ultimately incremental change? Or is Recovery a set of transitions that doesn't set out to answer existing questions but seeks to provide solutions to a range of questions distinctively its own? In short, is there a genuine Recovery Paradigm?

The Recovery Paradigm in its own words.

William White is a writer, an historian of the addiction field and a Recovery Activist. He has produced a very clear and instructive definition of Recovery Paradigm change and its current potential impact on the current drug treatment system. Writing in the Journal of Substance Abuse Treatment in 2007, he describes us as being "on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm".[12] 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." He further describes Recovery as an **organizing concept** (my emphasis). "Recovery as an organizing concept poses financial and ideological threats to existing social institutions and professional roles that have been granted cultural authority to manage AOD problems."[13]

William White describes the Recovery Paradigm in a clearly formulated and balanced way. White writes both as an historian and an activist. As an historian, he takes extreme care to present his radical message in a way that is uniquely well located in the history of our field. At the same time, he doesn't shrink from making clear that existing drug treatment providers may well feel threatened by the Recovery Movement. "The recovery paradigm is spawning alternative institutions (e.g., recovery advocacy organizations, peer-based recovery support centers) and roles (e.g., recovery coaches, personal recovery assistants, recovery support specialists) that are challenging treatment institutions and competing with them for status and financial resources."

Equally, however, he warns Recovery Activists not to be elitist in their definitions of who is and who is not in recovery: "A particular definition of recovery, by defining who is and is not in recovery, may also dictate who is seen as socially redeemed and who remains stigmatized, who is hired and who is fired, who remains free and who goes to jail, who remains in a marriage and who is divorced, who retains and who loses custody of their children, and who receives and who is denied government benefits."

In his "Pathways from the Culture of Addiction to the Culture of Recovery",[14] first published in 1990, William White describes the pioneering collaboration of Vincent Dole and Marie Nyswander and its early beginnings in mid-1960s New York. He praises the model of methadone maintenance developed by Dole and Nyswander and draws the readers' attention to "the rehabilitative intensity of the original program design." White contrasts the model approach of Dole and Nyswander with the version of methadone maintenance that became the norm in the United States from the late sixties. "Methadone maintenance emerged as a major social policy strategy in the late sixties, not as a vehicle to address the needs of narcotic addicts, but as a vehicle to reduce urban crime…Many of the early programs constituted little more than methadone filling stations, staffed by too few persons with too little training to recreate the model of rehabilitation pioneered by Drs. Dole and Nyswander."

White is keen to leave this failed paradigm behind, but equally keen to emphasise to Recovery Advocates that those on methadone scripts are not to be denied the status of recovery, nor are they to be granted second class status by recovery communities. "How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence."[15] Use of the phrase "medication-assisted recovery" would help legitimize the recovery status of people who are using medically monitored medications such as methadone…but might also risk creating a recovery class structure in which this group would be seen as less than full members of local recovery communities."

White thus balances a fundamental critique of a what he describes as

'methadone filling stations', but is also emphatic on not abandoning those methadone patients who themselves are seeking recovery. White's critique, despite its important balances is a thoroughgoing and critical examination of much that has become established in the United Kingdom over the past thirty years.

The second set of questions requires us to attempt to locate and contextualise the Recovery Movement and the debates and discussions it has engendered within a much broader framework. That framework involves setting Recovery and Drug Treatment within a nexus of key changes currently transforming public services in general, and, in particular, the key sectors with public provision that impact upon our work with drug users.

This second set of questions may seem like an unwelcome diversion for those deeply immersed in the Recovery Movement. Focusing upon anything other than the immediacy and importance of the exchanges about the current drug treatment system may seem like an attempt to slow down and, ultimately, to derail the current debate. There are, however, important reasons for attempting to better locate discussions about both Recovery and drug treatment in a more comprehensive contemporary framework.

Firstly, unless we in the drug treatment sector reorganise our thinking about our present and past, we are going to continue to sanction an isolation from mainstream developments. This isolation may not have served us badly in the past, (the generous funding of our sector is, arguably, one benefit that our isolation has brought with it.) Now, however, we must look again at our own ways of describing and periodising our history given that our own historiography was both symptom and cause of our ongoing isolation.

Secondly, we must look at all those changes that are currently taking place, changes in social care, changes in system planning, changes in policy orientation, fundamental changes, changes which invariably are described as paradigmatic, and will determine, whether we like it or not, where our field, the drug treatment field sits within the whole. Put crudely, what are the paradigm changes impacting directly on our field. What are the paradigm changes claimed for other sectors, services and professions? How do all the changes fit into an overall configuration, and, most importantly, what should our field aspire to and work towards within this new configuration?

We will, of course, not change what happened in the past. In this respect our history is inviolable. It will be important to understand, however, that some of the things that we understand about our field and its history need to be reviewed in terms of what is happening in the broader health, social care, criminal justice and welfare reform fields at the present time. For our field the contrast between social care transformation and welfare reform is particularly stark and challenging. This is much more than an academic exercise. At this time, all work in our field should

conduce to one broad end and that end is to better enable our field to recognise that drug users, or if one prefers misusers, are first and foremost, human beings. They are human beings before they are 'patients', or 'offenders', or 'job seekers'.

In order for this broad end to inform our most basic values, however, we need more than ever before to understand where we fit in the bigger picture. We need, moreover, to be able to organise our discussions about the bigger picture in a way which makes broad sense to all those who are affected by drug treatment and both the immediate and broad impact of our work.

We need to go beyond the categories of some of our existing ways of thinking in order to see where our philosophy of care, our policies and our practice connect up with relevant new approaches across the whole public sector and where appropriate beyond. We will need to identify how and why our traditional ways of periodising our own history are not the last word on the matter. We will need to see that above our traditional Public Health and Criminal Justice paradigms there is an overarching governmental approach of risk reduction that has remained in place for the past twenty-five years and, notwithstanding the need for review and criticism, is unlikely in any event to disappear.

Having grasped this point, however, we will then need to go even further and recognise that the creation of the 'Risk Society' in the United Kingdom and the associated philosophies of risk reduction and 'responsibilisation' are themselves no longer the last word in government thinking. Of course, managing the level of risk at level of the whole population is no bad thing. It is almost certainly safe to say, that in policy terms at governmental level this approach is here to stay; it has and will command very broad democratic and popular endorsement. From this point of view, only the most idealistic among us can conceive of a drug treatment policy that takes no account of managing the broader risks and harms of drug misuse. All acknowledge that drugs like heroin and crack cocaine are potentially dangerous. Beyond the costs and dysfunctions of incarceration, there is the damage to communities, with the greatest damage invariably attaching to the poorest communities. The costs of policing and responding to drug related harms are enormous. Not surprisingly, calls for the introduction of new methods of regulating the supply and distribution of currently illegal drugs are pretty constant. This present paper will not involve itself in those discussions, legitimate and important though they are.

For better or worse, all acknowledge that our current system of control inevitably involves a significant proportion of drug misusers in the criminal justice system. For those of us working in the drug treatment system, therefore, to dream of some kind of strategic escape from the criminal justice system under the current Misuse of Drugs Act is misguided. We should stop thinking in narrow terms about criminal justice as opposed to health. We should be working ever more closely with our colleagues in the criminal justice system but according to the new values which the current circumstances of change and review make possible. These

values emerge directly from the many current sources of criticism and affect many areas of public service delivery; we are certainly not unique nor alone in subjecting ourselves and being subject to serious and sustained criticism on the question of appropriate values and their correct application.

3 Aligning the Drug Treatment System with the Key Dimensions of Change affecting Public Service Reform.

We are undergoing a period of profound change and within the drug treatment system we need to reach beyond our traditional verities in order to connect up and better align ourselves with the key dimensions of change taking place at this time. The key dimensions of change for these purposes can be referred to as follows: 1) Putting People First; 2) From the Particle Paradigm to the Social Paradigm; 3); From Reductionist Thinking to Systems Thinking and 4) a. Risk and Responsibilisation and b. Recovery and Re-Responsibilisation. These dimensions of change link debates about organisations, partnerships, sectors (such as the drug treatment sector) and enable specific debates about preferred change to be contextualised within a more challenging set of connections.

4 Key Dimensions of Change: ONE Putting People First.

One of the gains that have already been secured by Recovery Advocates in and beyond the United Kingdom is an understanding that people must come first. It would be quite unacceptable, from the standpoint of this fundamental recognition not to connect up the Recovery Advocacy movement with the great changes currently taking place in Social Care and Health.

The Putting People First Concordat: a historical protocol

The Putting People First Concordat,[16] a proclamation and manifesto signed by a range of key stakeholders, including the Secretary's of State for Health, Work and Pensions and Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services. It identifies an "urgent need to begin the development of a new adult care system" One that is "on the side of the people needing services and their carers." The Concordat describes itself as an "historical protocol" and acknowledges that its production was driven by the necessities of demographic change. The introduction states that: "Demography means an increasing number of people are living longer, but with more complex conditions such as dementia and chronic illnesses. By 2022, 20% of the English population will be over 65. By 2027, the number of over 85 year-olds will have increased by 60%. One can probably assume that we may well be at the dawning of the age of "historical protocols" driven by necessity.

The **Values** of the Concordat state: "in the future, we want people to have

maximum choice, control and power over the support services they receive."
The section on **Engagement/Consultation** says: "If we are to win the hearts and minds of all stakeholders, especially frontline staff, it is essential that they are participants in the change programme from the design stage onwards."
As one would expect, The Concordat has much of relevance and value to say on how and why it is critical to "Put People First". In addition, it has, as we will see, much to say on working together to secure joint outcomes. It also understands the value of prevention, advocating "A locally agreed approach, which informs the Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm." Not surprisingly, the Concordat has little if anything to say about promoting a safer and more responsible society. The Concordat does not include those areas of care and case management where there is a degree of coercion. Drug users are not mentioned. Nevertheless, the Concordat provides a key blueprint for the future.

The Concordat states that "The Full range of relevant local statutory, voluntary and private sector organisations need to be fully engaged…" and, on more than one occasion emphasises the critical role of front line staff. What of front line staff? What of the workforce more generally? What of professionals? Or experts? Perhaps most importantly, what of the role that organisations play in ensuring that people are put first? The Concordat, both by definition and requirement, is not a 'bottom up document'. In its own words, "It is unique in establishing a collaborative approach between central and local Government, the sector's professional leadership and regulator." The appeals to hearts and minds "of all stakeholders', especially front line staff", is heartfelt and, one senses, delivered from a considerable eminence.

In their forthcoming paper, The Politics of Recovery, David Best[17], Teodora Groshkova and Paul McTague, discuss the role of workers and services, of 'experts', (their emphasis), and professionals in somewhat different terms. Their model of putting people first has much in common with the Concordat. They state that "The advent of the 'recovery agenda' in UK Government strategies, particularly the "Road to Recovery" in Scotland, has challenged the pessimistic assumptions about the likelihood of recovery and it is our aim in this article, to articulate some of the assumptions and implications of this change in focus."

Best *et al,* describe Recovery thus: "Recovery is about empowerment of users and communities. It is about creating the right conditions that enable these groups to regain the power over their life stories out of addiction -- the ownership of recovery is personally driven and community-based. Recovery is owned by the person in recovery - it is their story and their journey."[18] When it comes to discussing the role of experts, workers and services, however, Best *et al* speak more candidly than the Concordat: "…the recovery agenda should be much more

egalitarian and should challenge the status of 'experts'. Professionals should be much more modest and honest about the limited role they can play in the recovery journey, and we should recognise the paucity of the 'science of recovery."[19]

Best *et al* continue: "As a consequence, workers and services must challenge what role they do play and where their activities may act as barriers to the recovery process. This will inevitably involve a 'de-professionalisation' of major aspects of client recovery."[20]

Some of the apparent differences in emphasis here need to be treated carefully. Both the Concordat and the paper by Best *et al* are, in their respective ways, calls to arms. Best *et al* identify a key priority as the reconstruction of the assumed centrality of the professional role and interventions, stating: "…long-term addiction recovery is not, or not simply, about the relationship between the individual and the treatment programme. It involves access to a range of personal and social opportunities (e.g. a meaningful job, healthy social ties) that occur independently of the actions of professionals and beyond treatment."[21]

This bears comparison with the Concordat's emphasis on de-emphasising the time spent on assessment: "A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy."[22]

Best *et al* state that "There is no expert who parachutes in with answers - the roles are all recovery components -coaches, advocates and activists are inter-changeable roles and this has implications for what we need to do as addiction specialists -learn new skills and roles, strengthen the leadership positions of service users and families and engage them as individual stakeholders and also as recovery community representatives"…"This agenda is not about de-professionalisation per se but about the recognition that we have much to learn from parallel fields, such as mental health recovery…"[23]

On the subject of mental health recovery, one of the main signatories to the Concordat, the Association of Directors of Social Services, in their 2008 discussion paper, Mental Health in the Mainstream commenting on ‘where we are now’ warn against complacency: "Whilst there is widespread multi-professional and cross -agency ownership of concepts such as "recovery" and "inclusion", ADASS remains concerned that deeds do not always keep pace with words."[24]

Best *et al*, in similar vein, identify recovery as "a fundamental re-shaping and re-constructing of how we see addiction and its resolution. We all have a responsibility for ensuring that it is not sabotaged by the same old power players doing the same things, changing only the language they use and the banners

behind them in conferences."[25]

In this context, the words of Donald Schon from nearly 40 years ago are recalled by Attwood *et al* (2003): "…established social systems absorb agents of change and de-fuse, dilute and turn to their own ends the energies originally directed towards change…When processes embodying threat cannot be repelled, ignored, contained or transformed, social systems tend to respond by change -- but the least change capable of neutralising or meeting the intrusive process."[26]

Undeniably important sets of "established social systems" in the drug treatment field are the organisations that deliver the treatment: the providers. It is often the case that one hears criticisms of drug workers in our field. In fact, it can seem sometimes as if the only thing that can unite parties of otherwise radically different viewpoints is their opinion of drug workers. What of the organisations that employ drug workers? What is one to say about their role in promoting change? How does one stop organisations from doing what Donald Schon said they do which is to de-fuse, dilute, and turn to their own ends the energies directed towards change?

How do organisations and organisational leaders use research, evidence and knowledge? In Using *Evidence: How research can inform public services,* (2007) Nutley *et al* examine how research can inform public services. The book examines in great detail the relationship between research, evidence and knowledge. Amongst other things Nutley *et al* are keen to identify the different uses of research by key constituencies such as policy makers, practitioners and organisational decision makers. For my purposes, in this discussion, it is this last group, the decision makers, that are a key focus. Nutley *et al* say that although it is important to study and understand the different impacts of research both in policy settings and in practice settings, it is also important not to neglect the third arena, that of decision makers: "… this 'meso-level' set of service actors -- those managing and shaping local service delivery organisations -- are worthy of more specific and sustained study of their habits of research use."[27] According to Nutley *et al*, "Organisation learning is an emergent field of study and there is as yet no overall agreement about what it is, let alone how it can be facilitated. However, in general it refers to the way organisations build and organise knowledge and routines, and use the broad skills of their workforce to improve organisational performance." "Organisations that deliberately seek to develop organisational learning are often referred to as learning organisations."[28]

In her discussion of learning organisations, Karen Legge (2005) states: "A problem is that, like many fashionable concepts, the more one probes the concept of a learning organisation, the more problematic it becomes."[29]
Despite these reservations, it is possible to identify the role of organisational learning in the Third Sector, at least in respect of learning in times of stability and growth.

Organisational Learning in times of growth and stability: promoting the 3 Cs.

Most drug treatment provider organisations have, in some form, a central objective of seeing and helping as many drug users as possible. The desire for growth as well as being a tangible sign of success, speaks fairly directly to this requirement. Growth can become, therefore, the unquestioned end of many drug treatment providers. This imperative to grow has many implications, not least for an organisation's approach to learning.

In order to successfully pursue growth, drug treatment providers have needed to be competitive, compliant and competent: the three Cs. In order to win new business they have needed to be able to beat competitors on price and on quality; they have needed to set their unit costs and support charges at an attractive level for those responsible for purchasing services and they have needed to comply with all relevant financial, clinical and safety standards as well as all other regulatory and guideline requirements stipulated by commissioners. In short: their services have needed to be both competitive and compliant.

In addition, in order to ensure that their service interventions are successful in their outcomes and safe, confidential and collaborative in their delivery, they have needed to ensure a talented, trained and committed workforce. In short: their workforces have needed to be competent. Therefore, a Learning Organisation, thus defined, is one that pursues the fulfillment of its broad ends (its purpose) by promoting those kinds of organisational learning that enable the organisation to be competitive, compliant and competent.

This definition of organisational learning is important for all those drug treatment providers that want to retain the kind of focus that will enable them to succeed and grow in the short term. All such organisations need to have a perspective of short-term success. After all, they may not live to survive in the longer term unless they are successful in the short term. The obviousness of this statement is important not to lose.

