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The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems

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Abstract

This article critically examines the implications accompanying the introduction and implementation of recovery-based policy. The article draws upon research conducted in Lancashire, England, where commissioners have been at the forefront of recent developments in ‘whole system’ models of commissioning. Empirical data are drawn on to make a series of new arguments about the tensions and practice implications of the new recovery agenda. The article has three main objectives. First, it explores current shifts in England, in which drug service commissioning has moved from being centrally funded and directed, to locally determined. Second, it references the rise of the well-informed user in the reconfigured landscape of recovery and the ways in which commissioning models may enhance or negate the contribution of user activists to local cultures of recovery. Third, it references the changing political context, in which austerity is being used to increase the pressure on provider services to demonstrate social value, utility and effectiveness. The article argues that there is a palpable need to re-politicize drug debates and recognize the structural and demographic factors which frame problem drug use, as well as the social and cultural factors which support or negate their opportunities for recovery.

Keywords

Recovery; Abstinence; Payment by results; Commissioning; Problem drug use

Introduction: Thinking and Doing Recovery

Despite the exponential growth of the substance misuse field over the last 30 years, addiction remains a pervasive social problem in the UK (Singleton *et al.* 2006). Under the New Labour administration (1997–2010), the drug treatment sector was subject to significant reconfiguration, investment and expansion (Buchanan 2010). A more central role for the criminal justice sector accompanied by centralized ring-fenced funding overseen by the National

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Treatment Agency (NTA) led to an increase in the numbers accessing and retained in treatment services. However, concerns have been expressed about an expanding treatment population ‘parked’ in substitute prescribing drug services (Dawson 2012), and the addictions field has become replete with debates surrounding recovery (Best *et al.* 2010; Laudet 2008; Wardle 2012). The most recent UK drugs strategy published in 2010, significantly entitled ‘Reducing Demand, Restricting Supply: Supporting People to Live a Drug Free Life’, aimed to increase the number of people achieving ‘full recovery’, explicitly presenting recovery as synonymous with abstinence (Monaghan and Wincup 2013).

On first appearance, a recovery oriented drug and alcohol treatment system may seem eminently sensible. In the field of mental health, where recovery has a longer history, Davidson, Rakfeldt and Strauss (2010: 10) argue that many people outside the sector automatically assume that services are recovery focused, asking ‘. . . if services are not focused on promoting recovery, what else might they be for?’. However, in the field of substance misuse the introduction of a recovery focused policy stirred some interesting personal and professional reactions. For example, in an exchange in *Drink and Drug News* (Boyt 2013: 11) entitled ‘The “R” word’, Alex Boyt, a service user coordinator from London, criticized the recovery agenda, expressing concern about the tendency to ‘plaster optimism over the struggles of the often disadvantaged, traumatized and neglected’. Boyt further questioned the lack of an empirical relationship between strong recovery communities and positive treatment outcomes. In response, the UK Recovery Federation contested Boyt’s portrayal of recovery communities and the recovery agenda as reductionist, arguing that it is important to recognize and respect the grass roots nature of the recovery movement that has largely developed outside, and independent from, mainstream treatment services (Sinclair *et al.* 2013).

This exchange highlights the contested notion of ‘recovery’, an issue articulated by Ian Wardle at the UK Recovery Academy Conference, when he posed the question, ‘What does it mean for recovery now that it has become the new policy orthodoxy?’ (Wardle 2012). The mixed and conflicted parentage of ‘recovery’ has constructed a discourse fraught with tensions from which many potential problems arise (Roy 2012), hence, there are important questions about how recovery is constructed and interpreted by different groups. Some express concern about an over-emphasis upon abstinence (Ashton 2008; UKHRA, UKRF and NUN 2012), others are uneasy with the recent top-down approach to recovery (Roy and Prest 2014), and some are concerned that the expansion in volunteer peer-led recovery services is a political move towards significantly reducing the paid workforce (Roy *et al.* 2013). Interestingly, a series of similar debates concerning the meaning and ownership of recovery have occurred within mental health. Peter Beresford, a service user academic, addressing a conference on mental health recovery and social justice asked, ‘. . . can we make ideas [like recovery] mean what we want them to, when the dominant use of them is so powerful, regressive and negative?’ (Beresford 2013).

