

**Harm reduction to recovery:
An exploration of worker perceptions of the 2010 National Drug Strategy**

by

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**Thesis submitted
for the Degree of Doctor of Philosophy**

2018

ACKNOWLEDGEMENTS

To Victoria - your contribution and support throughout this PhD deserves a co-writer credit. You kept me going when I wanted to stop and gave me the support I needed to cross the finish line. I genuinely could not have done this without you, nor would I have wanted to.

To Alex - your arrival delayed the completion of this project but made completing it all the more important. One day I may make you read this, but only if you've been naughty.

To my supervisors: Steve, Tom and Ian – thank you for bearing with me through the era of zero productivity and the era of intense productivity. Your support throughout this research has been fantastic and has been a constant source of motivation. You have always been there for me and I owe you more than words can say. I promise to stop sending you enormous word documents now.

To the treatment providers that allowed me access to their staff and services and particularly to the staff that took part in this research – I know how busy you all are and the time you gave me was invaluable.

To Kevin Lawton-Barrett – for inspiring me to pursue this career and supporting me throughout.

To Jo Mockeridge – casually saying “that sounds like the new penology” blew the doors off this research.

To Martin O’Neil – you have constantly supported me throughout this research by being a sounding board and a voice of support. You believed in me when I didn’t. Thank you.

To Alice Cooper – your battles with addiction made me interested in the subject and your music provided the soundtrack for much of this research and to my life in general.

To my parents and grandparents – you have supported, inspired and educated me throughout my life. The person I am today is the person you made me. Just in case anyone needed to know who to blame.

Abstract

In the 2010 National Drug Strategy (NDS) the coalition government outlined their vision for reimagining drug treatment for the approximately 400,000 problematic drug users in the UK. This strategy drew heavily on the recovery model of treatment that was already being used within Scotland to reported success. It was argued that this model would increase the successful outcomes of treatment by encouraging those within treatment to become abstinent from drug use and to reengage with the community. In parallel with the coalition vision of the 'Big Society', the new treatment model would also work with communities to ensure reengagement and meaningful life post-addiction, encouraging a social life outside of drug use and a return to work. Coupled with this change in treatment model, the government also started to trial 'Payment by Results' (PbR) pilots throughout the UK, with payments for the service provider made on the basis of the client leaving treatment and meeting a number of criteria. In the preparation for the reform of the treatment services, those administering the treatment were not consulted by government before the reforms were implemented and are largely absent from academic research into recovery itself.

This qualitative research explores the views of drug workers, employed in three different sites within one local authority area, in relation to changes to the recovery model of treatment. Within these sites, accounts from 26 practitioners including treatment centre managers, locality managers, commissioners and front-line drug workers were generated using semi-structured interviews to gain an insight into their perceptions of recovery and their relationship with the 2010 NDS. This research found that all workers supported the recovery model to an extent, with abstinence seen as being a more positive outcome than is reflected within existing research. There was less support for the measures of successful treatment, with most workers from all sites viewing measures of success within drug treatment as lacking rigour and being open to abuse by treatment providers. There was some evidence that this was seen to be a problem that was eliminated by the PbR system, with workers feeling that their results were more accurate given the additional scrutiny that PbR brings.

Overall, this research demonstrated a broad support for the principles of recovery, with workers uniformly supporting abstinence as a goal and the broader focus of recovery being seen as a step forward in treatment. This thesis concludes with a summary of the findings and recommendations for policy and practice.

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Abbreviations

| | |
|-------|---|
| AA | Alcoholics Anonymous |
| ACMD | Advisory Council on the Misuse of Drugs |
| ATR | Alcohol Treatment Requirement |
| BBV | Blood Borne Viruses |
| CA | Cocaine Anonymous |
| CfPS | Centre for Policy Studies |
| CPD | Continuous Professional Development |
| CSJ | Centre for Social Justice |
| DANOS | Drugs and Alcohol National Occupational Standards |
| DDU | Drug Dependency Unit |
| DIP | Drug Intervention Programme |
| DRR | Drug Rehabilitation Requirement |
| DWP | Department for Work and Pensions |
| NA | Narcotics Anonymous |
| NDS | National Drug Strategy |
| NTA | National Treatment Agency |
| PbR | Payment by Results |
| PDU | Problematic Drug Users |
| PHE | Public Health England |
| QCT | Quasi-Compulsory Treatment |
| TOPs | Treatment Outcomes Profile |
| TTP | Trust the Process |
| TUPE | Transfer of Undertakings (Protection of Employment) |
| UKDPC | UK Drug Policy Commission |

Chapter 1: Introduction

1.1 Introducing the researcher

I never intended to write about drugs or drug treatment. When the 2010 National Drug Strategy (NDS) was released I was working as a Drug Intervention Programme (DIP) worker and was in the process of searching for a potential PhD subject. I had been working in this role for nearly two years and had finally started to understand the purpose of my role and the motivations and needs of the drug users that made up the local population. I started in the criminal justice system working for probation whilst an undergraduate and had moved on to work for DIP at the end of my Master's degree. My history of working for Probation certainly informed my approach to working in DIP, with close collaboration with the Police and Probation underpinning my own approach to drug treatment. I very much accepted the harm reduction rhetoric and worked hard to secure prescribing and treatment for as many clients as I could. Looking back, I can now see I very much subscribed to the "quantity is better than quality" approach to treatment with my main goal to get as many drug users into treatment as possible. This was in part driven by the national targets for arrest referrals, a belief that being in treatment was safer for the client and my own competitive desire to be 'the best' (whatever that means now) at my job. In hindsight, I was very much a product of the political climate of the times, with my focus on drug treatment, prescribing and engaging clients in treatment reflecting the government position on addiction. Then the 2010 NDS was launched by the coalition government and it seemed to undermine everything I thought was important about treatment. I finally had a subject, I had something to fight against, to be interested in. I wrote my proposal, started my research and now I am here. I am not the same person who was outraged at the proposed changes to treatment, but they exist in the writing of this work. They need to be addressed.

I have included this section within my PhD as a method of demonstrating my mind-set at the outset of the project, my own biases and predetermined ideas about what this project would show. As well as my own foolishness and arrogance at daring to presume I knew my

colleague's beliefs and how they would react to changes within our industry. Suffice to say, these ideas were nothing short of fundamentally changed by this research. To say that my own perspective has changed is an understatement, but I feel it is important to see the biases that originated this project as they demonstrate both the origin point of the research and my own starting point as a researcher.

1.1.1 The researcher and recovery

Reflecting on my time as a drug treatment worker, I can now see my first impressions of recovery were cynical and borne entirely of a prejudice that treatment was something done to a client for their own benefit, rather than a collaboration between worker and client. I had watched Russell Brand's documentary on recovery¹ and whilst I found it interesting (and Brand himself funny), I felt it missed the point of treatment. I felt it also misrepresented the relationship between people in positions of power (workers) and drug users themselves. My own experience was of disillusionment with false promises and broken treatment plans, that clients would promise the world if it got them into treatment and then would do what suited them. The concept of clients actually wanting (rather than saying) to be drug free was alien to me. I viewed Brand's ideas as cloud cuckoo land, promises made to a famous man with a camera rather than any deeply held desire to change. Given the context of this project, I see this belief as a natural by-product of the client/worker relationship, particularly the power dynamic between worker and client. My own understanding at the time was that clients would tell you anything that they thought you wanted, if it secured them something (usually access to treatment or a community sentence rather than jail). To an extent this is a belief I still hold, although I now recognise this is borne of the power disparity between worker and client rather than an inherent dishonesty of drug users as a whole. What I then viewed as dishonesty, I now see is part of a coping strategy for drug users that serves as a way of negating or equalising the power disparity between themselves and the worker as well as an

¹ Russell Brand "From Addiction to Recovery" (2012)

effective method of negotiating the intimidating process of treatment. I also noted the lack of worker input into the 2010 strategy, even within the consultation phase workers were a minority view, with clients and service providers given primacy. This was a view that was echoed by my colleagues who encouraged me to redress the balance through my research. As I started outlining the project, I viewed this as a well-intentioned but ultimately misguided attempt to change the system of treatment. My own research sought to rebalance this discussion by including the workers and their views on treatment; it would serve as a counter-weight to the client-centric recovery model. By 'telling it how it is', I could influence the discussion surrounding treatment. I could stop people meddling with what they did not understand. Then I read Gyngell's (2011) paper.

This was one of two major turning points for this project, before it even started. It turned what had started out as an attempt to (naively) balance the commentary away from the client and back toward workers *and* clients, into an attempt to fight against the elimination of drug treatment. In reading the paper, I saw outlined the clear desire to use recovery to eliminate community drug treatment, to promote AA/NA to be the local form of treatment and to fund small detox communities with the benefit payments of the clients themselves. Government input would be minimal and the financial cost to the tax-payer would be negligible. Within the paper was the quote from Kirkwood (in Gyngell 2011) that would serve as a key point of the project: that drug workers were the impediment to truly adopting recovery as the model of treatment. This project then changed, it became less a rebalance and more a fight to give voice to those that were not represented in this paper. A voice to those who were seen as the only impediment to the removal of community drug treatment. A naïve belief that a) this research would do anything to rebalance the voices surrounding drug treatment and b) that Gyngell's paper was seen as being a dominant voice on drug treatment simply because it was published by a think tank. As I write this now, this seems foolish but at the time it became a key motivation in refining the scope of the research.

As the research progressed, I started to work within a recovery oriented treatment project and I saw recovery upfront. I started to see that recovery was not the elimination of drug treatment, but was a method of justifying cuts in treatment. Treatment end dates and ensuring clients knew their treatment was limited became the focus. Fixed treatment models and an erosion of worker discretion also became the norm. It was in this setting that another experience would also change the direction of this study. I worked with a client who had missed his follow-up appointment upon being released from prison and we had not been made aware of his release (not uncommon). He presented to the service ten days after release and now reported using around £100 per day of heroin. Usually, this would not be a problem and we would be able to get him prescribed within forty-eight hours on a minimal dose of methadone and then build up his dose until he stopped using. I left the client in the waiting room and went to find out when he could get seen by a doctor. I was told that under the new model, he would now need to attend a “motivational” group on the Friday and then would be allowed to see the doctor the next time a slot became available. Under our new model, it was important to ensure the client ‘wanted’ recovery, hence the motivational group. However, because of the popularity of the doctor sessions, he could not see the doctor the following week and would not be permitted to travel to another service centre (as was the usual policy) as that was not permitted under the new model (there was now no money for a travel warrant). I pointed out that this man was at high risk of overdose and could potentially die if not seen soon. I pointed out that we had a duty to help him reduce his harm and to get into treatment (as far as I was concerned, this was still a key component of our jobs). I was told not to be ‘overdramatic’ and that this was all that could be done under the new model, that he was free to attend the drop-in NA sessions that ran every day. I was also informed that he was likely to ‘kick off’, so I needed to see him in the waiting room and not let him through the security door. I had never felt so exposed, telling an increasingly distraught man (in public and with a braying audience) that there was nothing I could do for him now and that he needed to come back on Friday. I escorted him from the building and watched him slump in the street crying. For the first time in my working career, I could not offer him

meaningful support or any words of encouragement; I was powerless. All of my own agency stripped from me and replaced with bureaucracy. I never saw that man again. Suffice to say he did not attend the 'motivational group' on the Friday, nor did he access treatment in the time between this incident and my leaving my job. If he did suffer a drug related death in that time I would not have known, as we never formally had any dealing with him. His treatment by us and therefore his measurement within our records would have been entirely based upon his attending the group. That he did not attend meant that he was not recorded as having contact. Essentially he didn't exist. This incident reframed my research design and I returned to my previous view that recovery was being used to undermine the foundation of community drug treatment. A belief I would hold until part of the way through the interview process.

1.1.2 The researcher and Payment by Results

During my career, I did not work within a Payment by Results (PbR) service, so my own impressions were formed on the outside. Suffice to say that I (like many of my colleagues) was not impressed with the concept and held it in (at best) contempt. Throughout the generation of this project I was convinced in my own belief that PbR was bad for treatment and that it would be held by the other workers. The interview questions were specifically designed to allow the interviewees to discuss their views of PbR, by being as open as possible. It was hoped that this would allow them to speak freely about PbR and to allow any criticism of the method to arise. It will spoil nothing of the research to follow to say that this was an assumption that was most incorrect and my own opinions most changed. Writing this now, I am most thankful that I took the approach to let the workers speak freely and did not allow my own biases to inform the interview process or questions. The results presented here are a testament to the candour that the drug workers spoke with in that my own initial views and expectations were not reflected within their opinions and answers.

I present this small introductory chapter as a means of explaining my own place within the research, the biases and expectations that were baked into the creation of this work, the preconceptions and motivations that fuelled the early portion of this research and the challenges and difficulties that the interpretation produced as a result of holding those beliefs. This research has been challenging to my own pre-conceptions as a researcher and as a former drug worker, but has also been a valuable process for personal and professional growth.

1.2 The research

This research takes place in the aftermath of the 2010 NDS and the ascendance of the recovery agenda within drug treatment. It takes place in three anonymised treatment areas, two recovery areas: (one of them Payment by Results) and one harm reduction area. The data was collected via twenty-six semi-structured interviews of various lengths, all of which were recorded and transcribed. It is the aim of this research to explore the relationship between policy and practice within drug treatment, particularly the relationship between treatment outcomes and definitions of recovery.

1.3 Outline of the research

Chapter two begins by introducing the historical perspective of drug treatment, using literature to analyse the key features of the development of British drug treatment. Whilst largely chronological, this chapter will look at the key developments within this field and how these shaped, and were shaped by, policy, actions and public opinion. This chapter will start to introduce a key theme within this research: that of the influencing speaker. This chapter will start to discuss the influence of disciplines, actors and theories on the structure of British drug treatment from the formation to the 2010 NDS. By understanding the development of treatment in the UK, it is possible to see the influence of outside speakers such as temperance groups, medical practitioners and drug users themselves, to visualise the historical formation of recovery as a concept and how this came to become the dominant

viewpoint of the 2010 NDS. It is felt that by understanding the historical development of British drug treatment (in broad terms), the reader will be better placed to discuss the influence of speakers (and the rise to prominence of those speakers) on the workers themselves, as will be addressed in chapters five, six and seven.

This chapter will also deal with the concept of recovery and how this came to be the dominant voice of the 2010 NDS. By looking at the growth of recovery as an outcome of treatment, the chapter seeks to prompt questions as to what recovery is and how/if it is possible to measure a self-determined outcome. The perceived opacity of recovery as a concept will be drawn upon throughout the research, with definitions and key components explored with the workers interviewed. In forcing the reader to question the definition of recovery and by presenting differing opinions on the nature of recovery, it is felt that the worker definitions given in chapter six will be more familiar.

This chapter will conclude by looking at the organisational influence on worker opinions. This is again a theme of this research, with organisational pressure and the routine activity of work found to be influential in the formation of the opinions of the workers interviewed. In this section, the concept of workers having monolithic opinions on treatment and addiction is challenged and the concept of professional identities is explored. Again, this is a key component of the research, with academic and sector discussions shown to view workers as indistinct groups, with shared values and shared ideas of what is and is not good treatment. This chapter represents the first challenge to this ideology, a theme that is explored throughout the analysis chapters and ties in to one of the founding reasons for this research, as shown in section 1.1.

Drawing on the discussion of managerialism and the influence of the 'new penology' begun in Chapter two, Chapter three will look at the relationship between neo-liberalism and drug treatment. This chapter will particularly focus on the relationship between the managerialism of drug work and how this has changed the treatment offered by treatment providers. This chapter will discuss the role that neo-liberalism has played on the changes in drug treatment under New Labour and then into the coalition period. It will then discuss how these changes have led to the 2010 NDS and how the recovery model of treatment represents a continuation of the neo-liberal and neo-conservative balance within policy. In the latter half of the chapter, the 'new penology' is reintroduced and applied to drug policy, with treatment outcomes and risk management discussed in detail. This chapter sets out a theoretical framework of understanding that is utilised within the rest of the thesis, but particularly within Chapter five where treatment outcomes and the managerialism of drug treatment are discussed in detail. Neo-liberal approaches to social policy will continue to be referred to throughout the thesis, and this theoretical framework will be used to critically discuss the formation of knowledge by drug workers.

Chapter four presents the methodology of the study and introduces the Foucaultian perspective of designated speakers within discourse. The chapter addresses my status as an insider researcher and the process by which I transitioned into becoming an outsider. This discusses the benefits of being an insider within research but also how this status can impact on the data collected and the interpretation of the data. It discusses the journey of the research and how the change from insider to outsider researcher affected areas such as: perception of the research questions, access to respondents and the interviews themselves. Within this chapter, the research questions will be developed and linked to the methodology with the theme of exploring worker experiences being central to the discussion. In this discussion, the demographics will be examined, including themes and trends in respondent data, as well as how the three sample areas were selected. This chapter will build toward the

reader understanding the purpose of the methodology and the reasoning behind the decisions made with regard to method type, sampling and research questions.

Chapter five is the first of the results and discussion chapters and discusses the role of outputs, Payment by Results (PbR) and their interaction with recovery and treatment. This chapter was chosen to lead the results chapters due to the importance of outputs in the discussions in the other two chapters. The importance of treatment outcomes on the definition of recovery became clear during data analysis and is impossible to separate from the other discussions. As such I have positioned this chapter first, by virtue of the other data chapters referencing material contained within it. Without this chapter being discussed first, there would be a lack of context within the other chapters that would impede the depth of the discussions within those chapters.

Chapter five addresses worker perceptions of treatment outcomes, particularly referencing the Treatment Outcomes Profile (TOPs) form that is completed throughout treatment. The use of the TOPs form is cited as being important throughout the sample, with the origins of measures of success being discussed by all groups within the sample. With part of the sample being under the PbR payment structure, this method of funding is discussed in detail, with workers from all treatment areas offering their opinion of the method and how it relates to recovery. Overall, this chapter will discuss the formation of measurement and how these measures impact upon the practice of the workers and their perceptions of the policies that are assessed with the measures.

Chapter six investigates the workers' relationship with recovery as a concept, particularly addressing the orthodoxy that workers are harm reduction focussed and thus will discount

recovery as a valid treatment model. This chapter starts by addressing the workers' relationships with harm reduction, discussing their relationship with harm reduction as a treatment model and their attachment to the key components. The relationship with recovery is developed by first looking at personal definitions of recovery, including material discussed in the literature in Chapter two. This is then compared to the organisational definitions of recovery, to analyse how workers relate to recovery within their workplace. Here, discussions of professionalisation are developed and defined, with the workers setting out their definitions of organisational culture, which build on the ideas discussed in Chapter two.

Chapter seven builds on this notion of organisational culture further, investigating the influences that workers consider important when researching drug treatment. In the initial design of this research, it was expected that the workers would discuss those people and institutions that were important to them and their formation of knowledge. However, in the data analysis, it became clear that the formation of knowledge was influenced by the process through which they gained the knowledge rather than the speakers themselves. This chapter therefore addresses the ways in which the workers build their knowledge, discussing the process of education, research outside of work, personal experience and in work experience to piece together a discussion as to what is important for worker knowledge creation and potential future impediments. This chapter draws on material from the previous two results chapters, drawing together the concepts of outputs and measures of effectiveness with notions of recovery to explore how workers form their knowledge. In drawing the material together from the previous chapters, it is possible to see the formation of worker knowledge and how policy decisions influence the knowledge creation surrounding recovery.

Chapter 2: Literature Review

2.1 Introduction

Drug treatment is one of the two pillars in the worldwide fight against illicit drug use. Along with prohibition/enforcement, drug treatment is seen as being valuable in helping those that are victims of drug addiction (Stevens 2007 and UNODC 2003), with the NTORS study demonstrating the relationship between drug treatment and a reduction in drug use (Gossop et al 2002). Whilst the type of preferred treatment is contentious, with commentators from various disciplines offering advice on what should and should not be the preferred method of treatment, treatment itself is generally seen as being necessary to help someone escape from addiction (Neale et al 2013). Research into the effectiveness of treatment is difficult to assess, with the sheer quantity of individual factors present in each case making scientific evaluation difficult if not impossible (Miller and Dunlop 2011).

