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GO 'Recovery': meaning and implications for treatment

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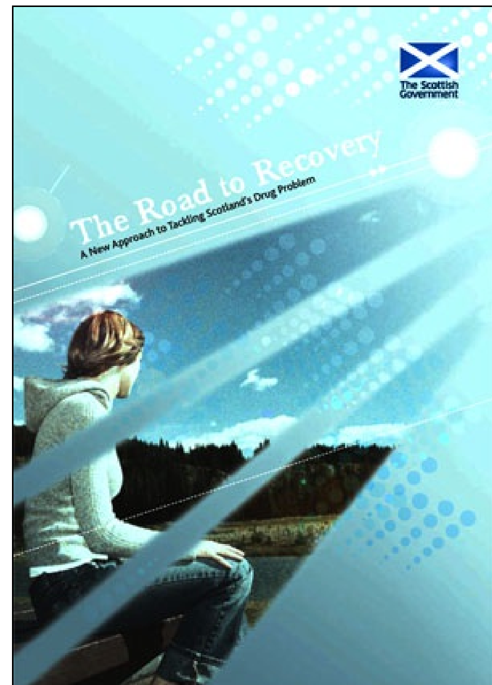
Though the term has a long history associated especially with 12-step-based approaches, the modern 'recovery' era in British addiction treatment services can be dated to its forefronting by governments in Scotland and England in May 2008, a new dawn (▶ Scottish strategy cover) which would reinvigorate treatment services stuck in the rut of preventing harm and crime rather than redeeming and regenerating lives. This hot topic reminds us the roots of the recovery era in the desire to contain public spending, queries interpretations which demand more of former problem substance users than many less disadvantaged citizens manage to achieve, and asks what in theory and in practice this all means for treatment services. The underlying theme is that in an "age of austerity", the ambitious rhetoric was not matched by the "intensive support over long periods of time needed to become drug free" and – notwithstanding genuine advocacy in the interests of a better future for patients – instead at a political level helped legitimise advancing the withdrawal of support in the form of long-term treatment.

The discovery of recovery

Recovery is at the heart of the treatment themes in Britain's national drug policies, featuring in the titles of both the English and the Scottish strategies, while the Welsh strategy committed the nation to "focus our efforts on helping substance misusers to improve their health and maintain their recovery".

What these strategies meant by 'recovery' was not spelt out, but the broad themes were clear: some of the most marginal, damaged and unconventional of people were to become variously abstinent from illegal drugs and/or free of dependence and (as Scotland's strategy put it) "active and contributing member[s] of society". Scotland's ambition echoed those of the government in England dating back to the mid-2000s for more drug users to leave treatment, come off benefits, and get back to work – and become an economic asset rather than a drain.



Inspirational vision of recovery depicted on 2008 Scottish drug strategy cover

At first under Gordon Brown's Labour government this ambition verged on the brutal, the UK drug strategy released in February 2008 seeming to threaten drug users on benefits with penury if they failed to "move successfully through treatment and into employment". The backdrop was the credit-crunch crisis dating from August 2007 which in April 2009 was followed by a promise by Conservative Party leader and later prime minister David Cameron to usher in an "age of austerity" to cut the budget deficit.

Though transition out of treatment and into employment was close to what later became 'recovery', of the six times that word was mentioned in the 2008 strategy, all but one referred to recovering financial assets from drug dealers, not recovery from addiction. South of the Scottish border, 'recovery' had yet to be discovered, but already preparations must have been underway to make it the dominant theme in the Scottish strategy released in May 2008. That month too, in England the initial stress on reintegration through employment enforced by withdrawal of benefits had in senior government circles morphed in to a more appealing label: "recovery".