Certainly, it is important that, for example, the Trustees of any Third Sector Organisation know and understand what success is. If they are able to identify what an organisation needs to do in order to be successful and, furthermore, to ensure that the organisation is doing it, then they will be doing their job as trustees. For most trustee body's doing their job well over the course of the past ten years has been ensuring that their organisations promote the three Cs.

If much of this sounds suspiciously simple and straightforward, then, in part, that is because the growth and development of the drug treatment field over the past ten years has been simple and straightforward. The strategic objectives of the national drug strategy as regards treatment have been very clear and very

straightforward: to cut waiting times; to increase dramatically the numbers in treatment and, finally, to hold those in treatment for a length of time sufficient for them to secure optimal therapeutic benefits. Ultimately, however, organisations have to examine the impact of pursuing targets in times of stability has upon their ability to learn, adapt and thrive in times of instability.

As regards the impact upon organisations of focusing significant energies upon the pursuit of targets, Jake Chapman, (2004) says the following: "Target setting may be a short-term way to stimulate and focus efforts to improve performance. However, a specific target can encapsulate only one element of a complex organisation, and its dominance is likely to undermine other aspects of the organisation that are crucial to its general and long-term effectiveness."[30]

Organisational Learning in times of Uncertainty and Retrenchment

All NHS, Third Sector and private treatment providers are having to look at a new broader definition of organisational learning. A definition which doesn't abandon the key and constant challenges of remaining competitive, compliant and competent, but which recognises the need to build a new strategic understanding of the kinds of change which we will all encounter over the course of the next ten years and the kinds of change that we will need to make in order to both survive and thrive in this new environment and also to accept the challenge of putting people first.[31]

Where will we go to learn; what principles underpin our learning; what criteria govern what we will accept and reject and what will anchor our learning and enable it to shape our organisations into the future? Nutley *et al* point out in this connection that "learning is not always about the acquisition of new knowledge. As with individuals, much organisational activity is based on custom and practice and there may be a strong case in some situations for 'unlearning' previously established ways of doing things."[32]

In their discussion of innovation (2007), Nutley *et al* focus specifically upon the ability of organisations to learn about learning, or as they refer to it 'meta-learning'. This "…usually underdeveloped, aspect of learning is the ability of organisations to learn about the contexts of their learning --when they are able to identify when and how they learn and when and how they do not, and then adapt accordingly."[33]

The authors emphasise the particular importance of the distinction between adaptive (single-loop) learning and generative (double-loop) learning. "Adaptive learning routines can be thought of as those mechanisms that help organizations to follow pre-set pathways. Generative learning, in contrast, involves forging new paths."[34]

"Both sorts of learning are said to be essential for organisational fitness, but by far the most common practices found in organisations are those that are associated with adaptive learning. On Generative or double-loop learning, Nutley *et al,* citing Argyris and Schon (1996), identify a more sophisticated learning lying behind the simple error correction of single-loop learning. A kind of learning "…which changes fundamental assumptions about the organisation and may lead to a redefinition of the organisation's goals, norms, policies, procedures or even structures. This is referred to as double-loop (or generative) learning, as it calls into question the very nature of the course plotted and the feedback loops used to maintain that course."[35]

Atwood *et al* (2003) comment that many organisations have become proficient at 'single loop learning'. They refer to it as 'error detection' learning of the kind that enables organisations to set objectives and monitor performance using modes of thinking and operating that leave the underlying assumptions unchanged. The authors use an uncomfortably relevant example by way of illustration. "…when an organisation loses a number of employment tribunal cases because of the failure to follow its own internal disciplinary procedures, questions are likely to be asked about what is going wrong. Single loop learning processes would probably identify such things as the need to apply the procedures more rigorously and the need for more careful record keeping on the part of managers. Steps would be taken to ensure that these errors were rectified…By contrast, double-loop learning would be stimulated by questions such as: How might we manage staff performance more effectively? What could we do to encourage staff to feel more valued and committed, reducing the need to take disciplinary action? What impact would any changes have on our customers?"[36]

Exploring these latter questions is, in the view of the authors, to go beyond the single-loop mode. It is arguable that it is also to go beyond the standard rhetoric of Human Resource Management. According to Legge (2005): "The importance of HRM as a rhetoric that speaks to the concerns of a wide range of stakeholder groups -- personnel and line managers, government and academics -- should not be underestimated."[37] Most Chief Executives, not excluding the present author, may well wish to embrace uncertainty and change; they may describe themselves as having a holistic, systemic view of their organisations; claim that their organisations share a company-wide vision and a culture of high trust; that they encourage empowerment at all levels; have leaders who encourage risk-taking and so on. Can we really claim that our organisations are like this? Perhaps so, but perhaps at the same time we will also be able to acknowledge that some of the above self-characterisations have as much rhetoric as reality.
If we are to tackle our own 'single-loop' habits and our own relative isolation as organisations within our sector, as well as the broader isolation of our field as a whole, then our discussions of change and transformation need systematically to examine, in Karen Legge's words, what is rhetoric and what is reality.

In trying to get beyond rhetoric, one is attempting, very provisionally, to

characterize statutory, Third Sector and private drug treatment providers from an organisational point of view and in a way which enables us to get off to an honest start when it comes to discussing how best we embrace Recovery, promote change and Put People First.

As a field we have sought to become professional and we have worked hard to professionalise. Our own developing understanding of what this means has developed apace and we are now much clearer in terms of critical areas of practice governance. We are clearer and more developed in the following key areas: client safety, confidentiality and access; client empowerment in service planning and delivery; client engagement in terms of choice of treatment and modality; and client outcome in terms of securing compliance with embedded research models. We are committed to occupational standards and the linking of those standards with service delivery, performance and outcome. We are better able to understand the need for regulation, audit and inspection.

Prior to any attempt to typify the nature of key areas of our work as a field, it is worthwhile noting the sheer heterogeneity of our employment base. Our workforce is extremely diverse. For instance, we have, across the Third Sector and also within the NHS, worked hard to bring those whose lives have been directly blighted by drug use into the work force. This is no mean achievement, although in operational and personnel management terms it often poses a risk. There are clinical governance issues that are uppermost in any decision to hire people who have been vulnerable to drug misuse and in some cases may remain so. Nevertheless, the UK drug treatment field has always had, often without spelling it out, a strong commitment to rehabilitation and reintegration.

At the same time as constantly refreshing our intake with ex drug users and current service users, we have also sought actively to recruit from a wide range of backgrounds. We have actively sought and succeeded in recruiting staff from the private sector; we have attracted significant numbers of staff from criminal justice backgrounds, prison officers, probation officers and police officers. We have a larger than ever number of nurses and social workers and we have recruited, and been glad to recruit, people from a wide variety of walks of life, people who do not have any professional background but who are, nonetheless keen to work in a field that has a clear commitment to working with an unpopular, marginal and needy group. They have been keen to join us and we have been keen to have them.

The numbers of new practitioners in our field has grown to accommodate the increase in numbers of people accessing and receiving drug treatment. The nature of our professionalisation and the speed with which it has taken place together with the accompanying demands for reliable monitoring of treatment episodes and treatment numbers and for outcome data (with the introduction of the Treatment Outcome Profile), has meant inevitably that front line workers have often been introduced to research principally in the form of a requirement to fill

out forms.

Our field, in recent years, has been built on large contract prescribing services and also on national rollouts of prison and community based criminal justice services. Many of these service contracts are won on the basis of competitive pricing. As a consequence, many of our services, in addition to being staffed by workers with a broad range of backgrounds, are further characterised by high case loads, quick turnover and detailed reporting requirements in respect of assessment, care planning and TOP compliance. We need, therefore, to examine a little more closely the character of these services in organisational terms. We need also to examine the role of organisational learning and, in particular, the manner is which research use is achieved.

Developing Research-Informed Practice.

Nutley *et al* (2007), describe a review undertaken in 2004 designed to promote research use in social care in the United Kingdom. This review, (Walter et al, 2004), identifies three broad ways of thinking about and developing research-informed practice. "These different approaches are encapsulated in three models: the research-based practitioner model, where research is the responsibility of individual practitioners; the embedded research model, where research use is achieved by embedding research in the systems and processes of service delivery, thus it is the service managers and policy makers who play a key role and the organisational excellence model, where the key to successful research use lies in the development of appropriate structures, processes and cultures within local service delivery organisations."[38]

The Research-Based Practitioner Model
In the research-based practitioner model "it is seen as the role and responsibility of the individual practitioner (for example, doctors, nurses, teachers and social workers) to seek out and keep abreast of the latest research, which then informs his or her day-to-day practice and decision making. …The model assumes that staff have relatively high levels of autonomy in conducting their day-to-day practice."[39]

The Embedded Research Model
Nutley *et al* describe the Embedded Research Model thus: "In the embedded research model, practitioners rarely engage directly with findings from research. Research enters practice by becoming embedded in service systems and processes, through mechanisms such as standards of care, inspection frameworks, national and local policies and procedures, intervention programmes and practice tools. …In this model, the key link is thus not directly between research and practice, but indirectly between research and policy/service management, and thence on to practice change. …Thus, the type of research use envisaged is overwhelmingly instrumental: getting research to have a direct

impact on practice decisions and actions. Again the emphasis is on research finding rather than the process use of research use, and the type of research privileged by the embedded model is again that relating to 'what works' bodies of knowledge. …The guidelines movement in health care to some extent reflects the embedded research model."[40]

These descriptions describe our own field's emergent and strong relationship with embedded models quite closely. Nutley *et al's* description of the embedded model continues: "The knowledge management literature suggests that the potential to 'bake' research knowledge into practice systems and tools will depend on the extent to which service delivery is already standardised and routinised: the greater the standardisation, the greater the potential for research-based practice tools. …However, ownership, interaction and local adaptation are all somewhat sidelined in the embedded research model."[41]

Their discussion concludes with the following warning: "There is some evidence to support the effectiveness of the embedded research model in achieving practice change but implementation of a centrally driven embedded research approach encounters at least two related problems: how to avoid a 'one-size-fits-all' approach and how to deal with practitioner resistance to more coercive forms of the model."[42]

The Organisational Excellence Model
Nutley *et al* describe the Organisational Excellence Model in the following terms: "In the organisational model, the key to developing research-informed practice lies not with individual practitioners or national policy makers, but with service delivery organisations: their leadership, management and organisation."[43]
Nutley *et al* go on to note: "It may be that different models are best suited to different circumstances. … it might seem that the research-based practitioner approach is best suited to professionally qualified staff and the embedded research model to non-professionally qualified staff."[44]

This discussion of different models of research is relevant to our field at this time. It also has a broader relevance in terms of the discussion about Putting People First. Organisations responsible for delivering the national drug strategy may recognise the embedded model of research described above. It may also be that the concerns of the ADASS cited above may be recalled at this point: "Whilst there is widespread multi-professional and cross -agency ownership of concepts such as "recovery" and "inclusion", ADASS remains concerned that deeds do not always keep pace with words."[45]

As a result of research of the kind undertaken by Walter *et al,* we may be in a better position to understand that turning 'words' into 'deeds' isn't just a matter of changing attitudes or changing 'organisational cultures'. It may go much deeper. It may be about transforming whole systems. It may be about Putting People First.

What of our workers, staffing those services with embedded models of research requiring extensive reporting, monitoring and recording? How do they see the drug treatment drive train and the organisations that deliver it? How are we to describe their role in such a way as to do justice to the reality of their everyday working lives? As our organisations, Statutory and Third Sector have become more competitive, more price conscious and more customer oriented, it may be appropriate to compare our approach with the approach of service-oriented organisations in the private sector. Of course, any such comparison needs to be made with care; my purpose is not to shoehorn our models of care and services into models developed in private, non-health, and non-social care settings. Caution notwithstanding, what undoubtedly does stand comparison is the increasing importance of competitive pressures and the impact that these pressures have on organisational structures and ideologies.

Marek Korczynski, (2002) has identified three broad categories of service work. At the bottom the 'service factory' typified by fast food workers; in the middle of the hierarchy is the 'service shop' and at the top of the hierarchy come professional services, comprising 'knowledge work'.[46]

Setting aside for the moment, the claim that many of us would want to make, i.e., that all our employees are knowledge workers and that we embed strategic capability at every level of our organisations, we need here to understand that in the context of Korczynski's analysis, knowledge work is a relatively elite category. Korczynski cites US research that indicates only 4 per cent of US service workers can be placed in this category. Karen Legge states that "in the UK, only 10 per cent of new jobs can be classified as knowledge work…"[47]

In the drug treatment sector, on this definition, with its tight criterion of 'high skill' and 'autonomy', perhaps only a few occupational groups would be identified unambiguously as knowledge workers: psychiatrists; clinical psychologists, senior academic staff, senior staff in the NTA, doctors, nurse consultants and public health specialists with a particular brief for substance misuse. This list is not exhaustive. It is, however, a list which attempts to identify those occupational categories which by dint of their high skills and relative autonomy, fulfill Korczynski and Legge's criteria for inclusion in the elite 'knowledge worker' category.

Korczynski (2002) throughout his work is keen to "shed light on specific types of service work, allowing students and analysts interested in specific types of service work to be aware of the factors that might make that form of service work take on particular characteristics."[48]

Korczynski has identified, in the middle category of service workers, those working in 'service shops' as opposed to 'service factories' or the relatively autonomous elite knowledge industries, the model of the Customer-Oriented

Bureaucracy. Much of what Korczynski says about this model seems to have a relevance to many large drug treatment services as they have emerged and developed over the past fifteen years. Bearing in mind the criticisms of Best *et al,* (2009), White (1996) and the aspirations for front line staff described in Putting People First (2007), it is worthwhile focusing on what Korczynski has to say about the customer-oriented bureaucracy and in particular upon what he describes as the "contradictory lived experience of service workers".[49]

"The contradictory experiences of service workers are informed by dual and potentially contradictory, logics underpinning how service work is organized and managed. On the one hand, service firms compete on the basis of price and efficiency of service delivery. This means that there are systematic and **strong rationalizing pressures acting on service organizations** (my emphasis). In order to compete, they are obliged to rationalize their work structures to lower costs and maximise efficiency. Thus, there is an important logic pushing service firms towards bureaucracy -- *a term used here in the Weberian tradition of describing a purely rational, efficiency-focused organization*. (Author's italics). On the other hand, service firms compete on the basis of service quality, such that firms can no longer compete *simply* by treating a customer as an object to be pushed along an assembly line. … Service work organization, therefore, is structured by the dual and potentially contradictory logics of bureaucratization and customer-orientation."[50]

Korczynski has some interesting things to say about Total Quality Management: "Total Quality contains within it both substantive rationality, in terms of acting in the interests of the customer, a key authority figure of society, and formal rationality, in terms of "hard" rational techniques to achieve efficiency within production. Its attraction to management is that it seeks to make symbiotic the relationship between these two forms of rationality. In this way, TQM appears to create a hermetically sealed space of legitimizing discourses."[51]

In this section, thus far, we have seen how Best *et al* insist when it comes to Recovery: "We all have a responsibility for ensuring that it is not sabotaged by the same old power players doing the same things, changing only the language they use and the banners behind them in conferences."[52] We have noted the concerns of the Association of Directors of Social Services that "Whilst there is widespread multi-professional and cross -agency ownership of concepts such as "recovery" and "inclusion", ADASS remains concerned that deeds do not always keep pace with words." We have also seen how the Putting People First Concordat understands and emphasises the crucial role of front line staff.

We have also noted how 'drug workers' have tended to be a common Port of Call for those wishing to locate blame for the inadequacies of the drug treatment system. All these observations and comments, informed and ill-informed, need to be set alongside a broader analysis of the underlying policy paradigm of risk-reduction and its implementation via the national drug strategy. In particular we

need to set this analysis in the context of a much closer, less rhetorical examination, of what the growth in drug treatment and the expansion of our sector has meant for: 1) our research methods 2) our organisational assumptions about what learning is and should be; 3) our human resource practices and the shibboleths that inform them and 4) the impact on our substantially new and significantly undertrained workforce.

At this point we may then revisit our best aspirations for Putting People First, for Recovery Oriented Drug Treatment Systems, for all systems that are "co-produced, co-developed, co-evaluated and recognise that real change will only be achieved through the participation of users and carers at every stage."[53]
It is unlikely that we will capture the full challenge that our aspirations call for unless we acknowledge, in the words of Atwood et *al* "The quest for greater accountability for outputs and outcomes has gone so far that many people in organisations are drowning in floods of bureaucracy emanating from above, which result in compliance, meaningless number chasing and low-trust cultures."[54] Equally we should acknowledge "For effective whole systems working, people, particularly those in positions of power and authority, need to be strong enough to admit that they are questioning their own perspectives, behaviour and learning."

This profound change in thinking about the nature of the role of experts and the nature of professionalism and the fundamental importance of working alongside service users rather than dealing with them as passive recipients of care is right at the heart of the Recovery and the Putting People First message. Both the self-directed support (Personalisation) model advocated in Putting People First and Recovery Oriented approaches can be modeled and further examined against this as well as the other key dimensions of change.