Research into treatment has generally been quantitative and from the service provider perspective, with government measures (such as the Treatment Outcomes Profile (TOPS) form) being quantitatively assessed for trends and successes (Neale et al 2013). Generally, it is held that for every £1 spent on treatment, £3 of savings are made through health, criminal justice and benefits savings (Gossop et al 2001), but there is no consensus on which methods of treatment offer the best results. In fact the value of £3 per £1 spent is also grossly misleading given the disproportionate value attributed to material goods lost to acquisitive crime (Connock et al 2007) and the lack of inclusion of existing treatment spending, thereby almost halving the cost of treatment in the 3:1 scale (Ashton 2007). This valuation is further complicated when we consider the 'value' attributed to natural ageing out of crime which can coincide with treatment, thereby clouding the picture of the value of treatment to society (Stevens 2007).

There is also no real consensus on whether drug treatment even offers benefits in reducing criminal behaviour, with studies like Bachus et al (2000) finding that being drug free does not necessarily represent a change in offending behaviour. Whilst there is research that finds a weak link between drug treatment and criminal desistance (see Hough 1996), there are problems when trying to directly compare the two variables. Much of the research into drug treatment focuses not on the treatment itself or on the dissuasive effect of treatment, but on the outcomes and best practice on how to achieve them (Webster 2007). It is much easier to study which treatment achieves the most measurable results rather than which generates the best results, further deepening the information gulf that policymakers must navigate. This has placed policy makers and drug treatment agencies in a difficult position, as whilst we can be sure that treatment is a morally and practically useful activity for society, we cannot be sure what activities achieve the best results (Howard 2007).

This is a phenomenon that is not limited to the UK; indeed worldwide drug treatment is driven by a desire to do good work, but is limited by an inability to create a consensus as to what 'good' is. Ultimately, this has led to a series of ideological debates over which treatment is the most 'moral' as well as which methods are the most effective. Whilst there is consensus that drug addiction needs to be tackled using 'social intervention and treatment', there is no consensus on what either of these terms mean, let alone how to implement them (Webster 2007). This confusion about terminology and action is at the heart of this piece of research with my own experience of working within drug treatment being one of disparate approaches and outlooks being marketed under the umbrella of cohesive treatment, and muddled official terminology being left to interpretation at 'street' level by drug workers.

2.2 The historical context of drug treatment in the UK

It is impossible to discuss the current landscape of drug treatment without acknowledging the methods and inspirations that came before it. The 'bed we made' historically, still has

ramifications for drug treatment today, with political structures as well as treatment responses being hamstrung and constrained by decisions made decades ago (Mold 2008). It would be impossible to give a fully realised historical perspective on the formation and implementation of UK drug policy within this thesis, but it would be remiss to discuss the formation and implementation of drug policy in the UK without some discussion of the historical background to those policies. This chapter draws from existing original research on the history of drug policy in the UK (see Berridge 1999 and Mold 2008 as examples) and serves to offer the background to UK drug policy formation and implementation. It will demonstrate the consistent throughline of British drug policy: the collaboration between medial and criminal discourses within the formation and implementation of policy.

In many ways it could be argued that society is still using rhetoric from the 20th century to define a problem that has so fundamentally changed that the answers we use no longer fit the questions asked. Yet this rhetoric is so prevalent in policy decisions and public discourse that without understanding the historical context of these arguments it would be impossible to discuss the present. In fact, Stevens (2011a p.86) goes as far as to describe drug policy as being an “ideological tool”, meaning that policy itself is driven by public opinion and most crucially public understanding of drug use. Nutt and Macken (2011) take this further, arguing that recent changes in policy have relied upon ‘lazy’ public opinions on drug use rather than empirical research, which is further supported by former government advisor Julian Critchley, who described policy as being mainly influenced by “tabloid irrationality and not by reference to evidence” (Mark Easton Blogsite 2008 cited in MacGregor 2010). Politically, the 20th century was defined as a series of ‘wars’, both physical and ideological, against Colonialism, Fascism and Communism to name a few. One of these ‘wars’ was the war on drugs, a push to move away from the normalised recreational drug use of the upper classes in the late 19th century toward a more puritanical abstinence from all mind altering substances (Stevens 2007).

2.2.1 The pre-twentieth century

In order to understand the development of drug treatment in the 20th century, it is important to understand the context of drug use in the 19th century. In this period, opiate trading was legal and was used as a method of purchasing desirable Chinese goods from an unbalanced market, where British goods (and indeed all Western goods) were not considered valuable (Stevens 2011a). The trade in opium to China from British controlled India allowed British companies to effectively trade Indian opium for Chinese goods, despite the illegality of importing opium into mainland China. This led to bastions of British trading, such as the East India Trading company, having to trade indirectly with Chinese smugglers (through intermediary British shipping companies) in order to sell their wares in China (Webster 2007). This process was supported by the state, with the British Empire going to war on two separate occasions (1839-42 and 1856-58) in the Opium Wars in order to secure trading routes and prevent the Chinese from 'unreasonably' attempting to control imports of opium. Ultimately, these wars led to the annexation of Hong Kong from mainland China (as a stable port for British trade) and a relaxation of Chinese import laws on opium (Stevens 2011a). The resulting flood of opium (by 1860 British imports of opium was around 60,000 chests or 3,750 tons per year) coupled with improved trading routes within China meant that opium addiction, which was already a problem prior to the flood, reached critical levels (UNODC 2008). With members of the ruling classes and the imperial army affected and the running of the country put at risk. Although the trade in opium reduced over the latter part of the 19th century, the resulting foreign (mainly Western) influence in China directly led to the Boxer rebellion. The prohibitive sanctions and reparations that resulted led directly into the fall of the Qing dynasty, Communist uprising and the development of the current Chinese state. Whilst it would be reductive to consider opium as the main catalyst for these major changes it is fair to say that British influence that resulted from this trade (and the military action that sustained it) was a major contributory factor. Given that British military action in Afghanistan in the early 21st century was partially in order to curb the trade in opium (and therefore

heroin), it is sobering to realise that just over a century ago the largest drug dealers in the world were British and supported by the might of the British military (Stevens 2011a).

The process of using state military strength to force an illegal trade on another nation is unthinkable now, with state resources usually being directed at disrupting illegal trade, or political pressure (rather than military) being used to open up resistant markets to legitimate trade. However, this type of action was indicative of the prevailing opinion on drug and alcohol use in the UK at the time, with trade and dominance of the military being the foundations of the British Empire. The relaxed attitude to opium trading also extended to opium smoking in the UK, with opium dens reflecting a relaxed attitude to drug taking that seemed to fly in the face of the modern understanding of Victorian Britain as being prudish. Normalised drug taking was not limited to just opium, but also coca, mescal, cannabis and following the invention of the hypodermic syringe in the 1840s, heroin and morphine (Mold 2011). Tea, coffee and tobacco were also introduced to the workplace as a way of improving productivity, in a trend still common today. Drug use was not limited to the upper and the (relatively) newly established middle classes, as working class people used drugs to alleviate pain and cure disease. Quackery and faux-science mixed freely with academic sciences, producing lotions and tinctures designed to cure a raft of illnesses without any real scientific backing. Opium (in the form of morphine and heroin) was a staple of many such remedies, as were alcohol and cocaine, often forming a cocktail of drugs that was more lethal than the illness being treated (Berridge 2005). An example remedy is Ayer's Cherry Pectoral, which was advertised as being a remedy for coughs, colds, influenza and consumption (as both a cure and a palliative medicine for late stages) and consisted mainly of morphine and grain alcohol in quantities that would be considered poisons rather than medicines by today's regulations (Olson 2006). This normalisation of drug use, plus the prevalence of cheap and strong alcohol (usually in the form of gin) meant that Victorian Britain had a greater substance abuse problem than would seem likely given the period's

prudish and conservative reputation. When you look at popular culture though, this permissiveness of drug and alcohol use is more visible, with writers such as Conan Doyle and Dickens making drug use a normal (and a generally uncommented upon) behavioural trait of central characters and the seemingly on the nose parable of drug use in Dr Jekyll and Mr Hyde (Cannon 2013). In order to attempt to control the levels of opium in circulation and to move drug users under the control of the medical profession, the 1868 Pharmacy Act prohibited the sale of opium based products unless through a pharmacy (Berridge 2005b & Shiner 2008). Despite this, opium remained easy to purchase with pharmacists offering ready-made opium laced concoctions, such as those made by Ayer for the lower classes and pharmacist prepared bespoke remedies for the richer patrons. The Act merely made procuring drugs (theoretically) more expensive and offered little support for those in the grip of addiction. The Act itself was subject to a number of exceptions and such limited enforcement that death rates for opiate use were actually back to being higher than pre-1868 levels by the end of the century. This indicates that whilst the legislation was there, desire to enforce said legislation was weak, possibly indicating that whilst politicians wanted stricter enforcement, public desire for enforcement was not as strong. The Act still served an important role though, shifting the narrative around opium sale such that it required professional oversight and that drug use (albeit focused on opium) should be controlled through the state (Berridge 1999). This was the first step towards prohibition, with the state now overtly involved in drug control and political opinion on who is and is not allowed access to narcotics overcoming public freedoms.

2.2.2 The temperance movement

In the mid-19th century a movement evolved pushing for abstinence from all mind altering substances unless being taken as a form of medicine. Although primarily focussed on alcohol, the temperance movement pushed for rich and poor alike to abstain from 'excesses', mainly alcohol and drug use (Mold 2011). This was aimed at getting the population as a whole to live a cleaner and more God fearing life. Heavily tied to the

Protestant tradition of forgoing pleasures of the mind in order to maintain the purity of scripture, temperance grew as a movement in the UK and USA during the late 19th century particularly amongst the working class who were especially affected by the excesses of alcohol (Berridge 2005). Whilst not as influential in the UK as the US (the UK movement never resulted in the sustained prohibition of alcohol for example), the temperance movement did become an influential pressure group on government, in part due to persuasive and effective lobbying of politicians. In 1854 the Sales of Beer Act restricted the sale of beer on Sundays, but the resulting riots meant that the act had to be repealed. The impact of the movement on the British people was more significant, with cartoons such as Cruickshank's "The Bottle" being used to push a political agenda through popular culture and introducing the idea of 'normal' levels of drug and alcohol use to the population. The narrative of 'excess', 'rock bottom' and then 'recovery' to a state of 'normal' ("the addicts arc") stems from this era and from the moralistic discourse of the temperance movement (Cannon 2013). Whilst never managing to get a full ban on the sale of drugs and alcohol, the temperance movement represented a critical change, whereby drug and alcohol use was now a political and moral concern rather than simply a personal choice. The morality surrounding drug use remains central to the arguments around what is and is not 'good' treatment, with the morality of sustained drug use continuing to be discussed with regards to British drug policy (see McKeganey 2011c for a 21st century discussion). Whilst it is impossible to directly identify the temperance movement in the current discourse surrounding drug treatment, the discussion of morality and in particular the role of morality in the AA/NA model is still central to the drug treatment discourse.

2.2.3 The medicalisation of addiction discourse

The late 19th century saw laws passed that would attempt to pass the drug and alcohol addicted into the care of medical professionals and define addiction as being a medical illness. The 1890 Inebriates Act and 1890 Lunacy Act sought to place drug and alcohol addicts under the control of medical professionals, with the Lunacy Act allowing the setting

up of asylums for the treatment of 'lunatics' (Webster 2007). Prior to this Act, paupers declared mentally ill, which would have undoubtedly have included drug/alcohol users, would have been sent to workhouses, prisons or houses of corrections. This Act allowed the state to incarcerate those deemed to be 'lunatics' and to attend to their treatment, thereby representing a coalition between the politicians and the medical profession and a merging of the political and medical within drug policy (Berridge 1999). Whilst this approach did not specifically address addiction, it could be used to incarcerate those whose addiction was most problematic. The updated 1898 Act allowed the state to set up 'inebriate reformatories' which could be used to treat those who were engaged with the criminal justice system rather than send them to prison (Mold 2018). In this way the 1898 Inebriates Act represented the first attempt of the state to use the criminal justice system to control the addictions of drug and alcohol users. Whilst the Act gave the power to local authorities to purchase land and build reformatories, there were only two such buildings constructed: one at Warwick prison for men and one at Aylesbury prison for women. These reformatories took a similar approach to rehabilitation that was popular in borstals in the 1980s, in that the regime and routine was harsh and built to provide long-term behavioural change that would 'fix' the deviant behaviours of the inmates. Similarly, the reformatories were built in picturesque country settings that removed the inmate from the urban setting, allegedly a cause of the 'intemperate' excesses that caused addiction (Hunt et al 1989). As Mold (2018) argues, this method of dealing with addiction served the purpose of dealing with individuals with problematic addiction, but not the wider public health implications of substance misuse. Whilst this was not the first instance of state control being used to control illicit drug use, it did represent a melding of state-based control with medical knowledge. This bifurcated approach would attack drug use from two polar opposite moral standpoints: the medical model that addiction was a disease and should be treated, and the criminal justice model where addiction was a vice and needed punishment (Shiner 2008). As the twentieth century begins, it is possible to see the foundations of much of the treatment approach that lingers today, particularly in the crimino-medical approach taken by the state and the tensions that

this approach would cause within British drug policy (Duke 2013). However this is also seen in the discourse itself, with words such as “addiction” and “alcoholism” developing meaning and entering common parlance (Berridge 1999 & Mold 2018) in part through the influence of medical professionals on a field previously dominated by morals.

By the early twentieth century opiate shipments from India had slowed, in part due to the west no longer needing opium to leverage deals with the Qing government. By the start of the First World War the UK government were looking to outlaw the possession of cocaine and opium, rather than the inebriating effect and associated behaviours. In part this was because of the ‘cocaine epidemic’ effecting the army at the time, leading to soldiers on leave causing crime and potentially undermining the ability of the army to dictate the course of the war (Berridge 1999). Because of the military connection, the substances themselves became the focus of criminal sanction rather than the effects of consumption. The 1916 Defence of the Realm Act was pushed through at the height of the First World War and fully criminalised the use of most drugs. Crucially though, the focus was placed mainly on those supplying the drugs rather than those consuming them, leading to high-profile cases involving drug supply to members of the armed forces (Mold 2008). This Act was supplanted by the Dangerous Drugs Act of 1920, but by this point international agreement had been reached that drug trading would be legal only for legitimate medical purposes (Mold 2011). By criminalising the unauthorised possession of cocaine and opium the UK government flipped their position on drug use, changing from uncontrolled legalised trade in drugs in the mid-19th century (such that the government were willing to invade another sovereign nation), to an outright ban on the same drugs just over fifty years later. This represented a wholesale rejection of the concept of controlled legalisation of cocaine and opium use, but other addictive substances (notably alcohol and tobacco) remained under controlled legalisation. It could be argued that this leniency stemmed from the riots of 1854 following the ban on alcohol, or that the banned drugs would be those needed for the war effort and

so could not be spared on anything as frivolous as recreational use. Either way, Webster (2007) argues that the timing of the act is also significant, with the UK bogged down in a new type of warfare and therefore in a state of political crisis. Under these circumstances, it is possible that the Act was not based on reasoned debate (from either the legal or medical field), but rather based upon moral determinations on what 'proper' behaviour entailed. Drug use was not 'moral' and as such needed to be controlled. The Act delineated the roles of treatment and enforcement, placing treatment with the Ministry (later Department) of Health and enforcement (eventually) with the Home Office, creating a loose alliance between criminal justice agencies and the medical profession (Berridge 1999 & 2005). The gradual interweaving of drug addiction responses (of which treatment was one) and criminal justice responses naturally pushed toward abstinence as a goal, as criminal sanctions cannot be allowed to tolerate further law breaking (Bean 2002). However, at this point it must be noted that, unlike the USA (which was engaged in a similar process of prohibition at the time), the assumption in the UK was that drug use was limited to the middle classes and a very small population that was mainly limited to London (Shiner 2008 & Webster 2007). It could also be argued that this assumption was influenced by class dynamics, with professionals and the treatment system being focussed on middle class drug use (Mold 2008). Despite creating such a partisan approach to drug use, the Act was seen as a solution to a very small problem. Whilst it could be argued that the act was naïve in its interpretation of drug use, it could also be argued that the problem lay not with the Act itself, but with the continued use of this approach when the number of users increased and the landscape of drug use in Britain changed completely.

2.2.4 The 'British' system of treatment

The 'British' system of drug treatment was formalised in 1924 by the Rolleston Committee (and the subsequent 1926 report they produced) whereby it was proposed that morphine and heroin could be prescribed by GPs to allow gradual withdrawal and a regular supply for those that could not reasonably be expected to detox (Berridge 2005b). This decision was

arrived at as a compromise between two positions on how best to treat addiction and was formed through a panel of medical professionals and outside influencers from the medical profession (Berridge 1999). The first school of thought was that drug use only became addiction over time and that sustained use of drugs would lead to the development of addiction. As such, a short duration detox (in an appropriate medical setting) would remove the drugs from the body of the individual and cure the addiction. The second school of thought was that addiction required treatment via a long duration of maintenance with steady doses of opiates to control the addiction and appease the withdrawal symptoms. The rationale for this was to prevent the patient suffering the pains of withdrawal and to slowly remove the opiates from their system with minimal pain (Mold 2008). The recommendations of the panel were for the introduction of maintenance prescribing of opiates, but that this should be to the end of removing opiates from the patient. Long-term maintenance was an option in particular circumstances, but these were deemed to be abnormal. However, the Rolleston Committee did not solely debate the medical value of proposed treatment, with doctors also offering comment on the moral harms caused by drug use (Mold 2008) and being charged with creating a legal definition that could be used in criminal convictions (Berridge 1999). Again this demonstrates the combined focus of drug treatment and policy in the UK, with morality, criminality and medicine all shown to be working in conjunction.

The resultant British system seemed remarkably tolerant of drug use, given the 1916 Act's prohibition of the possession of opiates (without prescription), but it is worth bearing in mind that the criminal justice strand of the Act was aimed at importation and selling of drugs and not at the 500 known users. Of the 500 drug users, one sixth were medical professionals themselves and thus were very unlikely to be in possession of prohibited drugs without prescriptions or legitimate reasons for their possession. Therefore, the Act was unlikely to criminalise many of the drug users using in the UK at the time and the criminal component was strictly aimed at those importing or selling drugs illegally (Webster 2007). This very small number of users is problematic for a number of reasons. Firstly, this is the number that

both the Rolleston Committee and the government used when considering the UK approach to drugs. This highlighted to them that drug use was a middle-class issue and that it could be controlled by medical treatment. Secondly, the number is problematic as it represents known drug users, which really means those known by their doctor. Given that the establishment of the NHS was more than 20 years away, this meant that the number represented those that could pay to have their drug addiction treated, thereby ignoring those drug users in poor paying jobs or in poverty. Despite these issues, the British system seemed to work, with the number of known users dropping from 500 in 1926 to 300-400 in the 1950's (BMA Board of Science 2013). This system worked to separate the user from the enforcement of the illegal markets not by criminalising their addiction, but the actors that allowed them to purchase unregulated drugs. The narrative was that the drug user was sick and not criminal and as a result should be treated by medical professionals and not punished (Reuter and Stevens 2007). The British system was considered such a success that it remained unchanged for nearly 40 years, until the 1960s changed the landscape of drug use in the UK and signalled a move away from the Rolleston model of treatment (Shiner 2008).

Thus far, addiction treatment had been focussed solely on opiates and cocaine, with little legislative focus on other types of drug addiction. Given the small numbers of opiate and cocaine users in the UK in the 1920s to 1950s the British system made sense, in that it proposed to contain the issue and limit contact with illegal sources of drugs by providing what was needed to either maintain or to detox from drug use. That the majority of drug users were middle-class users whose addiction had come from a habit that had got out of control was also important. In the main, it was understood that these were not people rejecting the system or status quo; they were not radicals who sought to undermine the system, nor were they criminogenic in general outside of their addiction (Mold 2018). There was no threat to social order in their addiction as was the case in the US, as these were working people with middle-class value sets who did not reject work or social order. As such,

the British system was perfect for the small number of drug users that fitted this categorisation. The British system started to struggle when users with poly-drug use or drug use outside of opiates and cocaine, or who were a threat to the social order through their lack of engagement with citizenship and community were introduced (Measham and South 2012).