The recovery agenda once the passionate pursuit of a small number of enthusiastic user-recovery advocates, whose activities provided a distinct

challenge to the prevailing top-down system at the time, has now become a central policy objective promoted and led by government (Home Office 2012). This political shift raises issues about ownership, interpretation and direction, ultimately raising difficult questions about any shared understanding of the term. In a prolonged period of austerity, the government's notion of recovery can easily appear focused upon cost cutting, abstinence and responsabilisation, rather than rehabilitation, social reintegration and developing the pathway to full citizenship (Monaghan and Wincup 2013; Roy 2013; Watson 2013). This social and political context raises important issues at a time when budgets and responsibility for the new substance misuse treatment system are now locally determined, no longer ring-fenced, and payment by results encourages service providers to concentrate on measurable outcomes rather than deliverables. This political shift creates both 'opportunities' and 'threats' for the substance misuse sector. Opportunities arise from the move away from a 'big brother model of commissioning' (Wardle 2012) in which commissioners and providers were essentially expected to dance to the tune of the NTA. In that era of treatment, the NTA was keen to lead the thinking for the sector as well as overseeing the doing through centralized monitoring frameworks. Decentralization, therefore, has the potential to allow greater flexibility to develop localized solutions to local drug and alcohol problems. However, in the past the NTA ensured the sector had a voice within central government and this may be lost in the new devolved regime (Sinclair *et al.* 2013). Now that the NTA has moved into Public Health England, and the ring fence funding removed, drug and alcohol services will have to be justified locally, and must compete alongside other health and social needs, in the wider competition for limited funding.

Whilst to date large-scale disinvestment in drug and alcohol treatment services has not occurred in the UK, the fear is that resources will soon become increasingly scarce, and as a consequence, unrealistic demands for immediate abstinence could increase. Monaghan and Wincup highlight that since 2008 welfare policy has begun to cast doubt upon the validity and worthiness of problem drug users' (estimated around 267,000) access to mainstream welfare benefits in England. More recently, under the £300 million 'Help to Work' programme, Chancellor George Osborne made clear that claimants with underlying drug and alcohol problems will be subject to 'Mandatory Intensive Regimes', as he pledges to end the option of 'signing on as usual' (Kirkup 2013). In this new political landscape, people with chronic drug dependence may be constructed as 'undeserving', making it difficult for drug treatment agencies to secure local resources and deliver effective services, and this could further undermine the citizenship claims of people with drug problems. These developments are in step with a wider neo-liberal reconfiguration that asserts everyone has the capacity to become self-sufficient consumers, and that welfare support and spending must be reduced. This climate of austerity is likely to further fuel the stigmatization of people on state benefits more generally (Bauman 2000), and especially those with drug dependency issues (Watson 2013).

In order to critically explore the combined impact of the government led recovery agenda, devolved budgets, and the serious competition for local

services in times of austerity, the next section examines two recent research projects conducted in Lancashire, England, where ‘whole system’ models of commissioning have been implemented. These research studies looked at drug treatment and recovery (led by the first author: Roy, Manley and Fowler 2014; Roy, Willocks and Buffin 2013), and highlighted the need for ‘outward facing’ services. Later, the article draws on evidence from a third research project, also conducted in the Lancashire area, that provides useful evidence about the development of local models of peer support and user involvement in drug services (Measham *et al.* 2013). New arguments are developed in this article by drawing upon evidence from these three regional studies to explore the tensions inherent in the new devolved recovery landscape and in the structures of support that might enhance the citizenship claims of problem drug users.