5 Key Dimensions of Change: TWO From The Particle Paradigm to The Social Paradigm

In her 1998 book Diseases of the Will, Mariana Valverde observes: "…the forgetful re-enactment of past debates is a major feature of contemporary debates on alcohol, and more generally of discussions regarding the relation between consumption, the passions, and human freedom."[55] Valverde's observations about debates on alcohol may be thought equally true regarding debates about drugs, probably more so.[56]

In the introduction to this paper, I drew attention to some of the ways in which the UK Drug Treatment field had become accustomed to viewing our recent history. I pointed to the common use of the word 'paradigm' and the use to which it had been put in describing our recent past. Peter Adams in his 2008 book *Fragmented Intimacy*[57] brings a paradigm-based analysis to bear on the subject of addiction. His analysis is, in the same way as William White's analysis, based

on an historical account of our thinking about addiction. It is, not surprisingly, substantially an account about the dominance achieved in our field by certain professions. Underpinning this description is Adams' central contention that our thinking about addiction is now beginning to go through fundamental change from a paradigm he describes as *The Particle Paradigm* to a paradigm he refers to as *The Social Paradigm.*

The Particle Paradigm

He defines the *Particle Paradigm* thus: "The term particle paradigm refers here to a cluster of assumptions that revolve around the idea that the self is primarily an individual object and that this object --or particle--is the appropriate focal point for understanding addictive processes. He then gives an account of how, through the disciplines of medicine and psychology, the *particle paradigm* came to dominate our field.

Adams describes how "…in the first half of the twentieth century leading figures in medicine in both Britain and the United States launched an ongoing campaign for recognition of addictions as primarily a medical issue. The following new terms emerged with progressively heavier reference to medical concepts: *disease of inebriety, alcoholism, addiction, and ultimately alcohol and drug dependence*." Adams says: "The medical term *dependence* emphasized the biological dimensions of addiction, such as tolerance and withdrawal, and firmly anchored understandings to the perspective that addiction or drug dependence emerges primarily from the individual as a discrete organism."[58] He then describes the emergence into the field of addiction of the discipline of psychology: "In the last three decades of the twentieth century, the strengthening discipline of psychology, supported by its improved scientific research methodologies, reasserted its contribution."[59] Adams notes the "ongoing sparring" and "occasional skirmish" between medicine and psychological studies of addiction, but advises us: "the rivalry is best seen as a sideshow. The main performance is reserved for the consolidating dominance of the particle paradigm."[60]

Continuing his historical account, Peter Adams describes the biopsychosocial model as "a relatively recent development of the particle paradigm that has evolved primarily to accommodate the rise of psychological study of addiction, and, to a lesser extent, recognize the relevance of social and cultural influences."[61]

"…Explanations could not be contained adequately within the bounds of the person, and vague reference to environmental influences no longer sufficed. Since both addiction research and theory were heavily invested in the paradigm, their challenge was to find a way to accommodate social process without transforming the paradigm itself."[62]

The Social Paradigm

The full measure of the paradigm shift Adams is describing as 'emergent' becomes clear when he moves on to describe *the social paradigm.* "In contrast to the particle paradigm, the social paradigm shifts the focus of attention away from people as discrete individuals and toward viewing people in terms of their relationships. This simple move catapults understanding into a different conceptual environment involving a significant shift in how personal identity is understood. …When it comes to reorienting addictions into a social world, the move also involves a fundamental shift in focus and interpretation. Instead of viewing addiction as an attribute attached to a particular addicted person, the central idea involves understanding addiction as a social event."[63]

Adams discusses what is involved in switching to a social world and observes "the leap into this world is no easy matter, especially for those of us who have lived and breathed particle assumptions for long periods. …Switching requires letting go of assumptions from one and taking on assumptions that belong to the other." He notes with concern the apparently unchallengeable strength of the particle paradigm, particularly in settings such as hospital addiction services or addiction research units. In these settings: "Talk tends to focus almost exclusively on counting and treating affected particles." "Nonetheless", he states, "in other contexts, such as in twelve-step groups, residential programs, and community contexts, the focus on individuals is never entirely secure."[64]

He provides the reader with a guide to paradigm shifting. We are enjoined to question old assumptions, beliefs, and explanations. We are advised that *the social paradigm* will involve us changing our vocabulary: "…this book makes use of limited set of new words and phrases that reinforce the relational nature of addiction. 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*." In addition, Adams states that paradigm shifting will require an openness to new territory: "An emergent paradigm is caught between partially relying on language and concepts from the previous paradigm, and partially grappling with developing its own terminology and way of thinking. Furthermore, it lacks the support of established research programs to credential its main assertions."[65]

Adams is clearly aware that the social paradigm is not the dominant paradigm at this time. In his discussion of **dominant** and **alternative** (my emphasis) he notes that: "As one paradigm gains dominance it also increases its access to political and institutional systems and process. …Once a paradigm takes strong hold, institutional systems, ways of speaking, professional practice, and even the design of buildings and clothes work together to reinforce its central assumptions. …It also means that alternative conceptions can no longer be seriously entertained, they are mere opinions or viewpoints, while the familiar

paradigm is solid and factual."[66]

In discussing the key features of paradigms, Adams describes paradigms as slow to change. "Their essential untestability and incommensurability mean both that it is difficult to convince people of the need to shift and that the prospect of a new world opens up as daunting and unfamiliar. Furthermore, particularly for core supporters of a paradigm, why should they shift? It is what they know and it has successfully helped explain things in the past."[67]

The approach taken by Peter Adams in *Fragmented Intimacy* is strongly reflected in the work of Jim Orford.[68] In *Community Psychology* (2008), he states "At the very heart of the subject is the need to see people -- their feelings, thoughts, and actions -- within a social context." In the first chapter of *Community Psychology*, Orford states that “Psychology has laid itself open to the challenge that it has neglected whole domains of its legitimate subject matter. There have been many critics of that position from within psychology itself, and their voices have been growing louder and more numerous."[69]

In Chapter 1 of Community Psychology, Orford introduces the reader to a wide range of critics of the existing, dominant ways of doing psychology. In Chapter 1, Orford discusses *Self-Efficacy and Other Individualised Concepts*, stating: "Nothing illustrates better the individualistic bias of psychology than its preoccupation with individual personalities abstracted from the settings and collectives of which people are a part.”[70]

In the preface to *Community Psychology,* Orford states: ""Whatever the topic, and whatever the level at which questions are posed, community psychology takes a critical stance towards power, class and inequality". One can see quite clearly from this point of view, in his latest work, a set of clearly political concerns accompany, inform and enrich a set of methodological concerns. Like Adams, but in a politically more explicit way, he too attacks methodological individualism in Psychology. This methodological critique is taken up and developed in his paper, *Asking the right questions in the right way: the need for a shift in research on psychological treatments for Addiction*, published in Addiction in 2008. In this paper, Orford's method is, in his own words, to conduct a selective overview of the literature on addictive behaviour change in order to identify possible reasons for the disappointingly negative results of methodologically rigorous controlled trials of psychological treatments in the addictions field. His findings, once again, in his own words, point to eight failings of existing research and his conclusion states unequivocally "Treatment research has been asking the wrong questions in the wrong way." He states that: (i) the field should stop studying named techniques and focus on change processes; (ii) change processes should be studied within the broader, longer-acting systems of which treatment is a part and (iii) science in the field should be brought up to date by acknowledging a variety of sources of useful knowledge.[71]

In this brief paper of only eleven pages, three of which are references, Orford's critique of some of the main prevailing, 'paradigmatic' approaches of clinical psychology are dissected in nothing less than a clinical way.[72]

Two of the *eight failings* that Jim Orford finds in existing treatment research are failing number 4: "Research designs have been based on a timescale that is inappropriate for a chronic, relapsing condition" and failing number 5: "Research has focused too narrowly on treatment technique, failing to take account of the fact that treatment is embedded within broader settings, family and social networks, and sets of circumstances."[73]

On these two failings, Orford's view is that: "Existing failings 4 and 5 may require a more radical break with the traditions imposed by the disciplines, such as psychiatry and psychology, that have imposed their methods on the field, and with the Research Councils in the United Kingdom and the National Institutes in the United States that have required particular ways of carrying out research. Those dominant ways and traditions have made us preoccupied with classifying and measuring individuals, labeling their problems and attempting to match them with suitable named treatments, to the neglect of the social systems of which people and treatment are part. That is, of course, a reflection of a western approach to medicine generally, and the dominant orientation in western psychology and even in social psychology, which has always tended towards studying the individual (e.g. cognitive social psychology)."[74]

Orford then goes on to identify how we might make progress in attempting to focus on **change processes.** *(my emphasis).* He makes six suggestions in all.

Suggestion 1
"We might start by studying the 'therapeutic climate' of the organizational setting in which treatment takes place. Moos and his colleagues over a number of years have built up a model of, and evidence for, the importance of the context in which interventions such as treatment for alcohol problems are provided. That model goes beyond the normal preoccupations of psychotherapy research by demonstrating that positive outcomes are related, not only to a high quality in the key therapeutic relationship, but also to the perceived high quality of relationships with the whole treatment team, high expectations for personal growth and change engendered by the treatment environment and a moderate level of organizational structure. This suggests that we look at the whole environment in which treatment takes place."[75]

Suggestion 2
"We should examine all the procedures that clients undertake in our search for sources of change, including referral and treatment-entry procedures, which may be among the most impactful for clients, and initial assessment procedures, which may be where much more change occurs than treatment theories have allowed .We might even wish to study the ecological, spatial or geographical

features of treatment environments"[76]

Suggestion 3
"We may have to seek collaborators with knowledge of organizations and wider systems. An important part of the argument is that a much broader and longer-term view needs to be taken. It may be that more thought needs to be given to creating long term care and monitoring contracts with heavy drinkers, drug misusers and problem gamblers. The internet and other developments in communications technology may help in that endeavour and at the same time open up new possibilities for researching change processes."[77]

Suggestion 4
"One aim should be to integrate studies of change during and after professional treatment and studies of naturally occurring trajectories of addictive behaviour change. The studies of treatment and nontreatment samples reported by Blomqvist [83,84] and Weisner *et al*. [85] approach what I have in mind."[78]

Suggestion 5
"A broader, longer-term view of change and change promoting systems would require us to broaden our theories of change, and our research methods, to include a number of change-enhancing settings and systems that we already know to be important but which our theories of change and our institutional and disciplinary affiliations and allegiances help us to keep at arms length. Candidates would undoubtedly include Alcoholics Anonymous [86], Gamblers Anonymous and other addiction mutual help organizations [89,90]. They might also include faith communities."[79]

Suggestion 6
“Yet another way in which we could think in systems terms would be in the language of social networks, including the networks of working relationships, or lack of them, that exist among the various agencies providing overlapping forms of help and the networks of family members and friends who are most concerned about another’s addiction and who might be best placed to provide support for change.”[80]

6 Key Dimensions of Change: THREE From Reductionist Thinking to Systems Thinking;

We have seen how Best *et al* and William L. White are promoting and in pursuit of a paradigm the organising theme of which is Recovery; how Peter Adams is promoting and in pursuit of a social paradigm where one of the key concepts is Reintegration and not Recovery; how Jim Orford is looking for a community focus that facilitates and promotes forms of research that study 'Theories and

Processes of Change'. We have also seen how the signatories of the Concordat are seeking paradigmatic change in the philosophy and practice of social care by getting key stakeholders, particularly front line staff, to work towards Putting People First. How does one gauge how to position our field in light of all these competing frameworks each of which is used to make sense of an increasingly complex world?

In *System Failure: Why governments must learn to think differently,* (2004), Jake Chapman argues that the rate of change has now reached a point where it alienates people".[81] Despite this alienation, Chapman does not feel that there is any refuge to be sought in denying the complex nature of our modern systems and their many and complicated ways of connecting and interacting each with the other. Chapman criticises current thinking about many policy problems as 'mechanical', 'reductionist' and 'linear'. "In many domains of public policy, the world in which the policy-maker aims to intervene is beyond complete comprehension. The complexity involved precludes the possibility of being able to predict the consequences of an intervention. Under these conditions the linear rational model of policy making fails to guide the policy-maker."[82] In *System Failure*, Chapman sets out to describe this developing world of complexity theory and its application to the systems within and across which we all work; he is just one of number of researchers, theorists and forums that have looked at complexity.

In *Placing Health: Neighbourhood renewal, health improvement and complexity* (2006), Tim Blackman's own exploration of complexity theory seeks to identify the difference that places make to people's health. "By using complexity theory to understand 'neighbourhoods', we can go beyond the empirical investigations of geographical variation to think about neighbourhoods as complex systems."[83]

In Approaches to Alcohol and Drugs in Scotland: A question of architecture, Scotland's Futures Forum (2007), uses a systems approach to help design interventions to reduce the damage caused by alcohol and drugs. Their remit was to explore the question: "How can Scotland reduce the damage to its population through alcohol and drugs by half by 2025?"[84]

In his introduction to complexity theory, Tim Blackman looks at straightforward or 'simple' policy issues. He notes that these less complicated kinds of problems are often referred to as 'tame' problems. "A relationship whereby A causes B in a linear and mechanical fashion is simple. Many such relationships operating together are complicated. *Complexity* arises when there is *interaction* between many elements, such as the relationship between A and B depending on interactions with C, D or E (a 'wicked issue' in policy terms). When this happens, emergent and difficult-to-predict properties can arise from the interactions."
Chapman also confirms this point: "One of the main insights provided by systems thinking is that in many areas the range of interconnections and feedback makes it impossible to predict, in advance, the detailed consequences of interventions.

Indeed, the consequences are often counter-intuitive."[85]

In this context, Chapman identifies drugs as a case in point: "An example of this can be found in the policy widely used to tackle the use of illegal drugs. It has been well established that the use of illegal drugs such as heroin leads to increased crime by addicts needing to purchase drugs and to the increased cost of health care for addicts. One widely used policy is to aim to reduce the supply of drugs through increased activity by police and customs officers tackling actual or potential importers and suppliers. If the policy succeeds, then the supply of drugs will be reduced. If the supply of drugs is reduced, then dealers will have to pay a higher price for a smaller quantity; so they will 'cut' the drugs with other chemicals in order to increase their volume and they will also raise the street price of the drugs. The raised street price means that addicts have to steal more to get their daily fix. The increased mixing with other chemicals significantly increases the health hazards associated with drug use. Thus to the degree that this policy succeeds in reducing the supply of drugs it will exacerbate the crime and health problems associated with drug use that it intends to reduce."[86]

Chapman regards this example as a relatively simple feedback operating in what he calls a highly complex area. It was in order to get to grips with this complexity that the Scotland Futures Forum employed the methodology of a systems mapping approach. Like Chapman, the Futures Forum recognised that "…interventions to reduce the damage caused by alcohol and drugs, regardless of how well intentioned, will have intended and unintended consequences somewhere else in the system. By using a systems mapping approach, we have been able to see those consequences more clearly."[87]

The Futures Forum attempted to ask and answer the following question: how can we reduce by half the damage caused to our population by 2025? The Futures Forum described Alcohol and Drugs as a "Wicked Problem" or "Complex Mess". Its outline methodology started with a recognition that the alcohol and drugs scene is complex and "its history shows that, in spite of efforts over many decades all over the world to control it, its scale and complexity has continued to grow."[88]

The Futures Forum: "Faced by the complexity and far reaching influences of alcohol and drug use and misuse…selected seven key areas as the basis of a comprehensive systems mapping approach." One of the seven key areas and one that related to each of the other dimensions was evidence and research. For the Futures Forum, however, "…a key issue here is that research is often fragmented and not much used."[89]

So much has been written about complexity theory and systems theory that one might be almost disabled by the sheer volume of the stuff. And what's it for? One of the unmissably clear messages in systems theory is that one probably has to try and think in ways that are not limited to simply one or two sets of terms. The

Scotland Futures Forum's macro level system-mapped framework links the key domains of drug related governance in all their complexity and enables the reader to grasp intuitively the interrelationship between these elements as a dynamic whole.

What is equally important in the Futures Forum approach is their discovery that their seven elements are the right elements and that furthermore they are the in the right order; it is the order of priority that is wrong: the sequencing needs simply to be reversed. In fact, the Forum feels that if one were to reverse the order of priority such that learning and research prefigured our understanding of each of the other six domains starting with communities, public health and prevention, then the possibility of reducing harm by half by 2025 would be a realistic prospect.

The technicalities of the system mapping approach adopted by the Forum are beyond the remit of this discussion. The relevance of the work, however, will become apparent throughout the remainder of this discussion. The policy and governance framework identified and modeled by the Futures Forum is a key overarching document in thinking about the development of Recovery at population wide level. The harm reduction strategy it describes, is simultaneously a community-development strategy, a prevention strategy and learning and research strategy all delivered with an overwhelmingly clear Recovery Orientation.

7 Key Dimensions of Change: FOUR a) Risk and Responsibilisation and b) Recovery and Re-Responsibilisation

a) Risk and Responsibilisation.

In terms of the hard measurable results of crime reduction policy, the First UK National Drug Treatment Policy (1998-2008) has been a success.
In addition to the crime reduction gains, there have been important health gains: reductions in drug related overdoses and in the transmission of blood borne viruses.