2.2.5 Other problematic drug use

The growth of cannabis, amphetamines and LSD use in the 1960s amongst the working classes and young people did represent a threat to society, with their popularity amongst subversives and criminals challenging societal norms in a way that 'traditional' addiction did not (Mold 2018). This expansion of recreational drug use amongst young people represented a change in the typology of who used drugs in the UK, moving from middle-class excess to a working-class youth movement. Amphetamines under the street name of 'purple hearts' or 'pep pills' gained the first exposure in the media and were made illegal in the Drugs (Prevention of Misuse) Act 1964 (BMA 2013). The media attention given to amphetamine use was representative of the attention given to all forms of drug use in the early 1960's, with increases in the use of heroin, cannabis and LSD all being given media attention in the early 1960's (South 2007). Cannabis use received additional scrutiny given its links to the hippie and counter-culture movement, making it doubly dangerous to the establishment as it was both deviant in and of itself and was associated with youth deviance that crossed class barriers. The Wootton Report (1968) was published following a Home Office Advisory Committee to discuss what was to be done about cannabis use by young people, again following media reporting of increases in use of the drug by young people and a steady rise in cannabis convictions in the same group. In a foreshadowing of the future of drug treatment, a discussion was had over the appropriate criminal justice response to cannabis use in young people. Yet unlike future discussions it was deemed inappropriate to drag more young people into the criminal justice system and instead the recommendation was for penalties to be relaxed for possession and that casual users of cannabis should not

receive custodial sentences (BMA 2013). The attention given to young heroin users resulted in an interdepartmental committee being convened in 1961 under the chairmanship of Sir Russell Brain, with the remit of discussing whether the prescribing of heroin to drug users was still appropriate. Interestingly, the committee reported that it was entirely appropriate to continue with the British system and that no changes needed to be made as the problem remained small. Yates (2003) argues that it took a long time for heroin and cocaine use to be taken seriously in the UK. With them being heavily associated with jazz music and Hollywood glamour, they were seen by the establishment as being alien to British culture and therefore something that might need to be corrected using methods appropriated from the US. This arguably led to a tenuous satisfaction with the existing British system, albeit with one eye on the US for inspiration should they have a better solution to a problem seen as being inherently American (Brewley 2005). By keeping the threat of drug use as 'other', the UK government missed an opportunity to revamp its drug treatment strategy to meet the new challenges of an expanding drug-using youth population and to tailor its response to the needs of the UK rather than seek to ape the US.

Alongside reports into amphetamine and cannabis use, media reports into a rise in the use of heroin amongst young people focussed on the British system and how exploitation of prescribing rules was leading to an increase in drug use. Despite being given a clean bill of health in 1961 (albeit naively), the British system of drug treatment would be named as the leading cause of increased use of heroin in the UK in the subsequent 1965 committee (Spear 2005). The Brain Committee focussed on the excessive prescribing of a few doctors, arguing that they were responsible for a glut of heroin that was being sold on the street and as a result were directly responsible for the rise in youth use of heroin (South 2007 & Mold 2008). Indeed this was highlighted by Irving "Benjy" Benjamin in the post-Brain reading of the report (Mold 2008). Benjamin, a pharmacist, argued that the number of addicts that he treated was vastly different to the numbers the Brain Committee considered to be accurate

for the UK and lay the blame directly at the feet of prescription-happy doctors. In terms of this thesis, Benjamin represents an interesting historical figure in that he is a frontline worker explaining to those in power the true nature of drug addiction from his perspective and countering the narrative being offered by government as to the true nature of addiction. Despite his enthusiasm, when the number of known drug users (problematic as that number may be) in 1964 (753) is compared to the post Brain Committee numbers (an increase of 4607 in the 1970s), it is hard to reconcile that the only cause of this rise is a number of prescription-happy doctors (Webster 2007). This boom in drug users occurs post-1967 and the passing of the Dangerous Drugs Act, which strengthened the rules surrounding the prescription of heroin and cocaine (BMA Board of Science 2013), indicating that it is unlikely that the source of this opiate boom was a number of rogue doctors, but rather a whole new source of heroin. Instead it was the brown heroin boom of the 1960s that allowed greater access to opiates for those from a lower socio-economic background. This also represented a subtle shift away from trusting medical professionals to deal with addiction, with criminal justice and morality starting to become more prominent voices in this matter.

2.2.6 Community drug treatment

The committee created new Drug Dependency Units (DDUs) that would become the main supplier of prescription heroin and cocaine and take the burden out of the hands of well meaning, but clearly (in the eyes of the committee) compromised GPs. That DDUs were usually headed by psychiatrists indicates that drug use was now viewed as a mental illness as well as a physical malady, with medical discourse branching outside of the physical aspects of addiction. Many psychiatrists were disinterested in treating (prescribing to) young people who they felt were clinically well, which created a problem whereby some young people could not gain access to the treatment they needed because they did not exhibit outwards signs of mental illness (Yates 2003). This movement of discourse and policy into the psychiatric field also allowed for the creation of 'therapeutic communities', DDUs that focussed on talking therapies and were patient led. These communities drew not just from

the field of drug treatment, but also from education and youth offending as well as the therapeutic communities in the US.

The therapeutic communities represented a change in focus for UK treatment. Drawing on their US cousins, they focussed on the idea of 'recovery' from drug addiction and promoted a drug free lifestyle; a goal for treatment which would reappear in the recovery models of treatment that have dominated the second decade of the 21st century. Therapeutic communities would also introduce group work to the treatment process, using the experiences of others to assist a drug user on their 'journey' to recovery. Again, this was ahead of its time, with group working being a staple of modern treatment. Although, it could be argued that this is due to the cost effectiveness of the treatment rather than the effectiveness of the treatment itself. The Brain Committee acknowledged this shift toward mental health treatment and classification of addiction by classifying drug addiction as a 'socially infectious condition' as opposed to being merely a 'disease' as was defined by the Rolleston Committee (Ministry of Health 1965 & Mold 2018). This meant that the rise in use could be attributed to social interaction and positive association with drug users, and as such drug addiction was now a public health issue. Positive associations between young people and drug users was now thought to increase the likelihood of young people taking up drug use, meaning that positive portrayals in popular culture could exacerbate the drug addiction problem. In part this was because of the now accepted linkage between increased consumption of drugs and alcohol and increased problematic behaviour linked to the consumption (Mold 2018). This linkage meant that treating addiction as a public health crisis was now the only logical step, with widespread reduction in use being seen as a reliable method of reducing problematic behaviour. This viewpoint can still be seen within the 2010 National Drug Strategy (NDS), where in her foreword Theresa May states that discussion of legalisation is not possible because of the harms that drug use causes to the community (HM Government 2010). In many ways this statement demonstrates that drug use is still

seen as a public health issue and that a relaxation in prohibition will cause an increase in problematic behaviour related to substance misuse.

The 1971 Misuse of Drugs Act was introduced in part to satisfy the UN 1961 Single Convention on Narcotic Drugs, whereby members were expected to conform on prohibition and conduct a unified fight against the international drug trade (Webster 2007). This also brought in the UN model of schedules of drugs, where harm, as well as medical use determined the 'class' that each drug was placed in. Those in the highest class (class A) would prompt the most severe criminal sanctions when in possession for use or sale. The Misuse of Drugs Act also introduced the Advisory Council on the Misuse of Drugs, an independent body charged with keeping the UK up to date on current trends in drug use as well as giving advice on how to deal with social issues associated with drug use in the UK (BMA Board of Science 2013). This council would provide cross disciplinary advice on the best course to chart with regards to emerging drug trends and would allow the government to base drug policy on reasoned scientific material rather than a dominant discipline being able to drive government policy. The Act would also continue the trend of treatment for users and punishment for dealers by separating out the offences of 'possession' and 'supply', thereby creating a two-tier system for dealing with drug abuse. Dealers would now be subject to the full force of the law, whilst drug users would be cared for by the medical profession. This mirrored the split of treatment to the Department of Health and criminal sanctions to the Home Office that occurred at the beginning of the century. However, much like the original split there was not a clear delineation between punishment and treatment, with the Home Office keeping records on the number of addicts within an area, a function that was supposed to have a purely public health function (Morgan 2014). In order to carry out this role, doctors were now obligated to record and notify the Home Office of people they judged to be addicted (BMA Board of Science 2013). This meant that the 'treatment' arm of the state would be obligated to operate as a form of control and the ostensibly medical data

of how many addicts were located in an area was controlled by the Home Office. Prohibition and treatment are again not easily separated within both policy and practice.

These two roles were also not so easily separated in real life, with drug user and drug dealer often inhabiting the same body, meaning that many of those supposed to be helped, were now subject to stricter criminal justice responses. This Act represented a broader trend in the UK of separating the user from the supplier and also separating the drug user from the crime they commit as part of their addiction. The overwhelming narrative was that these were people with a disease, and not people who were inherently criminal. The UK government were content to keep drug addiction firmly in the field of the medical professional, with discourses dominated by discussions by medical professionals, both physical and psychological. In part this represented an expansion of the public health framing of drug use in the 1960s, with additional measures being taken to control the number of people using drugs and measures of the number of problematic drug users being collected (Mold 2018).

2.2.7 Methadone

Along with developments in treatment, the 1970s also introduced methadone as a method of treatment, replacing heroin as the prescribed drug of choice for maintenance and detox. This is a significant development as this represented a move away from tolerance of drug use and step toward the 'harm reduction' trend that would dominate the next twenty years (Mold 2008). Unlike heroin, methadone is orally administered, meaning that the user no longer needs to inject the prescribed medication. In the 1980s, this was used as a method of controlling HIV/AIDS transmission between injecting drug users and was considered a leading reason as to why the UK had low transmission rates compared to other EU nations. However, in the pre-HIV days of the 1970s, this was not a consideration in the decision to adopt methadone (although Hepatitis was still a concern), with injection and the harms associated with injecting scarcely considered within policy. Although safe injection education started in the UK in the 1960s, indicating that HIV/AIDS was not the instigator of harm

reduction, but merely the catalyst that thrust it to the forefront of drug policy (Brewley 2005). Instead the rationale was to reduce the amount of street level heroin available in the UK, as the official perception was of gullible or corrupt doctors over-prescribing heroin to drug users (South 2002). By switching to methadone, the street level sales would dry up as the high from methadone was much more limited and therefore unattractive to new users or those that wanted to use on top of their prescription. This obsession with the street heroin being from official sources represented a disconnect between the two arms of government in charge of drug addiction and treatment, with both managing to miss the importation of heroin from abroad. This official explanation disastrously ignored the geo-political landscape of the time, missing the real sources of cheap high quality heroin and culminating in the heroin 'epidemic' of the 1980s and an explosion of new users (BMA Board of Science 2013). Methadone treatment also aimed to prevent some or all of the acquisitive crime that heroin users commit to buy street heroin. By stabilising heroin users on free methadone, it was argued that market forces would shrink the size of the illegal heroin market as the profitability would reduce (South 2002). Users themselves would also be sated and would not need to commit offences in order to get drugs. Methadone would serve three purposes, it would reduce the market in illegal drugs, prevent crime and prevent overdose-related deaths. All three of these ideas would come to be challenged within the early part of the 21st century.

2.2.8 The rise in heroin use

The late 1970s saw the opening up of previously closed legal and illegal trade routes, mainly in the East and Middle East. The 'Golden Crescent' region of South West Asia experienced changes in government and opened up to trade from the west, including the trade in heroin from Afghanistan (McDermott 2005). This allowed cheap and pure Afghani heroin to flood into Europe exactly at the time when DDUs were tightening prescribing rules. For users that were not able to access treatment, this meant easy access to high quality heroin and for the first time a real alternative to prescribed medication. The quality of the heroin meant that it was capable of being smoked in a manner reminiscent of opium in the Victorian era rather

than injected as was usual with heroin. This reduced the psychological barriers historically associated with heroin use and a myth was perpetrated that 'chasing' heroin was not addictive (Yates 2002). These two causes are cited as a major contributors to the heroin 'epidemic' experienced in the UK in the 1980s (Griffiths et al 1994 & Morgan 2014). The use of heroin also started to spread out of the capital for the first time, meaning that areas previously untouched by hard drug use now had steady markets. Particularly badly effected were Liverpool, Glasgow and Edinburgh, which saw rapidly growing heroin user populations and the accompanying social concerns. The scale of the expansion was unheard of, with the population of users of around 5,000 in the 1970s paling in comparison to between 74,000 and 112,000 users at the end of the 1980s (Morgan 2014). The government response to this crisis was the publication of the first drug strategy *Tackling Drug Misuse* published in 1985 and aimed at tackling the harms caused by a group of 'problematic drug users', who were seen to have problems outside of merely their addiction (BMA Board of Science 2013). This response saw coordinated interventions and the establishment of interdepartmental working groups, moving the discussion of what to do about drug treatment away from medicine and into the hands of wider public policy. The rules surrounding prescribing substitute medication also became stricter, with the publication of the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* in 1984 (BMA Board of Science 2013). The political response also included additional funding (initially £2 million, but rising to £18 million), with a focus on community treatment with 60% of the funding going to set up new community outreach centres. This served to further remove the generalist GP from drug treatment, but increased the influence of community prescribing workers, many of whom were predominantly from a psychiatric background (Yates 2002 & BMA Board of Science 2013). This served to move the discourse surrounding drug addiction from the purely medical into the social and political, and brought 'problematic behaviour' to the forefront of the discussion.

The 1980s expansion had repercussions for the treatment services, with a wide-ranging expansion of services under the National Network of Drug Treatment Services leading to a movement away from London and into the counties. Yates (2003) argues that this expansion worked to minimise or even eliminate the therapeutic community model of treatment, as only 10% of funding was allocated to this treatment model. In part, this is due to the cost associated with inpatient treatment being significantly higher than outpatient community treatment. However, it can be argued that this type of treatment is much cheaper than prison, which at the time was becoming an increasingly likely outcome for drug users. The devolution of funding for drug treatment to local authorities also worked against the therapeutic communities, as they routinely drew patients from a wider area than just the local community. This was part of the success of the model, removing the user from their community and placing them within a new community of like-minded and supportive people reduced the triggers associated with drug use and significantly increased the success of the treatment. These types of community were expensive to set up, needing land, property and staffing around the clock that community treatment would not need (Yates 2003). Given that the benefits of the communities were aggregated over a wide area, this meant that the communities seemed expensive to set up as well as being not necessarily beneficial to the local authority area. However, therapeutic communities demonstrated significant gains in getting those that took part to be drug free, offering an effective method of treatment that resulted in serious changes in behaviour. They would continue to be held up as good examples of effective treatment and would serve as examples of the effectiveness of targeted treatment for right-wing think tanks in the early 2000s (Gyngell 2011).

Therapeutic communities were also of limited use in the battle against HIV/AIDS, which was becoming increasingly important as the 1980s crept on. Methadone and needle exchange clinics allowed local authorities to combat drug use whilst also offering the public protection function of reducing the spread of infectious blood borne viruses (BBV) (Mold 2018).

Methadone offered users an alternative to injecting and street heroin and needle exchanges allowed those who continued to inject to do so in the safest manner possible. Whilst it is argued that needle exchanges could actually increase the risk of BBV transmission by making users less careful with plentiful needles (Gyngell 2011), there is little evidence of this in practice. However, the criticism that needle exchanges amount to an official acceptance of injecting behaviour is worth considering. McKeganey (2011a) argues that stigmatising deviant behaviour has worked with other substance-based offending (such as drink driving) and as such, the absence of a moral content has harmed drug treatment effectiveness. Despite this, the low infection rate for HIV/AIDS in the UK compared to the rest of Europe could be considered as a success for this approach (Mold 2008). This is the point where a schism occurred in drug treatment, with those concerned with minimising the risks of drug use breaking off into the harm reduction/minimisation faction (hitherto referred to as “harm reduction”) and those concerned with the use of drugs and pushing for the cessation of drug use, moving toward abstinence as a core concept. This can also be seen as a schism in the pillars of UK treatment, with the harm reductionists embracing the discourse of medical treatment and abstentionists arguing from a more moral platform. Whilst this is an oversimplification of the overall argument of both sides, it is worth considering the discourse surrounding addiction itself and how this impacts upon the policy implemented to deal with addiction. The harm reduction faction would go on to dominate drug treatment (arguably to the detriment of the more stigmatising moralistic “abstinence” faction) for, the next twenty years. This split would occur within academia too, with academics such as David Best and Neil McKeganey arguing for abstinence as the foundation of a national treatment model, whereas scholars such as David Nutt and John Strang would push for safer drug use and personal choice within treatment.

2.3 Harm reduction

At its heart, harm reduction is a rejection of the ideological position that drug use can and should be eliminated and instead embraces the concept that drug use is inevitable, if not

normal, and as such risk should be mitigated as much as possible (McDermott 2005). As Hart (1990 p.138) describes it, harm reduction is “an example of Government stomaching one ‘evil’... in order to obviate others”. Whilst this pragmatic approach to drug treatment is not exclusively the remit of harm-minimisation proponents, it is a defining feature of the treatment method. It is also not completely necessary for someone to subscribe to this belief to engage in this type of treatment. However, it is a defining trait of this approach to treatment, and as such needs discussing when looking at the impact of harm reduction as a treatment model in the UK. The dominance of the harm reduction model is complex and has not been definitively explained, but it can be argued that it is related to the rise of managerialism and risk management in the 1990s. Given the emphasis placed upon risk management associated with drug use within the model, this seems an adequate explanation. The HIV/AIDS panic in the 1980s primed the drug treatment industry to consider treatment; not radically as was the case in the 1960s and 1970s, but instead in terms of what had directly measurable results. Reducing the risk of BBVs in injecting drug users has a moral component: the wish for government to protect its citizens from harm and to reduce the risk that those not associated with drug use could be harmed by the side-effects of use (such as from needle-stick injuries or unprotected sex). The government even conceptualised this risk, stating that the risk from HIV/AIDS spreading due to drug use, was greater than the harms caused by drug use itself (Mold 2018 & Stimson and Hart 2005). Yet harm reduction is often criticised as being a robotic, bureaucratic response to drug addiction, obsessed with numbers yet not actually working to cure anyone. Where a commentator sits on this issue can often be defined by their stance on drug use itself and this is certainly how I defined my own position. My view is that there is a moral component to harm reduction, and that at its heart it is a treatment model that seeks to enhance the welfare of the majority, although sometimes this is at the expense of the minority. This is because harm reduction is a utilitarian treatment model that seeks aggregate over individual gain and as such is open to valid criticism for leaving behind certain drug users, especially those that do not wish to change their behaviour or those who wish to make major changes to their lives. In this way,

it is possible to criticise the harm reduction model as failing those that wish to make the most significant changes to their lives by being abstinent of all drugs. It is this trait which most effectively allowed the proponents of abstinence to paint harm reduction as cynical and lacking in any real 'end game' for the user (Gyngell 2011). The lack of judgement present within harm reduction does make it a convenient treatment model for drug workers too, as there is little judgement or conflict between worker and user, thereby making interactions simpler to manage.

2.3.1 Crime and drug use

The move toward drug use being seen as a social problem in the 1980s paved the way for the explicit linkage between drug use and crime, with the 1995 drug strategy *Tackling Drugs Together* marking the moment when drugs and crime became explicitly linked within the political discourse. This strategy drew on existing academic thought on how drugs and crime are related, with the tripartite model (Goldstein 1985) setting out clearly the linkage between drugs and offending. Goldstein's model is straightforward, offering three common sense explanations for criminality occurring due to drug use:

- a) Psychopharmacological – brain chemistry is changed through drug use thereby making violent offending more likely.
- b) Economic-compulsive – offending is driven by the need for money caused by drug addiction.
- c) Systemic – illegal drug markets are illicit and by their nature violent and regulated not by government, but by traffickers and dealers.

This model has been widely cited for over three decades and its longevity is in part due to the fact that it equally applies to prohibition and legalisation advocates (Stevens 2011a). Using this theory, it appears to be 'common sense' that to reduce crime we should reduce the number of people who use drugs, or limit access to drugs. Therefore, to enter into a discussion about legalisation or decriminalisation is to deny the harms caused by drug use

(HM Government 2010). Those in favour of legalisation however, use the model to show that harms caused by the illegal market would be eliminated should drugs be legalised (Reed and Whitehouse 2018). It could be argued that both points miss out on the main thrust of Goldstein's model: that economic-compulsive criminality would not be diminished under either model. As this is the primary motivator for the majority of drug-related crime, either argument could be seen as merely tinkering at the periphery of the drug-crime problem. Regardless of any criticism, Goldstein's model is firmly entrenched in the heart of policy makers, the media and the public.