Lessons From Research: Outward Facing Services and Systems for Reintegration

Best *et al.* (2010) described outreach as one of the essential treatment-related strategies to enhance recovery. The Drug Strategy 2010 recognizes outreach activities as a fundamental and important aspect of a recovery management model of substance misuse treatment. In Roy, Willocks and Buffin (2013), the notion of ‘outward facing services’ is used to emphasize the need for greater community engagement, addressing the changing skill sets required across the substance misuse workforce if large-scale recovery in the community is to be achievable. This is not to deride or devalue the continued importance of traditional skills or services in the drug treatment sector developed by previous policy frameworks. For example, the provision of substitute drugs continues to be an important foundation for the creation of stable and meaningful lives for some dependent drug users. Good casework remains essential in promoting recovery from dependent use of drugs, although more mobile and diverse forms casework may be required as the substance using landscape and the demographic profile of users continue to change.

Unfortunately, top-down bureaucratic approaches to service delivery, part of new managerialism, have eroded professional autonomy, tending instead to prioritize exhaustive levels of documented client assessments of need (Kirkpatrick 2006). These practice characteristics increased the risk of workers seeing clients as deconstructed sets of deficits (Monaghan and Wincup 2013), rather than people with strengths who may have difficulties with substance misuse. Managerialism has also been marked by a withdrawal from community engagement, fewer home visits and the centralization of office locations, which has further isolated health and social welfare staff from the local communities they serve. In this context of bureaucratization and geographic isolation, it is easy for practitioners to engage service users within the organizational context, rather than appreciate the wider cultural and community context in which individual patterns of problem drug use develop, and in which recovery must be enacted. This structural ‘disconnect’ increases the risk of drug problems becoming decontextualized and understood as an individual pathology where the focus is to build personal agency. If the ambitions

of recovery policy are to be successful, issues relating to social isolation and marginalization will need to be recognized by policymakers and understood and addressed by practitioners (Buchanan 2006; Sumnall and Brotherhood 2012). Policy and practice will need to place much greater emphasis on the social location of substance misuse than has been evident in previous policy frameworks, and in particular understand the wider structural, geographical and demographic inequalities that frame ill health generally and drug problems in particular (MacGregor and Thickett 2011). This will involve an explicit focus on stigma, discrimination and exclusion, which represent significant barriers to full recovery (Buchanan and Young 2000b; Lloyd 2013).

Establishing a period of reorientation through a process of social reintegration is a significant challenge for clients who have been isolated for years in a long-term drug dependent lifestyle (Buchanan 2004). The new drug and alcohol workforce will, therefore, need to include highly skilled community workers capable of identifying and recognizing personal strengths, support networks and local resources to make this transition possible. This challenge highlights the importance of practitioners working outside the building premises, and forging stronger community links with agencies and individuals. It will involve meeting service users in their own homes or in other spaces and places in the community where they spend time.

Research in Lancashire found that meeting people in their own home, rather than the workplace, increased the chance of practitioners adopting a more holistic approach and provided them with a stronger contextual appreciation of wider substance related issues (Roy *et al.* 2013). This research identified two strands of community outreach work which had been developed by the local provider service: 'Engagement Outreach' – a mechanism to re-engage and better understand clients, particularly those who do not attend office-based appointments by visiting them at their home addresses; and 'Assertive Outreach' – which seeks to develop relationships with a range of community individuals and organizations, to promote recovery networks and enhance interagency working and referral. In this research, practitioners suggested that one of the main values of both Engagement and Assertive Outreach was that it led to a greater understanding of the client's social context, and with this came increased empathy and a better appreciation of need. Interestingly, this finding is also noted by Priebe, Watts, Chase and Matanov (2005), who explain how community outreach teams have been widely established in mainstream health services, as part of attempts to reach patients who are either difficult to engage, or choose to disengage. Roy, Willocks and Buffin (2013) found that a quick home visit following a missed appointment alleviated isolation and helped address any emerging issues:

'If someone misses on a Monday, in that same week we can be in touch with another appointment and delivering it by hand. We at least know that the appointment gets to the house, if not directly to the person themselves.' (recovery worker) (Roy *et al.* 2013: 15)