In this Labour was not just catching up on Scotland but also on the Conservative opposition. In July 2007 David Cameron's "New Conservatives" had released the fruits of their addictions policy think-tank. In contrast to Labour's strategy, "recovery" was the shorthand used for its overarching philosophy. "Towards Recovery" was the heading of the section on policy reform and for treatment in particular, "The ultimate goal ... should be recovery and rehabilitation through abstinence," requiring a "radical reform" in treatment away from substituting legal for illegal drugs and "facing the fact that abstinence is the most effective method of treatment". Not much survived of what would have been the expensive shift to residential rehabilitation services and the structural reforms the report saw as needed to pursue recovery, but recovery itself and the associated abstinence objective and denigration of maintenance prescribing became embedded in Conservative thinking, and with the advent of David Cameron's government in 2010, in national policy.

But the strands later to be woven into recovery had been gathering several years earlier, prompted by the felt need from the mid-2000s to make economies in addiction treatment services and to contain public spending, especially the welfare benefits on which these services' patients overwhelmingly relied. Though total funding was increasing, in England since at least 2002 *per patient* funding had been falling (1 2) when in 2005 an "effectiveness" strategy developed by the National Treatment Agency for Substance Misuse complained of the "lack of emphasis on progression through the treatment system" leading to "insufficient attention ... to planning for exit". Foreseeing a time when funding would be less available, the agency's board was told that "Moving people through and out of treatment" will create space for new entrants "without having continually to expand capacity".

> *In an "age of austerity", the ambitious rhetoric was not matched by intensive support*

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Opposing the previous stress on retention – the yardstick on which services were then being judged – this new emphasis on treatment exit was given an unwelcome boost when in 2007 the crime-reduction justification for investing in treatment was challenged by the BBC on the grounds that treatment should be about getting people off drugs. There was no gainsaying the seemingly incriminating fact that in England in 2006/07 just 3% of patients were recorded as having completed treatment for drug problems and left drug-free. It was the shock of that challenge and the economising turn away from retention to treatment exit which fed through to Labour's 2008 national drug policy. Announcement of a three-year standstill in central treatment funding until 2011 – a real-terms cut at a time when the caseload was expected to rise further – focused attention on squaring the circle by getting more patients to leave as well as enter treatment.

By then firmly linked to the term 'recovery', in 2014 the emphasis on treatment exit remained in government circles, eliciting a robust defence from the Advisory Council on the Misuse of Drugs of long-term opioid substitution therapy for heroin users. The following year the Conservative Party's election manifesto made it clear that the council's message had been rejected, continuing in the name of "full recovery" to condemn "routine maintenance of people's addictions with substitute drugs".

We all want 'recovery' – but what is it?

Do experts and the people on the ground envisage recovery in the same way? Not all, and the definition of recovery has been so contested and so crucial that special commissions have been set up to try to reach a consensus. Most influentially for the UK, in 2008 the non-governmental UK Drug Policy Commission brought 16 experts together to thrash it out. They couldn't agree what *being* recovered was, but did agree that *getting* recovered is "characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society." Their brief report expanded on each element of the definition, explaining that that by "control" they meant "comfortable and sustained freedom from compulsion to use" – the traditional treatment goal of sustainably ending addictive patterns of substance use. But that was, they said, not enough: recovery is not just about ending pathology, but about gaining "positive benefits ... a satisfying and meaningful life".

Of as much importance was what was *not* in their definition. Abstinence was missing, and so too was leaving treatment, a rejection of government ambitions to move patients through and out of treatment as a step to getting (back) into work. The commission's 16 accepted the work objective, but in a softer formulation which allowed for other routes to a meaningful and productive life. Though there was a passing nod to the social determinants of getting into and out of trouble with substance use, it has been seen as not enough to rescue their report from placing the responsibility for and control over their recovery at the door of the individual substance user, and by extension the responsibility (or blame) for non-recovery. In contrast, the recovery capital concept (▸ below) directs attention to the supports made accessible by the wider society. Rather differently too, in Scotland a government-commissioned working group placed the social and cultural environment at the heart of its recommendations about reorienting alcohol treatment to recovery. For these experts, "A shift from an individual and substance based understanding to one that has its base in social networks" meant that "families, peer groups or other significant social networks should be an important part of any planned intervention." Extending further still from the individual patient, services would need to "Develop 'whole population' approaches that create environments which discourage alcohol and drug misuse and encourage positive health behaviour change."