Monaghan (2012) however, notes how this relationship is exaggerated and is not representative of actual offending behaviour, further demonstrating the disconnect at the heart of drug policy and a stumbling block to meaningful change in policy. Central to the harm reduction ideology is reducing the harms associated with criminality, with one such harm being the economic cost of drug related criminality. The cost of drug motivated acquisitive crime is normally estimated using the number of crimes self-reported by drug users or are based on arrestee interviews, both of which are methodologically flawed. Stevens (2007a) found that drug users are more likely to be arrested for trigger offences than non-drug using offenders, thereby skewing their numbers in the interview process. This means that the interview rate is artificially higher than for non-drug users who are less likely to be arrested. The criminal careers of drug users are also extrapolated from arrest data, meaning that their offending rate at the point of arrest is considered to be indicative of their offending career as a whole. This is not the case, as drug user offending is often driven by increased drug consumption, meaning that a drug user will offend more as their consumption rises. Stevens (2007a) found that this offending behaviour is often at its peak prior to arrest, meaning that drug user criminal careers are artificially inflated when considering the impact of their offending behaviour. It is also worth noting that the process of "taking into consideration" or "nodding" has been shown to artificially inflate the criminality of cooperative

offenders on arrest, as the offender can admit to offences without fear of increased sentences or may sometimes be rewarded with reduced prison time for cooperating. Also, given that Cleveland Police admitted to giving arrestees hard drugs in return for 'confessions', estimating criminal careers based on arrestee data is the worst kind of 'voodoo criminology' (Stevens 2007a and Patrick 2011).

Academic research into the cost of drug-related crime has recognised the methodological issues associated with this type of research and has advised not to use the research as proof of the drug-crime link (Holloway and Bennett 2004). Yet they continue to be ignored by policy makers who further proliferate the linkage between drugs and crime. Any attempt to significantly deviate from this narrative is difficult and often requires acknowledging the relationship between crime and drug use as part of the discussion. Disentangling drug use and crime is further complicated when we consider that there are significant doubts over causality (Monaghan 2012). Policy makers generally ignore the possibility of decriminalisation (which is often conflated with legalisation in the media, further confusing the issue), again stymieing the prospect of meaningful discussions about drug policy and also limiting the position of legislators who are artificially constrained by public opinion. In the 2010 NDS, then Home Secretary Theresa May stated that decriminalisation of drug possession was not an option for the UK as it did not recognise the complexity of the drug problem, nor did it recognise the harms that drug use poses to the individual (HM Government 2010a). That exactly the same argument could be made against prohibition was not acknowledged and represents the power that linking crime and drug use has over policymakers.

The linkage between drug use and crime caused a subtle shifting of the narrative of drug treatment, further moving the main commentary from the medical profession and toward

criminal justice. This was further exacerbated in the early 1990s by the work of then Shadow Home Secretary Tony Blair, who maintained (through to the end of his premiership) that the majority of crime is committed by a small number of persistent offenders and of these, two thirds are problematic drug users (PDUs). Blair was merely tapping into the persistent narrative of the time, as dating back to the 1980s the Home Office was increasingly attempting to link drug use and crime through research in the UK and with research from the US that found similar results (Stevens 2007a). The results of these studies have linked acquisitive crime, volume crime and drug use to the point that they are almost synonymous in the public discourse. Although it is worth noting that this rhetoric is changing, with recent changes in discourse (notably post-2005) seeing drug users being painted as economically inactive and lacking in citizenship as well. The 1991 Criminal Justice Act cemented the drug-crime link in law, creating the Schedule 1A(6) order which was a punishment aimed at drug users and designed to reduce drug consumption (Stevens 2010). Whilst these orders were scarcely used, they represented a change in the criminal justice system, whereby a person's private behaviour could directly affect their sentence for a criminal offence (Stevens 2010). This further confused the medical/legal divide in policy, with medical intemperance being sanctioned by the criminal justice system. Further, it represented the imposition of the criminal justice system on the healthcare response to drug use (Reuter and Stevens 2007).

Blair's assertions as Shadow Home Secretary, coupled with New Labour's "tough on the causes of crime" rhetoric, forced Labour to address the issue of drug offending when they came to power in 1997. Whilst this can be seen as a cynical land-grab of the traditionally Tory 'law and order' debate, the resulting expansion of drug treatment was the largest in history and represented an unheralded investment in drug treatment (ACMD 2017). Chief amongst the investments was the introduction of the 'Drug Intervention Programme' (DIP), designed to increase the referral rate into treatment of those caught within the criminal justice system (Mold 2008). At a cost of around £150 million per year, this represented a

major investment in drug treatment, most specifically in those who were criminally active. Under this era of investment, the number of people within drug treatment reached just over 300,000, representing a significant increase in the quantity of people accessing treatment, particularly those who were also subject to the criminal justice system (Home Office 2009). The growth in the number of people in treatment during the New Labour era is a testament to the government's commitment to remove drug users from illicit use and into treatment. It is also an example of the commitment to harm reduction as a philosophy for treatment as a whole. By focusing on the goal of getting users into treatment, it was argued by critics that the government lost sight of the end goal for the client, leaving them trapped in a perpetual cycle of treatment with no exit point being provided by the treatment provider. The term "parked on methadone" would become shorthand for this entry-focussed method of treatment, and would usher in a new way of looking at treatment: one that arguably inverts the problems of harm reduction and focuses excessively on the end goals of treatment.

2.4 'Recovery' and the 2010 National Drug Strategy

The introduction to the 2010 NDS promised a "fundamentally different approach to tackling drugs" (HM Government 2010a p.3), utilising the concept of recovery to enable drug users to shift from drug taking back into wider society. Whilst not the first time recovery had been mentioned within a national drug strategy (it had a prominent role in the 2008 Scottish Drug Strategy), this represented a more fundamental policy shift. However, it should be noted that according to Paul Hayes (Chief Executive of the National Treatment Agency), the shift toward 'exit oriented' goals in NTA policy started around 2005, well before the coalition drug strategy and well within the New Labour period of government (Duke et al 2013). This was not acknowledged by the coalition government, who argued that the 2010 NDS represented an end to the days of 'parking' someone on methadone and 'leaving them to rot', as well as the days of drug use being tolerated within treatment (HM Government 2010 & ACMD 2014). Most interestingly, this change also meant that gone were the days of harm reduction as the dominant treatment method. The paradigm had shifted and recovery was now seen as the

choice of drug users, drug treatment professionals and crucially, the government itself. McKeganey (2014) identified that there was no mention of the term 'harm reduction' at all within the document, indicating a significant break from the policy of the previous three decades and a move in line with the 2008 Scottish Drug Strategy (SDS). Although this is a little disingenuous, as there are mentions of harm reduction principles within the policy, they are just couched within the context of recovery. Whilst on the surface this seems like a government searing the policies of the previous parliament from the record, this (initially at least) represented very little in the way of change from the 2008 NDS and many of the harm reduction principles remained within the strategy, just not explicitly named. Whilst the 2008 NDS mentioned recovery, this was largely seen as a response to the Conservative party resurgence and their embracing of recovery, rather than being a real step change in the way we delivered treatment. As a result, we have a strategy that states it is a "fundamental change" in treatment, yet yields very little in the way of policy change from the previous strategy, which was itself seen as not completely grasping the concepts of recovery.

From the outside, the change in focus of the 2010 NDS from the population-wide, risk-based treatment of harm reduction to the individualistic, outcomes-focussed treatment of recovery is a rejection of the 'new penology' that typified the New Labour approach to drug treatment. Indeed, we see a movement away from the fatalistic, chronic-relapsing condition of addiction, whereby treatment would only be part of the cycle of addiction, toward the more traditional moralistic judgement on drug use (McKeganey 2011c). Yet, this moralising about drug use does not actually address the underlying morality of drug use, it merely places a moral responsibility on the drug user as a citizen (Aitkenhead 2010). Under the new strategy, drug use is wrong and harms society as a whole (even those untouched by addiction or crime) as well as the individual. By choosing to use drugs, the user has harmed society and needs to rebuild their relationship with the community and society as a whole, as well as rebuilding themselves (Cannon 2013 & Fomiatti et al 2017). Treatment serves as a measure

of social restitution as well as a curative for a malady, and in this sense is vastly different from the harm reduction model. Drug users are seen as being 'other', and treatment is a method of reintegrating or rehabilitating the user into society (Carlin 2011). This seems like a change in the way society sees drug-related deviancy and certainly a move toward what Feeley and Simon (1992) called the 'old penology'. Certainly, the rhetoric of the strategy matches their description of the 'old penology': focussed on personal guilt, individualistic in outcome and moral in judgement. However, the stigma comes not just from the criminal harms associated with their behaviour, but also from the economic cost that their inactivity causes. Drug use is to be stigmatised, but those that are not economically active are also doubly deviant, costing society not just through their drug use, but through the benefits they claim (Wincup 2011). By using recovery as a moving goal post and citizenship (read *employment*) as one of the foundational components, drug users can be classified in terms of risk to society. Those who are using drugs but are economically active are seen to be 'recovered', whilst those that are using drugs and are economically inactive still have a way to go before they can be considered 'recovered' (Monaghan and Wincup 2013). Whilst the demonisation of drug users on benefits is not a new component of the drug strategy (New Labour similarly concerned themselves with benefits given to drug users) it is the concern being pushed to the forefront that is new, as well as the focus of being drug free for those that are not economically active. Recovery and employment (paid or voluntary) are entwined in such a way that recovery seemingly cannot happen without employment. Indeed, Monaghan and Wincup (2013) argue that this focus on employment is actually at the expense of recovery, with many forced into work before they are ready and as a result relapsing or never getting drug free in the first place. This muddies the waters as to what recovery is; is it a state associated with being drug free, being free from compulsive behaviour or merely associated with economic productivity? Without clarity from the government on what they seek, it becomes difficult to measure success or failure when providing treatment and concepts such as recovery become self-defined, making provision of clear, structured treatment difficult. This can be seen in the study by Subbaraman and

Witbrodt (2014), where they found that despite still being classified (using government measures) as alcohol dependent, 18% of their sample of current drinkers identified themselves as being 'in recovery'. In this instance, what we see is that government measures of success are meaningless to the drug users themselves, as they have self-defined as being 'in recovery' and have reached a point of their 'journey' which represents completion to them. If we are allowing those in treatment to set the goals, how are measures such as Payment by Results (PbR) to be implemented? How can we reconcile the self-defined concept of recovery with the government set targets for treatment to achieve? Also, if recovery is a self-defined label, then how can the government hope to measure success?

2.4.1 What is recovery?

As much as the 2010 NDS discusses drug use as being immoral, it offers little to stigmatise the behaviour of those recreational cocaine and cannabis users who already hold jobs. In fact, in this respect the 2010 NDS offers little that is new in the way of treatment for these individuals (beyond community support from 'recovery champions'), focussing instead upon those whose drug use has made them economically inactive as has been the case throughout all previous NDSs. Given that 91% of drug users are unemployed at the point of entering treatment, this seems like no real difference in the focus of *who* is treated, just in the *focus* of the treatment and the measure of a successful outcome (Stevens 2011b). This focus on economic harm includes within it measures of criminality that remain consistent with the New Labour strategies, meaning that drug users will still be subject to the criminal justice system in similar numbers to the previous government (Stevens 2011b & Duke 2013). Then Home Secretary Theresa May, in the introduction, offers little to indicate any change in criminalisation of drug use instead sticking with the New Labour mantra that drug use causes harm which is commensurate with criminal sanction (HM Government 2010a & Monaghan 2012). Under the coalition government, the criminal sanctions that were introduced under New Labour would stand, with the measure of dangerousness of economic activity having been added to this measure, rather than replacing it. In this sense, the 2010

NDS does not actually deviate from the 'new penology' at all, in that drug users are still ranked and treated according to their 'dangerousness'; it is just that the measure of dangerousness has been adjusted to include economic harm over criminal harm. The dominant 'voice' of drug treatment has moved from the criminal justice system to the benefits and welfare system.

Regulation of the aggregate population was a key feature of the harm reduction treatment model under New Labour and is again rejected as being ineffective by the coalition government. Preventing group harm was seen as a key component of the New Labour drug strategies, with treatment successes being seen as entries into treatment and sustained retention within treatment. It could therefore be argued that treatment or rehabilitation was seen as secondary to classification and administration of the population (Feeley and Simon 1992). This was not acceptable in a recovery model treatment system, as users should be guided to recovery and a key component to this was leaving treatment (Home Office 2014). In this sense the 2010 NDS does deviate from the 'new penology' in that it seeks to rehabilitate the individual and to promote them to a better state of being. However, it should be noted that this 'individual' treatment is accompanied by additional quantitative assessment and regulation, especially in areas where payment by results is being used. The narrative of recovery also serves to change the discussion on what is and is not successful treatment as under harm reduction; those leaving treatment by dropping out are unsuccessful completions of treatment. Under the recovery model, these are not 'unsuccessful', but merely steps on the journey to recovery. The treatment was not wrong, it was the drug user who was not ready for recovery who was at fault. Accusations of institutional failure can be levelled at the New Labour regime in every drug-related death, drop out from treatment and occurrence of criminal activity. Recovery is insulated from this criticism as it is the user who is not ready and not the system which is at fault. By choosing to measure and assess the effectiveness of those leaving treatment, the government have

again not abandoned the traits of the 'new' penology, but have dressed it in different clothes. Aggregate measures of the population are continuing, they are just changing their measurement point. Dropping out of treatment, previously a measure of failure is no longer being seen that way, with the fault lying with the user and not the service itself. Indeed, criticism of the PbR model has highlighted that this method of treatment may actually cause treatment to be tailored to those with the easiest to achieve quantifiable problems. Those with the most difficult needs, those that most need to be in treatment, may be dissuaded by the lofty goals of recovery or turned away from treatment as their goals are less likely to be achieved and thus the service is less likely to be paid for their treatment (Jones et al 2017 & Grace et al 2016). Recovery will still be seen as a success, but those that most need treatment could be excluded, thereby making the measurement of success not the successful treatment of all drug users, just those that are 'ready' for treatment. Similar to the example of reshaping 'recidivism' in Feeley and Simon (1992), this reshaping of 'relapse' into a measure of how much a user needs treatment mutes the expectations of treatment, changing the narrative from 'treatment for all who need it' under New Labour, to 'treatment for those who can benefit' under the coalition. This is echoed by Gyngell (2011) and McKeganey (2011a) who argue that there is an economic necessity to remove treatment from those who 'refuse' to reduce their drug consumption, further supporting the argument that drug treatment should be for those that would be most likely to be drug free rather than it being for those that need it the most.

As has already been shown, the 2010 NDS failed to offer a concrete definition of recovery, despite around 100 uses of the word within the document and it clearly being identified as the key foundation of the entire strategy. Instead, it refers to recovery as a personal journey and that the goals and end points are going to be different based on individual circumstances. Even the precursor green paper (Ministry of Justice 2010) failed to provide a precise definition of what 'recovery' meant to the government, merely offering areas which

support recovery: “freedom from clinical dependence, reducing reoffending, and getting a job” (Ministry of Justice 2010 p.29). These areas of support were reiterated within the 2010 NDS, but were crucially not expanded upon, leaving treatment providers and front line workers to interpret the concepts themselves. This was actually already in place with the UK Drug Policy Commission (UKDPC 2008) definition of recovery being widely accepted within drug treatment groups (Duke et al 2013). However, it must be stated that the UKDPC definition is a form of compromise between two ‘wings’ of the drug treatment ‘civil war’ with hard-line full abstinence, as it incorporated medically assisted recovery within the definition (Duke et al 2013). Whilst the meaning of recovery is unclear within the 2010 NDS and the precursor green paper, both papers make clear that being drug free should be the goal of treatment and being drug free would assist with achieving recovery (McKeganey 2014). This linkage between abstinence and recovery persists to this day, with both terms often conflated (despite, as seen in section 2.4 users who define themselves as being ‘in recovery’ not necessarily being drug or alcohol free) so as to now be interchangeable in many discussions (Witbrodt et al 2015 & Neale et al 2013). Whilst it is tempting to consider the lack of a formal definition of recovery within the 2010 NDS as semantics, this is a vitally important discussion to have as the entire rationale and function of treatment is subject to this debate (Neale et al 2011a). By failing to concretely define recovery, treatment services are free to interpret or develop their own meaning of the word, and thus the meaning of government drug policy, as they will. This opens the discussion of what treatment is to debate, with moral and philosophical understanding of addiction potentially being used as the interpreter to government policy. However, Lenton (2007 cited in Duke et al 2013) argues that changes in policy often resolve themselves, with outcomes that are feasible and achievable within budget constraints usually winning. In this sense, it is natural for recovery to become defined by treatment exits and short-term treatment given the policy was implemented against the backdrop of sweeping cuts to funding (ACMD 2017) and the ‘Big Society’ model of community accountability. However, this ambiguity can leave drug users’ choices on what treatment they can have bound by their geographical location, rather than a

central policy or evidence based treatment, as it is stakeholders and local Drug and Alcohol Action Teams that are defining the meaning of 'recovery' rather than central government.

The lack of a clear consensus definition for recovery is clear throughout the literature, with definitions from the Betty Ford Institute Consensus Panel (2007 and 2010) as well as the UKDPC (2008) being commonly used by many researchers. Despite these definitions being commonly used, none are uniformly accepted as *the* definition and none are mentioned in the 2010 NDS as examples of definitions the government are to adhere to or that they used to design the strategy. This can be problematic as the lack of definition can lead to the goals of the strategy being opaque to those outside of the recovery community, including those seeking treatment. Those within the community however, do not see the lack of a formal definition to be an issue and perhaps even view it as a strength of the approach, allowing treatment services to design person-centred treatment models that focus on the addiction and not the substance (McKeganey 2014). Indeed the Betty Ford Institute Consensus Panel (2007) even went as far as to say that having a formal definition of recovery was not needed, as those that have it know what it is. Whilst this has historically been sufficient as a test for obscenity (*Jacobellis v Ohio*) or as a method for gauging whether an object is art or not, it is insufficient as a foundation for a national drug strategy. Subjectivity in policy, especially when combined with the introduction of new methods of commissioning (PbR) and widespread organisational and ideological change, is unhelpful for those attempting to implement the changes and can be an impediment to achieving any real change.

The lack of a formal definition of recovery causes further problems when introduced into the managerialism of modern social policy. This is in part because an individual-centred model that is based upon personally defined goals which can also be defined at a local level is difficult to quantify. This, therefore, also makes measuring the effectiveness of treatment

difficult, a combination which makes effective measurement of the success or failure of policy difficult. Feeley and Simon (1992) argue that modern social policy can be typified by the quantitative assessment of outcomes and measurement of effectiveness that can be used to justify policy decisions. These become difficult to achieve when there is no formal decision as to what a successful outcome is, as there is no formal criteria defining success or failure. The chronic cyclical nature of addiction also makes determination of successful results difficult, with periods of abstinence by no means demonstrating that the user has conquered their addiction, and dropping out of treatment not demonstrating a failure in the treatment. McKeganey (2011b) identifies this as a problem for the treatment services, with re-entry to services being potentially seen as a failure of treatment, rather than an inevitable part of the cycle of addiction. In fact, re-entry to treatment should be seen as a positive, when the alternative is illicit use of illegal substances. However, under a payment by results model, these could easily be seen as measures of success and failure.

In attempting to determine the features of recovery, the Betty Ford Institute Consensus Panel (2010) give guidelines on durations of sobriety:

- Early: 1-12 months
- Sustained: 1-5 years
- Stable: greater than 5 years

Yet even these are guidelines rather than fixed figures, as recovery is an individual process and should not be conflated with abstinence, which is merely one component of the whole. Best et al (2012) used the less ambitious definition of 12 months *primary* drug free and a self-belief (by the client) that they were in recovery as their definition to determine inclusion in their study on recovery. This means that for the purposes of the study a service user must be in 'sustained' abstinence before being considered to be in recovery, although it does only require primary drug abstinence, rather than full abstinence from all drugs. The government measure of 12 months of non-presentation to treatment was used in the Jones et al (2017)

study into payment by results treatment services. This measure of 'success' means that successful recovery is less concerned with the concept of abstinence and more concerned with absence from treatment, which can be achieved without abstinence at all. In fact, it is only returning to treatment that is seen as a negative outcome, as demonstrated in research carried out by the government, whereby an 'unplanned exit' with no further re-presentation was considered an indicator of a person 'finding recovery' on their own (HM Government 2017a). This ignored the significant issue of clients losing faith in treatment and staying away, changing areas to try new treatment or even dying. Under the 2010 NDS this means that someone could leave treatment to go back to drug use and as long as they do not re-present to treatment within 12 months (or even 6 months in some services), this is seen as not being a negative outcome (although crucially it is unlikely to be seen as a positive outcome). This would perhaps indicate that the goal of abstinence is not as crucial to the concept of recovery (at least as far as the government is concerned) as just getting drug users out of treatment and into employment.