It is claimed however, by Pat O'Malley (2008) that in addition to the measurable gains in crime reduction and health, as well as all other reductions in risk to users, communities and society, there is a critical normative gain accruing from the implementation of harm reduction policies. This gain results from the risk

reduction strategy actually empowering the drug user, in a number of ways, to behave more responsibly. This is what one might call, and O'Malley and other writers on government and crime have called: Responsibilisation.

According to Pat O'Malley, "What is immediately evident in harm minimizing policies is that drug users are normalized in ways that are characteristically neo-liberal. As noted, drug users may be rendered individually responsible for harms created to others and to themselves. But this 'responsibilisation' is not intended to render the user a target for social exclusion, punishment or blame: quite the reverse. Drug users are to be 'empowered' to deal with their problems responsibly, and to govern the collateral harms of their drug use. This empowerment includes giving users advice on harm minimizing practices of drug administration and consumption; access to methadone programs aimed at making users more able to manage and reduce their drug use; and the availability of services such as therapeutics and training programs. Responsiblising drug users is thus not tied to a responsibility for past actions, to a process of shaming or blaming, but a responsibility for governing future harmful consequences of their drug use."[90]

A very important element in the process of successful responsibilisation is that: "The category of the 'responsible drug user', paralleling so much other neo-liberal responsibilising of individuals, assumes a rational choice actor. As a result, another familiar pathologized subjectification---the enslaved 'drug addict'--is also muted or erased altogether from harm minimizing discourses."[91]

The notion of the rational choice actor has been exposed to considerable examination and not a little criticism over the course of the past decade. Rational Choice (or Public Choice) theory has functioned as the ideological cornerstone of the neo-liberal, free market view. It is founded upon the principle of choice and believes that individuals are rational actors who are motivated by self interest and that this self interest is clearly represented in terms of the choices that they make. Criminologist David Garland, (2001) describes the emergence of neo-liberal theories of crime thus: "Contemporary criminology increasingly views crime as a normal, routine, commonplace aspect of modern society, committed by individuals who are, to all intents and purposes, perfectly normal. In the penal setting, this way of thinking has tended to reinforce retributive and deterrent policies insofar as it affirms that offenders are rational actors who are responsive to disincentives and fully responsible for their criminal act acts."[92]

Garland contrasts the new criminologies with what went before, what he describes as 'penal-welfarism' or 'correctional' criminology: "Where correctional criminology took criminal conduct to be a product of social influences and psychological conflicts, and regarded the criminal as a deep subject, not altogether in control of his or her behaviour, the rational choice model regards criminal acts as calculated, utility-maximizing conduct, resulting from a straightforward process of individual choice. …It sees offenders as rational

opportunists or career criminals whose conduct is variously deterred or dis-inhibited by the manipulation of incentives--an approach that makes deterrent penalties a self-evident means for reducing offending."[93]

Pat O'Malley identifies the importance of attempts to socially include drug users under this neo-liberal approach and to avoid the demonizing language of 'drug addict' and 'drug abuser' because these kinds of descriptions produce what Garland, in an earlier essay, describes as a 'criminology of the other', "where the offender is to be regarded as monstrous, unlike 'us', and thus a ready candidate for exclusion and coercion. The category of the 'drug user', however, creates a 'criminology of the self'. Drug users are like 'us', for they (too) are rational choice actors."[94]

In 'Culture of Control', Garland describes the emergence of 'responsibilizing' neo-liberal criminology founded on policies of inclusion that require citizens to take active steps to ensure their security, safety and welfare: "Property owners, residents, retailers, manufacturers, town planners, school authorities, transport managers, employers, parents, individual citizens…the list is endless…must be made to recognize that they have a responsibility in this regard"[95]

Inclusion is not something assured, something that one can count on simply by virtue of living in a neighbourhood, being a member of a broader community or a citizen of a country. Social citizenship is no longer a given. Inclusion requires an active orientation where every aspect of a person's life becomes the subject of choice.

This move toward a culture of control where the exercise of control is not principally a top down responsibility that resides with the state requires a control that every individual must exert in respect of his or her own lives. Nikolas Rose (1996) notes the changes that Garland describes in Culture of Control and identifies them as marking what he calls, *the death of the social*: "…'the social' in the sense in which it has been understood for about a century is nonetheless undergoing a mutation. … In this new world: "The human beings who were to be governed --men and women, rich and poor--were now conceived as individuals who were to be active in their own government."[96]

Rose describes modern western government as *'advanced liberal'* government. He moves on to describe how such governments choose to deal with all those who are either not able or willing to actively manage their own risks in order to secure their 'inclusion'. Rose describes those unable to manage their own risk as "…those unable to accept their moral responsibilities as citizens for reasons of psychological or other personal incapacity, those who might be enterprising, but who willfully refused to operate within the values of civility and responsible self-management, such as New Age travelers or drug abusers." These 'abjected' persons are subject to a 'moral problematization'. The State's role, in respect of

these 'particular zones and persons', will ensure an appropriate modulation of conduct via "…the intensification of direct, disciplinary, often coercive and carceral, political interventions in relation to particular zones and persons."[97]

The approach Rose describes is clearly evident in the Home Secretary's Forward to the latest (2008-2018) national drug strategy: "We have targeted those who commit crime to feed their addiction by using compulsory drug testing on arrest and assessment by a drugs worker. This is backed up by tough sanctions for those who do not comply, including, in some cases, custodial sentences. This has contributed to a fall in recorded acquisitive crime of around 20 per cent."[98]

To recap: this part of my discussion is describing what might be called the 'normative dimension' of recent British drug treatment. The psychological underpinnings of our strategic approach to treatment have assumed that punishment is disincentivising and that treatment is incentivizing. In return for compliant behaviours, the drug user is rewarded with injecting equipment, substitute drugs, access to training and education, etc. These compliant behaviours are themselves to be viewed as normative gains in so far as they empower drug users to make positive health and social integration choices: thus, Responsibilisation.

O'Malley endorses this approach as being both more 'collective' and 'inclusive' than those practices informing neo-conservative discourses on the 'war on drugs'. At the same time, however, he asks the key question concerning any harm reduction approach: "…how are problems cast as harms? In terms of which knowledges, and with what effects" His answer: "In the case of drug harm minimization, such knowledge is provided by a narrow band of 'expertise'. This socio-medical expertise has defined beforehand the nature of the problems, defined the harms, and specified the risk-based techniques through which drug use is to be registered and governed. But what of other definitions of harm that even this enlightened program may ignore or override?"[99]

In O'Malley's view, "The tolerance of harm minimization is entirely instrumental, grounded in expert evaluation, not based on other more democratic forms of social solidarity. Perhaps we have arrived at a critical issue concerning risk. The model of drug harm minimization--as a risk regime--very explicitly is both expert-driven and statistical." For O'Malley, this 'critical issue' throws up a 'key question': "If we are to democratize decisions about risk and security, how should we relate the knowledge of experts to the preferences of the lay public whose lives are affected?"[100]

There is then an issue about drugs policy and drug treatment in so far as it is not fully understood, supported or owned by the lay public in whose name it is ultimately enacted. This dichotomy, between expert and lay knowledge is of critical importance in respect of drug strategy. In respect of crime reduction, the experts appear to have been vindicated and in this precise respect the

government is happy to address the lay public about the achievements of the strategy as above. The contingent support that the public has extended in respect of the crime-reduction element of treatment may not be extended to include the other less clear and, perhaps, less tangible benefits. To this end, the government strategy, published in 2008, is a document that, in tone, is both responsibilising and inclusive in O'Malley's sense, but also 'morally problematising' at the same time.

The government wants us to "be clear that drug users have a responsibility to engage in treatment in return for the help and support available." The responsibilisation agenda could hardly be spelled out more clearly than here: "However, we do not think it is right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome barriers to employment. So, we will explore the case for introducing a new regime that provides more tailored and personalised support than that which is currently provided by the existing Incapacity Benefit or Jobseeker Allowance regimes. In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment." And, the Home Secretary's last words in her Foreword make the responsibilisation point again: "we expect drug users themselves to take responsibility, and will help them to do so."[101]

Supporting the government's responsibilisation messages are clear messages about social inclusion, so here: "While we have been successful at fast tracking people into treatment, we need to focus more upon treatment outcomes, with a greater proportion free from their dependence and being re-integrated into society, coming off benefits and getting back to work" and here: "ensure that the benefits system supports our new focus on re-integration and personalisation."[102]

At the same time as emphasising 'responsibilisation' and 'inclusion', however, the government is clearly intending the lay public to understand that illegal drug use is morally problematic and will not be tolerated: "Our ambition is clear. We want a society free of the problems caused by drugs. Our aim is that fewer and fewer people start using drugs; that those who do use drugs not only enter treatment, but complete it and re-establish their lives"…"Through our new drug strategy, and the action that will flow from it, we will continue to send a clear message that drug use is unacceptable; that we are on the side of communities; that we demand respect for the law and will not tolerate illegal or antisocial behaviour…"[103]

At this point, it is very clear that the view of HM Government, in speaking to the lay public, has departed clearly from the expert-driven harm minimization discourse described by Pat O'Malley. Here is his description of what many harm minimization experts feel about illegal drugs "…harm minimization puts stress on the idea that 'consumers' --another neo-liberal subjectification--of illicit drugs are not categorically distinct from the rest of us. We all exist in a society in which drug problems are systemic. As noted, alcohol and tobacco consumption, in

particular, are invariably pointed to as the principal generators of drug related harm in most societies. Illicit drug users are thus rendered 'normal'--if not unproblematic--for the 'problem' is not only one of individual responsibility, but a social problem in societies said to be 'saturated with drugs'. This issue thus takes on a more collective and inclusive sense--infinitely more so than in neo-conservative discourses of the 'war on drugs'."[104]

There is then, quite clearly, when it comes to harm-minimization and risk-reduction an expert view and a lay view. The government, for its part, is willing to take on board elements of the expert view in respect of 'responsibilisation' and 'inclusion', but is definitely not prepared to acknowledge that all drug use is the same and that, therefore, users of illegal drugs are 'normal'. This move is not one the government wants or is prepared to countenance. In fact, for those who are not willing to actively responsibilise, the government will ensure, in Nikolas Rose's words, an appropriate modulation of conduct via "…the intensification of direct, disciplinary, often coercive and carceral, political interventions in relation to particular zones and persons."[105]

In Rose's view the fundamental principle of post-welfare, post-social government is that we are all to be "active elements" in our own self-government. There are to be no exceptions to this rule. This is the first rule of 'the contemporary politics of competence'. Rose says: "This perception extends to those whom I have termed the abjected. Whether they be construed as excluded by socio-economic forces, marginalized by virtue of personal incapacity or pathology or morally alien on account of their dependency, depravity or delinquency, their alienation is to be reversed by equipping them with certain active subjective capacities: they must take responsibility, they must show themselves capable of calculated action and choice, they must shape their lives according to a moral code of individual responsibility and community obligation."[106]

Writing in 1996, Rose might have been describing the National Treatment Agency (founded 2001) when he says that "…it is possible to argue that new territory is emerging, after the welfare state, for the management of these micro-sectors, traced out by a plethora of quasi-autonomous agencies working within the 'savage spaces', in the 'anti-communities' on the margins, or with those abjected by virtue of their lack of competence or capacity for responsible ethical self-management."[107]

We have seen how neo-liberal experts in harm minimization may wish to 'normalize' illegal drug use, but that government's in 'Advanced Liberal' societies need to reserve the right to morally problematise the abjected and to separate them out for special and potentially punitive treatment.

According to Nikolas Rose, Advanced Liberal Government's seek constantly to divide the citizenry such that there are, at any one time, the included and the marginal. The investment challenges for the included are numerous: "In rearing

children, in schooling, in training and employment, in ceaseless consumption, the included must calculate their actions in terms of a kind of 'investment' in themselves, in their families, and maximize their investment with reference to the codes of their own particular communities. But the marginal are those who cannot be considered affiliated to such sanctioned and civilized cultural communities. Either they are not considered as affiliated to *any* collectivity by virtue of their incapacity to manage themselves as subject or they are considered affiliated to some kind of 'anti-community' whose morality, lifestyle or comportment is considered a threat or a reproach to public contentment and political order."[108]

In this part of the discussion, we have looked at the role of harm minimization as a risk reduction strategy. We have also seen how, for those harm minimization experts described by Pat O'Malley it has a clear, normative component. This normative component is an expectation and requirement that drug users actively responsibilise their lives. This active taking of responsibility had been a discernable if not a high impact element in the UK government's first national strategy. Nevertheless, the linkage of Risk and Responsibilisation are identifiable parts of what O'Malley describes as the neo-liberal framework of harm reduction.

b) Recovery and Re-Responsibilisation

In this section I will describe attempts to Re-Responsibilise drug users via the new drug strategy, the Welfare Reform Bill and the new regime of 'support and expectations'.

The new national drugs strategy, *Drugs: protecting families and communities* will, like its predecessor, run for 10 years. It was launched with something less than a fanfare. Notwithstanding its modest emergence, however, it is a very radical document. Amongst other things, it offers, in its own words, "A radical new focus on services to help drug users to re-establish their lives."[109]

Among the strategy actions thus identified is an action that will "Use opportunities presented by the benefits system to provide support and create incentives to move towards treatment, training and employment." This strategy action has been further developed in the December 2008 White Paper, "Raising expectations and increasing support: reforming welfare for the future" which, at the time of writing, is passing through parliament as the Welfare Reform Bill where it is currently about to be debated at the Committee stage in the House of Lords.[110]

The Green Paper of 2008, "No one written off: reforming welfare to reward responsibility", the White Paper itself and the Welfare Reform Bill based on the recommendations in the White Paper have been extensively debated in within and without parliament. The issues of being 'coerced' into treatment on the basis of a 'propensity' to misuse drugs and the proposal to take sanctions against

those who fail to engage with the new drug and employment programme have been subject to considerable scrutiny and criticism.[111]

DrugScope have sought to amend the legislation as it passes through parliament. In particular, they have proposed amendments that seek to: ensure interviews about drug use are conducted appropriately; require reasonable grounds for suspecting somebody has a drug problem; provide safeguards for substance related assessments; limit inferences that can be drawn from a refusal to answer questions; remove the drug testing provisions; give right of appeal against decisions and judgments; restrict disclosure of information from investigative processes; remove the information sharing; protect people from coerced treatment; remove sanctioning powers and place a limit on those sanctions that are enacted in the forthcoming bill.[112]DrugScope's briefing and amendments have been presented at the Public Bill Committee Stage. They represent a detailed series of challenges to the extensive new framework of support and expectations put in place by the Bill.

The first drug strategy was an example of weak responsibilisation; the new drug strategy is strongly re-responsibilising tied as it is to labour market activation and strong integrationist outcome measures.

If one looks at the 2008 Drug Strategy, *Drugs: protecting families and communities*, it is clear that henceforth drug treatment will be described increasingly in terms of reintegration and employment, as well as offending and health. More specifically, treatment **outcomes** will be defined in these terms. The role of the benefits system will provide a major means where by drug misusers may be re-responsibilised. So here: "The benefits system must support our new focus on re-integration and personalisation. In order to ensure that it provides the right level of support and creates incentives for people with drug problems to move towards treatment, training and employment…" And here: "These changes are a first step in helping clients to overcome barriers to work…" And here: "…we do not think it right for the taxpayer to help sustain drug habits when individuals could be getting treatment to overcome barriers to employment." And here: "In return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment".[113]

This new framework of expectations and sanctions is, in effect, a set of requirements that oblige drug users claiming benefits to re-responsibilise their daily lifestyle behaviours in all those areas that can be identified by Job Centres as not conducing to the end of securing gainful employment. This end has, as a result of the 2008 Drug Strategy, become the primary end of treatment for all those drug users who are out of work. Under the heading, 'Our new approach', abstinence is described as 'the goal of all treatment.' This is in itself is a newly 'responsibilising' feature. Even abstinence, however, has to take its place, albeit as an ultimate goal, behind the immediate priority for treatment that is to enable

drug users receiving drug-assisted treatment to "experience a rapid improvement in their overall health and their ability to work, participate in training or support their families." Having secured this end: "They will then be supported in trying to achieve abstinence as soon as they can."[114]

We have seen that the new national strategy is strongly responsibilising in its thrust and requiring of new forms of activation on the part of drug users. The language of the new UK drug strategy, *Drugs: Protecting Families and Communities* is firmly situated within a ‘rights and responsibilities’ framework, a 'something for something' culture, which has become dominant in the United States and Europe. Within this framework, there is a very strong emphasis on work and worklessness.