> *About gaining "positive benefits ... a satisfying and meaningful life"*

No one has more authority than US recovery guru William White to say what it entails. In 2008 his definitive monograph said adopting recovery as an objective meant a shift in treatment from isolated bouts of professional care forced by a problem which has become intolerably severe or attracted attention, to on the one hand, intervening before things have descended to this point, and on the other, locating treatment as often merely the first step to extended "recovery maintenance". In this vision, the focus shifts to systems around the clinic within which the patient must eventually reshape their life in community with others who have done or are trying to do the same, secured by ties to family, community, and work. Arguably, it is this aspect of the recovery vision which most productively redirects our attention. At the same however, it also redirects the challenge from changing what to a degree can be controlled by treatment services – the intra-clinic environment – to an external environment more intractably unfriendly to their patients.

When in order to measure recovery Dr White had to pin down what it was, he saw it as "an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)." But writing six years later he reflected the fact that defining 'recovery' remained a contested work in progress, in which for individuals who may be included or excluded from its ambit, "The personal stakes are high".

Counsels of perfection or of necessity?

Though expressed as a process of 'moving towards', the implication that recovering from addiction entails developing lives more fulfilling than many who never had these problems was well represented by a definition from the US agency for substance 'abuse' and mental health. It saw recovery as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." In there were: "Making informed, healthy choices that support physical and emotional wellbeing"; "A stable and safe place to live"; "Meaningful daily activities ... and the independence, income and resources to participate in society"; and "Relationships and social networks that provide support, friendship, love, and hope". Explaining its vision, the agency said, "Recovery encompasses an individual's whole life, including mind, body, spirit, and community".

Former problem substance users surveyed in the USA, nearly all of whom were now abstaining from drink and/or drugs after treatment, also saw recovery as entailing desirable qualities beyond not being dependent, including: making a contribution to society; ability to experience inner peace; growth and development; being someone people can count on; gaining inner strength; and taking responsibility for the things you can change (1 2). Deleted by the researchers as "extraneous" or counsels of "perfection", nevertheless the respondents also overwhelmingly endorsed items such as, "Living in a way that is consistent with what I feel and think", "Appreciating the positive things in my life", and "Making sense of where I've been and who I am today".

Though a critic who wants to open up recovery to non-abstainers and who sees "perfection" and "giving back" to the community as requiring too much, still Maia Szalavitz includes being "socially and occupationally healthy in a stable way" and "functional work and social relationships" in her definition of recovery.

If collectively these definitions sound like having to become more worthy and better balanced than many who have

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> *Rejected were the "superhuman" requirements demanded by prevailing formulations*

If collectively these definitions sound like having to become more worthy and better balanced than many who have never got deeply into trouble with substance use, that's also how it seemed to a sample of problem drug and alcohol users in and out of treatment in England – representatives of the people who it is hoped will achieve recovery. When in 2014 they were asked what recovery consisted of, none of the drug-focused criteria identified by senior treatment staff gained widespread endorsement. Instead, participants "repeatedly argued that recovery meant 'being normal' and 'living life like everyone else'." The route to 'normality' entailed neither being like each other nor like other people, but was an individual itinerary, and would be diverted, limited and shaped by the usual human frailties and faults. Rejected were the "superhuman" requirements which seemed demanded by prevailing formulations.

In a substance-using society, abstinence from psychoactive substances might be seen as just such a requirement. Though insisting on abstinence as a prerequisite for other people's recovery is in Britain commonly rejected, that should not blind us to the fact that for many problem drug users and drinkers, abstinence is the prime component of their own visions of recovery. But at the same time, they may embrace seemingly contradictory components like safer or reduced drug use.

