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1           **Problematising ‘Recovery’ in Drug Policy within Great**  
2           **Britain: A Comparative Policy Analysis between England,**  
3           **Wales and Scotland**

4  
5  
6   **Introduction**

7   The notion of recovery has become integral to drug policy in several western  
8   jurisdictions, including the United States, Australia and Great Britain (Laudet,  
9   2007; Lancaster et al., 2015). These nations have used recovery to mark a  
10   paradigm shift; heralding new forms of treatment. However, the way in which  
11   recovery should be defined has remained a contentious issue as the concept is  
12   used to make claims about what users of drug services want, what type of  
13   services should be provided and how treatment outcomes should be measured.  
14   These tensions are particularly acute within Great Britain (GB) (encompassing  
15   England, Wales and Scotland). Whilst the United Kingdom Drug Strategy (HM  
16   Government, 2010, 2017) applies to England, Wales and Scotland, the Welsh  
17   and Scottish Governments have used the powers given to them through  
18   devolution to establish their own policies. Under devolution, the Welsh  
19   Government has powers to make decisions relating to a range of areas including  
20   health, social services and education, but has no formal powers to address law  
21   and order (Brewster and Jones, 2018). Scotland, by contrast, has devolved  
22   powers in relation to law and order as well as health, social services, education  
23   and welfare (McAra, 2008). Consequently, England, Wales and Scotland have  
24   all defined recovery in different ways; each establishing distinct priorities and  
25   expectations.

26         The concept of recovery from addiction within GB emerged from  
27   debates about whether harm-reduction or abstinence should be favoured  
28   (McKeganey, 2014). Harm-reduction approaches, with an emphasis on opioid  
29   maintenance and needle exchange programmes, had become dominant in the  
30   1990s due to national treatment guidelines (see ACMD, 1988) designed to lower  
31   the risk of blood-borne infections through needle sharing. Harm-reduction  
32   policies remained in place throughout the tenure of the New Labour  
33   Government (1997-2010) and were especially relevant as increasing emphasis  
34   was given to delivering drug treatments within the criminal justice system  
35   (Seddon et al., 2008). However, several criticisms of harm-reduction  
36   approaches arose which led to the emergence of recovery-based policies.  
37   Research conducted with problematic drug users in Scotland (McKeganey et al.,  
38   2004) and in England (National Treatment Agency 2007) indicated that a high  
39   proportion accessing services did so with the goal of becoming free from drugs.  
40   Although there was a debate about how these findings should be interpreted  
41   (e.g. Nelles, 2005; Trace, 2005), press reports began to question the harm-  
42   reduction orthodoxy; particularly methadone maintenance prescriptions (see

1 Duke and Thom, 2014). Added to this, political criticism came from the right-  
2 wing think tank The Centre for Social Justice, who argued that the Government  
3 had abandoned drug users through a “routine and mass prescription” of  
4 methadone, which could not be justified, “on either clinical or ethical grounds  
5 (2007, p. 25).” Following these criticisms, the notion of recovery was used to  
6 signal a change in treatment orthodoxy in Scotland (Scottish Government,  
7 2008), Wales (Welsh Government, 2008) and GB as a whole (HM Government,  
8 2010, 2017). As has been established elsewhere (Zampini, 2018), how recovery  
9 came to be defined can be viewed as a political process; with competing special  
10 interest groups seeking to influence how the concept should be framed.  
11 However, the ways in which recovery is constructed in GB’s national drug  
12 strategies and what effects these constructs might have on the governance of  
13 recovery across GB, remains unclear. This understanding is important to  
14 generate because previous policy research has found that the ways in which  
15 policies present a certain issue (e.g. drug recovery), can create a further policy  
16 problem (e.g. Bjerger et al., 2020). Further, Bacchi notes, that “certain ways of  
17 thinking about ‘problems’ reflect specific institutional and cultural contexts”  
18 and that, consequently, problem representations should be viewed as contingent  
19 (Bacchi, 2009, p.14). Therefore, a cross-national examination of what recovery  
20 is represented to be in GB’s national drug policies can both offer an awareness  
21 of how recovery is thought about by policymakers and an understanding of how  
22 this places expectations on local policymakers and treatment providers.