Whilst the concept of 'recovery' is nebulous, the place that abstinence plays within it is also opaque. As seen above, the government targets for recovery are actually more a measure of being out of treatment, and concerns about drug use are fuelled by concerns about crime and economic activity rather than the risk of the behaviour to the individual. Monaghan (2012) argues that this is a viewpoint which has changed over the development of the Tory drug policy, with early material equating recovery and abstinence, but this evolved to instead mean a reduced reliance upon the state rather than anything directly linked to drug use. Abstinence is also cited as a type of recovery capital (see section 2.4.1) meaning that it supports recovery but is not essential to achieving recovery. However, the government state that being 'drug free' should be the goal of treatment, presumably meaning that recovery and abstinence should be achieved together if treatment is to be considered successful. Yet this is not reflected in the outcomes for PbR, where absence from treatment is the trigger for the

service being paid and not a client being drug free. In their 2004 study, McKeganey et al found that over half of drug users presenting for treatment wanted to be 'drug free'. This supported the idea that drug users were being failed by treatment services and were not achieving the outcomes they expected within treatment, a foundational claim of the recovery movement. However, a follow-up study by Neale et al (2011a) found that users who expressed that they wanted to be drug free were actually expressing a much more nuanced opinion than simply wanting to be clean of all drugs. Similarly, they also did not necessarily mean that they wished to maintain this state forever and that the duration of being drug free changed from person to person. Miller and Dunlop (2011 p.196) refer to this as the "diet today, cheesecake tomorrow" type of motivation, whereby the motivation to remain drug free changes from person to person, day to day and cannot be aggregately applied to a group over any duration. Whilst an important breakthrough in terms of challenging existing thinking on treatment, McKeganey et al (2004) ignored the changes in motivation that typify a treatment journey for a drug user, meaning that declarations of a desire to be abstinent are accepted as being consistent throughout the treatment duration. That these declarations came from service users themselves was used as evidence that the population wanted to be abstinent, even though that population differed in what being 'drug free' meant and also ignoring the recognised trait of service users to adopt the ideology they feel will most swiftly enable them to enter treatment (Neale et al 2011b). By homogenising the population like this, we reduce the number of treatment options available and potentially drive away service users from treatment entirely as well as reduce the discussion on treatment to two diametrically opposing sides. This situation is neither productive for the development of treatment, nor for the service users themselves.

When considering the meaning of abstinence, it is important to consider the meaning of being 'drug free', as whilst from the outside this seems like a simple concept (and one that makes it attractive to those not familiar with drug addiction) it belies a complexity which has

led to a muddled definition and vague goals for service users to achieve. The most obvious meaning of being drug free is being free from all illicit drugs (Witbrodt et al 2015 & Laudet and Humphreys 2013). This is attractive as it removes the service user from drug using circles, thereby preventing crime, and helps to rehabilitate their identity (see section 2.4.3) (Laudet and Humphreys 2013 & Fomiatti et al 2017). However, the concept of drugs being licit and illicit is not straightforward, as intent forms a substantial part of the legality of the drug, with drugs that are medically required being legal if prescribed, but illegal if not. This would mean that a client could be 'drug free' as they are not consuming heroin, but they can still be taking opiates as they are prescribed a legal opiate (such as tramadol, codeine or morphine) for a physical illness. The client is technically drug free, but is still taking their drug of choice, albeit now on prescription. Whilst the intent of the client is to only use the drug for pain relief, they are still using the same type of drug that caused them to enter treatment in the first place. This is further complicated when you consider the prescription of benzodiazepines for mental health conditions, as these drugs are often used in conjunction with heroin and can be a source of addiction in their own right. Drug users are often treating their own mental illness with drugs, and prescription medication is necessary for them to alleviate the symptoms. In order to be drug free, do they need to give up this prescription (as this drug can or has been abused) or can this be considered an exemption? This is further complicated by the prescription of methadone, as this drug is legal when prescribed and can be used as effective treatment for a chronic health condition (addiction) and, as a result, it would qualify for exemption under the same conditions as other addictive medication used to alleviate other chronic conditions. However, long term prescribing of methadone was the main issue that recovery (and thus abstinence) was introduced to prevent (McKeganey 2014). If it is possible to be 'drug free' whilst on methadone, has anything changed? If we do not allow people to classify themselves as 'drug free' because they are using methadone, where does that leave other addictive medication? In their attempt to address this issue the Betty Ford Institute Consensus Panel (2010) stated that if a client was taking addictive medication under prescription and following the guidelines, then they could consider

themselves 'in recovery' and as a result, those that are taking methadone are also considered to be 'in recovery'. Accepting this definition would mean that those clients identified as being 'parked on methadone' in the 2010 NDS are actually in recovery. This situation becomes problematic, as recovery was sought specifically to address the issue of individuals remaining in treatment and on methadone long term. Witbrodt et al (2015) attempt to differentiate between those who feel they are in recovery and use alcohol and those who are abstinent with their designation of abstinent and non-abstinent recovery. However, this is applied to alcohol-only addicts and is much more problematic to apply arbitrarily to drug users, given the blurred line between legal and illegal drugs and substitute prescribing, concepts that are generally not applicable in alcohol treatment.

A more pressing concern is alcohol, with drug users (particularly heroin users) often switching addictions from drugs to alcohol once they start to detox (Neale et al 2013). In order for the client to be drug free, do they also need to be alcohol free? Again, a strict definition for this is not forthcoming, with the Betty Ford Institute Consensus Panel (2010) stating that abstinence from alcohol is absolutely a cornerstone of recovery. This is perhaps more indicative of their 12-step roots than a meaningful definition, given their acceptance of methadone and other addictive drugs whilst being in recovery. Subbaraman and Witbrodt (2014) found that definitions of recovery in alcohol-addicted service users was much more varied, with a spectrum of responses across various studies indicating that being in recovery was defined by what the service user felt was progress rather than a fixed goal. That alcohol users can be seen to be in recovery (in fact it is self-defined) whilst still using their primary substance of abuse, again demonstrates the problem with utilising ill-defined concepts as measures of success or failure of treatment. This problem is further exacerbated if we include the addiction to tobacco, with many service users addicted to nicotine despite being in recovery and being seen as abstinent (Neale et al 2011b). Again, the Betty Ford Institute Consensus Panel (2010) offered an explanation for this: that the decision to exempt tobacco

from considerations of abstinence was a “purely political” (p.201) decision and was undertaken for fear of offending or ostracising people who considered themselves already in treatment. They did highlight that this decision was made so as to not remove the designation of recovery from those who already claimed so (considering that recovery is generally a label one places upon oneself, this seems disingenuous), but that tobacco addiction would need to be considered in the future. Of all the accepted definitions of recovery, it is the UKDPC (2008) definition that offers the most insight into the levels of alcohol and nicotine use that is permitted when in recovery. This definition ties their use (and the use of an intoxicant) to control, meaning that as long as the person is controlling their use, they can be considered to be in recovery (ACMD 2013). Whilst this definition is useful for helping to conceptualise recovery and what it would look like in practice, it is worth reiterating that this definition is not deemed acceptable by full abstinence advocates, particularly in the US where controlled use is considered ‘in remission’ rather than ‘in recovery’ (ACMD 2013 & Duke et al 2013). As such, it would be remiss of this thesis to accept this definition categorically, as full abstinence advocates were found within the cohort of interviewees and as such this definition would not represent their views.

Given that the definition of recovery can be viewed as being contentious, it is similarly problematic that the often conflated terms ‘drug free’ and ‘abstinent’ are similarly ill-defined. Too often these terms are defined not through a functional definition, but through a political agreement (as with tobacco in the Betty Ford definition) or through ideological rhetoric. If abstinence is about generating an increase in moral discourse surrounding drug and alcohol use, then criticism of their use should not be watered down so as to make recovery itself more achievable. Similarly, if abstinence is a key component of recovery (so much so that they are often confused) then it cannot be considered to be a personal interpretation, as this will directly affect treatment on a person-by-person basis, with drug workers applying

differing standards of abstinence based upon their own ideals and not a centralised standard.

Another common thread to recovery is the promotion of citizenship or social responsibility. The Betty Ford Institute Consensus Panel (2010) stated that they took their definition of citizenship from the UKDPC (2008 p.5) definition: “participating in the rights and responsibilities of social life”. In terms of what this means for the individual, the UK Drug Council define this as participating in family life, and gaining employment either paid or voluntary, which ties back into the government position of economic activity and reduced reliance upon the state. This focus on work as a method of achieving recovery is linked to the concept of recovery capital, with work being a crucial component of both physical and human capital as well as an implied component of cultural capital (HM Government 2010). Similarly, it represents the change of focus for drug treatment, with the dominant voice no longer being the criminal justice system, but the welfare system.

The third strand to recovery cited in the 2010 NDS is the reduction of criminal behaviour. In this instance, the strategy is remarkably unchanged in ideology from those that came before it. In fact, the prevalence of this strand in the 2010 NDS demonstrates that the historical balance between medical treatment and criminal justice prohibition is still present (Duke 2013). Under New Labour, there was an unprecedented expansion of the criminal justice system to include drug and alcohol offending. The focus on problematic drug users (PDUs) that categorised Blairite criminal justice policy has been continued under the coalition. In their consultation responses HM Government (2010b) highlight that there is to be a move away from prison sentences for those addicted offenders that the sentencing framework identifies as being suitable for community sentences (ATRs and DRRs), but that prison is a necessity for some drug using offenders. In another preservation of the status quo, the

government also dismiss any calls to decriminalise or liberalise drugs in the UK citing the “complexity of the problems involved” (HM Government 2010b p.4), thus rendering the discussion moot. It would appear that the issue in both the 2010 NDS and the consultation response is that the government have conflated (either willingly or unwillingly) the concepts of decriminalisation and legalisation (Carlin 2011). This is because their discussion of increased drug use and risks of young people trying drugs seem more at home in a discussion over the legalisation of drugs rather than removing the criminal justice burden that possession of drugs poses. Nutt (in Aikenhead 2010) states that the focus on legality vs illegality is endemic within government. They refuse even to compare the harms associated with illegal and legal activity, let alone consider making risky behaviour legal again. This stifling of the discussion is a further demonstration of the stranglehold that public opinion has on drug policy, with Nutt and Macken (2011) commenting that the coalition government seemed to eschew evidence-based policy in favour of ‘common sense’ approaches that are more easily understandable by the public as a whole. It can be argued however, that for the strategy to be fully recovery focussed, there is an argument to be made for reducing the number of those in treatment who are forced to be there. It would appear that the government wishes drug treatment to straddle two stools, offering tailored support for those that wish to change their lives, whilst also offering structured support for those who are forced to be there. Despite offering a ‘new approach’ to drug treatment, it can easily be demonstrated that the 2010 NDS offers a rebalancing of the three pillars of drug policy, with morality and medical knowledge still being balanced out with a prohibition focussed criminal justice pathway.

When looking at the three main strands of recovery from the government’s perspective, it becomes clear that the statement that this was a fundamentally different drug strategy is not necessarily true or false. From one perspective, the strategy represents a change in focus from ensuring that those with drug problems remain in treatment and a minimum risk to

themselves and others, the model which typified the New Labour response to drug use (Stevens 2007b). In this new model the user is encouraged to stop using drugs, pushed to be drug free and enter society as a reformed and productive individual. These are noble ideals and it would be difficult to criticise them for their intentions. It is also difficult to support the harmful practice of illicit drug use when the damage such use does to the community and the individual is well researched (Home Office 2014). However, the strategy is also criticised for being a status quo in morality and thinking, dressed up in new clothes to justify budget cuts to the third sector, of which drug treatment represents a significant proportion (Coote 2011). Indeed, it can be argued that the 2010 NDS represents the height of coalition governance, with Conservative punitiveness countered by Liberal Democrat care (Duke 2013).

As has been demonstrated, the meaning of recovery is muddy and open to interpretation, meaning that the client and the treatment provider are unsure of what is expected of them and what the end goals are. Similarly, the goal of being 'drug free' is open to interpretation and seems a politically constructed solution to a created problem (unemployment) rather than being an actual object in its own right. As such, it is up to the treatment provider, the client and the treatment worker to determine what 'drug free' means for each individual client group or even each client themselves. This has a knock on effect for treatment itself, with the possibility of clients that were 'parked' on methadone being able to be considered 'in recovery' (given a particular interpretation) under the new strategy, with only their reliance upon the state being viewed as problematic. Granted, there is a focus on prescribing services being limited-time solutions rather than a lifetime medical intervention (as was previously the case), but this is no means spelled out in any great detail and is left to the treatment provider and the local authority commissioners to determine. It is therefore merely the concepts of 'citizenship' (read *personal responsibility*) and being out of treatment that separate the 2010 NDS from those that precede it. In this strategy, it is not the concept of

'recovery' that has been introduced, but more the refocussing of the narrative from crime and criminality to welfare and work. It is in this area that we do see fundamental change, with drug users pushed toward employment and out of drug services rather than into the criminal justice system and treatment (Monaghan and Wincup 2013). Again though, we see a further opacity in the recommendations, with vague guidelines being left to the local authority, treatment agencies and treatment workers to interpret and determine what is suitable treatment. In this way the 2010 NDS is fundamentally different, as it represents a movement away from centralised governmental guidelines and toward a more localised approach to treatment (HM Government 2010a). As such, the vagueness of the guidance is to be expected as it falls to each local authority to interpret what recovery means to them as long as they push drug users out of treatment and into work.

2.4.2 The history of recovery

The introduction of recovery to UK treatment did not occur in the 2010 NDS and instead originates in research into the Scottish drug treatment programmes. McKeganey et al (2004) carried out a study of 1,007 drug users entering treatment in Scotland, asking questions about what the client's goals were for treatment. Whilst this research was not aimed at introducing the recovery agenda, it sought to determine the effectiveness of treatment services for each client, opening up discussion on what effective treatment is and on client motivation. In line with other 'evidence based' movements of the time, it sought to root treatment in academic study and promote a more efficient method of understanding addiction.

The study asked users to provide an answer as to what they sought from treatment as they started a new episode of treatment. It is crucial to point out that this does not mean that the individual started treatment for the first time, merely that this was their first contact with the treatment agency to set up treatment at this time. A number of those sampled will likely have had long periods in treatment before and so are well versed in the treatment process. Of

those sampled, 56.6% stated that they desired to be drug free or abstinent as their only goal from treatment, whereas 0.7% stated that their goal was to learn how to use drugs more safely (McKeganey et al 2004, McKeganey 2014). This report challenged the effectiveness of harm reduction being the goal of treatment, an approach to treatment which had been dominant since the 1980s. This was an attempt to introduce the thoughts and desires of the drug user into the treatment process, which was seen to be absent during the 'cookie cutter' treatment goals of the early 2000s. Whilst it could be tempting to read these results as a fundamental rejection of the goals of harm reduction, it would also be entirely reductive; a short answer to a vague question being used to define a radical shift in policy. McKeganey (2014) highlights this issue himself, arguing that the responses were not a fundamental rejection of harm reduction, but rather a timely reminder that drug users may wish to achieve more from treatment than merely being in treatment. Whilst McKeganey highlights the flaws in rejecting harm reduction in favour of abstinence, this is precisely what has been proposed in larger discussion, with abstinence being cast as being diametrically opposed to harm reduction (particularly by Government in their strategy) and that the two are incompatible within a coherent strategy (Miller and Dunlop 2011).

Neale et al (2011a) carried out further research into what clients wanted when attending treatment, using qualitative interviews to deepen the discussion beyond merely a one word answer. Whilst the study found people who truly wished to be abstinent (although the meaning of 'abstinent' is also contentious, see 2.4.1), the desire to be abstinent or drug free was vastly more complex than was originally proposed. It is key to consider that when a person wishes to be drug free, what that actually means to them: free from all drugs? For all time? Free from use of the problem drug? Alcohol? Tobacco? This answer to a simple question has a number of connotations for the respondent, which need to be considered when designing treatment around them. For example a drug user who wishes to be free of heroin use for the rest of their life will require different interventions to one who wishes to be

heroin free for a period of stabilisation before resuming reduced use again. Both these examples may give the answer “drug free” to a question of “what are your goals of treatment?” but both have radically different outcomes for the treatment worker to consider. Whilst it could be argued that this is an argument over semantics, it is important to consider the client in the discussion, as they will be receiving the treatment programme designed based upon their answers. For the first client, a heavy diet of education and training, abstinence group work and community support would be an appropriate treatment programme. For the second client it would be much more appropriate to consider harm reduction and overdose prevention in order to prevent future harms. Whilst this example is not used to say that these two clients could not engage in the same treatment, it serves to highlight the difference in focus that these two clients would need and the difference in their meanings of ‘drug free’. It is also valuable to consider the appropriateness of abstinence for the client, with not all clients being able to achieve abstinence from the offset or even at all (Newman 2005, Neale et al 2011 & Roberts 2005). The response to this paper by the Scottish government was measured, offering the conclusion that whilst this research was important, but that rehashing the debate between abstinence and harm reduction was unhelpful. They also concluded that the future of Scottish policy was in a blend of treatment methods that worked for the client, and that the client should be the driving force for the treatment and not the state or treatment provider. The denial of a “once size fits all” (McKeganey 2014 p.959) approach signified that the government refused to engage in intellectual and philosophical debate over drug treatment.

The findings of McKeganey et al (2004) were supported by a report conducted by the National Treatment Agency (NTA 2007). This study used questionnaires to gauge the levels of satisfaction from service users across many areas of their treatment and found that those within treatment generally wanted to be drug free as their future goal. The overall desire to be drug free varied between main drug types, with 91% of heroin users wanting to be drug

free or aspiring to be drug free. Most damning was the response from methadone users, with nearly 71% expressing a desire to be drug free as their final goal (NTA 2007 p.9). These results seemed to validate the findings of the McKeganey et al (2004) study and indicated that treatment services were filled with abstinence-desiring drug users. McKeganey et al (2006) wrote a follow-up paper which discussed the periods of abstinence attained by a sample of the original population. The percentage of this population that achieved any kind of abstinence for both male and female clients was under 10% (for females it was nearer 5%). This was seen to show that clients entering treatment were considering abstinence to be their goal, yet were failed by treatment, which prevented them from achieving this. Harm reduction was seen to prioritise future harms over future successes and conservatively kept people in treatment to prevent further risk, rather than let people leave once they felt they should. In accordance with the stated original goals of the project, it was concluded that this amounted to a vast waste of resources, both on the part of the state (in terms of treatment) and the client (in terms of time and effort) and achieved little more than getting the client into treatment. In fact, it could be seen to dissuade clients from contacting services again as they felt they would not get closer to their end goal. Crucially, it was concluded that this meant that the treatment did little to move the client on from treatment, placing the blame for continued drug use at the door of the treatment service and not the individual. The pessimism of harm reduction was deemed to be directly responsible for people continuing to use drugs.

The importance of the McKeganey et al (2004 & 2006) papers was felt outside of academia and the niche world of addiction treatment, and was taken by the Scottish Parliament as an example of what could be achieved in their devolved drug strategy. Rather than the balance between harm reduction and recovery that typified the 2005 response, by 2006 the First Minister of Scotland himself expressed a desire to see treatment adopt a more drug free focus, meaning that less people would be trapped in treatment. Common to this discussion

were the problems associated with prolonged methadone use, ignoring the major benefits that methadone can give to an individual, as well as perpetrating the myth that methadone is more addictive than heroin (Kosten and George 2002 and McKeganey 2014). It should also be noted that the majority of the discussion surrounding the wastefulness of treatment stemmed from the opposition Conservative party. Their desire to embrace recovery also came from research carried out by the Centre for Social Justice (CSJ, set up by former Conservative party leader Ian Duncan Smith) which sought to push for radical changes to the treatment model.