Imbued with conventional ideas about what constitutes a good and worthwhile life, prevailing conceptualisations of recovery were criticised by Kari Lancaster, an Australian drugs researcher, as based on "neoliberal assumptions about work, productivity and what it means to live a 'contributing life' which fail to take into account the differences in the normative and social contexts of people's lives." In other words, there are more ways of being worthwhile than are envisioned by middle-England (or middle-Australia) perspectives. Another concern was that these definitions imply that "people who use drugs who are not 'in recovery' always already exist somehow outside of community and cannot live meaningful and fulfilled lives." The first limitation will exclude many from the dignity of recovery, the second, from the dignity of meaningful and fulfilled lives – exemplifying William White's reminder that in defining recovery, the personal stakes are high.

Some perspective can be gained on these issues by shifting ground from dependence on illegal drugs, or 'alcoholism' of the kind treated at specialist services, to dependent smoking. Would we say someone who has sustainably stopped smoking or who smokes only once in a while, but hasn't found a job, is still on benefits, maybe even offending, and who remains at a loss for meaning in life, has failed to recover from their addiction? Imperfect they may be, but only in ways they share with many people who have never been addicted, and perhaps too in ways not entirely under their control, like employment, housing and family relationships.

But for socially unacceptable addictions to illegal drugs and drinking of the kind that drives one to seek professional help, perhaps there are good reasons why these wider issues intrude. By the time you have narrowed down to the minority who try drugs like heroin and cocaine, the very few who become regular users, those of the former who become clinically dependent, and then the subset of those who want to stop but can't without treatment, then you have selected a highly atypical and usually multiply and deeply troubled population – the caseload of drug addiction treatment services. Dependent drinkers of the kind seen at specialist services are also disproportionately the most severely affected, multiply comorbid and intractable, grooved over many years into a dependence rut from which they have few levers and perhaps few reasons left to extricate themselves.

Demands transformation of treatment

Having defined the desired 'recovery' outcome as far as we can, now we can work backwards to what that means for treatment. Logic dictates it should determine how to assess success and the inputs needed to achieve it. Whether counsels of perfection or counsels of necessity, prevailing conceptualisations imply that treatment services will need to gear up with integrated access to vocational experts, family re-unification inputs, artistic and creative opportunities, and whatever else for their patients is needed to move towards a meaningful and productive life which leads them to welcome, and be welcomed by, mainstream society.

Potentially that transforms addiction treatment into an endeavour of daunting proportions, involving not just the overcoming of substance use problems, but the bolstering of the patient's 'recovery capital', seen in the UK and in the USA as a key task for recovery-oriented treatment systems.

'Recovery capital' refers to the "breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from [alcohol and other drug] problems". According to the social scientists who coined the term, these include: being able to rely on the support of acquaintances and friends; financial stability and capital; the knowledge, skills, qualifications, health, mental health, and other traits essential for optimal negotiation of daily life; and the ability to divorce oneself from subcultural norms which promote substance use and instead embrace "the prosocial norms of the dominant culture". Set against these on the negative side of the equation are physical and mental ill-health and the impact of being imprisoned. It is immediately apparent that positive capital is often in very short supply among the multiply damaged and disadvantaged caseloads of public sector treatment services, while negative capital is common.

The concept's originators warned that it had "Major implications for treatment providers and policymakers." Aware of these implications, some argue that inputs related to non-drug focused elements like wellbeing and social reintegration are not essential components of the treatment of addiction, but the business of other welfare, employment and health services. The UK group which defined recovery did not let treatment off so lightly. Their definition was, they said, about "the goals of treatment and rehabilitation ... that could be applied to all individuals tackling problems with substance misuse, and all services helping them."