23 The purpose of this study is to develop a better understanding of how  
24 recovery is represented, highlighting variances across jurisdictions in England,  
25 Wales and Scotland. In the following sections we set out our approach, before  
26 providing our analysis of the recent national drug strategies of England,  
27 Scotland and Wales. We conclude our study by providing recommendations for  
28 future drug policy research.

## 29 **Approach to Policy Analysis**

30 We employed the post-structuralist ‘*What’s the problem represented to be?*’  
31 (WPR) approach to policy analysis (see Bacchi, 1999, 2009; Bacchi and  
32 Goodwin, 2016). This approach is now firmly established within drug policy  
33 analysis (see Bacchi, 2018) and offers a tool to critically interrogate and  
34 challenge the assumption that policies act as “prescriptions to fix problems”  
35 (Bacchi, 2009, p. 1). This is done by identifying the problems implied by the  
36 ways in which proposed solutions are constituted as object of thought within  
37 discourses. As such, the WPR approach rests upon the premise that a critical  
38 analysis of political texts or discourses can illuminate the “deep-seated ways of  
39 thinking that underpin political practices” (Bacchi, 2018, p. 1). In other words,  
40 the WPR approach, seeks to illuminate the presumptions and narratives which  
41 constitute the problem which the policy seeks to address.

42 The WPR approach has been used to analyse drug policy elsewhere (e.g.  
43 Lancaster and Ritter, 2014; Farrugia et al., 2017; Bacchi, 2018; Thomas and  
44 Bull, 2018; Brown and Wincup, 2020) and can be understood as a ‘*way of*

1 *thinking*' rather than a standalone method of analysis (Bacchi, 2018, p. 6,  
2 emphasis in original). To facilitate this way of thinking, the WPR approach  
3 offers a six-question guide (see Table 1). Given the aims of our study, we used  
4 questions one, two and five specifically. Our decision to draw on these particular  
5 questions was pragmatic as others have focused on how representations of the  
6 problem came about and it was beyond the scope of our project to consider how  
7 the constitution of the problem has been defended. Bacchi (2012) asserts that  
8 the proposed six question guide is interrelated, in that it allows the insights from  
9 one of the six questions to inform the others, and vice versa. Instead of serving  
10 as formula for analysis, Bacchi recommends its use in a flexible manner and  
11 encourages the analyst to view them as tools to inspire a way of critically  
12 questioning what relevant policies propose to address. As such, we confirm that  
13 the use of only three specific questions has allowed for an adequate analysis and  
14 has revealed sufficient understanding.

**Table 1**

WPR Six-question guide to policy analysis (adopted from Bacchi, 2012, p. 21)

- |   |
|---|
| <ol style="list-style-type: none"><li>1) What's the 'problem' (for example, of 'problem gamblers', 'drug use/abuse', 'gender inequality', 'domestic violence', 'global warming', 'sexual harassment', etc.) represented to be in a specific policy or policy proposal?</li><li>2) What presuppositions or assumptions underpin this representation of the 'problem'?</li><li>3) How has this representation of the 'problem' come about?</li><li>4) What is left unproblematic in this problem representation?</li><li>5) What effects are produced by this representation of the 'problem'?</li><li>6) How/where has this representation of the 'problem' been produced, disseminated and defended?<br/>How has it been (or could it be) questioned, disrupted and replaced?</li></ol> |
|---|

15

### 16 ***Establishing Text***

17 Within the WPR approach, political texts or discourses are understood as  
18 'institutionally supported and culturally influenced interpretive and conceptual  
19 schemas' (Bacchi, 2005, p. 199).

20 In order to unpack cross-regional variances of recovery  
21 problematisations, we considered the UK Drug Strategy (UKDS) 2017, the  
22 Substance Misuse Strategy for Wales (SMSW) 2008-2018 and the Scottish  
23 Drug Strategy (SDS) 2008 (see Table 2). The UKDS and the SDS both focus on  
24 drug misuse whilst the Welsh strategy focuses on the misuse of drugs and  
25 alcohol. We retrieved the drug strategy documents from a specific search on the  
26 UK Home Office website ([www.gov.uk](http://www.gov.uk)), the Scottish Government website  
27 ([www.gov.scot](http://www.gov.scot)) and the Welsh Government website ([www.gov.wales](http://www.gov.wales)) by using  
28 the search terms drug policy AND strategy OR England OR Scotland OR  
29 Wales. Whilst this search brought up other material (such as ministerial  
30 statements and policies on drug licensing), these sources were not used as they  
31 did not refer to recovery in any detail. Although we considered reviewing local  
32 policy documents, we found that only a limited number of Local Authorities  
33 published their policies on the web and so chose to concentrate on national  
34 documents only. Our chosen documents were saved in pdf format. As we were

