Problematising 'Recovery' in Drug Policy within Great Britain: A Comparative Policy Analysis between England, Wales and Scotland

Introduction

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

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

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

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

Approach to Policy Analysis

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

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

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

Table 1
WPR Six-question guide to policy analysis (adopted from Bacchi, 2012, p. 21)

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?
2) What presuppositions or assumptions underpin this representation of the 'problem'?
3) How has this representation of the 'problem' come about?
4) What is left unproblematic in this problem representation?
5) What effects are produced by this representation of the 'problem'?
6) How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

Establishing Text

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

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

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

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

The Analysis Process

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

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

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

Findings

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

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	• Service users' ambitions • Quality of treatment • Tailor-made treatment • Users' abilities to utilize all services offered
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	• Service users' motivation • Absence of harm to socio-environmental factors • Independent/non-harmful use
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	• Shared aim of drug and alcohol services • Lack of accessibility of tailor-made services on a local level • Lack of collaboration between specialist and other services

A Problem of Goals and Ambitions

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

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

These definitions encourage 'recovery' to be understood as a subjective concept "which will mean different things to different people (MacGregor,

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

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

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

A Problem of Product Quality

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

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

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

A Problem of Service Collaboration and Teamwork

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

> "recovery systems require close collaboration and effective partnership working to deliver the full range of end-to-end support for those with drug and alcohol problems (…) including the housing and homelessness sector, children's services, and social care (…) mental and physical health care and employment services provided by Jobcentre Plus (p. 28)."

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

are viewed as playing a 'passive' role in their recovery, seen as that the responsibility for a 'successful' recovery is given to the service provider, specifically their ability to collaborate with other relevant social services.

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

Discussion

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

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

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

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

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

Conclusion

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

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

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