The first national drug strategy had what one might describe as a weak responsibilising agenda which stipulated treatment and harm-reduction related obligations on the part of the drug user. For example, ensuring one returned used needles to the needle exchange; attending for appointments and agreeing to periodic urine testing in order to establish one's medical and prescribing requirements. During the latter part of the first drug strategy, there was also a requirement to attend for an assessment in the event of having been arrested and tested positive for heroin or cocaine

Notwithstanding the quasi-coercive nature of the Drug Intervention Programme, however, the new 2008 approach, thus described, goes well beyond the weak responsibilising features of our approach to treatment over the course of the first national strategy. The new approach acknowledges that "While large numbers are entering drug treatment, with most deriving significant benefit from it, too many drug users relapse, do not complete treatment programmes, or stay in treatment for too long before re-establishing their lives. … We will examine how we can best support those leaving and planning to leave treatment with packages of support to access housing, education, training and employment. We will deliver better outcomes, with more people becoming re-integrated into society…"[115]

Mark Gilman, the Regional Manager of the National Treatment Agency for the North West of England describes in a similar manner the current treatment situation, but in terms that are framed in what he calls the ‘language of recovery’: "An awful lot of people have come into treatment, they've got into treatment relatively quickly compared to previously, and we've managed to retain them in treatment for a minimum of 12 weeks; which is the minimum amount of time for treatment to take any kind of effect. But so what? So you've got 200,000 plus people in treatment in 2008? Where are they going to next? Well, recovery is the place they're going to, they're going to join the rest of us in society; going into work, looking after their children and all the things you would expect successful treatment to do."[116]

Mark Gilman, in addition to being the North West manager of the NTA, is also the national lead on Recovery for the National Treatment Agency. For Gilman, it is a matter of importance that the Re-Responsibilising Work First thrust of the new drug treatment strategy with its ever tighter and stronger emphasis on active labour market policies is consistent with the emerging Recovery agenda that he is passionate about and has done so much to build. This is a considerably challenge for a civil servant, who has to balance the competing demands of both Responsibilisation and Recovery.

The Recovery Agenda has been an issue for policy networks in the UK since it first emerged into prominence in the UK in 2007. In March 2008, the United Kingdom Drug Policy Commission convened a Recovery Consensus Panel and asked this panel to produce a vision statement for recovery. The statement was published in July 2008 and reads as follows: " The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society."[117]

The Recovery Consensus Group clarified what was meant by "control over substance use" thus: "The term "control over substance use" is deliberately inclusive of both abstinence and maintenance approaches to recovery -- both can provide the necessary control over substance use, as can other approaches. However, it was agreed that neither 'white knuckle abstinence' (with a constant fear of relapse) alone nor being 'parked' on prescribed drugs (with little consideration of individual needs and aspirations which may change over time) constituted recovery."

The Recovery Consensus Group has thus attempted to balance the role of substitute drug prescribing and the role abstinence in the drug treatment system. This continues to be a subject of considerable dispute. Mark Gilman believes that the current prescribing policies and the 'stabilisation' they afford drug users coming into treatment can be situated best within a 'language of recovery'. "There is an importance about having a language in order that we can articulate to people what we're doing. I like the language of recovery because it's optimistic and most people understand it. If you stop ten people in the street and you ask them what the point of drug treatment is, I guarantee that nine out of ten people will say to get people off drugs. The difficultly we have is that the reality of it for a lot of people is that there's a stage whereby they won't be coming off drugs, they'll be stabilised on safer drugs, cleaner safer drugs and therefore there will be a period during which we will be managing addiction. It's much better to have somebody on Methadone, Buprenorophine or Diamorphine provided by a doctor, safely and cleanly, than have them out there having to raise the money to buy street drugs of dubious purity. So stage one: Get people in treatment, stabilise them and manage their addiction."[118]

Best *et al* (2009) in a paper that follows on from their paper, Politics of Recovery,

challenge the view that treatment always provides benefit and suggest that: "…there is an actuarial risk that we have not considered adequately in the unquestioning belief in the virtue of structured drug treatment as the core response to substance problems." Best *et al* also draw attention to the potential risks of stabilisation as well as its benefits: "…for all the stabilising good that is done by this 'risk averse' model of treatment, it offers the real risk of medicating through windows of opportunity for change and so preventing long-term recovery and identity change. What makes this more problematic is that there are good reasons for both client (loss of benefits, fear of withdrawal, concerns about life options and employment prospects) and worker (governance and risk fears about relapse, poor structures for delivering change interventions, lack of evidenced change models, as well as the numbers and targets relayed through their managers) to elongate the clinical relationship."[119]

In respect of the clinical relationships, Mark Gilman speaking on the issue of control says that the creation of Recovery Oriented Integrated Systems requires that drug workers give control back to individuals. "My personal view--it's not an NTA view--is that one of the negative things that's evolved somewhere over the last 25 years is that we've developed a sense of infantilism; we treat men and women in their 40's even 50's as if they were children." "… I think one of the biggest problems we've got in the entire addictions field is infantilism, making infants of grown men and women who consequently internalise that and become victims. One of the biggest barriers to personal recovery is a sense of being a victim 'it's not my fault, somebody did it to me'. If you hold onto that then you're going nowhere. And unfortunately there are almost examples of co-dependency whereby certain drug workers become dependent on the addict and they have a very unhealthy relationships where one infantilises the other and the other plays it back as victim."[120]

The view that somehow the mainstream workforce in the British drug treatment system is colluding with, and may even be helping initiate, a lowering of expectations on behalf of the service user is worrying. Mark Gilman isn't alone in expressing it. David Best has expressed it in his recent work and has been expressing it for some time. In this discussion, I have not sought to exonerate ‘the workforce’ or sections of the workforce from all blame in respect these criticisms. Clearly there are numerous examples of workers approaching their clients with pessimism and an insufficient understanding of an appropriate and positive engagement, where choices are clearly identified as part of a co-produced assessment and care plan. It is important, however, to note that we have not as a field sought collectively and explicitly to challenge the attitudes of ‘chronicity and pessimism’ that beset some common approaches in our field. To this end, it is important to focus on organisations and systems as they are managed and run as well as the processes whereby these systems are commissioned. I will be examining the commissioning of recovery in my conclusion. Until proper discussions and debate takes place at national level, it is regrettably the case that when it comes to dishing out blame, the workforce will

cop for it.

Unlike the methadone debate where there is a clear difference of opinion, where one can line up opponents, organise debates, sell tickets, sit back and watch, most of the current differences of opinion in the field are, if not more nuanced, then more difficult to unpick in terms of what ultimately might be going on.

Clearly, however, something is going on when it comes to the discussion about whether or not drug use is a *Chronic Relapsing Condition.* When asked about the subject, Mark Gilman states: "This is one of the more controversial areas of contemporary drug treatment. Is drug addiction a chronic relapsing condition? Well…probably. It's certainly chronic in as much as it lasts for a long time, or it *can* last for a long time. It's certainly characterised by relapse; relapse is the norm not the exception. It takes people quite a while to get into addiction and for most, quite a while to get out. Not many people in my experience--and I've been 25 years working in this game -- not many people have woken up one morning and said 'I'm packing it in, I'm never doing it again' and from that day on they haven't. Most people make that decision and then through a series of trial and error, lapse and relapse, they finally get there. The problem with chronic relapsing condition as an *idea* is that it does have a tendency to breed pessimism, because it gives people the idea that they'll never be cured; because its chronic, because it's relapsing it's with you for life and therefore it can only ever be managed. So then we start to move into a situation where we start to manage addiction as opposed to actually introducing recovery. So is it chronic?…yes. Is it relapsing?…yes. Does it mean you've got it forever? Absolutely not! There are millions of people that have been in this position and are not any longer."[121]

If we turn now to *No One Written Off: A response to the Department for Work and Pensions' Welfare Green Paper,* one of the *Recovery Reviews* produced by the UK Drug Policy Commission (2008), it states as its opening point: “Drug dependence is a disorder, often chronic and relapsing in nature, not simply a lifestyle choice. Many problem drug users (PDUs) have multiple, long-standing problems which will require long-term, multi-component solutions as part of a "rehabilitation package".[122]

On page 5, the Review quotes the World Health Organisation on the neuroscience of psychoactive substance use and dependence: "Substance dependence is a complex disorder with biological mechanisms affecting the brain and its capacity to control substance use. It is not only determined by biological and environmental factors, but psychological, social, cultural and environmental factors as well. Currently, there are no means of identifying those who will become dependent -- either before or after they start using drugs." And again:

"Substance dependence is not a failure of will or of strength of character but a medical disorder that could affect any human being. Dependence is a chronic and relapsing disorder, often co-occuring with other physical and mental conditions."[123]

This is the biopsychosocial model as described by Peter Adams (2008): "The central advantage of a *biopsychosocial* model is that it recognized the complex and multileveled nature of addictions. It encourages medical and psychological approaches to work side by side, and it recognizes the legitimacy of social orientations. Its key challenge is to find a way of communicating between the three orientations." Ultimately Adams feels that the model fails the challenge: "The frame fails to acknowledge that adopting a truly social orientation on addiction requires a move away from the particle assumptions inherent to biological and psychological theories."[124]

In some respects, one might interpret this as a prospectus for stasis. One can understand how specifications like the ones above may well be read as reasons for believing the prognosis for 'Recovery' isn't necessarily very good. One might also read them as a kind of "Keep of the Grass" sign posted by the medical profession. One might want to argue that the UK Drug Policy Commission may be one of Best *et al's* "same old power players doing the same things, changing only the language they use and the banners behind them in conferences."[125] In this sense, the UK Drug Policy Commission may be thought by some to be lacking in genuine independence.

The evidence, however, shows a continuous stream of reports and submissions that are critical of government policy. Certainly, the Commission is well stocked with people who are members of influential policy networks. Certainly, it would be very surprising if the Commission came out in favour of the wholesale legalisation of drugs or the abandonment of any medical role in the supervision and care of drug users. It wasn't designed to 'take positions', certainly not ill-advised ones; it was brought into being to commission research that would develop a different kind of evidence base to that being developed by the Home Office, the Ministry of Justice, the National Treatment Agency and, now, the Department of Work and Pensions.

It is worthwhile remembering that National Treatment agency may upon occasion be described as an arms length body in terms of its functioning and relationship to government, but it has never been granted the remit to disagree with government policy formation and development at any of its published stages.

The work of the UK Drug Policy Commission is designed, in part, to shed new light on some of the pressing and perennial problems we face as a field, both in a policy and treatment sense, and also to canvas views nationally and internationally about best practice. Some of us may well wish the Commission took different positions in respect of some of its submissions and reports, but it

has brought an influential and different set of well-informed criticisms to bear on the key issues. Its work on the Welfare Reform bill is very important in this respect.

Talking about the term 'policy community' in respect of alcohol, Betsy Thom says: "The term 'policy community', developed in the UK by Richardson and Jordan (1979), characterises the central policy-making machinery as divided into sub-systems organised around central departments. These sub-systems, and the close relationship that exists with outside lay or professional groups or institutions are 'policy communities'.[126]

The UK Drug Policy Commission in its work around the Welfare Reform Bill, (including its response to the Green Paper, its employment report, Working towards recovery--with its research commissioned from Manchester University and the latest briefing in the House of Lords) has been addressing, amongst other things, a Department of Work and Pensions which has a very considerable influence and experience in policy development up to and including the framing of statute.[127]

Anne Daguerre (2007) describes 'policy communities' as "tight policy networks characterised by frequent interactions, shared beliefs and common values." She describes the genesis of New Labour's policy on welfare as it emerged around a policy community in the Treasury and the then Department of Social Security between 1997 and 2000.[128]

In her account of the policy community that formed around the New Labour government, she discusses the role of the economist, Professor Paul Gregg. Professor Gregg is the recent author of the Gregg Review, which ran alongside the consultation on the Welfare Reform Green Paper and provided what the DWP describes as "important, independent, examination of the expectations which are at the hear of our welfare reforms."[129]

Anne Daguerre notes the contribution of economist Richard Layard, author of *Happiness*, and an early advocate of the welfare-to-work approach who "has been referred to as the founding father of the New Deal. "…this group enjoyed a great amount of stability in terms of its membership since the mid-19990s. Academic and professional expertise plays an important role in this group, which is the reason why it is more accurately described as an epistemic community.[130]

Quoting Haas (1992), Nutley *et al* describe 'epistemic communities' as groups "with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain."[131]
Nutley *et al* note "Through the legitimacy given by their professional training and claims to expertise, members of epistemic communities can secure unique

access to and influence on the political system: knowledge is their main source of power."[132]

One is dwelling on this area of policy formation and in particular on the long standing and stable policy community that has informed the work of the Department of Work and Pensions in order to help understand much of the thinking in the Welfare Bill and the White and Green Papers that preceded it. The major influences in this area are economists. Daguerre discusses their beliefs and values and their stability over time: "The first, and probably most important, core value is the quasi-religious belief in the virtues of work, as opposed to inactivity. …The second belief is the emphasis on rights and responsibilities: …It follows that at least some degree of compulsion and sanctioning is acceptable and can be used when people fail to comply with labour programmes requirements:… The third common core assumption is that the aim of active labour market policies is to raise people's employability by helping individuals change their behaviour and their mindset:…This belief derives from the endorsement of supply-side policies and the subsequent abandonment of job creation schemes.…The fourth belief, at least in the initial stage of welfare reform, was based on the superiority of the Work First approach as opposed to the Human Capital Approach.…The fifth belief is that there is that there is a great degree of voluntary unemployment -- despite protests to the contrary in official policy documents which repeatedly state that the vast majority of people on IB want to work. Last but not least, all actors share the preference for a flexible labour market with relatively low paid jobs subsidised by generous in work benefits in order to make work pay and foster employment growth."[133]

Daguerre then describes the three phases of this government's 'workfarist' policies implemented between 1997 and 2006. "The first stage, policy formulation and programme design (1997-98) is dominated by the influence of the Treasury and to a much lesser extent by the Department of Social Security (DSS), now the Department for Work and Pensions (DWP). The second stage is led by the DWP under the close scrutiny of the Treasury. It consists in further unifying the treatment of economically inactive people and expanding the various New Deals to all categories. The last stage (2003-present) consists in the implementation of the reform of Incapacity Benefits. The Prime Minister's Office initiated the reform of IB but increasingly delegated policy design to the DWP, with the approval of the Treasury."[134]

Anne Daguerre's is a comparative study looking at welfare in the United States, France, Denmark and the United Kingdom. In each of these countries she identifies an 'outsider group' that become a 'target population' population for the 'insider' population: "In most cases, the cultural frames held by 'insiders' are relatively homogenous, as well as their ways of constructing 'problems', that is target populations: third-world immigrants in Denmark, single parents in the United States (with a continuing racial subtext), social assistance recipients in France and Incapacity Benefits recipients in the United Kingdom."[135]

One can see these dividing practices, between insiders and outsiders, at work in the executive summary of the DWP White Paper: Our goal is a system where everyone has personalised support and conditions to help them get back to work, underpinned by a simpler benefits system and genuine choice and control for disabled people."[136]

Daguerre notes welfare regimes in countries like the United States and the United Kingdom with a Work First approach tend to analyse social exclusion as a combination of poor personal characteristics and behaviour: "The tendency to blame the poor for their own fate coexists with emotional pledges for understanding, empathy and compassion for the truly unfortunate."[137] Understanding, empathy and, one might add, control: genuine control.