1 focused on recovery specifically, we only examined the stated recovery aims  
2 sections of each document. We searched the key terms recovery AND aims in  
3 each document to identify relevant sections.

4 Throughout our approach we used the UKDS to refer to practice in  
5 England as the policy fully governs this jurisdiction. Whilst the UKDS applies  
6 to Wales and Scotland as nations within the UK, the SMSW and the SDS  
7 identify the different strategies adopted by these nations under devolved powers  
8 and so these documents are used to refer to Welsh and Scottish policy  
9 respectively. Although these drug strategies are now partially outdated, we  
10 considered these documents because these were the most recent ones at the time  
11 of conducting this study in 2018 (see limitations below). Since then, Scotland  
12 has published an updated strategy in 2018, entitled ‘Rights, respect and  
13 recovery: Alcohol and drug treatment strategy 2018’ and Wales has published  
14 an updated version in 2019, entitled ‘Substance Misuse Delivery Plan 2019-  
15 2022’. Further, we acknowledge that recovery policy discourse extends beyond  
16 these documents (i.e. encompassing treatment policies and relevant stakeholder  
17 perspectives). However, we selected these strategies as they articulated the  
18 dominant position on recovery in these jurisdictions. As we highlighted in our  
19 introduction, the documents were produced during a significant point in  
20 recovery policy discussions in GB and therefore provide valuable insights into  
21 how discourses around recovery come to be represented and contested.

### 22 23 ***The Analysis Process***

24 Having established relevant sections on recovery (i.e. stated recovery aims), we  
25 followed the WPR question-guide to analyse the content of these. We began by  
26 systematically interrogating the problem representations in each separate  
27 document, drawing from question one (What’s recovery represented to be in the  
28 English, Scottish and Welsh drug strategy?). Our objective here was to develop  
29 ‘problem questioning’ by identifying how recovery was represented as an object  
30 of thought. We began our analysis by looking at the stated recovery aims in each  
31 policy document and by questioning how each aim implied recovery as a  
32 problem (problematizations). We achieved this through asking: *how is recovery*  
33 *constituted by the ways in which the policy proposes to address recovery?*  
34 Following this, we drew on question two with the objective of reflecting on, and  
35 identifying, the underlying premises in the representations of recovery (referred  
36 to as conceptual logics). By drawing on the literature, we questioned which  
37 presumptions must have been in place for policymakers to represent recovery  
38 in that way. We asked: *what is assumed?* and *what are the taken-for-granted*  
39 *assumptions?* In line with Bacchi’s suggestions (2009), we were careful to not  
40 highlight which beliefs are held by policymakers (i.e. their bias) but instead  
41 aimed to make explicit the conceptual logics which lie behind these  
42 problematizations. In doing so, we began to facilitate their deconstruction  
43 (Bacchi, 2012). Lastly, we drew from question five to consider what  
44 implications these recovery representations could have for practice and for the

1 service user community. We assessed how these recovery problematisations  
2 may limit the ways in which recovery can be thought about, put into practice  
3 and how they might shape people’s understandings of recovery.

4 Facilitated by these questions, our content analysis included systematic  
5 searching and coding of key words and patterns (i.e. binaries, categories and key  
6 concepts) within and between policy documents (Corbin and Strauss, 1990,  
7 2008; Chowdhury, 2014). This was carried out by one researcher but later  
8 discussed by both researchers. After discussing and reviewing these data,  
9 similar content was merged into codes and then grouped into themes. This  
10 information was initially organised on an Excel spreadsheet and subsequently  
11 compiled in table format (see Table 2).