Hopes for reconciling limited resources with expanded ambitions were pinned on a change of heart among services (and especially prescribing-based services) to supplement or replace a 'keep them safe' mentality with more risktaking, optimism and dynamism, and in the capacity of dependent drug users and ex-users themselves to bootstrap their ways to recovery via mutual aid, along the way challenging the stigma which impedes recovery and leads those in recovery to hide from view.

Operationalising the objective

'Recovery's' great utility is its elasticity, allowing it to act as an unarguably desirable objective under which disparate stakeholders can unite, even if in practice they interpret it differently, a role it plays in UK national strategies. But this also means it is too nebulous a concept to be used as a target or yardstick in itself. For these purposes, recovery has to be broken down into components and then into concrete, observable events which signify those components, entailing the risk that what for some stakeholder is its core meaning will be lost in translation.

Arguably that was the case when it came to making recovery objectives concrete enough to be used for the payment

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Arguably that was the case when it came to making recovery objectives concrete enough to be used for the payment-by-results funding of English services. Among the criteria, recovery as envisaged in the national strategies was notably lacking. Employment and whether the patient was active in and contributing to society were put aside in favour of more readily measured and achieved elements, like feeling OK and not offending. It was perhaps a recognition that implementing the transformational vision in the strategies would be a stretch in an era where conventional routes to a normal life through employment and stable housing were shrinking or remained in short supply, and the resources to elevate patients from near the bottom rungs of society to at least near the average were being stripped back.

Individualisation seems another way the criteria are at variance with understandings of recovery. When money hinges on the achievement of objectives, these have to be consistent, concrete and prescriptive about what they expect from treatment services, clashing with the insistence of recovery advocates and patients themselves that recovery is a highly personal journey with no 'right' or 'best' way. In theory local schemes could create a space for the patient's ambitions in their payment criteria, but this is not a required element or one included in the national criteria, nor one which sits easily within a system predicated on observable outcomes the public and their representatives recognise and are willing to pay for. Instead schemes pre-set what counts as success without reference to what the individual patient wants, and in a way services cannot afford to ignore.

> *Achieving recovery partially boils down to terminating care and not rapidly readmitting patients*

Practicalities if nothing else mean the schemes often specify in-treatment and treatment exit measures rather than post-treatment recovery indicators, and the post-treatment indicators are confined to routinely collected criminal justice and treatment records which bear a loose relationship to treatment success. Though introduced in the name of recovery, the national framework for the schemes places a premium on drug-free discharges of patients who then are not seen in treatment and other records for at least a year – on the face of it, at odds with the continuing contact presupposed by the recovery vision and by understanding of the chronic nature of treated addiction. The same limitations apply to the national public health objectives for England against which local authorities are held to account, which have also adopted treatment exit and non-return as their sole recovery-related criterion. Via these mechanisms, in practice being seem to achieve recovery objectives partially boils down for treatment services to terminating care and not rapidly readmitting former patients.

On the ground?

A fundamental problem for services is that just as their remit is being extended to encompass recovery and the building of recovery capital, the resources available are being cut, in some areas, dramatically. As explained above, this conjunction is, however, no accident, but flows from the roots of recovery in the imperative (as seen by national UK governments) to save money both on addiction treatment and on welfare and other benefits. What became known as 'austerity' both drove the cuts and created the ground on which recovery grew as a positive and appealing way to call for more patients to leave and not re-enter treatment, support themselves and their families, get a job, and contribute to the economy.

Transferred to local authorities facing deep funding cuts, it is not just that addiction treatment services themselves are feeling the pinch, but also that the wider supports needed to pursue a recovery agenda are weakening. Surveyed in 2014, 88% of responding services dealing with people suffering multiple problems including addiction felt "welfare changes had a negative effect on their clients' overall wellbeing, and 86% on their mental health". About as many said their clients' housing prospects had worsened and three-quarters that welfare 'reforms' were leading to ill health due to poor nutrition. In the addiction sector, these adverse effects of government policy on welfare and housing would erode the recovery capital seen by the same government as promoting the recovery objective they say should be the treatment mission.