Point 36 of the Executive Summary to the White Paper states: "We want to see a new right for disabled people, giving them greater choice and control over the public money currently spent on their behalf. We will legislate to give them a 'Right to Control', giving them the power to take a range of funding streams to which they are entitled as an individual budget, and trailblaze this approach in selected public authority areas before deciding next steps following evaluation."[138]

The White Paper is not guilty of appropriating the language of recovery, a la Best *et al's* fears. It does however, completely gobble up and spit out the language and spirit of personalisation as spelled out in Putting People First. There the emphasis, one will recall was, "on the side of the people needing services and their carers." We recall that the **values** of the Concordat state that "in the future, we want people to have maximum choice, control and power over the support services they receive." The Welfare Reform White Paper, and the Gregg Review, which is accorded its own chapter within it, restates *personalisation* as *activation.* So, the White Paper looks forward to tomorrow's benefits system in distinctly active terms: "This would be a benefits system that doesn't just catch people, but propels them forwards."[139]

In addition, the White Paper reworks *personalisation* as *responsibilisation: "*The White Paper retains the twin goals of our welfare reform in providing more support to help people overcome the disadvantages they face in the labour market, while at the same time increasing personal responsibility.*"* And: "*…*we will help people develop work habits and employability skills while underlining their responsibilities to actively look and prepare for work. By requiring claimants with drugs problems to take up treatment options, we will help both them and society as a whole."[140]

Above all, the White Paper restates *personalisation* as *conditionality:* "Current conditionality tools for the non-Jobseeker's Allowance group have genuine limitations: we have not yet made the most of the potential power of

conditionality." And, "The visibility and effectiveness of the sanctions regime could be improved: evidence from behavioural economics suggests that sanctions will only drive behaviour if they are clear, transparent and well understood."[141]

The terms of reference of the Gregg Review include an intention "To set out a vision for a more personalised conditionality regime -- and what this might look like in practice. This should be based on the objective that expectations and potential sanctions are challenging, appropriate and effective--given individuals' needs and circumstances." The White Paper also identifies the need "To consider the implications of the latest evidence from the fields of behavioural economics and social psychology for conditionality policy."[142]

The Welfare Reform Bill and the White Paper upon which it was based are something quite new for the UK Drug Treatment Sector to digest and respond to. The world of behavioural economics is a world of incentives and a world of sanctions. "As the Gregg Review recommended, the sanctions should be clear and crisp and should engage people by changing their behaviour."[143]

The UK Drug Policy Commission, in their response to the Green Paper, notes: "Evidence from the USA also suggests that use of benefits sanctions to enforce participation in employment schemes may be ineffective and have negative impacts on the families of problem drug users."[144]

In respect of disability, the UK DPC response to the Welfare Green Paper argues against any mandatory disclosure of drug use by arguing that if drug use was an eligible need and qualified for welfare benefit then it may well encourage voluntary disclosure, thus obviating the need for mandatory disclosure. The response states: "In Australia, alcohol and drug dependence is specifically identified within their assessment framework for their Disability Support Pension."[145]

Such a new eligibility may indeed work in the way the UK Drug Policy Commission suggests. Would this be acceptable to the public, however? The late Richard V. Ericson (2007) put the matter thus: "At the beginning of the 21st century, social security systems are strained and part of the politics of uncertainty. The capacity to know is limited in two interconnected ways. First, in many fields of health and welfare provision, the medical and human sciences have very limited ability to assess a person's incapacity and need for benefits. Second, there is uncertainty about how to frame the benefits system in sustainable ways: how can the system ensure reasonable benefits without mortgaging the lives of future generations through debt financing?"[146]

In these circumstances, one would not wish to be a problem drug user, notwithstanding any eligibility for benefit, nor that small degree of protection and dignity afforded by a medical diagnosis. Given the reality that Ericson describes,

one would wish those problem drug users who are able to become abstinent to do so at the earliest possible opportunity. And if their aspiration to become abstinent was being thwarted, as Bes*t et al* suggest is the case, by a regime that requires drug users to enter treatment and thereby, in some cases, acquire a dependence that they didn't possess at the outset, then it may well be that one can expect a series of strong challenges from individuals and organisations alerted to such a possibility.

“In neo-liberal regimes, the dominant response is to reduce benefits by both limiting eligible disabilities and restricting the terms and conditions of benefits where eligibility remains. Benefits are constructed as temporary, exceptional, and abnormal. Integral to this construction is a strategy of treating some disability and welfare statuses as if they are criminal. This criminal association is meant to convey that the person receiving social benefits is a social enigma, someone to be stigmatized and scrutinized for being a drain on collective prosperity. It legitimates treating everyone in the status as a potential source of fraud, and paves the way for a regime based on laws against law and surveillant assemblages."[147]

But what of those who, for whatever reason, are unwilling or unable to become abstinent and are therefore consigned for a period of time to this new regime of 'personalised conditionality' and 'surveillant assemblages'. What of their rights? The rights of drug users, admittedly never a popular cause, are surely of some importance. If people are going to feel secure and unthreatened in their dealings with their Job Centre Plus and with the local treatment service, secure in a way which makes the prospects of improving their circumstances greater rather than less, is this not too an item for the Recovery Agenda? It's certainly a key concern and responsibility for the drug treatment field. This is why agencies like DrugScope and the UK DPC have raised such a large number of important critical questions concerning the Bill and its provisions as it makes its way through parliament.

In Anne Daguerre's view, however, notwithstanding the evidence available for supporting our view, we need to determine "the extent to which welfare policy communities can resist radical ideological and political pressures for change in this particular sub-sector."[148]

We may feel that we are substantially at the beginning in terms of those new UK agendas of personalisation; of recovery; of the social paradigm and of a more complex understanding of 'wicked' problems. At the same time, however, we may also feel that in terms of much of the ideological infrastructure that has underpinned our thinking about social care, drug use, welfare and community empowerment over the past 25 years, we are certainly coming to the end. How these underlying tectonic shifts in ideology will impact on policy and practice in our welfare, care and treatment sectors remains to be seen. Something,

however, quite deep down in the core of our most basic thinking about rights and responsibilities and individuals and communities is beginning to shift.

It's not yet clear how we in the drug treatment field will steer between the Scylla of the biopsychosocial model, as worked up and refined by the World Health Organisation, and the Charybdis of behavioural economics (a Particle Paradigm if ever there was one). Nevertheless, it is important to try to see beyond these dilemmas. Some elements within the emerging UK Recovery Networks may be entirely comfortable with the *re-responsibilising*, *conditionality* of the Welfare Reform Bill. Others may want to move beyond its Particle Paradigm, its behavioural economics and its activation discourses. In the words of Anne Daguerre, "By focusing on the individual behaviour of the poor, activation discourses overlook the structural disadvantages faced by vulnerable groups in today's capitalist societies."[149] Where do we in the drug treatment field stand in respect of this debate?

We have seen how government will listen to harm reduction experts, up to a point. Nowhere is this more clearly identified than in the manner in which the government and its experts canvassed opinion about key proposals in respect of Welfare Reform. As the White Paper puts it: "The views of people who responded to the consultation are important, but we also wanted to understand broader public opinion to build a consensus that would make changes to the welfare state durable. So we commissioned public opinion research to examine key proposals from the Green Paper. Most policies covered in the research enjoyed high levels of support, with at least eight out of ten people backing them."[150] The Green Paper proposal that enjoyed the most support in terms of respondents agreeing strongly was the requirement for unemployed drug users to tackle their problem or face a stronger sanctions regime. Over 70% percent of those canvassed strongly agreed with this requirement.

When DrugScope canvassed its own predominantly drug treatment provider membership about the Green Paper it found pretty much the reverse. The statement to which members were asked to respond in terms of agreement and disagreement was as follows: 'So long as you are providing appropriate support, it is fair to require problem drug users on welfare benefits to engage with drug treatment and employment services and to sanction people who do not engage by cutting their benefits'. In response to the sanctions proposals put thus, 35.4% of DrugScope members disagreed, 37.5% strongly disagreed, 14.6% agreed and 2.1% strongly agreed.[151]

One may return at the end of this section to Pat O'Malley's key question, posed earlier in this part of the discussion: "The tolerance of harm minimization is entirely instrumental, grounded in expert evaluation, not based on other more democratic forms of social solidarity. Perhaps we have arrived at a critical issue concerning risk. The model of drug harm minimization--as a risk regime--very explicitly is both expert-driven and statistical." For O'Malley, this 'critical issue'

throws up a 'key question': "If we are to democratize decisions about risk and security, how should we relate the knowledge of experts to the preferences of the lay public whose lives are affected?"[152]

The government's own risk reduction agenda is a re-responsibilised version of the first drug strategy influenced far more by the 'particle paradigm' of behavioural economics' than the 'biopsychosocial model of the World Health Organisation. Their particle paradigm of choice conforms more precisely to their survey-informed view of what the public wants. They have decided that the re-responsibilisation of drug users requires a conditional form of personalisation with a strong set of sanctions for non-compliance.

8 Conclusion

a) Commissioning Recovery Oriented Systems of Care

As a treatment provider, I am of course keen to learn as much as possible about how we can transform our systems in the directions I describe above. It is important to learn from those who are undertaking system change. In an interview conducted in 2006, Arthur C. Evans, Director of the Philadelphia Department of Behavioural Health describes *The Recovery-Focused Transformation of an Urban Behavioural Health Care System.*[153]

In the interview, Dr. Evans states: "It is clear that many of the people we serve have co-occurring mental health and emotional disorders. As we listened to the stories of people in recovery, it quickly became clear that we needed to find a way to serve these people more holistically. It was critical for us to have a vision of recovery that really incorporated both addiction and mental health, and an integrated vision through which we could plan and allocate funds for both mental health and addiction services. …Our goal is to move toward a unified framework of behavioural healthcare."[154]

Dr. Evans describes the systemic challenges of service transformation thus: "Our goal is systemic and lasting change in the design and delivery of behavioural healthcare services. As a result, we made a conscious effort to think about: 1) how we want thinking to change, 2) how we want people's behaviour to change, and then 3) how we want to change the policy, fiscal, and administrative contexts to support the behavior and thinking that we ultimately would like to see in the system. All of our system-transformation activities keep these three areas of focus in mind."[155]

Key elements in a comprehensive, commissioning *Blueprint for Change* require providers to: "Emphasize the rights of people in recovery to participate in and direct service decisions, plan for services, and move toward self-management of

their own recovery journeys in collaboration with the people who serve them" and also to: "Shift the primary service relationship from an expert-patient model to a partnership/consultant model" and "Move toward assessment procedures that are global (holistic), strengths-based (rather than pathology-based) and continual (rather than an intake activity)."[156]

Dr. Evans stresses the importance of what he describes as parallel process: "…the relationship we want to see between our direct-care providers and those they serve must be mirrored inside our department, both in the relationship between our department and the treatment providers and in our relationship with other community organizations. This realization has forced us to think about our own behavior and how it helps or hurts our system-transformation efforts."[157]

The developing commissioning relationship with the provider community is described by Dr. Evans as follows: "I think that they are becoming more trusting of and more open with us. We are trying to move away from a policing role--the 'gotcha mentality' that we in government can drift into. We are trying to move toward a partnership model that emphasizes our need to work together toward a shared recovery vision."[158]

On the necessary training for the workforce, Dr Evans says: "The training that most behavioral health professionals get offers no consistent recovery orientation. You can't assume people have been trained from this perspective, so it must become part of everyone's orientation and training within the field. We felt that we needed to put a significant amount of resources into training, to help people have a different way of thinking about work, but also to help them have a different way of behaving."[159]

b) Final Thoughts

This discussion has examined the notion that, at any one time, one particular paradigm is dominant. It has also examined a slightly modified view that at any one time there can be an overarching paradigm that exhibits a degree of continuity, whilst subsuming distinctive sub-paradigms at particular periods within a longer historical time frame. In this sense the Public Health paradigm (1986-1995) gave way to the Criminal Justice Paradigm (1996-present), but that both paradigms, despite considerable apparent differences were sub-paradigms of a broader, actuarial, population-wide policy of risk-management. This paradigm described by Seddon *et al* (2008) and also by O'Malley (2008) can be regarded as a set of assumptions and practices around reducing the harm of illegal drug use to users, communities and society at large. Integral to this all-embracing notion of harm reduction was a set of expectations placed upon drug users. This *responsibilisation* of drug users requires them to comply with minimal

expectations around their drug using behaviour in return for treatment, advice, and support, and, where necessary, palliative care. In return, therefore, for facilitating and making possible a drug using lifestyle within the framework of the law, drug users have been expected to behave responsibly in their range of drug using behaviours. I described this approach, characteristic of treatment and harm reduction policy since the late nineteen eighties as a weakly responsibilising approach.

I went on to examine briefly the view held by William L. White that we are on the threshold of a new therapeutic recovery paradigm founded on nothing less than a new philosophy of care; a fundamental revolution about what treatment is and should be. A revolution that brings into play those seeking to recover from drug use as far more than mere patients. Writing in the Journal of Substance Abuse Treatment in 2007, he describes us as being "on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm". The writings and work of William White and a gradually emerging understanding of the events in the United States that he describes, both as an historian and as a Recovery activist, have emerged in this country in light of a recognition that the balance of our own national treatment strategy needed to shift.

This recognition was most thoroughly framed and discussed for the first time at the National Treatment Agency's 2005 National Treatment Conference. This conference was both a high water mark, in terms of the achievements accruing from the first National Drug Strategy, and also an opportunity for a first analysis of where we, as a field, needed to go in terms of a more effective treatment strategy. In particular, we focused upon an enhanced 'treatment journey' and what that would mean in terms of our workforce being better able to engage, assess and shape an appropriate range of expectations, experiences and outcomes within and along this 'treatment journey'. It was in this context and out of the discussions that subsequently followed over the course of the next eighteen months that we began to examine the concept and process of Recovery.

In the North West of England and in Scotland the young recovery movement began to coalesce around a preliminary agenda. Prominent in this agenda was a call for more abstinence-based services and clearer and earlier signposting of their availability. This developing Recovery Agenda has brought with it a greater awareness of the development of a Recovery Movement in the United States. In this country we have drawn increasingly upon the work of William White who has become widely known and read over the course of the past eighteen months. His descriptions of the Recovery Paradigm and the accompanying Recovery movement have served as an inspiration and organising point for many Recovery activists in the United Kingdom.

In addition, to examining Recovery in terms of what its own key exponents say, I

argued that it was necessary to try to place Recovery in the current United Kingdom context. In this context, I selected what I described as the key dimensions of change and sought to briefly describe these dimensions and draw out in a provisional and preliminary way some of the implications both for the UK drug treatment field and also, within our field, for the development of a Recovery Perspective. I looked in turn at the role and impact of the Putting People First Concordat: a top-down call to action on behalf of government and the top professionals within the social care field. I noted a fairly clear set of comparisons in terms of the Concordat's philosophy and the philosophy of Recovery. These comparisons were aided by a brief look at the latest work of David Best *et al* in Western Scotland. I noted that much of what the authors of the Concordat were calling for as necessary would also be required in the context of the UK drug treatment field, were it to seek to transform itself in a similar fashion.

I then undertook another brief examination of what might be described as organisational learning. I set out two perspectives: organisational learning in times of growth and stability and, alternatively, organisational learning in times of change and uncertainty. I described how, over the course of the recent past, drug treatment provider organisations in the United Kingdom have grown and developed. This growth and development has been facilitated by the championing of organisational values, policies and practices conducive to the 3 Cs: competitiveness, compliance and competence. I drew out some of the characteristics most prevalent in drug treatment providers and questioned what the impact of developing as competitive, compliant and competent organisations had been on their propensity to change, to engage in critical self-examination and to work across organisational barriers.

I also looked briefly at how our field has utilised research and the impact of embedded research models as regards workforce development and learning. I drew extensively on the work of Sandra Nutley *et al* in this discussion. I also indicated, albeit very provisionally, that it is illuminating to break down our workforce into its component parts and to examine the claims our field might have to be part of an identifiable 'knowledge sector'. Our field is now driven by numbers, targets, and throughput in addition to quality and customer satisfaction. In these respects, drawing on the work of Marek Korczynski, I identified the organisational structures of many large drug treatment services as resembling Korcznski's Customer Oriented Service Bureaucracies. In contrasting the learning and development challenges of organisations and their workforces during periods of stability, on the one hand, and during periods of uncertainty and change on the other hand, I hope I was describing some of the challenges we face as a field in moving towards practice that is based on a new philosophy of care founded on the values of personalisation and recovery.

In the second key dimension of change, I examined the recent work of Peter Adams and Jim Orford. Both Adams and Orford are psychologists and both have focused in their recent work on describing a new set of priorities for the discipline

of psychology. Peter Adams, in *Fragmented Intimacy,* describes a strong trajectory within the discipline of psychology that is moving from an essentially clinical and individualising form of understanding addiction, *the particle paradigm*, to a new way of understanding addiction as first and foremost a social process affecting more than one person, *the social paradigm.*

Jim Orford, in a 2008 paper for Addiction, enjoined the field to begin '*Asking the right questions in the right way'*. His paper describes '*the need for a shift in research on psychological treatments for addiction'.* Both Adams and Orford situate psychology within communities rather than within the counselling rooms of treatment services. Both writers have profound and extensive concerns about how to seek clarity and coherence in this current period of what Orford describes as *'epistemological turmoil'.*

In similar vein, Adams describes the discipline of psychology as poised on the threshold of an emergent 'social paradigm'. In this period he points out a degree of uncertainty and confusion, positioned as we are between two profoundly different ways of construing addiction. Adams identifies these in-between periods, where no one paradigm has absolute dominance as potentially interesting and fruitful. In these periods, new and important questions can be asked and explored outside the confines of the dominant frame of reference. This stimulus to thought and enquiry more than counterbalances the attendant confusions that arise when people are trying to make sense of the world using more than one frame of reference. Looking as an outsider at the developments Adams and Orford describe as taking place within psychology has a strong resonance in terms of the broader uncertainties facing all of us in the drug treatment field. We are poised, it seems, on not one paradigmatic threshold, but a number. It remains for discussion and debate to determine where the cross-over points are and what we can learn from each paradigmatic migration.

The next dimension of change was to examine yet another paradigm shift from reductionist thinking to systems thinking. This transition is described in a multitude of ways using a new terminology that describes how hitherto we have been guilty of thinking in simple, silo-based, reductionist ways where really what we ought to have been doing is thinking in complex, integrated, system-based ways. This onset of 'complexity theory' has grown in tandem with the strongly critical consensus that has emerged around the target driven, disconnected nature of much national and locally implemented public service reform. Under the overall rubric of change, we are required to look more fundamentally at systems and how they interconnect, how they can be nested one within the other, and how they can be mapped.