The Centre for Social Justice (CSJ 2007) called for drug-free, recovery focussed treatment, arguing strongly against the prescription of methadone at any stage within drug treatment. Their calls for recovery oriented treatment matched with the goals of the then-opposition Conservative party that was campaigning on social responsibility and a curbing of unemployment and inactivity (Conservative party 2010). A series of blogs between 2010 and 2011 by Kathy Gyngell from right-wing think tank, the Centre for Policy Studies (CfPS) similarly attacked the harm reduction orthodoxy, arguing for a more localised, streamlined community-focused treatment model. Gyngell (2011) argued that treatment should be led by the local community, with recovery the main goal and residential rehabilitation the main focus of treatment. It should be noted that her push for residential rehabilitation was not in addition to methadone treatment and community harm reduction, but replacing it entirely. Under this model, funding would be directed at small local rehabs with much of the money for treatment coming from the surrendered benefits of the drug user rather than a radical rethinking of drug treatment budgets. Costs would be kept low through the use of market forces by keeping supply high, and as a result it was estimated that residential rehab could be achieved for a similar price to the taxpayer as methadone treatment (Gyngell 2011). In fact Gyngell proposed a wholesale reduction in funding for community drug treatment by funding only those who wished to be abstinent and a radical overhaul of the treatment

providers, putting treatment back into the hands of local small businesses. Community treatment would exist merely as a funnel to push clients into the residential rehab system and as a result would require reduced funding. Methadone maintenance was to be considered 'cost ineffective' and reducing the numbers in treatment but subjecting them to more efficient treatment was to be the better model (Gyngell 2011 p.25). Economics and notions of effectiveness were to be the foundations of this treatment model, and not preventing drug related deaths (although Gyngell does refute this point) or blood borne virus (BBV) transmission. Key to her idea was a purge of harm reduction loyalists from drug treatment, as these were impediments to recovery goals. Whilst radical, her proposals to replace the harm reduction centred workforce with a recovery focused one is not uncommon, with McKeganey (2011b) and Page et al (2016) also proposing similar changes in their attribution of the failure of recovery treatment to staff attitudes. Reduction of harm to wider society was to be sacrificed in order to reduce the financial harms associated with drug use. Central to the thesis is that methadone treatment is not a cheap and effective treatment as the costs are more significant than previously argued, meaning that the benefits to society from this treatment should be reassessed. Gyngell (2011) cites treatment costs for methadone as being £300 per year, yet attributes over £3,800 per year to treatment simply by dividing the cost per year of the treatment budget by the number of users in treatment. This is clearly done to misrepresent the cost of methadone prescribing by conflating the cost of all treatment (including the operating costs) with the cost of merely prescribing methadone. This is done to provide an argument that methadone is not value for money and that the budget for treatment could be better spent elsewhere. Similarly, she argues that the costs of residential rehab do not have to be as expensive as they are commonly perceived to be. In this Gyngell has support, with Ashton (2007) and Connock et al (2007) also arguing that methadone treatment does not produce the level of savings to the public that it is commonly attributed, and that a change in the way we treat addiction is needed. Indeed when victim costs from crime (usually goods as a result of acquisitive crime) are removed from the cost calculation per drug user to the public, methadone treatment is no longer

significantly cheaper or more effective than no treatment at all (Connock et al 2007). Whilst this is a big exclusion, it does ask the question: is drug treatment a healthcare initiative, social welfare programme or crime control? The answer to this question determines the inclusion or exclusion of the victim of crime costs and also helps to define the ideology behind treatment. It is not only the government who need to make this judgement, with treatment providers and treatment workers needing to make this determination when they work with drug users. The answer helps them to determine the treatment they are to provide and the outcomes which they will use to determine if a client is successful or not.

Whilst both the CSJ and CfPS question the financial effectiveness of methadone treatment, they also ask of wider society what our responsibilities are as citizens. In this respect, drug users are charged with neglecting their duties and responsibilities as responsible members of society. They are seen as providing little of merit to society and acting as a drain on the public coffers through benefits and costs associated with their activities. Again this echoed the policy of the Conservative shadow government, with questions about rights and responsibilities (Wincup 2011) being asked alongside proposed cuts to welfare in general (Conservative Party 2010). The narrative of community-based resources and community-led, need specific provisions were also tied closely to the 'Big Society' project that typified the caring conservatism of future Prime Minister David Cameron's bid for government. The overlap of recovery ideals (personal responsibility, community-focussed local government) with the wider narrative of the shadow and then coalition government made recovery an ideal treatment model for this type of government as much as the risk-centred, managerialist harm reduction model fitted the New Labour goals of government.

Pressure was additionally placed on the New Labour government following media attacks on methadone prescribing, in particular the BBC articles by Mark Easton (BBC 2008) on the

numbers of clients exiting treatment. Easton challenged the head of the NTA, Paul Hayes, on the number of clients leaving treatment per year. The NTA response was that the problem with methadone “is not that it doesn't work, but that it works too well” (BBC 2009), a response that seemed ill-judged given the statistical evidence that seemed to indicate to the contrary. The poor numbers of drug users leaving treatment, around 8.8% in 2006/7, seemed to support to the criticism of methadone and harm reduction. When coupled with the research by McKeganey et al (2004 & 2006), this seemed to support the narrative that drug users were being failed by treatment and that willing and able users were being parked on methadone and not guided to abstinence.

Resistance to the harm reduction model was also growing within the NTA itself, with David Best (a former NTA research lead) and Mark Gilman (a regional manager of the NTA in the North West) building evidence and momentum for change (Wardle 2012). Gilman was a former advocate of methadone maintenance in the 1990s, offering some of the more influential arguments for the practice at the time. Despite being hostile to psychotherapeutic treatment, Gilman conceded that 12-step anchored, recovery oriented residential rehabilitation worked to produce significant changes in criminally active drug users.

Ethnographic research was also utilised to demonstrate the disparity between the NTA focus on methadone maintenance and the goals of drug users receiving this treatment. This movement toward recovery within the organisation was vital to the growth of recovery as a model (the ‘recovery agenda’). By 2008 recovery had transformed from a small grass roots movement to being the dominant treatment model in both the Scottish and UK drug strategies, and would be the narrative surrounding treatment for the forthcoming general election (Wardle 2012). We can track the growth of recovery as a concept through a simple Google Scholar search, which demonstrates an almost exponential growth of recovery-based research from the turn of the century (Kaskutas et al 2015). The growth of discourse on recovery has reached the point where discussions of treatment are “overwhelmingly”

dominated by recovery ideas and concepts (Miller and Dunlop 2011), with harm reduction now reduced to the outskirts of common discourse. Similarly, there is a risk that the debate surrounding treatment has moved on so far that the concepts of harm reduction and recovery are so incompatible that it is now an ideological debate rather than a discussion of how best to serve the consumer (Miller and Dunlop 2011 & Lancaster et al 2015), and in order to further the debate this ideological approach needs to be abandoned (McKeganey 2011b).

Whilst stated as being a fundamentally different approach to treatment by the UK government, recovery has a long history and is strongly associated with the US 12-step treatment programme and temperance movements in general. Indeed the concept of being 'in recovery' brings to mind group work, sharing and making restitution with society, areas highlighted by the 2010 NDS as being key to their concept of recovery. The 12-step model is ubiquitous enough within addiction treatment that it is considered as shorthand in fiction for addiction treatment, with characters commonly indicating their addiction by saying they "need a meeting" or by being shown in an Alcoholics Anonymous (AA) meeting sharing their problems. It can be argued that the language of recovery and AA is the language of addiction for the majority that have never been directly involved in drug/alcohol treatment (Cannon 2013). Therefore, forming public policy which draws on this tradition is 'common sense' and appeals to those outside of the addiction community as they 'know' (through passive absorption of media) this is a way that works. The adoption by popular culture can be seen as stemming from the roots of the abstinence movement, with preachers and evangelical Christians forming the early groups that publicly espoused the virtues of abstinence, thereby 'spreading the word' outside of the usual closed society of addiction treatment. The publication of 'addiction memoirs' in the late 19th and early 20th century, also served to ingratiate the concept of recovery into the mainstream consciousness (Cannon 2013). This practice remains common in the 21st century too, with former US presidents

George W Bush and Barack Obama both devoting portions of their autobiographies to their recovery, and with the recovery-centred biographies of celebrities, most notably in the UK: Russell Brand. David Cameron even confessed to drug use before the 2010 election, a level of candour that is unheard of in right-wing British politics (Nutt and Macken 2011). The narrative structure of excess followed by a redemptive arc within the biographies is useful to organisations seeking to promote their message. With spirituality, abstinence and socialism (to name a few) using these arcs to sway the reader to their agenda. This plurality of use often leads to narratives being unchallenged and the narrative of redemption being accepted into the public knowledge of how addiction ‘works’.

AA itself was founded in 1939, spinning off from the ‘Oxford Group’ of addiction treatment following the publication of the book ‘Alcoholics Anonymous’ (Cannon 2013). The original group was formed of former marketing and public relations executives following the great depression, giving AA a base of supporters who were adept at making messages that were designed for mass consumption. The original concepts of AA and their ideas on recovery also fit with the national interests, with Christian piety, spirituality and the disease model of addiction being distilled into one package. The concepts within the AA model also fit with the narrative of the time, with concepts such as the dangers of excess and greed being publicly cited by Franklin Roosevelt as causes of the great depression. FDR even referred to the pre-depression US as a “drunkard” in some speeches, linking excess and inebriation with bad behaviour and the ‘mess’ which the New Deal needed to deliver the US from (Cannon 2013). FDR similarly invoked the concept of national values and rebuilding from within in his speeches on the New Deal, further linking the rebuilding of the New Deal with the rebuilding of a drug user. These sentiments rest at the heart of the AA ideology, with recovering addicts needing to rebuild themselves, through reparation with wider society.

The concept of “reconstruction of the self” (Cannon 2013 p.117) mirrors exactly the policies of the New Deal and demonstrates the power of national debate to propel concepts into the mainstream, even in areas entirely unconnected. This mirroring of drug treatment and national debate can also be seen in the 2010 NDS, where the concepts of fiscal, social and personal responsibility seen in the narrative surrounding austerity are mirrored in the discourse on drug treatment (Wincup 2011). Concepts such as the ‘Big Society’ (promoting volunteerism and social responsibility) are replicated in terms of ideals that recovering drug users should aspire to and capital that will be used to aid recovery itself. Volunteer organisations are a central component of the drug strategy, being touted as solutions to areas such as drug education, mentorship and mutual aid networks (AA and NA are directly cited as examples of these networks) (HM Government 2010a).

The concept of the ‘recovery champion’ is cited as a role for those within recovery (but perhaps unable to find paid work) and is designated the role of peer support and recovery cheerleader within the treatment community. Those that are not able to provide for their community through paid employment instead serve as ambassadors, offering support for those drug users in need whilst also ensuring that recovery is maintained as the goal to aspire to. These roles are not expressly designated as being volunteer positions, but are also not discussed as new jobs and are merely ‘encouraged’ to aid with others’ recovery, without any explicit mention of financial gain. Personal responsibility is also highlighted, with the recovery journey being described as an “individual person-centred journey” (HM Government 2010a) and the paper highlighting those individuals that are in receipt of prescribed medication and have jobs, families and productive lives. Recovery is seen as being linked to citizenship and responsibility, whilst those on substitute prescribing are shown as being a general drain on society (Wiggin 2012). An approach echoed within the ‘Big Society’ whereby social problems are abdicated onto the local community, with a focus on local, personal responsibility (Cabinet Office 2010). Closures of local public houses in

rural areas were often targets of the 'Big Society', with local initiatives to buy failing businesses being championed. In this instance, community responsibility was seen as being the answer to a question which would likely have resulted in discussions about the purpose of capitalism and the role of wider societal responsibility. Instead of these discussions, those that lost local services were seen to be lacking in community spirit and a 'they did it why can't you' attitude abdicated responsibility from government to the local community. A tacit designation of 'worthy' and 'unworthy' communities could also be seen to be generated by this discussion, with those that lost services having not worked hard enough to keep them (Wiggan 2012).

Whilst recovery predates the austerity agenda, it does share similar traits and follows a similar narrative of abhorring excess and exulting responsibility. By ensuring that the strategy fits seamlessly with the governmental narrative of the time, it seems to appear to be a coherent, fitting and modern take on drug addiction. This allows a lay reader to fill in the blanks in the strategy with their own knowledge of drug addiction, which is usually found from fiction and which is largely drawn from abstinence-based narratives (Nutt and Macken 2011). Whilst these gaps serve to help the policy earn favour with voters, these gaps again prevent treatment agencies from being directed as to what central government want from their treatment services. This abdicates responsibility from central government to local government, commissioners, treatment agencies and ultimately, their staff.

2.4.3 Spoiled identities

A common thread in the narrative of drug addiction is that of redemption and the process of becoming a 'new person' through effective treatment. It is common to see user narratives discuss concepts such as 'new life' or 'second chance' when describing recovery (Laudet and Humphreys 2013). This process is also echoed in the 2010 NDS, with frequent references to 'change' and a return to productivity highlighted as a key goal (HM Government 2010a). Most interesting though, is the acceptance that being a former drug

user is a barrier to employment and that without widespread change to our views of drug users, this will not change. This is significant as it recognises the concept of a “spoiled identity”, that the impression we give to the world and from which others draw their impressions of us has been in some way tainted, so that others will not interact with us in a ‘normal’ manner (Neale et al 2011b). Drug use is seen to have additional power when forming identity, with other addictive behaviours such as sport, smoking and eating not having the same level of mutating effect on how others see us (Fomiatti et al 2017). As a result, the addict identity often becomes the primary identity for the user, with all social interactions passing through this identity. The primary identity becomes the reason for all actions and any behaviour (deviant or otherwise) is seen to be the responsibility of this identity. Recovery seeks to change this identity by introducing new situations, groups and responsibilities to the user. The recovery model recognises these problems of identity and attempts to rehabilitate the identity of the user as well as change their addiction. By recovering the identity as well as the individual, the user also builds their recovery capital, allowing them access to drug free groups that would be beneficial to long term abstinence (Fomiatti et al 2017). It is believed that by being around drug free individuals, the drug user learns the behaviours and mannerisms of the ‘normal’ group, thereby allowing them to further reintegrate into society. Furthermore, by removing them from others who are engaging in drug use, it is felt that the temptation to use is reduced and it becomes easier for the client to remain drug free. However, in the context of ‘recovery champions’ it is difficult to see how these individuals are actually removed from socialising with drug users as this has become their vocation rather than a pastime.

2.5 The views of workers

A key area that this research sought to address was the understanding of drug treatment workers of the recovery agenda. Research into drug workers is limited and unusual (Simons et al 2017) in comparison to the quantity of research from a provider level (usually quantitative, such as Gossop et al 2002) or at the client level (such as Lopez Gaston et al

2010). Two pieces of research into the role of frontline British drug workers are Weston (2016) and Seddon et al (2012), with both pieces of research looking into the part British drug workers play within the treatment field. Research into worker beliefs and organisational behaviour, however, generally originates from the US or Canada (such as Culbreth and Borders 1999, Eversman 2010 and Chandler et al 2011) and is focussed on counselling rather than the British system of key working. This limits the comparability of the studies as the workers in the US and Canada are usually graduate counsellors or therapists who have a background in substance misuse, whereas the UK model employs people from a variety of backgrounds and specialisms. Similarly, there is a difference in the workers' relationship with drugs, with in-recovery workers generally outnumbering those who are non-recovery (have never had treatment for a substance misuse problem) but are still trained in psychosocial interventions (Culbreth and Borders 1999 & Duryea and Calleja 2013). In the UK this is not the case, with workers having a diverse background but workers with an in-recovery substance misuse problem being a minority. Within existing research, it is argued that in-recovery workers are more likely to recommend 12-step based treatment and are more likely to be rigid in their outlook on what treatment works, offering mainly what worked for them in their recovery and being less likely to deviate from this path (Simons et al 2017 & Culbreth 2000). Culbreth (2000) argues that (in the US and Canada) there exists a conflict between workers in recovery and those who are not, finding that there is antagonism between the two approaches. Workers who are in-recovery are more likely to have negative opinions as to the quality of work of their non-recovery peers. This is partially explained by an 'expertise or experience' debate as to which has primacy, with academic support mainly being for experience being an equalising factor (Culbreth 2000 & White 2009). This was an area of contention for Best et al (2010) too, with workers interviewed in the UK disliking peer support workers being granted an equality of expertise with professional drug treatment workers. It was identified as being a major stumbling point for the acceptance of recovery within the UK, as peer support was identified as being a key component of successful treatment. Within this

research, acceptance of peer support and peer support workers as being equals is being used as an indicator of recovery ideology being accepted within the treatment services.

Within the research into drug treatment, there is a lack of focus on the role and perspective of the drug worker, perhaps in line with the perceived lack of professional status for the role. In British research where the opinions of workers are given, it is often through the lens of the drug user's views on the opinions of workers. Quotes of workers are largely absent from the research (see Lopez Gaston 2010 & Rance and Treloar 2015). In cases where workers are able to give their opinions, it is often focussed on policy or procedure (Seddon et al 2012) and intermingled with other professionals (HM Government 2010b) or focussed upon a specific type of treatment model and presented as a consensus (Best et al 2010). There is also a particular characterisation of the drug worker as closed minded and medically focussed (Best et al 2010 & Lopez Gaston et al 2010) which this research seeks to challenge. As highlighted within Chapter two, one of the main catalysts for the change to recovery as a dominant model is the perception that the harm reduction model was not optimistic enough and served merely to 'park' users on methadone (McKeganey 2014). Similarly, research into drug worker opinions and drug treatment has generally categorised drug workers as being pro-methadone, pro-harm reduction and serving as a barrier to the general application of recovery as a model (Page et al 2016, Best et al 2009a & Kelly 2017), or being in some way motivated into keeping the drug user in treatment for a long time (Best et al 2009b). Again, this is a characterisation that this research seeks to challenge as it does not reflect the experience of the researcher within the field.

2.5.1 Worker perspectives of organisational ideology

As well as the workers' opinions, it is important to research their perspectives within the organisations as this is the perspective they will present to the client in treatment. However, when considering the role of the worker within an organisation, their personal ideology should not be ignored or their opinions considered to be homogenous. The concept of a

singular voice for all drug workers is baseless, offering little insight into the group beyond their working practices. As can be demonstrated with other organisational groups, the personal ideology of those groups is as much a part of their professional being as is their work within the organisation (Coulangeon et al 2012). The perception of drug worker culture is of it being monolithic, with workers generally appearing to be resistant to recovery and in favour of methadone maintenance (Best et al 2010, Lopez Gaston et al 2010 & Best 2017a). But, as has been shown with Police culture (Pauline and Gau 2018), the concept of monolithic occupational cultures should be challenged as it leads to generalisations about the responses to occupational stress. In the case of drug workers it leads to generalisations of the treatment available and can be used as a crutch to prevent critical analysis of new types of treatment. Without research into the occupational culture and ideology of drug workers, it is impossible to comment on the acceptability of advances in treatment or changes in occupational practice.

In the limited existing research into drug workers, it is possible to glimpse organisational culture and the interaction between personal belief and working practice. In their work on the acceptance of crime reduction as a component of drug treatment, Weston (2016) clearly identifies areas where drug workers are and are not accepting of organisational definitions of treatment. Within this, they demonstrate that drug worker knowledge is constrained by the organisational focus of the treatment provider and contract they provide. As such, knowledge of mental health support (particularly dual diagnosis) and multi-agency working outside of the CJS is stunted within the sample of workers. This is particularly problematic given the status of drug treatment as 'knowledge work', whereby knowledge is deployed to make reality governable (Seddon et al 2012). By limiting the knowledge available to workers, we limit their ability to make changes to the client's life and thereby limit the ability of treatment to have a meaningful effect. In this way organisational culture, particularly in regards to the

meaning and definition of recovery, is vitally important as it cuts to the heart of the purpose of treatment.

Research into worker perception of recovery is important if there is to be insight into the role recovery is playing within modern drug treatment and any absence of worker voices within the discourse surrounding treatment will only serve to obscure the true picture. Discrepancy between occupational and personal definitions of recovery are similarly important, with workers in other occupations demonstrating that personal views are not necessarily indicative of worker activity. This represents an identification that their personal ideology has not matched up to that of the organisation, but also a resignation that as a professional group they do not have power to change public policy, so have adapted their professional response to match the ideology of the provider (Polcin 2014). This is the adoption of the professional identity of the 'drug worker' (Simons et al 2017), whereby the worker accepts that their own beliefs may not be replicated within the employer. The professional identity of the 'drug worker' is an acceptance of the organisational philosophy of recovery being linked to abstinence, despite this not matching up to their own personal ideology of recovery, but linking them to their personal attributes. This acceptance is also of a very specific form of abstinence: free from illicit use of heroin and cocaine and free from prescribed opiate replacement medication, as this replicates the government definition of recovery and an acceptance of the data the worker collects on recovery (Mason et al 2015).