'It's really important part of the service, had we not gone there today and had that conversation and really pushed her to come back, I don't know what would have

happened to her, getting out into people's homes is so vital, it's not nice to see people in that state but it's vital (to developing holistic understandings).' (recovery worker) (Roy *et al.* 2013: 15)

The responses of the recovery workers emphasized that outreach tended to result in improved engagement with the service. Several commented that it acted as a reminder or a 'push' to clients who had either forgotten their appointment or purposely missed it:

'Yes it does bring people back in, particularly if you get to talk to them in person and in their own home. You can talk through why they haven't attended, it might be a practical barrier such as transport and if that's the case you can together come up with a plan but it might also be something more psychological, like they don't get on with their key worker, so you can then work on that, maybe shifting things around, the main thing is getting them back in.' (recovery worker) (Roy *et al.* 2013: 15)

There are a multitude of reasons why people fail to engage in treatment, including personal ambivalence, geographical isolation or limited finances, and issues such as feeling they have not been listened to by workers, or feeling excluded from the treatment decision-making process (Priebe *et al.* 2005, citing Lang *et al.* 1999; Lloyd 2013). However, research into outreach in mental health services discovered that even the most hard to engage clients wanted help with their problems, and valued outreach support which focused on user priorities, practical assistance and improving quality of life (Davies *et al.* 2009). Roy, Willocks and Buffin (2013) found similar messages:

'They may fail to turn up to appointments or keep DNA-ing but when you get out there into their homes, they really do want and need your help and are usually open to it.' (recovery worker) (Roy *et al.* 2013: 15)

'For some clients that disengage there's great value in going out there and sitting listening to them, letting them talk about why they have missed or not turned up, showing them that their views about treatment are important, you know if there's something that's not working for them, working out what it is and finding a way forward together. For some it's just a case of giving them a bit of additional care and attention when they are in a vulnerable place and that can be the nudge they need to show them, look someone does care here, I might give them (the service) another go.' (recovery worker) (Roy *et al.* 2013: 16)

However, in addition to developing a trusting relationship with clients, practitioners in this study explained how both Assertive and Engagement Outreach could enhance empathy by enabling staff to better appreciate the context and circumstances of their client's lives:

'Seeing them face to face you get a true picture of how they are doing and the circumstances you find them in give it all away you know, they might say they are doing ok, might even blag they are ok to their recovery worker on the phone, but if you get to the house and find them unwashed, unshaven and the house in a state, you know

categorically things are not how they say they are. Then the effort starts to encourage them to come back in as well as helping them to sort out other problems they then reveal to you. (recovery worker) (Roy *et al.* 2013: 19)

As Lang *et al.* point out (Priebe *et al.* 2005, citing Lang *et al.* 1999), if an outreach worker has a good understanding of a client's life, the worker is in a much better position to support that client. According to White and Cloud (2008), one benefit of Assertive Outreach is that individuals with high problem severity and low recovery capital can be better accessed and supported. Furthermore, Mikkonen, Kauppinen, Huovinen and Aalto (2007) suggest one of the key values of outreach is to establish contact and provide appropriate support to marginalized groups. Roy, Willocks and Buffin (2013) found that providing services in a client's own environment could help a recovery worker to identify and address the barriers that deter clients from accessing treatment, as one worker explained:

'Domestic abuse is one thing that springs to mind, on the phone that client might be like yeah I'm ok, and even in service they might be yep I'm coping but when you get into their homes and its face to face, things become much more obvious and it's your role to help sort that out there and then. I had a client who was in an abuse situation and we needed to get her out of that house. So I needed to take prompt action and contact the relevant services to support her in that process. In that situation, it was the abuse that was actually stopping her engaging. If we had not gone into the home, it's unlikely we would have ever found that out. Once we got her moved, she started engaging again, so you see outreach really is so very important.' (recovery worker) (Roy *et al.* 2013: 19)

A further benefit of outreach is that practitioners not only improve relationships with their clients but can also build relationships with significant others (Resnick and Resnick 1984). These individuals are often vital in terms of a client's recovery capital providing a valuable form of social support. As Godley and Godley (2015, forthcoming) have noted, the presence or absence of family and peer support is a particularly powerful influence upon recovery outcomes. Resnick and Resnick (1984) suggest that involving family members can often be the key to helping the client deal with difficult issues that they might otherwise seek to avoid.