## 12 **Findings**

13 Although the English policy (UKDS), the Welsh policy (SMSW) and the  
14 Scottish policy (SDS) were produced independently, our findings show that  
15 problematisations of recovery overlap and intersect (see Table 2). We identified  
16 three dominant themes: (a) recovery as *a problem of goals and ambitions*; (b)  
17 recovery as *a problem of product quality*; (c) recovery as *a problem of service*  
18 *collaboration and teamwork*. We identified the first theme predominantly in the  
19 Welsh and Scottish policy, the second theme predominantly in the English and  
20 Welsh policy, and the third theme in all three policies. Regarding our second  
21 aim of unpacking conceptual logics, we recognized notions of service user  
22 responsibility in the first theme, and notions of agency responsibility in the other  
23 two themes. In this section, we first describe how recovery is problematised,  
24 then explain which implicit values seem to have shaped these problematisations,  
25 and lastly discuss what effects are being produced by these recovery  
26 problematisations.

27

**Table 2**  
Representations of ‘Recovery’ in analyzed documents

Policy Title	District	Page	Goal/Aim	Representation of ‘Recovery’
Drug Strategy 2017	UK	28-38	Increase the rates of those recovering from their dependence; Raise ambition for full recovery by improving treatment quality and outcomes, ensuring that interventions are tailored to people's needs; Enhancing the use of wide range of services offered	<ul style="list-style-type: none"> <li>• Service users’ ambitions</li> <li>• Quality of treatment</li> <li>• Tailor-made treatment</li> <li>• Users’ abilities to utilize all services offered</li> </ul>
Substance Misuse Strategy for Wales: Working Together to Reduce Harm 2008-2018	Wales	30-41	Enable, encourage and support substance misusers to reduce the harm they are causing themselves, their families and communities, and ultimately return to a life free from dependent or harmful use of drugs and alcohol	<ul style="list-style-type: none"> <li>• Service users’ motivation</li> <li>• Absence of harm to socio-environmental factors</li> <li>• Independent/non-harmful use</li> </ul>
Scotland’s National Drug Strategy 2008: The Road to Recovery: A new Approach to tackling Scotland’s Drug problem	Scotland	21-35	Making ‘recovery’ the explicit aim of all services providing treatment for people with problem drug use; a range of services which are tailored to the individual needs of service users must be made available on a local level; treatment services must integrate effectively with other services to address needs besides addiction	<ul style="list-style-type: none"> <li>• Shared aim of drug and alcohol services</li> <li>• Lack of accessibility of tailor-made services on a local level</li> <li>• Lack of collaboration between specialist and other services</li> </ul>

1  
2

### 3 *A Problem of Goals and Ambitions*

4 Welsh and Scottish policies frame recovery as individualized goal. The  
5 recurrence of the words ‘full potential’, ‘aim’ and ‘achieve’ attest to this theme  
6 (see Table 2). In taking this approach, the Welsh and Scottish policies see  
7 recovery as being primarily defined by drug users. For example, the Scottish  
8 drug policy identifies that:

9 “recovery is about helping an individual achieve their full  
10 potential – with the ultimate goal being what is important to the  
11 individual, rather than the means by which it is achieved (SDS,  
12 2008, p. 23).”

13 These definitions encourage ‘recovery’ to be understood as a subjective  
14 concept “which will mean different things to different people (MacGregor,

1 2012, p. 351).” Similarly, Welsh policy identifies recovery as a subjective  
2 measure, however some tensions within this policy should be noted. For  
3 instance, recovery is seen as being defined by the individual (see Table 2) but  
4 at the same time, the policy also suggests that services should, “enable,  
5 encourage and support users (...) to reduce harm and to return to a life free from  
6 dependent or harmful use of drugs and alcohol (SMSW, 2008, p. 30).” As such,  
7 the ‘end-goal’ of recovery is assumed to be abstinence, juxtaposing the notion  
8 that recovery pathways should be defined by the service user. By creating a  
9 policy to “enable, encourage and support the user to reduce harm to themselves  
10 and others (ibid, 2008, p. 30)”, the service user’s (in)ability, (lack of) ambition  
11 and goals become the problem of recovery. These problematisations seem to  
12 lodge within two underlying, binary presumptions: that (a) the service user may  
13 not want recovery and thus must be motivated by external agents, and that (b)  
14 once motivated, service users can exercise self-governance and self-discipline;  
15 making rational decisions about their health.