This kind of systems-based theory has gone quite quickly from the repertoire of organisation and change management consultancy to the mainstream. It is now a requirement for Local Strategic Partnerships and part of the contemporary wisdom of bodies like the Audit Commission. Despite the fads and fashions of

the market place in systems thinking for senior partnership personnel, it is very useful to have moved into a period where one is encouraged to make connections rather than developing models of change which are unnecessarily and unhelpfully compartmentalised within the boundaries of one sector or discipline.

In this respect the work of Scotland Futures Forum is a notable advance in thinking about the population-level governance and management of drugs and alcohol problems. Henceforth, we have a model that identifies a connected series of domains, each of which can be mapped against others and all of which can be presented as a single dynamic system. The Futures Forum went far beyond the traditional and profoundly compartmentalised ways of thinking about drug policy. The Forum sought explicitly, from the outset, to join things up in a way that was both intuitive and simple to grasp whilst, at the same time, being sufficiently complex to do justice to our current complicated and disconnected machinery of drug governance, policy, treatment and prevention. Its key strength was to refocus our thinking on early intervention rather than interdiction at a late stage, when careers are shaped and damage done; to focus on how one supports development, partnership and change at the community level and, last but not least, (in fact first and before everything in the work of the Futures Forum) a new enriching role for research.

The Futures Forum drew upon expertise from around the world and asked some big questions in respect of the kind of change necessary to answer questions about harm and damage. The answers were not couched in the traditional language of harm reduction as palliative care, but were much more forward looking, requiring, amongst other things, a more informed, pragmatic approach to prevention. In the view of the Forum, prevention is about being able to control supply; to intervene early and effectively in those communities where drug and alcohol misuse is endemic; to draw upon the energies of drugs users, families and communities in developing recovery based practice and to require a better informed electorate to help generate popular support for a series of population wide interventions that seek to align and better regulate current forms of governance. The Forum's *Approaches to Alcohol and Drugs in Scotland* represents nothing less than a developed attempt to promote a Recovery inspired architecture of governance and policy for the next 15 years. It is an essential part of our emerging thinking about Recovery as a systems-based, population-wide, community-led series of connective initiatives and strategies.

The next key dimension of change I described as emerging from the new direction clearly outlined in the new 2008 UK Drug Strategy and described more fully in the 2008 Green and White Papers on Welfare Reform. I describe the 2008 UK strategy as an attempt to go beyond the responsibilising framework of the 1998-2008 strategy towards a new framework of re-responsibilisation set forth as a set of expectations and sanctions in the new Welfare Reform Bill

passing through parliament at the time of writing. This new framework is described by the Gregg Review as a new form of Personalised Conditionality. Organisations like DrugScope and the UK Drug Policy Commission have developed detailed responses to the new and far-reaching proposals contained in the Bill. The work of these organisations is extremely important both in identifying the potential damaging impacts of the Bill when it becomes law and drawing attention to those of us in the field who might not have been aware of what will be required of us as a profession. I described the challenges faced by Recovery Activists like Mark Gilman, who have to manage the re-responsibilising elements of this new strategy at the same time as promoting Recovery. I ask whether for some re-responsibilisation and recovery amount to essentially the same thing.

My own view is that re-responsibilisation is an attempt to further marginalise, impoverish and stigmatise those drug users who, for whatever reason, are unable to comply with the requirements of Job Centre Plus in their push to reduce the numbers of drug users claiming incapacity benefit. This clearly is political territory and as such is bound to be contested within the drug treatment field as well as without it. I drew attention to the Department of Work and Pensions' own survey on the strong degree of public support that they are able to command for their proposals to introduce sanctions against non-compliant drug users. I also cited the very different conclusions that DrugScope arrived at as a result of a membership survey conducted in 2008. There is very little doubt that drug users are not popular in society at large. One worries that they will be even less popular as a group in the current financial crisis where public expenditure will be subject to fierce and critical scrutiny by the mass media. At the same time, however, it is important for the drug treatment field that we understand that there are places where a line will need to be drawn if our professional integrity is to survive intact.

We must not be seen to be supporting the requirements of a set of government employment policies at the expense of service users. We must not require people to undergo periods of stabilisation on substitute drugs when they may not need or want such treatment. Equally, we must not withdraw such medication simply in order to bring treatment to an end in pursuit of the new strategy's own stated treatment goal of abstinence. Abstinence isn't the goal of all treatment. Recovery is the goal of all treatment. The UK Drug Policy Commission's Consensus Vision on Recovery is an important reference point here. We may well require that more drug users coming into treatment are encouraged safely towards earlier abstinence than has been the case. It is important that such planning and service development takes place in the context of an understanding that Recovery must be tailored to the needs of individuals and not tethered to some political goal set by a administrations that seek to introduce active labour market policies and cost savings as key policy priorities.

We are capable as a field of making profound transformations in our practice and

in our fundamental philosophy of care. We should aspire to the same objectives as are set out in the Putting People First Concordat. Here the emphasis is on choice and control rather than compliance and conditionality. Drug users will never be popular and our field cannot afford to set itself against the views of the public. If, however, we have concerns about what is being asked of us in the name of treatment, we must make these concerns clear. In this context, as a field, we owe a strong debt of gratitude to DrugScope and the UK Drug Policy Commission and also to those organisations and individuals who have spoken out against the Welfare Reform Proposals in our own field. Sacrificing our professional integrity in the name of labour market activation, personalised conditionality and a re-responsibilisation of unemployed drug users is not consistent with a person-centred Recovery Orientation.

My own wish, therefore, is for a Recovery Orientation strongly aligned with a Social Paradigm set within a systems-based, community-driven approach and delivered by a profession strongly committed to Putting People First in an unconditional way.

At this time, as always, we need to move forward together as a field. We should not be afraid to draw upon our full range of experience and understanding about the causes of drug related harm, neither should we shrink from reaffirming our core values. This is a time of uncertainty and change and we have the opportunity, therefore, of learning in new and challenging ways about how to develop a principled, professional and humane range of interventions appropriate to a broad philosophy of Recovery.

Ian Wardle
7th June, 2009

Footnotes

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[1] A paradigm and what are sometimes called 'paradigm shifts' don't just involve new ways of thinking about a problem. It involves the kind of transition in thinking which doesn't just come up with new answers but which arrives at breakthroughs in understanding where the subject in question is grasped from the point of view of an entirely new set of questions. It is claimed, therefore, that the questions that were asked about how best to protect the public from the spread of HIV/AIDS as a result of sharing injecting equipment were entirely different from the questions that were asked about how best to protect the public from drug related property crime.

[2] **Paradigm 1: The Public Health/AIDS paradigm (1986-1995)** In the mid 1980s, the major social concern about the threat from the spread of HIV/AIDS promoted wholesale changes in the Drug Policy and Treatment field. From 1986 onwards, the health of the public was deemed at threat from the spread of HIV by the sharing of used injecting equipment. The public health policies that emerged from this fear fundamentally changed the way UK drug treatment

services were designed and delivered. This new era and the governing paradigm that shaped it were ushered in by the publication of two landmark reports on Drug Misuse and AIDS, published in 1988 and produced by the government's Advisory Council on the Misuse of Drugs chaired by Ruth Runciman. These reports stated that henceforth the threat of HIV/AIDS was to be deemed greater than the threat of drug misuse. This single statement turned the drug treatment field round on its axis and sanctioned the introduction of forms of provision hitherto unthinkable: needle exchanges were piloted; new forms of outreach working were developed employing drug users as peer workers and educators and prescribing protocols became more flexible in response to the need to make treatment more attractive. This Public Health approach became, over a very short space of time, the dominant paradigm. In our field, for many commentators, it still remains the paradigmatic example of paradigmatic change.

Paradigm 2: The Criminal Justice Paradigm (1997-2008) Over time, the threat of AIDS was perceived to have subsided and the public concern shifted to the harms and impact associated with drug related crime. In 1992 an apparently close correlation between property crime and offenses under the Misuse of Drugs Act was identified by key law enforcement agencies such as Greater Manchester police. This correlation, questioned at first, later became accepted as one of the key knowledge foundations of a new approach which accepted that drug misuse was a major cause of a range of property offences, in addition to being the cause of much community disruption and dislocation. The crime agenda was championed by the incoming Labour government and became the cornerstone of the first national strategy that Labour introduced in 1998, a year after taking power. It is no exaggeration to say that the National Drug Strategy throughout its ten-year duration (1998-2008) was sold to the public on the basis of its impact in cutting crime.

[3] Seddon, T., Ralphs, R., and Williams L. Risk, Security and the 'Criminalization' of British Drug Policy, British J. Criminology (2008) 48, 818-834, p 824-825.

[4] Against this perspective, there have been many in the drug treatment field who have argued, and argued forcefully, that the Public Health Paradigm (1987-1995) and the Criminal Justice Paradigm (1997--2008) were fundamentally different and were both ethically and practically speaking sharply at odds, each with the other. Certainly, the role of criminal justice was vastly expanded under the Labour Government's National Strategy and the introduction of a range of new, quasi-coercive measures for securing increased numbers of problem drug users into treatment was a clear departure from what had gone before.

[5] "The thesis that the government of deviance has tended to shift, in the twentieth century, from disciplinary techniques aimed at normalizing individuals to less direct and less intrusive, more actuarial measures aimed at reducing opportunities and controlling risks, a thesis developed in an extensive literature across subfields of sociology, would therefore seem to be perfectly adequate to understand changes in ways of governing alcohol." Valverde, M. (1998)-- Diseases of the Will: Alcohol and the Dilemmas of Freedom, Cambridge

University Press. (The author does go on to qualify this statement, however, in respect to continued clearly 'moral' aspects of alcohol policy.

[6] O'Malley, P.--Experiments in risk and criminal justice, Theoretical Criminology, Sage Publications, Vol 12 No. 4 November 2008. pp 451-468, p 457-458.

[7] Ibid., pp 452-453.

[8] The goals set for us by the National Strategy were clear, achievable and set out over the medium term and, critically, the year on year incentives were attractive. Over the course of the past ten years the drug treatment field has been rewarded very significantly in return for pursuing a range of straightforward, quantitative targets.

[9] Throughout the ten-year period of the strategy, the role of the criminal justice element of the strategy had grown and become more prominent. Major investment in drug work in Prisons had taken place in 1999 and again in 2004 and, starting in 2003, the Drug Intervention Project provided a range of community based criminal justice services designed to bring greater numbers of problem drug users quickly and effectively into treatment. For some within our field, our success was marred by the direction that the strategy had taken. During these years and immediately thereafter there were frequent discussions about whether we had sold our soul to criminal justice and lost our bearings as a field previously dedicated primarily to the health and welfare of drug users.

[10] These targets have come variously to be referred to as 'proxy' targets, 'process' targets, 'output' targets and 'tame' targets. Despite our relative isolation from other health and social care providers over the course of the last period, we have, like all public services come to understand that what matters is not 'outputs' but 'outcomes'. Like many of our colleagues in health and social care we also understand that one of the key difficulties regarding 'outcomes' is not their achievement, it is defining what they are in the first place.

[11] Of course these two views are not mutually exclusive. I am separating them out chiefly for the purposes of clarity of exposition.

[12] White, W.L. (2007) Addiction recovery: Its definition and conceptual boundaries, Journal of Substance Abuse Treatment 33 229-241, Elsevier

[13] AOD stands for Alcohol and Other Drugs

[14] White, W.L. (1996) Pathways from the Culture of Addiction to the Culture of Recovery", Hazelden, Minnesota, p188

[15] White, W.L. (2007) Addiction recovery: Its definition and conceptual boundaries, Journal of Substance Abuse Treatment 33229-241, Elsevier

[16] Putting People First: A shared vision and commitment to the transformation of Adult Social Care. LGA, ADASS, NHS, 2007

[17] Best, D., Groshkova, T. and McTague P., (2009) The Politics of Recovery, DrugLink, DrugScope, London. (forthcoming)

[18] Ibid

[19] Ibid

[20] Ibid

[21] Ibid

[22] Putting People First: A shared vision and commitment to the transformation of Adult Social Care. LGA, ADASS, NHS, 2007

[23] Best, D., Groshkova, T. and McTague P., (2009) The Politics of Recovery, DrugLink, DrugScope, London. (Forthcoming)

[24] Mental Health *Into The Mainstream:* An ADSS discussion paper. 2008

[25] Best, D., Groshkova, T. and McTague P., (2009) The Politics of Recovery, DrugLink, DrugScope, London. (Forthcoming)

[26] Schon, D. (1971) Beyond the stable state, New York, NY: Random House, p40 *quoted twice! in* Leading Change, A guide to whole systems working-- Margaret Attwood, Mike Pedler, Sue Pritchard and David Wilkinson. Polity Press, Bristol 2003, p 6 and 55.

[27] Nutley, S.M, Walter, I. and Davies H.T.O., (2007) Using Evidence: How research can inform public services, The Policy Press, Bristol. Pp 7-8

[28] Ibid, p 163

[29] Legge, K., (2005) Human Resource Management: Rhetorics and Realities, Palgrave Macmillan

[30] Chapman, J. (2004) System Failure: Why governments must learn to think differently, Demos, Second Edition, p 58.
Chapman also cites Donald Schon in emphasising that we must become adept at learning in times of change and instability: "The loss of the stable state means that our society and all of its institutions are in continuing processes of transformation. We cannot expect new stable states that will endure even for our own lifetimes. We must learn to understand, guide, influence and mange these transformations. We must make the capacity for undertaking them integral to ourselves and our institutions. We must, in other words, become adept at learning. We must become able not only to transform our institutions, in response to changing situations and requirements; we must invent and develop institutions which are 'learning systems', that is to say, systems capable of bringing about their own continuing transformation. The task which the loss of the stable state makes imperative, for the person, for our institutions, for our society as a whole, is to learn about learning." Schon, D.A. (1971) Beyond the Stable State, London: Temple Smith, cited in Chapman, J. (2004) System Failure: Why governments must learn to think differently, Demos, Second Edition, p 62

[31] Atwood *et al,* discussing core values for whole systems development put substantially the same point in the following way: "Learning--putting learning at the heart of what we do and a recognition that it is as important to honour what is and what works as it is to encourage new ways of thinking and acting." Attwood, M., Pedler, M., Pritchard, S., and Wilkinson, D. (2003) Leading Change: A Guide to Whole Systems Working, The Policy Press, Bristol, p xvi

[32] Nutley, S.M, Walter, I. and Davies H.T.O., (2007) Using Evidence: How research can inform public services, The Policy Press, Bristol. p 163

[33] Ibid, p 164

[34] Nutley *et al* cite Argyris, C. and Schon, D.A. (1996) Organizational learning II, Reading, MA: Addison-Wesley. in this context.

[35] On Adaptive or single-loop learning, Nutley *et al* note the following: "The core insight from early work on cybernetics (a technique for designing self-regulating systems) was that a system's ability to engage in self-regulating behaviour depends upon building information flows that enable negative feedback. It is the negative feedback loops within a system that allow it to detect when it veers away from a desired course and this in turn triggers corrective behaviours to bring it back on course. This basis level of detection and correction of error is referred to as single-loop (or adaptive) learning. Inspection activities within many service areas provide a good example of such a learning routine."

[36] Attwood, M., Pedler, M., Pritchard, S., and Wilkinson, D. (2003) Leading Change: A Guide to Whole Systems Working, The Policy Press, Bristol, p 84

[37] Legge, K. (2005) Human Resource Management: Rhetorics and Realities, Palgrave Macmillan, p xv

[38] Walter, I., Nutley, S., Percy-Smith, J., McNeish, D. and Frost, S. (2004) Improving the use of research in social care. Knowledge Review 7, Bristol/London: The Policy Press/Social Care Institute for Excellence. quoted in Nutley, S.M, Walter, I. and Davies H.T.O., (2007) Using Evidence: How research can inform public services, The Policy Press, Bristol. p 203

[39] Nutley, S.M, Walter, I. and Davies H.T.O., (2007) Using Evidence: How research can inform public services, The Policy Press, Bristol. p 205

[40] Ibid., p 210-211

[41] Ibid., p 210-211

[42] Ibid. p 213

[43] Ibid., p 214 According to the authors: "…Initiatives to promote research use within this model focus on changing the culture and context of the organisation…The organisational excellence model focuses on the need to reflect local circumstances and priorities when learning from research. The organisation is not seen as merely a conduit for getting externally generated research findings to impact on practice, as might be seen in the embedded research model. Instead, organisational learning is foregrounded, through local experimentation, evaluation and practice development based on research. Research knowledge thus becomes integrated with other types of local knowledge including routine monitoring data, experiential knowledge and practitioners' tacit understandings…Research knowledge becomes integrated with other knowledge sources in a much more dynamic and interactive process, though testing out research findings and shaping them to local contexts and experience. 'Use" of research is part of, not separate from, this broader process of knowledge creation. …The view of research use underpinning the organisational excellence model is thus more interactive and iterative rather than strictly linear."