Assertive Outreach enables active links to be made with community organizations, venues and other key individuals who can then more easily refer people into treatment services, however, more importantly they can be essential in facilitating and supporting the reorientation and reintegration process – crucial in realizing recovery assets for service users. Roy, Willocks and Buffin (2013) identified that outreach workers had developed links with a range of local organizations and communities, including local mosques; the Emmaus homeless organization; local church groups; sex workers; a local recovery café; the police; recovery festivals; and local pubs. This form of outreach work not only builds recovery capital locally (White and Cloud 2008), but also communicates something important about where the work of drug and alcohol service provision should take place. Outreach can break down barriers and

improve communication between the treatment organization, local agencies, practitioners and the wider community. In the context of shrinking resources and the enduring significance of stigma and exclusion, accessing these wider networks of support is likely to become ever more pressing, and is necessary, if people with substance misuse difficulties are not to become further marginalized (Lloyd 2013).

Recent work in Lancashire by Measham, Moore and Welch (2013) identifies a series of other problems in developing visible recovery and locally relevant models of user activism:

By its very nature, being part of the recovery community requires self identification as a drug (and drug service) user or ex user. Whilst participation in . . . recovery activities was an invaluable source of support and inspiration for the majority, not all service users wanted to be part of this community (Measham *et al.* 2013: 66)

The authors describe a series of tensions inherent in the process of creating visible recovery communities. First, some people do not want to identify as someone 'in recovery', either because they see this identification as stigmatizing or because the locally available recovery community – or its activities – do not appeal to them. Second, the predominance of largely white male injecting drug users in some treatment services may skew the look of recovery communities limiting the appeal and interest of clients outside this dominant group. The danger is that recovery communities might become rather inward looking mono-cultural and, however unintentionally, a new way of institutionalizing and containing those with long-term drug careers. These issues are not peculiar to this sector. Many different forms of community grouping recognize that the cost of some taking part is that others will either be excluded or will choose to exclude themselves (Spandler *et al.* 2013). However, it is for these reasons that the ways in which user activism and visible recovery are developed and supported at a local level are so critical, and whenever possible maintaining a diversity and range of user groups is important.

In Lancashire, the commissioners have supported the development of two linked organizations: Red Rose Recovery (RRR) and the Lancashire User Forum (LUF). RRR is a social enterprise supporting people in recovery to improve their own lives as well as supporting others. It works with communities across Lancashire and develops links with charities, leisure groups, colleges and local businesses. The LUF is a service user group, which provides a series of forums drawing together service users, families, carers and interested professionals, providing regular feedback to service providers and commissioners. It also organizes social and cultural events and an annual festival for people in recovery. Both organizations have been instituted on a countywide basis creating an overarching and area-wide framework rather than one that develops locally within service structures. Also the structure for RRR sees it managed by the Community and Voluntary Service, an umbrella organization that supports and represents the interests of other voluntary organizations, community groups and charities. Measham, Moore and Welch (2013) argue that this has been an intentional device and

important for integrating people with substance misuse problems within the wider community.

In the case of the LUF, the focus has been on building on people's individual assets instituting the now popular US model of Asset Based Community Development. This has led to a series of collaborations with local communities and businesses, opening up volunteering opportunities for people in recovery. Examples of these include canal clean-ups, community clean-ups and the restoration of a canal boat.¹ The approach in Lancashire recognizes that for those in recovery from drug problems, stigma remains a huge barrier to integration into the wider community. The approach of the LUF provides a ready-made community as well as opportunities for involvement in range of volunteering opportunities allowing people to develop skills, confidence and a sense of involvement. One defining feature of the whole system commissioning structure developed locally is that the chair of the LUF also sits on the Drug and Alcohol Action Team Board. These different structures aim to give recognition of the need for user input into commissioning systems at a strategic level, and of the need for a countywide structure not one rooted in the local service system.