16 The former presumption sets the user up as someone who neglects  
17 societal and state-level expectations by not engaging with services unless they  
18 are ‘charmed’ into treatment by outside forces or are coerced through social  
19 control measures (Stevens and Zampini, 2019). Here, traces from the implicit  
20 notions of the “deviant’ drug user can be identified, which regard the service  
21 user as ‘irresponsible, unreliable and a harm to the economic balance of society’  
22 (Smith and Riach, 2014, p. 36). The latter allows service users scope to identify  
23 which types of treatment are likely to benefit them most. Additionally, service  
24 users are assumed to have a good understanding of the risks and consequences  
25 associated with drug use and to be able to identify the most appropriate  
26 treatments from a range of service options. Here, the ‘expert hat’ is assigned to  
27 the service user. However, whilst this appears to afford the individual greater  
28 autonomy such policies have been criticised for prioritising notions of  
29 individual responsibility over collective rights, with the wider aim of reducing  
30 welfare budgets (Roy and Buchanan, 2016). These strategies also assume that  
31 individuals will be motivated to maximise their own health (Lancaster et al,  
32 2015) and overlooks the fact that decisions on treatments or interventions may  
33 be difficult for lay people to make. Additionally, more responsibility over health  
34 and illness means more possibility for blame and victimization, leaving the  
35 service user in a vulnerable position. Fraser (2004) posited that this presumption  
36 may have been fostered deliberately by society as it “identifies the individual  
37 rather than social or political structures as the origin of problems and solutions  
38 (pp. 200-201).” In sum, recovery policies which propose that ambition for  
39 recovery must be enhanced and recovery goals must be individually defined,  
40 seem to have been shaped by the underlying knowledge which understands the  
41 service user’s lack of ambition, lack of motivation and ill-defined goals as the  
42 problem of recovery. This underlying knowledge however seems to contradict  
43 itself, in that it holds that service users must be helped to pursue recovery,  
44 however, *can* help themselves once they are in recovery. Consequently, this has  
45 the effect of positioning the service user as neither a consumer nor a patient, but



1 as someone who is fully capable, yet at times unwilling, to make deliberate  
2 choices and decisions with respect to their recovery trajectory.

### 3 *A Problem of Product Quality*

4 Across both, the UKDS (2017, pp. 28-38) and the SMSW (2008, pp. 30-41), the  
5 repetitive use of key words ‘treatment, service, quality, evidence’ and  
6 ‘measures’, indicate that recovery was seen as something externally driven by  
7 services. As table 2 shows, the English policy focuses on “enhancing treatment  
8 quality and improving outcomes (ibid, 2017, p. 28)”, akin to Wales’ priority for  
9 recovery which involves the evaluation of service “quality” so that “better  
10 performance and efficiencies in treatment services (ibid, 2008, p. 31).” can be  
11 accomplished. Although the SMSW has the stated aim of “including jointly  
12 agreed outcomes or goals [between users and providers] (SMSW, 2008, p. 33)”,  
13 the main emphasis within the policy is on service provision. Actions to achieve  
14 “better” treatment include the development of staff so that they are “competent,  
15 motivated, well-led, appropriately supervised and responsive to new challenges  
16 (ibid, 2017, p. 30).” Treatment is further enhanced “through tailored  
17 interventions for different user groups (ibid, 2017, p. 28).” Another factor  
18 addressed across the Welsh policy is the need to market recovery services by  
19 ‘expanding outreach’, thereby portraying the service user as someone who must  
20 be actively “identified” by treatment providers and who must be “engaged” in  
21 services (ibid, 2008, p. 31). Finally, both policy documents emphasize the need  
22 for a service’s flexibility in adapting to the “changing patterns of substance  
23 misuse over time (ibid, 2008, p. 31)”, to thereby maintain their appeal to the  
24 service user community. Responsibility for a user’s recovery is here on the  
25 service provider who must continuously improve, tailor and market their service  
26 (product).