2.6 Recovery and this research

The 2010 NDS did not introduce the concept of recovery to drug treatment in England and Wales; in fact it further developed the concept from the 2008 NDS. What it did implement was a wholesale redesign of the drug treatment system from an instrument of the criminal justice system to one of the welfare system. What is clear though is that these kinds of redesigns are not uncommon and represent a change in what Foucault (1972) called the

'speaker' in a discourse. For instance, in the early part of the 20th century, medicine took over as the primary voice in addiction discourse from criminal justice. Whilst the criminal justice agencies did not stop discussing addiction and drug use (or else criminal justice policy surrounding drug use would cease), they lost their primacy over the discourse on addiction itself (rather than drug use, which they retained). Again, over time the primary role medicine had in driving the discourse surrounding addiction was eroded by the rise of psychiatry and then criminal justice again in the New Labour era. It is important to consider that whilst these fields each held the driving role in the discourse (and thus policy) of the time, the other fields still discussed addiction, but were denied the audience they once had. The shift to recovery from harm reduction merely represents this same kind of change in primary speaker, with one subtle difference: there is no 'field' as such behind recovery, it is instead an amalgam of ideas and speakers. Recovery supporters would likely consider their primary speaker to be drug users themselves and certainly it is possible to see why they would argue this. McKeganey (2014) certainly framed it this way, suggesting that recovery is the voice of the drug user made into policy. Whilst it would be impossible to deny this, it is important to consider the role that other speakers have had. Fiscal conservatives and social libertarians from the right have added their weight to the discourse, prominent academics (such as McKeganey himself) have offered support and celebrity endorsements (such as Russell Brand, George W Bush and Barrack Obama) have brought the discussion to areas of society that previously would not have discussed such matters. It would also be remiss not to mention that the discourse surrounding addiction has been reframed from a criminal justice exercise to a welfare issue, framed within the national narrative of austerity, with government linking the narrative of recovery into the narrative surrounding the national recovery following economic crisis. In this context, the creation of the drug user as 'other' is useful, as it helps to justify spending cuts across a number of sectors under the guise of restructure (Monaghan and Yeomans 2016).

Despite the change in primary speaker, we have also seen a change in the level of clarity given in the NDS, with contentious terms such as 'drug free' and 'recovery' being used as if they are definite objects that we can easily identify, rather than socially constructed methods of describing a problem that does not exist outside of the context of the problem itself. As Lancaster et al (2015) describe, the problems described by policy are often developed to be solved, rather than existing in the world beforehand. Certainly, it could be argued that the state of being 'drug free' cannot accurately be described without reference to the law or biology. As shown by the Psychoactive Substances Act 2016 (which essentially outlaws all stimuli unless decreed by law to be legal) even this is problematic in the extreme. Recovery itself is also vague and opaque to the public, offering a relatable journey but not actually describing the relevant landmarks along the way. Instead it is the purpose of the drug user and the treatment provider to supply context for the journey and to define the goals that the addict must hit in order to achieve abstinence.

It is this interpretation that this research project seeks to explore, by discussing the nature of recovery and the construction of concepts of addiction with professionals at the local level. Where recovery stemmed from the voices of the addicted, this project seeks to understand the voices of those that provide treatment, with the aim of understanding the relationship between public policy and those that are forced by their role to interpret it. This research will be examining this process at a number of levels within local treatment, from local commissioners to treatment managers and finally to substance abuse workers themselves. By discussing the process through which they understand addiction, treatment and recovery it is hoped that some understanding will develop of the relationship they form with the policy that guides their actions, but also the speakers they listen to, the influence of their background and their ideology on addiction.

The purpose of this chapter is to demonstrate the historical context of the shift in drug policy within the UK as well as the theoretical underpinning of the recovery movement. The 2010 NDS indicates that the UK policy of prohibition and third sector treatment are historical values and that these are not up for debate, in effect enshrining the status quo of drug use as being morally wrong and a crime. As has been shown here, these values are ever changing, with the UK historically adopting a more tolerant approach to drug use that echoes the European, Catholic traditions of our geographical neighbours rather than the prohibitionist, Protestant traditions of the US (Stevens 2011a). In comparison to the US, the UK has only relatively recently adopted strict prohibitive policy with regard to drug use. As this chapter has demonstrated, the policy on drug use and especially drug treatment has changed focus as well as primary discipline throughout the past century, moving between medicine, criminal justice, psychology and now to user-informed policy. Whilst these speakers gain primacy for a time, there continues to be a wide discourse on the benefits of treatment that emanate from all speakers; it is merely that one gains prominence within policy. Currently, the policy is focussed on discourse coming from users and user-based research. However, there remains an economic core to the current NDS as well as an ideological shift toward responsibility which underpins the coalition policy in general. It is this responsabilisation of drug use which represents the largest change to existing drug policy. With users no longer seen as passive participants in addiction who need to be protected from risky behaviour, but rather as motivated participants who have not just a stake in their own treatment, but also a responsibility for the damage their addiction has done to society. This change to responsibility echoes the shift to societal responsibility that was a core of the 'Big Society' project and the benefits policy under the coalition. Behind all the policy lies the austerity agenda too, with cuts to funding being a central component of the NDS as well as the change in philosophy. As has been demonstrated, the language of personal responsibility is a through line through the NDS, austerity agenda and recovery as a whole meaning that that policy has a veneer of logic that makes sense in the political climate following the 2008 financial crisis. This linkage of addiction discourse and economic policy is

not a new concept, with FDR using the language of addiction and AA in his speeches surrounding the New Deal.

This chapter has also demonstrated the opacity of the concept of 'recovery' and how the NDS does not offer much in the way of clarity regarding the concepts surrounding successful treatment. Within the policy of introducing recovery, it is possible to see a further advancement of prohibition surrounding drug use. There has been an increase in the moral language used to judge drug-using behaviour and this has been linked back to the concepts of citizenship and responsibility. However, there is no guidance on what is expected of a drug user to achieve 'recovery' under the government policy. This reflects the theory surrounding recovery, with academics and addiction clinics differing in subtle, but meaningful ways on what recovery actually means. As can be seen within the chapter, it is impossible to demonstrate a universally held set of criteria for achieving recovery, with much of the literature pointing to this being a state reached by the user when they themselves feel they have achieved it. This flexibility in outlook is a strength of the concept, with users able to set their own goals. But in a policy which further advances the managerialism of drug treatment that typified the New Labour government, through the introduction of payment by results, this represents a poor measure to quantify success. Without receiving understanding from central government on what is deemed to be successful recovery (beyond being out of treatment) it is up to the local drug treatment community to determine the 'real' meaning of recovery, which leads directly into this research.

Summary

It is the premise of this chapter that the roots of recovery lie in the historic narratives surrounding treatment and only by examining current treatment in a historical context is it possible to see the origins and influences of policy. Similarly, it is important to see the historical context of recovery itself in order to attempt to create a working definition of a

concept that has been historically difficult to define. This chapter also looked at those that provide treatment, with workers examined as a group and existing narratives and understanding explored. This will be examined further in later chapters, with existing understanding evaluated and academic preconceptions discussed in context with this research.

Chapter 3: Neo-liberalism and Drug Treatment

3.1 Introduction

In Chapter two the 'new penology' was applied to drug policy in the UK as a method of understanding how risk assessment entered drug treatment discourse and practice. In this chapter, the role of the 'new penology' will be applied to UK drug treatment as a whole, looking at the changes within policy and how these have changed the treatment offered to service users. This chapter serves as an expansion of the discussion held in Chapter two, expanding on the main themes and theories associated with the 'new penology' and applying them to drug treatment and policy. Where Chapter two presented the historical context of modern drug policy, this chapter serves to examine that same policy through the lens of the 'new penology'. In doing so, it is possible to examine the role of risk assessment within UK drug policy and the changing definition of what 'risk' means within treatment. This chapter will also examine the theories of Garland and O'Malley who expanded upon the 'new penology' by speculating upon the origins of this change in policy. In looking at managerialism and the influences of neo-liberalism and neo-conservatism on drug policy, it will be possible to discuss the practicalities of engaging in drug treatment within this period. The creation of this theoretical framework allows the physical act of treatment to be discussed within the context of measurement, risk management and outputs, demonstrating the relationship between the act of treatment and the surrounding practice for workers. This discussion proved to be important in the interviews with drug workers, with the practicalities of 'knowledge work' being informed by the 'knowledge' being used as much as it is by professional practice (Seddon et al 2012). As such, a discussion about the formation of worker 'knowledge' and how government policy impacts upon this knowledge (for example, through treatment outcomes) is vital. As these theories mainly discuss the circumstances surrounding the origins of the 'new penology', this chapter will address them first. Whilst addressing interrelated theories outside of chronological order may seem initially counterintuitive, it is felt that within the context of this chapter this approach will provide the reader with a greater understanding of the main issues than a chronological discussion.

3.2 Contradiction and volatility

Before discussing the work of Feeley and Simon (1992) this chapter will discuss the work of David Garland, who also sought to explain the 'contradiction and volatility' of modern penal policy. Garland (1996a) argued that the changes in modern penal policy are explained by the normalisation of crime and the associated state reaction. He argued that crime itself had reached the level where perception of it had now transformed into an expected state, with citizens adapting their lifestyle to anticipate crime rather than expecting the state to protect them from it. This was similarly reflected in the 'criminologies of everyday life', such as routine activity theory and rational choice theory which increased in visibility at the time (Garland 1997). In these theories, crime was seen as expected and the offender was a rational individual. In short: crime was normal and so were offenders. In these criminologies, the offender is no longer an 'other' seeking to be cured, but one of 'us' merely changed by the situation into being a criminal and rationally acting in the situation they are placed within (Garland 1996a). This created criminogenic locations as well as situations, and criminal intent was being relocated out of the body and into society. In this respect, the criminologies of the time reflected the normalisation of crime as a whole, with criminality increasingly being seen by the population and government as something that cannot be cured or eradicated and merely something to be deflected, prevented or managed (Malkin 2005). This normalisation continued into the state itself, with state actors no longer viewing crime (and as a result, criminals) as an object which could be controlled, but rather a fact of life which needed to be prevented and managed through risk management. When looking at drug policy it is possible to see this process being replicated, with drug use being identified as normal. Even the theories surrounding drug use identify the drug user as rational, with the adoption of AA/NA thinking about addiction dominating the current discourse surrounding drug use (Singleton and Rubin 2014).

Because of the normalisation of crime the state is placed in a predicament, as the preferred solution is to retreat from crime, as nothing can be proved to actually change crime ('nothing works') (Garland 1996b). In essence, the state would remove itself from crime control as it does not work, yet this would be political seppuku, with the party not only showing 'weakness' to the populous with regard to crime, but also offering their opponents political ground from which to attack them. The seizing of the 'law and order' political territory by Tony Blair and New Labour in the 1990s demonstrated the potency this area still had with the electorate and it could not be abandoned without significant consequences (Brownlee 1998). This lack of confidence in being able to change crime rates meant that the state could do little to control the crime rate, but it could still manage the *effects* of crime. Garland (1996a) offered two solutions taken by the state in order to address the normalisation of crime: adaption or denial. Adaption represented the state changing their responses to crime to adapt to its new status as normal, whereas denial represented the state attempting to double down on their capacity to control crime through punitive action.

3.2.1 Denial

Garland (1996b) refers to the doubling down of the state as being 'denial', a quixotic attempt to reassert the state's primacy over crime. This often takes the form of punitive punishment of particular individuals as a demonstration of the state's power. The government response to recent acid attacks is an example of this kind of response, with government offering new legislation and sentencing powers as a solution to an emerging problem (Worley 2017 and Dearden 2018). This is despite existing laws and powers already covering the offence and there being little indication that these new laws and powers would actually impact upon the prevalence of this crime. In their impotence, the government resort to punitive shows of power to demonstrate to the public that they still have 'control' over crime, leading to the growth of populist punitiveness. This response typifies Garland's (1996a) denial response, with increased sentences being used to reassure the public that the state can do something

about a crime concern when in fact this is beyond the state's control, leading instead to a ratcheting up of sentences for criminal offences.

This archaic response of using sovereign power to crush an 'other' represents the state's inability to protect society and as such represents the futility of attempting to control crime in the modern world when 'nothing works'. This can be directly compared to the public execution of Robert Damiens, with the state demonstrating their power to the public using the bodies (or in this case liberty) of criminals (Foucault 1972). Again, this response is visible in drug policy, with 'special' sentences being designed for drug users (DRRs, drug wings) and the resultant sentences largely being more punitive than for a non-drug user (Stevens 2010). Here the state is trying to show that it can 'deal' with drug use and offer society a solution. In the vein of New Labour's "tough on crime, tough on the causes of crime" mantra, early 2000s drug policy balanced this increased punitiveness with the knowledge that the tougher sentence would carry with it drug treatment. Whilst they are serving the denial function by offering tougher sentences, they are also being 'tough on the causes of crime' by seeking to cure addicts of their addiction. This echoes the Rolleston era discussions as to what is the cause of addiction, with the removal of drugs from the body being seen as a cure for addiction by some medical professionals of the time (Berridge 1999). In this case the government seeks to remove drugs from the body in order to cure the criminality. By replacing illicit drug use with prescribed medication, the criminal will no longer need crime and thus be 'cured' of their criminality.

In the harm reduction policies of the early 2000s it is possible to directly view the increased punitiveness of state responses to drug use, with DRRs being used to keep risky drug users within the criminal justice system (CJS). From this perspective, the measure of 'risk' associated with drug users is their risk of reoffending. By keeping drug users within the CJS

(through punitive sentencing), the state is reducing the risk associated with that individual. In the recovery model, the discourse surrounding treatment is that it works, but that the client needs to engage fully. Here the blame for failure is placed upon the client for whom treatment is unsuccessful and as a result, the state response (loss of treatment, benefit sanctions) is justified (Wiggan 2012). Again, it is possible to see the measure of risk here too, with the 'risk' measured being their likelihood of entering paid employment.

Contrary to Garland's (1996a) other method of adaption, denial serves to remind the public of the power of the state through symbols of the past as well as demonstrations of sovereign power. Harkening back to the 'golden years' of criminal justice is a common factor within this response; in essence the state is providing the public with periodic reminders of the potency of its power by reminding them of how society functioned before crime was normalised. Simon (1995) argues that this is actually a form of nostalgia and is unconnected with the facts of modern life or even the period that is being reflected upon. Calls for 'boot camps' and other forms of militaristic punishment do not reflect the nature of modern day military training. Similarly, even the time they reflect back upon is absent from modern life, with manual labour and manufacturing no longer dominant pillars of the economy (O'Malley 1999). This means that punishments which would serve to reintegrate the offender into society through these means no longer have any meaning. It would be unlikely that a proponent of boot camp style punishment would encourage a truly modern form of this punishment as it would prepare the offender for a career in the service industry and would not constitute the physical labour that categorised this type of punishment in the past. This is despite the service industry being the largest employer in the modern UK and therefore the most likely route out of unemployment and crime for the offender (Department for Business Innovation and Skills 2011).

This nostalgia is not just reserved for time period, but also the punishments themselves. Caning, the death penalty and physical torture can be seen to enter the public discourse when the denial response is being invoked (O'Malley 1999). In terms of drug treatment we see the recovery model itself being built upon the idea of treatment working for others so it will work for everyone. The addict's narrative of a fall and then a redemption is used as an example of how things have always worked, with nostalgia for successful treatment being used to propel current treatment (Cannon 2013). This notion of abstinence working for some is key to the recovery model, with recovery champions being employed to demonstrate that treatment can be successful (HM Government 2010). In this narrative, the state (through the form of drug treatment) is seen as being effective when it allowed drug users to be drug free. Similarly, in discourse on drug consumption rooms or heroin prescription we can see nostalgia for the older 'British system' where the state and wider society stayed out of a private medical event.

3.2.2 Adaption

Under this response, the state will enter into a period of retraction, offering a more 'hands off' response to crime and crime control. For Garland (1996b), this represented an evolution of the state response, with state agencies shedding responsibility for crime and crime control, and the community and non-state organisations taking the burden. Under this response, the offender is painted as being little different to other members of the state, meaning that crime itself is normal and criminals are not 'other' (Miller 2001). This absolves the state of the responsibility to 'cure' the offender as it is accepted that they are no different to the rest of society. As part of an adaption strategy the state will mobilise non-state agencies and pass responsibility to them to deal with crime control. This 'responsibilisation strategy' represents an adaption to existing crime control strategies, whereby the state removes itself from the direct process of crime control and instead operates at 'arms length', using the third party agencies to manage crime for them (Miller 2009). This results in the state taking a new role in crime control: that of manager, assessing the work done by other agencies as well as

observing the efficiency of the work. In this way the state abdicates its responsibility for crime rates and for crime control in general, yet it does not lose any of its power to control. Rather, it gains additional means of control through the additional roles it has taken on in managing the non-state agencies (Gray and Salole 2005). The state now directs the control and the measures of success and failure whilst losing much of their accountability for it. This strategy also serves to change the discourse surrounding crime control, with discussions surrounding crime control now focussing on expenditure, efficiency and effectiveness, replacing rehabilitation and causes of crime as dominant discussions (Garland 1996b).

Agencies themselves will go through a transformation, with individual cases being expelled as the primary measure of success. Now measures of throughput and budget responsibility are seen as the key drivers of criminal justice agencies. For example, looking at the most recent HM Prison and Probation Service annual report (HM Prison and Probation Service 2018) we can see the managerial focus. Deaths in custody and the low levels of escape are given primacy (in position and length of discussion) over more traditionally rehabilitative measures such as education and employment. Garland (1996a) argues that this method of adaption serves to not just reduce the state intervention in crime control, but also to insulate the state from criticism when crime does not fall or when recidivism rates increase. By reframing the debate around crime control, the state is able to temper expectations surrounding crime control, in part because the state is no longer directly in control of crime control. It is the stakeholder who will take the blame for rising crime rather than the government. HM Prison and Probation Service (2018) demonstrate within their report that measures of throughput (completed orders) are more important a measure of success than traditional rehabilitative measures of success. Although, if they were to underperform in this area, it is the service which will take the blame and not the government as a whole. Devolution of responsibility has rendered the government merely a manager, rather than provider of rehabilitation. Within the context of drug treatment, it could be argued that

recovery as a model is merely a development of the adaption method, with the government abdicating responsibility to the community (both the drug community and the local community) to solve the issue of drug use. However, through the use of outcome measurement they are able to retain control of the direction of treatment and to ensure it matches with national definitions and policy. In drug treatment policy, this is demonstrated in terms of the practice of the workers themselves. As is demonstrated in Chapter 5, workers face this abdicated state responsibility directly; workers are charged by government to deliver effective treatment but the measures of that effectiveness are controlled and changed by the state.

3.2.3 Subjectification

Garland (1997) cites Foucault as an inspiration for his ideas on normalised crime and its responses. Particularly, he draws upon the ideas of agency and the 'active subject'. In this Foucault (1982 cited in Garland 1997) is describing the way in which power is exercised through the actions of society as a whole. Citizens are created and are empowered to have 'agency' (the power to make decisions) by the state. These citizens are then shaped, so that their choices and ideas align with a particular organisation (in this case the state itself). The citizen is capable of making choices, but these choices are not 'free', in that they are not without constraint. The shared norms of society itself serve to control the range of their choices. The citizen will in turn internalise the norms and rules of the state and thus the citizen serves as a willing participant in their own 'subjectification'. In this way, the state does not need to use sovereign force or discipline to control their subjects; the citizens control themselves through their own (restricted) choices. Garland (1997) links this to the concept of adaption, with citizens acting together to 'choose' not to commit crime, or to work on crime prevention techniques. In this way the individual is 'responsibilised', in the same way as non-state agencies are, to prevent crime. Again, this serves to limit the state's liability for failure whilst also failing to dilute state power (Hakkarainen et al 2007). If we consider car insurance (insurance being a key foundation for many of Garland's ideas), we can see a narrative that

citizens are responsible for the reduction in risk that insurance brings, rather than the state protecting the citizen from harm through better road safety. The state even reserves the right to punish those that are irresponsible enough to not have insurance and yet still use the roads, providing them with power which would not exist without car insurance. The consumer has agency in that they are free to make choices (to have insurance or not, to drive or not), but these are not free choices. They appear within boundaries and state prescriptions, which mean that the consumer cannot truly make a free choice (Garland 1997), yet the choice 'seems' free and the citizen has subjectified themselves. In terms of crime control, the citizen is free to choose to not protect themselves from crime, but as a responsabilised individual, they have made the choice not to protect themselves and so the blame for crime sits with them and not the state. Garland (1997) uses the example of drug use and how it is not seen to be morally wrong, but is instead viewed as imprudent as it will likely lead to prison. Here the citizen has not made a 'free' choice as such, as the norms of society have constrained those choices, yet the choices will seem free. In subjectifying themselves, the citizen has made themselves a part of the state, but also part of the punishment for breaking the rules.