Developing Visible Recovery and Supporting User Activism

In recent years, welfare service professions have been exposed to competing views about knowledge and expertise, and pressured to re-scope the extent and form of citizen participation (Roy 2012). This neo-liberal approach to welfare provision has advanced a consumerist/entrepreneurial model of self-interest. Simultaneously, further pressure has arisen from New Social Movements, user groups and advocacy forums, which have sought change within and beyond the welfare state – under the banner of democratization (Annetts *et al.* 2009). This has led to ongoing questions from service users about the authority and expertise of welfare professionals, and simultaneously, by a series of bureaucratic mandates from central government, which have increased centralized reporting and restricted autonomy.

In this social and political context, it could be argued that the 1980s/90s harm reduction era (in its different guises) appeared to involve a more natural solidarity between workers and users. However, an alternative interpretation is that the power relations in that era were often one-sided – more akin to a paternalistic model – and too often dominated by the agendas of professionals (Froggett 2002). This tension, in part, spawned the user-led Recovery Movement that operated outside the domain of the statutory services, that championed the rights of the recovered drug user to be free from stigma and accepted in society. However, the concept of recovery has, arguably, been hijacked and reconfigured by government and increasingly aligned with welfare-to-work policies (Deacon and Patrick 2011). We argue that recovery policy hides as much as it reveals, concealing neo-liberal notions of citizenship, in which recovery becomes important to ensure responsabilisation, accountability and relentless risk management, behind a philosophy of social inclusion.

Calls for more user and community participation in the design and delivery of services have come from the centre (from politicians), and from the margins

(from user activists), reflecting the complex and contradictory parentage of the recovery concept (Roy 2012). From 1997 onwards, law and policy guidelines have progressively enshrined participation and partnership as key requirements for health and social care service delivery (Carnwell and Buchanan 2009). However, Stenner, Barnes and Taylor (2008) question the impact of this apparent participation on marginalized groups, while Cowden and Singh (2007) question the top-down style of user involvement in health and social care delivery, suggesting the voice of the user has become something of a fetish 'held up as a representative of authenticity and truth' (Cowden and Singh 2007: 7), but seldom having any 'real influence over decision making' (Cowden and Singh 2007: 15).

On a positive note, while it has been difficult for former problem drug users to secure employment (Spencer *et al.* 2008), Measham, Moore and Welch (2013) identify that the shift towards recovery has provided opportunities for paid and volunteer roles for ex-users in and beyond the treatment services. These roles operate on the belief that those involved will use their experience, in part, to inspire and support others in their recovery journeys, as well as helping to develop and shape the treatment system. However, while the presence of recovered problem drug users in the system is motivating to those early in recovery, and it allows everyone in the system to see the positive contribution that ex-users can play in a recovery oriented system of care, there is a need for caution in that the pressure, expectation and responsibility attached to certain roles *can* be detrimental to some people's own recovery (Shapiro 2012, emphasis added). It is important to emphasize that these debates are not unique to the field of substance misuse. In the field of mental health, movements such as 'mad activism' have increasingly sought to reclaim stigmatized representations of mental health users and the burgeoning 'mad academy' has sought to challenge the prevailing knowledge base in the field, as well as changing the make up of those who produce the knowledge informing it (LeFrançois *et al.* 2013). Arguments about employment and vulnerability have been extensively rehearsed in this sector too, with some observing that although employment can involve stress, the stresses of continued unemployment are generally much worse. While the objective of employment in recovery services will suit some clients, it is vital employment and education opportunities also become available beyond the sector.