27 By proposing a policy that aims to enhance the quality and effectiveness  
28 of services, the (level of) quality and effectiveness of services is produced as the  
29 problem of recovery. By looking more closely, this problematisation seems to  
30 be underpinned by the presumptions that every user should ideally want to  
31 engage with drug and alcohol services to work towards recovery, as well as that  
32 the service user’s ability to recover is contingent upon the quality of services  
33 provided and upon how well the service user can be influenced by recovery  
34 marketing campaigns. As consequence, service users are viewed as consumers  
35 of recovery-based services, implying that they can, and are able to, engage with  
36 the best recovery *product* from a range of recovery product options. Such a  
37 consumer-based notion suggests that services have a duty to publicize provision  
38 in a way that allows users to make comparisons between services. These  
39 assumptions are addressed by policies which propose that service providers  
40 exercise more intentional and frequent outreach (see paragraph above). It also  
41 assumes that service users can easily evaluate services and make a rational  
42 decision about a range of treatment options. However, this overlooks the fact  
43 that the service user may be disadvantaged, may not be educated about addiction  
44 or may face other challenges which could prevent them from wanting to engage

1 with a service, such as homelessness or access to services (Lancaster et al.,  
2 2015; Whiteford et al, 2016; Andersen and Kessing, 2018; Lucas et al., 2018).  
3 Additionally, this notion disregards the fact that some drug and alcohol services  
4 have extremely long waiting lists (with an average of up to six weeks) due to  
5 resource cuts and extremely high demand (ISD Scotland, 2018). These  
6 presumptions have parallels with professionally-led models of care in which  
7 medical treatment providers are assigned the expert position and problematic  
8 drug users are acknowledged as ‘patients’ in need of treatment (Heilig, 2015).  
9 Whereas multi-disciplinary expertise is acknowledged, such models narrow  
10 recovery down to the duration in which service users engage in  
11 treatment/services. As such, notions which understand recovery to be a lifelong  
12 phenomenon, initiated and maintained by the service users themselves, are  
13 disregarded (McKay, 2016). To summarize, the problematisation of recovery  
14 treatment quality and effectiveness can be seen to produce a narrow  
15 understanding of the drug policy problem by reflecting a position in which users  
16 are viewed as recipients of care with limited autonomy over their own recovery.

### 17 ***A Problem of Service Collaboration and Teamwork***

18 The frequent use of key words ‘collaboration, partnership’ and ‘full range of  
19 service’ are found across all three policy texts and identify recovery as a shared  
20 responsibility across health, social and voluntary services (see Table 2). For  
21 example, the UKDS (2017) identifies that:

22 “recovery systems require close collaboration and effective  
23 partnership working to deliver the full range of end-to-end  
24 support for those with drug and alcohol problems (...) including  
25 the housing and homelessness sector, children’s services, and  
26 social care (...) mental and physical health care and employment  
27 services provided by Jobcentre Plus (p. 28).”

28 The importance of shared responsibility between several services is also  
29 emphasized in the SDS (2008) which stresses that treatment services should  
30 “integrate effectively with a wider range of generic services to fully address the  
31 needs of people with problem drug use (p. 24).” The goal of recovery in this  
32 context is seen to be service users’ abilities to maintain a stable lifestyle through  
33 addressing their addiction issues and obtaining stability in their family, housing  
34 and employment affairs. Furthermore, these goals are seen as being dependent  
35 on effective teamwork by health, social and voluntary services. Here, the  
36 emphasis is placed on the need for services to work with one another. By  
37 creating a policy with the aim to deliver collaborative service between a variety  
38 of services (e.g. housing sector, homelessness sector), it implies that recovery is  
39 understood to be the matter of (a lack of) collaboration between all such  
40 services. This problematisation seems to be lodging in the presumption that  
41 recovery is subject to combined biological, psychological, social and cultural  
42 components and that drug services must have a shared aim of facilitating  
43 recovery through collaboration. Pertinent to this problematisation, service users