[44] Ibid., p 219

[45] *Mental Health Into The Mainstream: An ADSS discussion paper*. 2008

[46] Korczynski, M. (2002) *Human Resource Management in the Service Work*, Basingstoke -- now Palgrave Macmillan, p 7

[47] Legge, K. (2005) Human Resource Management, Basingstoke: Macmillan, p 10

[48] Korczynski, M. (2002) *Human Resource Management in the Service Work*, Basingstoke -- now Palgrave Macmillan, p 7

[49] Korczynski, M. *Understanding the Contradictory Lived Experience of Service Work -- the Customer-Oriented Bureaucracy* in Korczynski, M and Macdonald C.L. (2009) *Service Work: Critical Perspectives*, Routledge.

[50] Ibid., p78.

[51] Ibid., p 82-83

[52] Best, D., Groshkova, T. and McTague P., (2009) The Politics of Recovery, DrugLink, DrugScope, London. (Forthcoming)

[53] Putting People First: A shared vision and commitment to the transformation of Adult Social Care. LGA, adass, NHS, 2007

[54] Attwood, M., Pedler, M., Pritchard, S., and Wilkinson, D. (2003) Leading Change: A Guide to Whole Systems Working, The Policy Press, Bristol, p 16

[55] Valverde, M., (1998) Diseases of the Will: Alcohol and the Dilemmas of Freedom, Cambridge University Press, p 203

[56] It's not clear, however, how much history is appropriate in any particular discussion about the present. There is after all, quite a lot of it to draw from. From this point of view, one would hope that historians of drug treatment attempting to intervene in current discussions and debates would be able to exercise a degree of selection in their choice of historical material and also to be able to push the historical narrative forward rather than getting bogged down in a particular period or issue. Of course, for some, any history at all is too much history and so, for them, any problems of selection and tempo do not arise.

[57] Adams, P.L. (2008) Fragmented Intimacy: Addiction in a Social World, Springer, p 25

[58] Adams describes how this trend culminated in the World Health Organization's consensual recognition in 1957 of alcohol and drug dependence as a syndrome with the following definition: *Drug Addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (ii) a tendency to increase the dose; (iii) a psychic (psychological) and generally a physical dependence on the effects of the drug; and (iv) detrimental effects on the individual and on society.* World Health Organisation Expert Committee on Mental Health (1957), Addiction Producing Drugs: 7th Report of the WHO Expert Committee. Geneva, World Health Organisation: 17-25.

[59] Adams describes the growth of psychology thus: "…with the rise of behaviourism during the 1960s, people struggling with addictions were beginning to be studied in terms of behaving particles, and this then led on to psychological explanatory concepts such as *conditioned responses, reinforcement contingencies, and cue exposure.* Later, shadowing the rise of cognitive psychology, internal psychological processes regained a foothold and behaving

particles became behaving-thinking particles. A new range of concepts were closely defined and studied, and let to terms such as *causal attributions, self-efficiency and motivational set.* Adams, P.L. (2008) Fragmented Intimacy: Addiction in a Social World, Springer, p 25-6

[60] Ibid., p 25-6

[61] One recalls William White's view that we are: "on the brink of shifting from long-standing pathology and intervention paradigms to a solution-focused recovery paradigm". White, W.L. (2007) Addiction recovery: Its definition and conceptual boundaries, Journal of Substance Abuse Treatment 33229-241, Elsevier

[62] Adams, P.L. (2008) Fragmented Intimacy: Addiction in a Social World, Springer, p 27. Adams' view is that "…the social dimensions of being human cannot be reduced to variable, factors, or influences attached to individual particles. Social processes sit less easily on a bed of particle assumptions. Instead of looking at addiction as a social event in itself, social influences themselves become condensed, abstracted, and particularised so that they can fit with the biopsychosocial frame. The frame fails to acknowledge that adopting a truly social orientation on addiction requires a move away from the particle assumptions inherent to biological and psychological theories.

[63] Ibid., p 27

[64] Ibid., p 31-32

[65] Ibid., p 33

[66] Ibid., p 23

[67] Ibid., p 22

[68] Orford, J. (2008) Community Psychology: Challenges, Controversies and Emerging Consensus, Wiley

[69] On the first page of Chapter 1 of *Community Psychology, (p4)* Orford points to the work of Bruner as follows: "Among the critics is Bruner (1990) who wanted to see the development of a new, 'meaning-centered, culturally oriented psychology" *(p 15)* He pointed to the disappointing way in which the cognitive revolution in psychology -- a reaction to the dominance of purely behavioural explanations grounded in animal models of learning, experimental methods, and a distrust of what people *say* as opposed to what they *do* -- had in the event been routed towards an emphasis on individual information processing, with computation as the ruling metaphor.…He accused much of psychology of displaying an anti-historical, anti-cultural, and even anti-intellectual bias. …" Bruner, J. (1990). Acts of Meaning. Cambridge, MA: Harvard University Press.

[70] Orford, J. (2008) Community Psychology: Challenges, Controversies and Emerging Consensus, Wiley, p 8

[71] Orford, J., (2008) Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction, Addiction. Volume 103, Issue 6, June 2008, Pages: 875-885

[72] Ibid

[73] Ibid

[74] Ibid

[75] Orford cites two references in respect of *Suggestion 1:* a) Gifford E. V., Ritsher J. B.,McKellar J. D., Moos R. H. Acceptance and relationship context: a model of substance use disorder treatment outcome. *Addiction* 2006; 101: 1167–77; and b) Moos R. Evaluating Treatment Environments: A Social Ecological Approach. New York: Wiley; 1974.

[76] Orford cites three references in respect of *Suggestion 2*: a) Epstein E., Drapkin M. L., Yusko D.A., Cook S. M., McCrady B. S., Jensen N. K. Is alcohol assessment therapeutic? Pretreatment change in drinking among alcohol-dependent women. *J Stud Alcohol* 2005; **66**: 369–78;
b) Timko C. Physical characteristics of residential psychiatric and substance abuse programs: organizational determinants and patient outcomes. *Am J Commun Psychol* 1996; **24**: 173–92; c) Wilton R., DeVerteuil G. Spaces of sobriety/sites of power: examining social model alcohol recovery programs as therapeutic landscapes. *Soc Sci Med* 2006; **78**: 649–61.

[77] Orford cites four references in respect of *Suggestion 3:* a) Ouimette P. C., Moos R. H., Finney J. W. Influence of outpatient treatment and 12-Step group involvement on one year substance abuse treatment outcomes. J Stud Alcohol 1998; 59: 513–22; b) Stout R. L., Rubin A., Zwick W., Zywiak W., Bellino L. Optimizing the cost–effectiveness of alcohol treatment:
a rationale for extended case monitoring. Addict Behav 1999; 24: 17–35; c) McLellan A. T., McKay R. J., Forman R., Cacciola J., Kemp J. Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. Addiction 2005; 100: 447–58; d) 82. Cunningham J. A., Humphreys K., Koski-Jännes A. Providing personalized assessment feedback for problem drinking on the internet: a pilot project. J Stud Alcohol 2000; 61: 794–8.

[78] Orford cites three references in respect of *Suggestion* 4: a) Blomqvist J. Paths to recovery from substance misuse: change of lifestyle and the role of treatment. *Subst Use Misuse* 1996; **31**: 1807–52; b) Blomqvist J. Recovery with and without treatment: a comparison of resolutions of alcohol and drug problems. *Addict Res Theory* 2002; **10**: 119–58; c) Weisner C., Delucchi K., Matzger H., Schmidt L. The role of community services and informal support on five-year drinking trajectories of alcohol dependent and problem
drinkers. *J Stud Alcohol* 2003; **64**: 862–73.

[79] Orford cites seven references in respect of *Suggestion 5*: a) Timko C., DeBenedetti A., Billow R. Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction* 2006; **101**: 678–88; b) 87. Brown R. I. F. Dropouts and continuers in Gamblers Anonymous: life-context and other factors. *J Gambl Behav* 1986; **2**: 130–40; c) Lesieur H. R. Working with and understanding Gamblers Anonymous. In: Powell T. J., editor. *Working with Self-Help.* Silva Spring, MD: National Association of Social Workers
(NASW); 1990; d) Kelly J. F. Self-help for substance-use disorders: history, effectiveness, knowledge gaps, and research opportunities.
Clin Psychol Rev 2003; **23**: 639–63; e) Humphreys K. *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press; 2004; f) Cameron D., Manik G., Bird R., Sinorwalia A. What may

we be learning from so-called spontaneous remission in
ethnic minorities? *Addict Res Theory* 2002; **10**: 175–82; g) Morjaria A., Orford J. The role of religion and spirituality in recovery from drink problems: a qualitative study of Alcoholics Anonymous members and South Asian men. *Addict Res Theory* 2002; **10**: 225–56.

[80] Orford cites in six references in respect of *Suggestion 6*: a) Scott J. *Social Network Analysis: A Handbook*, 2nd edn. London: Sage; 2000; b) Foster-Fishman P. G., Salem D. A., Allen N. A., Fahrbach K. Facilitating interorganizational collaboration: the contributions of interorganizational alliances. *Am J Commun Psychol* 2001; **29**: 875–905; c) 40. Barber J. G., Crisp B. R. The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction* 1995; **90**: 269–76; d) Copello A., Orford J., Hodgson R., Tober G., Barrett C. on behalf of the UKATT Research Team. Social Behaviour and Network Therapy: basic principles and early experiences. *Addict Behav* 2002; **27**: 345–66; e) 95. Galanter M. *Network Therapy for Alcohol and Drug Abuse*, 2nd edn. New York: Guilford Press; 1999; f) 96. Meyers R., Miller W., Hill D., Tonigan J. 1999 Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. *J Subst Abuse* 1999;
10: 291–308.

[81] Chapman, J. (2004) System Failure: Why governments must learn to think differently, Demos, Second Edition, p 62.

[82] Ibid., p 62

[83] Blackman, T. (2006) Placing Health: Neighbourhood renewal, health improvement and complexity, Polity Press, Bristol, p. 2

[84] Scotland Futures Forum (2007) Approaches to Alcohol and Drugs in Scotland: A question of architecture, Scottish Government.

[85] Blackman, T. (2006) Placing Health: Neighbourhood renewal, health improvement and complexity, Polity Press, Bristol, p. 31

[86] Chapman, J. (2004) System Failure: Why governments must learn to think differently, Demos, Second Edition, p 27

[87] Scotland Futures Forum (2007) Approaches to Alcohol and Drugs in Scotland: A question of architecture, Scottish Government. p3

[88] Scotland Futures Forum (2007) Approaches to Alcohol and Drugs in Scotland: A question of architecture, Scottish Government. p8. The forum drew on the work of Robert Horn, a leading expert on methods of mapping
complex social problem fields, characterises a
wicked problem or a complex mess as follows:

- no unique "correct" view of the problem;
- different views of the problem and contradictory solutions;
- most problems are connected to other problems;
- data are often uncertain or missing;
- multiple value conflicts;
- ideological and cultural constraints;
- political constraints;

- economic constraints;
- often illogical or multi-valued thinking;
- numerous possible intervention points;
- consequences difficult to imagine;
- considerable uncertainty, ambiguity;
- great resistance to change; and,
- problem solver(s) often out of contact with

the problems and potential solutions. Robert Horn's work can be found at www.stanford.edu—~rhorn

[89] Scotland Futures Forum (2007) *Approaches to Alcohol and Drugs in Scotland: A question of architecture,* Scottish Government. p12. Starting with the picture in 2008, the Futures Forum identified the seven key areas as: 1) the culture of substance use and the constant; 2) the international and national governance systems; 3) the range of enforcement activities to address breaches of regulations and criminality associated with alcohol and drugs; 4) the range of treatment interventions and recovery support; 5) the overall Public Health and the quality of advice and information available; 6) substance abuse problems as they manifested at the local community level; and, finally at the end of the story and relating to all these dimensions, 7) the evidence and research produced over the past four decades.

[90] O'Malley, P.--Experiments in risk and criminal justice, Theoretical Criminology, Sage Publications, Vol 12 No. 4 November 2008, p 458.

[91] Ibid., p 459

[92] Garland, D, The Culture of Control: Crime and Social Order in Contemporary Society, Oxford University Press, 2001. pp 15-16.

[93] Ibid., p 130. Garland goes on to say: "After more than a century of social scientific research that complicated and refined the understanding of criminal offending; after a mass of evidence has been accumulated to show that criminal acts are typically embedded in, and produced by, definite social and psychological relations; rational choice analyses have, abruptly and without ceremony, swept aside all such complexity and empirical findings. With the certainty of armchair philosophers and economic modellers they insist that crime is, after all, simply a matter of individual choice--or anyway can be treated if it were."

[94] O'Malley, P.--Experiments in risk and criminal justice, Theoretical Criminology, Sage Publications, Vol 12 No. 4 November 2008, p 459. citing Garland, D. (1996), 'The Limits of the Sovereign State', British Journal of Criminology 36: 445-71.

[95] Garland, D, The Culture of Control: Crime and Social Order in Contemporary Society, Oxford University Press, 2001. p 126

[96] Rose, N. 'The death of the social" Refiguring the territory of government', Economy and Society 25 (3) (August 1996): 327-56. Reprinted Miller P., and Rose, N., (2008) Governing the Present, Polity Press, p 87

[97] Ibid., p 102

[98] H.M. Government (2008). Drugs: protecting families and communities. Home Secretary's Foreword. p 4

[99] O'Malley, P.--Experiments in risk and criminal justice, Theoretical Criminology, Sage Publications, Vol 12 No. 4 November 2008, p 459. citing Garland, D. (1996), 'The Limits of the Sovereign State', British Journal of Criminology 36: 445-71. p 459
[100] Ibid., 460
[101] H.M. Government (2008). Drugs: protecting families and communities. Home Secretary's Foreword. p 6, 7
[102] Ibid., p 3
[103] Ibid., p 4, p 7
[104] O'Malley, P.--Experiments in risk and criminal justice, Theoretical Criminology, Sage Publications, Vol 12 No. 4 November 2008, p 459. citing Garland, D. (1996), 'The Limits of the Sovereign State', British Journal of Criminology 36: 445-71. p 459
[105] Rose, N. 'The death of the social" Refiguring the territory of government', Economy and Society 25 (3) (August 1996): 327-56. Reprinted Miller P., and Rose, N., (2008) Governing the Present, Polity Press, p 102
[106] Ibid., p 105
[107] Ibid., p 105
[108] Ibid., p 98
[109] The full list of Key Strategy Actions in respect of drug treatment are as follows: 1) Develop pilots to test new approaches which can provide better end-to-end management through the system, including a more effective use of pooled funding and individual budgets, and with a sharper focus on outcomes; 2) Develop a package of support to help drug users, and particularly those causing the most harm, to access and complete treatment and to re-integrate into society; 3) Use opportunities presented by the benefits system to provide support and create incentives to move towards treatment, training and employment; 4) Ensure treatment is personalised and outcome-focused, making full use of new treatment approaches that are shown to be effective; 5) Draw on significant new funding to support research into developing better forms of treatment. Drugs: protecting families and communities. The 2008 drug strategy. (February 2008) HM Government. p 27
[110] Department of Work and Pensions, (2008) Raising expectations and increasing support: reforming welfare for the future"
[111] Department of Work and Pensions, (2008) Raising expectations and increasing support: reforming welfare for the future" 6.36, p 117
[112] www.drugscope.org.uk—WelfareReformBill_DrugScopeAmendments.pdf
[113] H.M. Government (2008). Drugs: protecting families and communities. Home Secretary's Foreword. pp. 30-31
[114] Ibid., pp. 28-29
[115] Ibid., p 29
[116] Gilman, M., (2009) Recovery Oriented Integrated Systems. Part 1 of a three part interview in The Word: Raising awareness of recovery from addiction. (Issue 2, May 2009)

[117] The UK Drug Policy Commission Recovery Consensus Group, A vision of recovery, (2008), UK Drug Policy Commission p.6
[118] Gilman, M., (2009) Recovery Oriented Integrated Systems. Part 1 of a three part interview in The Word: Raising awareness of recovery from addiction. (Issue 2, May 2009)
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[129] Realising Potential: A Vision for Personalised Conditionality and Support. (December 2008) Department of Work and Pensions
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[131] Haas, P.M. (1992) 'Introduction: epistemic communities and international policy coordination', *International Organization*, vol 46, no 1, pp 1-35. cited in Nutley, S.M, Walter, I. and Davies H.T.O., (2007) *Using Evidence: How research can inform public services*, The Policy Press, Bristol. p 107
[132] Nutley, S.M, Walter, I. and Davies H.T.O., (2007) *Using Evidence: How research can inform public services*, The Policy Press, Bristol. p 108.
[133] Daguerre, A. (2007) Active Labour Market Policies and Welfare Reform: Europe and the US in Comparative Perspective, Palgrave Macmillan. pp 68-69 Regarding the fifth belief see, Raising expectations and increasing support: reforming welfare for the future (2008). DWP p 71, box 4.2 "Levels of participation in back-to-work activity among the non-Jobseeker's Allowance groups are relatively low: there is a strong desire to work among large numbers

of people in these groups, but levels of take-up for current programmes are very low in comparison with that for Jobseeker's Allowance claimants."

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[155] Ibid., p3

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[158] Ibid., p8

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