Supporting the Citizenship Claims of Problem Drug Users in the Landscape of Recovery

One useful idea emerging from the field of mental health is that recovery is best conceived as a civil rights issue (Davidson *et al.* 2010). In the field of substance misuse, this idea might be helpful in drawing attention away from the divisive debates over philosophy, ownership, terminology, de-skilling, etc. towards a more united claim of citizenship for people struggling with substance misuse problems (Roy and Prest 2014). Recovery from chronic drug dependence is hard enough in itself, but when combined with discrimination, social exclusion and stigma, and further exacerbated by austerity measures, people with dependency issues may feel they are neither welcome, nor

accepted as citizens, and this may make the process of recovery insurmountable, perpetuating personal isolation and social exclusion (Lloyd 2013). Steven Frosh (2001) poses the following question about the relationships we have with the communities in which we live:

How does one imagine oneself in connection with a community, a culture or a nation . . . What is it that allows one to feel part of a social order, able to take up 'citizenship', neither excluded nor excluding oneself? . . . To be a citizen, one not only needs to formally belong somewhere; one has to feel that this belonging is real. (Frosh 2001: 62)

The link to citizenship is useful in part because it helps reframe the issues about recovery away from the debates around policy and practice, towards fundamental issues concerning the inclusion of people with substance misuse problems in wider society. Recovery communities in Lancashire identify that people with long-term substance misuse difficulties find themselves socially isolated, shunned and disqualified from engaging in wider society.² Research by Buchanan and Young (2000a) found this process of marginalization eventually takes its toll upon the way people with drug problems see themselves, and this internalized identity creates significant challenges, 'Discrimination has led many problem drug users to internalize and blame themselves for their position. This loss of confidence and self-esteem is a serious debilitating factor' (Buchanan and Young 2000a: 414).

Unfortunately, achieving recovery does not always bring requalification and acceptance within wider society, so recovered problem substance users are often consigned to pursuing acceptance, identity and employment exclusively within the narrow domain of drug services; swapping a drug-centred lifestyle for one that is centred upon drug services. This institutionalized level of discrimination and social exclusion could be argued to be a breach of human rights (Jenesma 2013). Framing the issues experienced by substance misusers as the marginalization of an oppressed group, might help to align the struggles of people with substance misuse issues with the similar citizenship struggles of those experienced by other groups (e.g. queer, Black, disabled and women) who have sought to challenge, unpick and reclaim the ways in which they are unfairly represented and treated (Roy and Prest 2014). Constructed in this way, recovery it is not simply a forward facing mission of social inclusion, it is about re-politicizing drug debates and reclaiming the past as an essential resource of collective resistance (Hoggett 2000, citing Hall 1990). This is important because a series of research reports demonstrate how the stigmatizing stereotypes about people who use illicit drugs, embraced by the wider community, not only diminish opportunities, but become internalized by those with drug problems and this significantly impedes recovery (Buchanan and Young 2000a; Roy 2012; Lloyd 2013). In this context, the development and support of activist organizations can be a key component of individual and collective resistance and recovery. However, within the new policy landscape, framed as it is by austerity, uncertainty and shrinking budgets, any investment in user activism risks the possibility that staff in recovery services may interpret it as a competition for diminishing resources. This can make

solidarity and partnership difficult to achieve in a context of all too real fears about job security (Bauman 2000). Hence, one challenge for commissioners is to support user activism and to enhance the possibilities of co-operation without enacting negative projections from existing staff.

Conclusion

This article has drawn upon three research studies to critically examine at a local level, the paradoxes of recovery policy, in which a wider government agenda of responsabilisation, the reduction of the welfare budget and highly individuated conceptions of citizenship have been hidden behind the language of recovery and social inclusion.