1 are viewed as playing a ‘passive’ role in their recovery, seen as that the  
2 responsibility for a ‘successful’ recovery is given to the service provider,  
3 specifically their ability to collaborate with other relevant social services.  
4 With respect to these presumptions, the problematisation of service  
5 collaboration has parallels with the biopsychosocial theories of  
6 addiction/recovery, which view single-factor explanations of addiction as  
7 inadequate, and thereby point to the need for multi-disciplinary assessments and  
8 services (Donovan, 2005). Consequently, commissioners of services are seen as  
9 being responsible for identifying need within their area, commissioning  
10 appropriate services, overseeing which provider is responsible for what (Taylor  
11 et al., 2016) and encouraging services to work together. However, several  
12 tensions can be seen as evident within such arrangements. Recent budget cuts  
13 have led local service providers to decrease their *value for money* as to survive  
14 in competitive tendering processes (Floodgate, 2018). For instance, specialist  
15 mental health services increased their intake threshold to focus on users with  
16 severe mental health issues, thereby leaving local drug and alcohol services to  
17 take on cases which are often too complex and out of their scope of expertise  
18 (Kalk et al., 2017). With such increased tension and competitiveness among  
19 services, a collaborative spirit may be elusive. In addition to this, although a  
20 holistic approach to addiction treatment is advocated within the policies, certain  
21 treatments are afforded greater weight than others. For example, in the arena of  
22 physical health both the English and the Scottish policies equate service users’  
23 physical health needs with those of blood infections, HEP-C or sexual  
24 infections. This leaves other physical needs, such as dental/oral hygiene, kidney  
25 or heart issues unconsidered, and thus contradicts the policies’ aims to “fully  
26 address (SDS, 2008, p. 24)” any physical or mental health needs. As such, the  
27 outdated presumption that all drug users pose a risk for transferring HEP-C to  
28 the public, on which the GB’s first drug policy was established, seems to have  
29 prevailed in today’s drug policy. Conclusively, recovery is constituted as a  
30 problem of teamwork and collaboration between service providers. Whilst a  
31 biopsychosocial understanding of addictions is implicit within this  
32 understanding, multi-disciplinary working remains hampered by resource  
33 limitations.

#### 34 **Discussion**

35 This study was the first to employ the WPR approach to critically comparing  
36 how recovery is constituted, and produced as a policy problem, in three different  
37 GB drug strategies. Findings indicated that for one, recovery is problematised  
38 as a matter of individual ambition and goals in the Scottish and Welsh strategies.  
39 By presenting recovery this way, the policy assigns responsibility to the service  
40 user which in turn seems to insulate commissioners and service providers from  
41 blame. A second way in which recovery is being problematised, and which  
42 dominates the Welsh and English strategies, is as tailor-made, high-quality  
43 treatment to be continuously improved and promoted by the service provider.  
44 This problematisation seems to stem from medical, biological and

1 pharmacological notions of addiction (Volkow and Koob, 2015) which view the  
2 service user as passive agent in their recovery process. A last representation of  
3 recovery refers to the collaboration and combined effort of multiple services, all  
4 of which seek to help the service user in their recovery. This problematisation  
5 was evident in all three national drug strategies. Whilst this problematisation  
6 may stem from psychological, sociological and environmental notions of  
7 addiction (Best et al., 2017), the user is still viewed as someone with little say  
8 in their own recovery process. Furthermore, this problematisation contradicts  
9 the ongoing financial pressures, and subsequent competitiveness, among local  
10 GB drug service providers (see Floodgate, 2018). Therefore, constituting  
11 recovery as being dependent upon service collaboration may pose unrealistic  
12 expectations for services. These findings imply that GB's national drug  
13 strategies may unintentionally disadvantage the drug service user community  
14 by requiring drug and alcohol treatment providers in England, Wales and  
15 Scotland to address recovery in different ways. This incongruency may not only  
16 cause confusion and/or frustration in service providers but also in users, who  
17 may enter treatment services in more than one part of GB. In summary, having  
18 used the WPR approach to analysing recovery in each of these national drug  
19 strategies allowed our study to highlight that the production of recovery aims  
20 has been influenced by an understanding that recovery is something independent  
21 of the person pursuing it, therefore potentially contributing to superficial und  
22 unrealistic practice guidelines.