By the former head of the National Treatment Agency for Substance Misuse, in 2014 we were reassured that despite the rhetoric, at national policy level the recovery agenda had not swept away support for approaches which had helped keep drug users alive and prevent drug-related crime. Crime-prevention does remain seen as a key treatment outcome, one which will tend to mitigate interpretations of 'recovery' that entail time-limiting treatment and relegating maintenance prescribing to a niche role. On maintaining the record of saving lives, the figures are not reassuring, the UK experiencing a substantial increase in drug-related deaths since 2012.

How far on the ground services have retained their previous focus or re-oriented to recovery – and what those which have reoriented meant by that – is unclear. In respect of drinking, in 2014 Alcohol Concern published the results of its audit of the priority given to alcohol in local plans across England. Almost entirely missing from the alcohol sections of the plans were a focus on recovery and the associated mechanisms of peer support, mutual aid and an asset-based approach. On the drugs side, writing in 2012 the campaigning organisation The Alliance had gained the impression that "in a number of areas across the country providers and commissioners seem to be struggling to interpret 'the recovery agenda' as anything other than service rationing, coerced reduction and detoxification and a new reliance on unfunded self-help groups to provide post-detox support." Whether this impression was due to the situations of the people who contact The Alliance for help or respond to their surveys, or reflects a general picture, is impossible to say, but reports of methadone maintenance being curtailed in the name of recovery are common.

Alex Boyt, a drug service user coordinator in London, is closer to the ground than many commentators and researchers. Prompted by a steep rise in drug-related deaths in England, in 2014 he asked, "Is the recovery agenda killing people?" His answer was, "You have to think in places it probably is." Reasons were that "People who used to be held by the treatment system are now confronted by goals for integrating into society the moment they make it through the door ... usually with an implied or overt requirement that prescribing is dependent on engaging. When successful completions (often code for getting off your script) became the focus, one of our local service managers said 'we have to get them in and out before we get to know them'." If this is the case, it would cast a worrying shadow over the claim in the Conservative Party's 2015 election manifesto to have "reformed drug treatment so that abstinence and full recovery is the goal, instead of the routine maintenance of people's addictions with substitute drugs." One side of that equation – curtailing treatment – may be happening, but perhaps not recompensed by widespread gains in the achievement of "full recovery".

There are also stories of whole-system reorganisation prompted by the policy turn towards recovery which truly do seem to embody the best of a recovery orientation. An example comes from Scotland where a wholesale redesign of services in East Renfrewshire to orient the system towards recovery was based on client and worker views and evidence on local provision and outcomes. Published in 2013, the plan predated the withdrawal announced early in 2016 of £15.4 million from the central pot for funding drug and alcohol services in Scotland.

Issues

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Issues

Among the issues raised by the recovery agenda are the fundamental one of whether we accept repeated and widespread post-treatment relapse as a sign of the intractability (or as US guidelines have it, the persistence of drug-induced brain dysfunction) of addiction, or a sign that treatment, commissioners and planners have failed truly to embrace the changes needed to reorientate to recovery. If treatment does make these changes, how many fewer patients will we be able to afford to treat, and will that be counterbalanced by greater success in closing the revolving door of treatment re-entry due to relapse? Is it simply beyond the reach of any feasible treatment service, even with partner services, to create environmental changes of the magnitude required to make recovery (as commonly conceptualised) the norm, such as the changes which led to rapid, widespread and lasting remission from heroin dependence among US Vietnam War returnees? Must we set our sights lower, and ameliorate while we seek usually only slightly to accelerate the normal processes of remission (tracked in these studies: 1 2 3 4) – or could that prove a self-fulfilling lack of ambition, too close to the 'parking' accusation levelled at methadone services in the name of recovery?

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