The centralized funding provided for drug treatment in the last 15 years in the UK has seen the development of a world class treatment system, one which has led to a greater engagement with services, as well as reducing drug deaths and levels of HIV and hepatitis amongst injecting drug users. These important gains deserve recognition. The new devolved funding structure for drug and alcohol treatment now absorbed within Public Health England means services will now be assessed and judged locally alongside other health and social care issues. In this competitive environment with diminishing resources, drug dependence may not be perceived as sufficiently deserving, and people with chronic drug problems may (unfairly) be viewed as responsible for their 'self-inflicted' situation (Lloyd 2013). Hence, it is conceivable that funding decisions may overlook the important structural and systemic context of problematic drug use and might prioritize a politically popular responsabilisation of chronic drug dependence, by insisting on immediate abstinence. This could lead to the 'derision of care' for a vulnerable group, and a major disinvestment in the sector (Hoggett 2000).

We argue that there is a palpable need to re-politicize drug debates and recognize the systemic, structural and demographic factors which underpin chronic drug dependency, as well as general health and social inequalities in the UK (MacGregor and Thickett 2011). US recovery activist William L. White (2009) argues that the prevailing intrapersonal focus of care models, neglects 'system level' processes and the 'larger physical and relational worlds in which individual recovery efforts succeed or fail' (White 2009: 146). This need, to look beyond treatment services and address social reintegration, has been highlighted by the European Monitoring Centre for Drugs and Drug Addiction (Sumnall and Brotherhood 2012):

Treatment alone is also not sufficient to prevent social exclusion of marginalized individuals, particularly as many problem drug users were already marginalized before they started using drugs. Without social reintegration interventions, there is a serious danger that the gains made during treatment will be undermined. (Sumnall and Brotherhood 2012: 17)

White (2009) advocates an approach to recovery based on the 'ecology of addiction', which explores how one's physical, social and cultural

environments support or preclude the resolution of drug and alcohol problems. We argue that the development of visible recovery and user activism can provide important avenues for some substance misusers to rebuild their lives. However, we also recognize that in the new landscape of recovery, it is here that the competing desires and politics of governments, agencies, users and commissioners have the potential to collide most problematically. Some service users and/or drug users who have not used services, quite rightly want opportunities to build on their own expertise and experience; inform service development; develop support outside services; enact volunteering; and pursue employment opportunities in and beyond the sector. In contrast, many in services fear that the rise of the volunteer and low paid workforce will be used by government as opportunity to reduce the overall cost of welfare, leading to extensive redundancies and weakening of the sector. A climate of insecurity and uncertainty erodes trust and solidarity, and the threat of unemployment makes the current environment a particularly difficult one for service providers and commissioners to develop user activism, without inciting the resentment and unease of staff, or a sense of competition (Bauman 2000).

The evidence in Lancashire suggests this is not inevitable and that different groups (commissioners, provider services, service users, wider communities) can work well together. The idea of 'outward facing services' developed in this article has been used to articulate the ways in which service practitioners must engage and interlink with these wider statutory and non-statutory services, as well as volunteers and peers, in order to extend core treatment and recovery provision beyond institutional settings, and to engage and support individuals in their own homes and link them into wider communities. However recovery is defined, it will only be possible to achieve if people are properly supported and able to re-enter society as full citizens. Narrowly defining recovery in terms of successful completion of treatment programmes, the production drug free urine samples, and the removal from state benefits is simply a new mechanism for managing people with drug problems as a risk population (Seddon *et al.* 2008). Whereas, full recovery arguably occurs when a person has properly regained control of his or her life; is no longer subject to stigma and exclusion; is able to access wider opportunities (education, employment and housing); and is able to participate and enjoy the privileges available to others in society. In all the excitement about ambitious policy objectives and debates over the ownership and understanding of recovery, it is important not to lose sight of the vulnerability of long-term dependent drug users, some of whom will need considerable support and care to rebuild lives that were often badly damaged *before* drugs became an issue (Hoggett 2000; Buchanan 2004). This will necessitate an interpersonal focus combined with a strong commitment to social justice and improving system level processes in the community.

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Notes

1. Personal correspondence with LUF and RRR.
2. LUF and RRR information film, <https://www.youtube.com/watch?v=qQCV8oIxRZw> (accessed 4 August 2013).

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