23 Although this study offers an original contribution to the wider  
24 literature, several limitations need to be borne in mind. First, this analysis was  
25 carried out as part of a larger project on recovery and therefore the analysis  
26 preceded the Scottish drug strategy, Rights, respect and recovery: Alcohol and  
27 drug treatment strategy (2018). Similarly, the Welsh drug strategy has been  
28 subject to an evaluation leading to the publication of the 'Substance Misuse  
29 Delivery Plan 2019-2022'. The difference between the old and updated drug  
30 strategy for Scotland lies in the promotion of harm-reduction. This was mainly  
31 in response to Scotland's drug-related deaths, which had almost doubled  
32 between 2009 and 2017. The new approach focuses on recovery-oriented  
33 systems of care and on a combined effort between different public health  
34 services to support the user and their families. Wales saw a slight decrease in  
35 drug-related deaths between 2016 and 2017 and its updated drug strategy has a  
36 broader focus on health, harm reduction and early prevention. Similarly, to the  
37 Scottish updated strategy, Wales has shifted its focus from encouraging  
38 abstinence toward maintenance drug treatment and speedier harm reduction.  
39 Given this, we would recommend that future research considers these  
40 documents. Second, the selection of national-level drug strategies, leaves us  
41 unable to draw inferences about policy implementation at a service level, or the  
42 effects thereof. Translating these findings into actions for local services is never  
43 a straightforward task. This is because the number of social actors involved as  
44 well as the diverse needs of these actors, including their professional ideologies,  
45 cultural differences and accessibility to relevant resources, all play a part in the

1 effective implementation and management of a policy (Hudson, 2004). For  
2 instance, drug service resources and service user demographics differ across  
3 GB, with different councils having different needs to address. Additionally,  
4 drug service workers are able to shape public policy on the ground as well, by  
5 exercising their autonomy in their work (e.g. they develop routines and  
6 simplifications for decision-making), what Lipsky (2010) defined as ‘street-  
7 level bureaucracy’. One way of resolving the difficulty that comes from trying  
8 to translate national-level policy into local-level policy would be through  
9 engaging people with lived experiences (e.g. service users and providers) in  
10 future policy research as well as in policy reforms. Engaging such expert voices  
11 in the abovementioned processes may offer important evidence which would  
12 otherwise be overlooked and may lead to meaningful and transformative  
13 consultations (see Ritter, 2015; Monaghan, Wincup and Wicker, 2018). Lastly,  
14 the findings on how different recovery problematisations might influence  
15 stakeholders, their practices and how they are being perceived reflects the  
16 authors’ interpretation. Therefore, more evidence, such as qualitative interviews  
17 or surveys with stakeholders, should be collected to more definitely assess the  
18 effects of these recovery problematisations.

19 Despite these limitations, we believe our article provides a valuable  
20 insight into recovery problematisations in GB’s national drug policy, as our  
21 analysis focusses on policy at a point at which new representations of recovery  
22 were being formed and contested. Further, the WPR approach has offered us a  
23 way to illuminate meaning-making in practices of recovery from drug misuse  
24 across GB. The WPR approach allowed us to critically consider the influences  
25 that lie at the heart of recovery policy decision-making, such as taken-for-  
26 granted assumptions about drug misuse. Further, the approach encouraged us to  
27 consider, and call attention to, how these recovery understandings impact  
28 different stakeholder groups. As such, we have been able to identify how the  
29 language within such policies can serve to contradict their stated aims, and, with  
30 that, contribute to a limited understanding of how recovery from drug misuse  
31 may be addressed. However, this particular focus on language in the WPR  
32 approach to policy analysis has limited us to providing an interpretive account  
33 of the recovery discourse, which assumes that stakeholders apply policy as  
34 policymakers intend. To address this weakness, future WPR research designs  
35 could benefit from including multiple data points, such as relevant policies,  
36 interview data of stakeholder groups and practice assessments over time.

## 37 **Conclusion**

38 This article extends current drug policy scholarship through a focus on recovery  
39 problematisations in three national drug strategies of England, Wales and  
40 Scotland. It is undeniable that contemporary drug policymakers face a complex  
41 political terrain with respect to the increasing burden that drug misuse issues  
42 place on GB’s economy, politics, public health and public safety. In this context,  
43 Bacchi’s approach has proven useful in highlighting the conceptual logics which  
44 underpin how recovery is addressed in GB’s drug policies. This information

1 may also prove useful for developing our understanding on why a gap between  
2 GB's drug policy aims and their enactment in service provision remains. We  
3 conclude that policymakers, policy analysts, researchers and educators in the  
4 addictions field must gain greater awareness of how problematisations in  
5 policies can pose potential pitfalls for the advancement of drug policies as well  
6 as contribute to a narrow understanding of recovery and of those pursuing it.

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