This concept of the 'active subject' ties directly into modern penality, with choice and cooperation being part of the tapestry of modern punishment (O'Malley 1999). A responsabilised citizen will recognise that it is the criminal who should rehabilitate themselves, rather than the state, as crime is normalised and the actor rational. If the actor is rational, then they know what they did was wrong and so cannot be rehabilitated beyond their own actions. In this way, the 'old' measures of successful criminal justice policy are washed away and replaced with actuarial measures of efficiency and risk, and they do not seem out of place with a citizen's expectation of crime control. Within drug treatment, the responsabilisation of the citizen is seen through the recovery model, with opportunities given to the drug user to recover from their addict status and re-join society as a productive

member (Carlin 2011 & HM Government 2010). Given that the AA/NA tenet of accepting responsibility for the damage you have caused to your local community is part of the 2010 National Drug Strategy (NDS), it could be argued that this represents the drug user acquiescing to society's views of drug use and them actually 'subjectifying' themselves. In this way, treatment serves not just as a method of 'curing' drug treatment, but also as a way of reintegrating drug users into society.

3.2.4 Neo-liberalism

The ascent of neo-liberalism as a dominant ideology of late twentieth/early twenty-first century politics also served to assist the responsabilisation of the state and individuals. With free market economics being a foundation of neo-liberalism, the change in discourse to be economic in nature was not incongruous; in fact it can be seen to be a radical new way of thinking about government. By reframing the crime control debate in economic language, the discourse seems fresh and the ideas new, despite actuarial concepts of risk being part of the CJS for centuries. Malkin (2005) argues that under neo-liberalism, the individual is changed into the client, being given a service by the state. Issues of race and class can disappear under the discussion of consumer rights and consumer feedback. This was personally a startling realisation, as my career was focussed around the use of the word 'client' to describe a drug user. It was argued by myself and my colleagues that the use of 'client' freed us from judgemental or stigmatising language, yet by using this word to describe the drug user, drug workers were assisting with changing the discourse toward economics and away from medical, psychological or social justice explanations of drug addiction. By calling the user a 'client' rather than a 'patient', 'victim' or 'offender' we were inadvertently marginalising the discourse of other explanations of addiction. McCorkle and Crank (1996) argue that this kind of change in organisational language represents a change in institutional authority, with dominant languages developing based upon the main influence of the organisation. This also ties into Foucault's (1972) idea of the dominant speaker defining the discourse surrounding a subject. In this case, it is the influence of economics and neo-liberalism on the

organisation and the dominance of these ideas within the political discourse that causes the linguistic changes. In adopting neo-liberal thinking, the major political parties would accept that sources of welfare would also be marginalised, with personal responsibility taking the foreground as the measure of personal achievement (Malkin 2005). The war on crime was abandoned in favour of a war on welfare. In terms of drug treatment, again the recovery model represents an advancement of the already neo-liberal harm reduction model. Here the 'welfare' of harm reduction is abandoned in favour of the responsabilisation of recovery. The state will encourage those dependent on the state for aid to 'better' themselves by reducing the aid available (Gyngell 2011). By testing 'motivation' (see section 6.3) and seeking to end methadone 'parking', recovery serves to reduce the number of people dependent upon the state for addiction welfare. The employment focus of recovery also serves to reduce the unemployment welfare reliance of this group too.

Garland (1997) discusses the role of economic language within the current discourse surrounding crime control as being a method of changing the mind-set of the population towards crime. As well as emphasising the role of budget management and performance measures within the agencies controlling crime, there is also the projection of economic ideals onto the populous. The concepts of Homo Economicus and Homo Prudens are applied to the population through responsabilisation, casting all individuals into the melting pot of rationality. This is further supported by the criminologies of the time, casting the offender as a rational actor and crime as normal. In this instance, the offender is cast as Homo Economicus: a rational actor merely seeking the best possible outcome for their actions. The victim is similarly cast as Homo Prudens: zero risk man, progressing through life taking no risks, meaning that any risk associated with their actions is their responsibility and not the responsibility of the state. By projecting these archetypes onto society, Garland (1997) argues that we actually create people, aggregates that reflect no one and everyone. By creating populations of people, we better allow for the treatment of people as groups and

not as individuals. This further fits in with the output measures of the criminal justice agencies, as without individualisation we can more accurately measure the efficiency of the agency, and aggregate measures of populations allow us to better determine the risk associated with those populations (Miller 2001). Similarly, incapacitation becomes the logical choice for punishment as it allows accurate measurement of outputs (completed sentences and escapes) without requiring any rehabilitative input from the state. In the climate of 'nothing works' it is rational to justify punishment using incapacitation as it matches the risk management of 'risky' groups typified by adaption.

3.3 Volatility in drug policy

According to Garland (1996a), it is the combination of the two competing methods of dealing with the normalisation of crime (adaption and denial) which produce the volatile and contradictory nature of modern criminal justice policy, with the state oscillating between the two responses to normalised crime. This means that the resultant policy also oscillates between being overly punitive (to demonstrate the primacy of the state) and hands off (to reduce the responsibility of the state). Within drug treatment, this oscillation is more difficult to see, with both harm reduction and recovery offering shades of the same neo-liberal responsabilisation agenda. However, it is possible to see more elements of denial in the recovery model, with the optimistic outlook of theoretical recovery being subverted by the 2010 NDS to be more punitive and reflective of 'denial' than harm reduction. Stevens (2011b) argues that the recovery agenda harkens back to a time when people knew that they should not start taking drugs and that if they did, they should stop. This period of time is imaginary, but represents an attempt to use historical reference to push for more punitive action, a hallmark of the denial response. Although, this observation is insufficient to completely explain either of the approaches, with both harm reduction and recovery demonstrating shades of both adaption and denial in different quantities. Yet it is still advantageous to try to better understand the policy decisions of government through the lens these responses produce, even if it is not sufficient to fully explain them. O'Malley

(1999) offers further explanation of this phenomenon arguing that Garland has misinterpreted the relationship between neo-liberalism and policy decisions. Instead, O'Malley offers a counter argument in the form of the 'new right' and that it is only through this lens that we can truly see the picture of crime control.

3.4 The 'New Right'

O'Malley (1999) identifies six methods of punishment in the modern penal environment which help to explain the modern policy decisions of government. It is my belief that these methods are shared with drug policy and treatment and can be used to explain the policy making decisions of government in regard to drug use as well as the backdrop to the relationship drug treatment professionals have with the policy. The six methods identified are: discipline, punishment, enterprise, incapacitation, restitution and reintegration.

- 1) Discipline - The use of strict sanctions to develop obedience in the offender.
- 2) Punishment - Similar to discipline, but lacks the rehabilitative discourse. Centres around the development of 'moral character' in the offender.
- 3) Enterprise - Involving the offender as an agent of their own punishment and cultivating their agency to make informed decisions. Generally positive in outlook and focussed on making self-fulfilling rather than self-denying citizens.
- 4) Incapacitation - Actuarial determination of sentence as well as apolitical justification for punishment. Rooted in the 'nothing works' justification for punishment.
- 5) Restitution - The state is a symbolic victim of the crime and as such the offender must make restitution to the state in order to atone for the crime. Based in the retributive ideal for punishment.
- 6) Reintegration - Allowing the offender to make recompense and reintegrate into society.

(O'Malley 1999)

When looking at treatment for addiction it is possible to see these methods reflected in the types of treatment offered through the last century. Within the recovery model, it is possible to represent all of these methods at different points, with criminal justice functions (such as DRRs) representing 'incapacitation', and 'punishment' and 'reintegration' representing the overall outcome for recovery. It is in the use of 'enterprise' and 'restitution' that recovery separates itself from other forms of treatment. The desire to engage the drug user in their own treatment and to assist them in making good judgements, as well as making restitution with the local community are key components of the recovery narrative and 2010 NDS (Best et al 2010 & HM Government 2010a).

Like Garland, O'Malley finds crime to be normalised and producing existential problems for the state. O'Malley also argues that the growth of an unemployed 'underclass' poses additional issues as the traditional rehabilitative role of punishment is no longer functional. The underclass represents a "permanently unemployed class" (O'Malley 1999 p.180) for whom the educational and vocational outcomes of punishment are pointless. In many ways this concept is shared with Garland (1996a), in that in both theories the traditional routes out of crime (employment and family) are excluded, trapping an 'underclass' into poverty, crime and unemployment. If these traditional routes out of long-term unemployment and criminality are blocked off, rehabilitative punishment is rendered wasteful and ultimately fruitless (Malkin 2005). This can be explained by the post-industrialist destruction of modernist work (generally manufacturing or skilled manual) which is closely tied to the penal system in Western nations. These forms of well-paid manual jobs would traditionally be the route out of criminality, but the destruction of these industries closes these options off (Gray and Salole 2005). The movement of working class jobs from manufacturing to services means that traditional prison rehabilitation would need to change and in some instances this is the case, with catering courses being offered to a small number of prisoners. However, this would require large scale investment in rehabilitation in prison at a time when Ministry of Justice

investment is in reduction. In the absence of suitable outlets for rehabilitation (and so a perceived lack of effectiveness), it falls to incapacitation to be the logical solution to crime control and with it risk based actuarial measures. The development of actuarial risk assessment tools follows not just a change in penal philosophy, but a general change in society toward risk management as a way of organising life (Miller 2001). Citizens are more aware of risk in their everyday lives, meaning that framing the crime control debate within the discourse of risk makes sense to the electorate. In this way O'Malley follows the explanation given by Garland, offering a description of the post-industrialist society and an explanation of the 'nothing works' ideology which dominates the penal policy landscape.

When considering drug policy the concept of risk is less obvious, however as Seddon et al (2012) discuss, drug workers are integrated into the CJS through their work with offenders and as such are required to engage with concepts of criminal risk in their day to day work. This means that workers are familiar with CJS concepts of risk and will conform to CJS reporting of risk. The New Labour policy of retaining drug users in treatment also echoes the concepts of incapacitation, with risk from these drug users managed by keeping them in treatment rather than the therapeutic value of treatment itself. Again, this means that whilst drug workers are not openly managing risk, the very nature of their work is risk based and a form of risk management. However, this is not the only use of risk assessment within drug treatment, with the concept of harm reduction also being closely tied to risk management. As Mold (2018) argues, the risks to the wider public from HIV/AIDS in the 1980s meant that drug use was considered to be a public health crisis and the implementation of harm reduction was a method of managing this risk. Given this focus on risk within drug treatment, it is useful then to consider how risk and risk management interact with organisational culture, structure and the application of drug treatment itself.

Like Garland, O'Malley recognises the war on welfare which underpins the neo-liberal political landscape and also the economisation of public policy under such a government (Malkin 2005). In neo-liberal democracies, the welfare state is recast as an agent of dependency, locking those supported by it into a cycle of dependency (O'Malley 1999). As rational actors, citizens 'trapped' by welfare are incapable of escaping and returning to productivity as it would be illogical to reduce their quality of life by abandoning the welfare upon which they depend (Wiggan 2012). By reducing the burden of welfare on society, neo-liberals seek to empower individuals to make their own decisions about how to live their lives. By 'freeing' the individual from the shackles of welfare, the state allows the citizen to transcend their current lifestyle (Wincup 2011). Again this links back to 'agency' and Foucaultian notions of decision making and freedom. By reducing the scope of the welfare state, neo-liberals remove the obstacle to making decisions, meaning that the individual is capable of agency in their actions. Responsibilisation serves to assist this process, with the state being slowly removed from citizens lives and replaced with non-state oversight which lacks the moral impetus to 'look after' citizens. Through this lens of neo-liberalism, we can see the rationale behind policies of reduction for the poor and the reduction of state-based actors in the lives of its citizens. This ideology also serves to assist with rationalising cuts in funding to drug treatment, with drug users recast as 'worthy' and 'unworthy' of treatment based upon their desire to be drug free. It is also possible to see the neo-liberal desire to reduce welfare in the change from harm reduction to recovery. The term 'parked on methadone' was used to describe the failure of harm reduction and cast it as an agent of dependency. Again, this agent is responsible for the cycle of dependency that the drug user is stuck within. It is only by removing this agent that the state can 'help' the user return to usefulness. Viewed through this lens, it is possible to see that recovery could be seen as an extension of the neo-liberal policies of government. By reducing the welfare of long term drug treatment, it is argued that the drug user will be more motivated to return to work and to abandon the drug taking lifestyle which is being propped up by treatment. This will be further discussed in section 6.3, where the importance of motivation in treatment is examined.

Despite there being clear evidence of neo-liberal thinking in criminal justice policy, it is telling that Garland (1996a) refers to the policy landscape as being 'contradictory', as policy influenced purely by neo-liberalism should have some element of coherence. O'Malley (1999) argues that Garland has missed an important strand of political policy when forming his ideas of adaption and denial. In tying these concepts to the neo-liberal political ideology he has missed out an important factor: neo-conservatism. It is argued that Garland's concepts of adaption and denial are not fully formed and do not explain the entirety of social policy (Lucken 1998). For example, the punishment of boot camps is easily explained as a denial response by Garland, but this misses the associated rhetoric of belonging and family that are also associated with neo-conservatism. By introducing the additional influence of neo-conservatism we gain an additional insight into the formation of the policy, allowing the policy landscape to be less contradictory. Combining these two ideologies into the 'new right' allows us to see the policy picture through a new lens (O'Malley 1999).

When considering the main areas of concern to neo-liberalism, we can see some clear themes: reduction of the state, reduction of welfare (largely related to the previous point) and the economisation of state function (including free-market principles) (Brown 2006). These can be demonstrated to be shared or at least sympathetic with those held by neo-conservatism. For example, the reduction of welfarism, as highlighted above, is also closely associated with neo-conservatism. Under a neo-conservative framework, the welfare state exists to eliminate the inequalities which are needed to index Darwinian social selection (O'Malley 1999). By reducing inequality, the traditional structures are no longer preserved and the status quo is not maintained. Allowing those that would normally be excluded (through the assistance of welfare), the state allows the erosion of the barriers to entry for careers which have traditionally been monopolised by the privileged, and therefore an erosion of the power of those traditionally powerful (Gray and Salome 2005). Reduction of the state welfare system is the only answer to this. This is despite the neo-conservative

belief that a strong interventionist state is important to control excess, including crime. Under this model the state needs to provide protections and support in order for members to belong to a society and is needed for a functioning state to occur. Within the neo-conservative model, the virtues of discipline, belonging, allegiance and loyalty are lionised and seen as being essential for a state to function correctly. In this way neo-conservatism seeks the same outcomes as neo-liberalism, albeit for different reasons.

Neo-liberalism and neo-conservatism also share an admiration of free market principles, with both arguing for the benefits of a competitive economic system and the application of free market principles throughout society (Brown 2006). Under neo-conservatism though, there exists a loyalty to the state and to the traditional collectives that bind us that is absent (or even derided) under neo-liberalism. Family and community loyalty are important virtues to a neo-conservative, often being introduced into policy through the rhetoric of 're-moralising' the state (O'Malley 1999). Under this thinking, free market principles in and of themselves are not enough; the state and the traditional institutions are there to guide us as well. In order for policy to be effective, it needs to allow the state to interfere in the morality of the nation. In this respect the nostalgia identified previously is understandable. It is a harkening back to a time of obedience and loyalty, where principles and morality governed the actions of the individual and the state. In the boot camp example given above, it is not unimportant that the boot camp model of training doesn't exist in the modern military. This is exactly the point, as it is referring back to points in history where the state was supreme and citizens were obedient (Gray and Salole 2005). This is the polar opposite of the principles of neo-liberalism, where the state is weakened and citizens are encouraged to govern themselves. In essence, this process is akin to the principles of denial that Garland (1996a) outlined, but with a definable ideological core for the historical focus. Neo-conservatism seeks to empower the state to intervene in the lives of those it sees as 'other', pulling policy towards punitive responses to crime. Rumgay (1989) refers to the concept of 'moral force feeding'

whereby the state fixates upon the ethical issues surrounding offending rather than treating the causes. Here the offender is dealt with through social and behavioural engineering, focussing on such activities as time and money management and personal responsibility (Lucken 1998). This can be likened to the re-moralisation of drug treatment argued for by McKeganey (2011c), whereby the morality surrounding drug use is re-introduced to the treatment system, or the responsabilisation of the individual under the AA/NA 12-step programme. It is also possible to see the concept of behavioural engineering at work, with treatment designed not just to cure the disease of addiction, but to provide the client with 'capital', the purpose of which is designed to ensure that the client can re-enter society as a functional and productive member.

If we appraise the recovery model in the context of neo-conservatism, it is possible to see a potential link between the 'new right' and the recovery model. The concept of recovery capital (a cornerstone of government recovery policy) lies in discipline, belonging, allegiance and loyalty also cornerstones of neo-conservatism (HM Government 2010 & Eade and Morley 1999). By encouraging the drug user to rebuild their relationships with their community what is also happening is the rebuilding of traditional neo-conservative values whilst abstinence makes a virtue out of discipline, with the user building a stoicism to prevent relapse. Similarly, the express links between community action and integration in the 2010 NDS line up with the neo-conservative value of belonging, and the moral tone of the recovery model echoes the neo-conservative desire to ensure the preservation of morality in public policy (Wiggan 2012). Whilst these links are not explicit, they seem to be in line with the neo-conservative ideology and may indicate an increased importance of the 'new right' in drug policy, particularly when considered in the same context as the change in cannabis classification from C to B (Brewster 2017). In this case we can see a definite pull away from neo-liberal ideals (which are generally incompatible with prohibition) back toward an interventionist state which is empowered to intervene in the interests of the citizens

(O'Malley 1999). This oscillation between neo-liberal and neo-conservatism in drug policy does not impact directly upon drug treatment as a whole (or at least is more difficult to identify), but does indicate a relationship between these two ideologies in government and drug users.

When examining the oscillation of policy, it is possible to see the push and pull of neo-liberalism and neo-conservatism at work. It can be argued that this 'bi-polar' relationship between the two philosophies is directly responsible for the 'volatile and contradictory' policies identified by Garland (1996b). In this way it is not the normalisation of crime which has caused the policy changes, but the emergence to prominence of neo-conservatism and neo-liberalism. However, beyond the trend of movement between the two philosophies, when using this theoretical framework it would still be impossible to determine which was in ascendance at the particular period of policy design and implementation. This arises because of the similarities that the two ideologies share, but also the way that both ideologies can argue for the same policy from their core principles. O'Malley (1999) cites the examples of Wilson and Zedelewski arguing for the expansion of imprisonment, with both arguing for the same policy, but for different reasons. Both these arguments are consistent with the core ideology of their respective philosophies, yet argue for the same result. For this reason, it becomes difficult to determine the primary ideology responsible for a particular policy decision, with both neo-liberalism and neo-conservatism being able to be read into the discourse in most instances. This is equally true for drug policy, with both ideologies seeming to push and pull at all twenty-first century strategies and neither being seen as dominant. Outside of the argument for 're-moralising' drug treatment, it is difficult to separate neo-conservatism from policies and practice previously identified as neo-liberal. Despite this, the concept of the 'new right' and the push-pull of neo-liberalism and neo-conservatism is still an insightful lens through which to analyse policy decision making. It can allow researchers to discuss the ideologies of the various actors involved in policy decisions and

implementation as well as allowing the researcher to view the volatility and contradiction identified by Garland (1996b) with a fresh perspective. It is also the view of this thesis that this lens allows a better understanding of the motivations of the drug treatment professionals in their relationship with drug policy, particularly their relationship with recovery or harm reduction.

3.5 Revisiting the ‘new penology’

Feeley and Simon’s (1992) theory of the ‘new penology’ is directly relatable to the work of Garland and O’Malley that has been outlined above. Under the ‘new penology’, managerialisation of the criminal justice system can be seen to be a direct result of the conundrum posed by the normalisation of crime as well as being a natural extension of the neo-liberal/neo-conservative ideological tug of war outlined by O’Malley. Indeed, the ‘new penology’ is a direct response to the evolution of crime into being considered to be an everyday occurrence (Miller 2001) and is also argued to be a postmodern interpretation of crime control (Simon 1995). The ‘new penology’ demonstrates a move from the rehabilitative crime control measures of the ‘old penology’ toward a criminal justice system categorised by risk assessment, managerialism and measures of effectiveness. In this way it can be seen to be the common thread between O’Malley and Garland and demonstrates a bridge between the two theories despite predating both.

The war on welfarism is present in both theorists’ ideas, with O’Malley (1999) identifying this common thread in both neo-liberalism and neo-conservatism. In contrast Garland (1996b) identifies neo-liberalism and most specifically the technique of adaption as being the cause of the reduction in welfare within the crime control methods. However, the ‘new penology’ eschews such ideological underpinnings. Under the ‘new penology’, Feeley and Simon (1992) identify the ‘market’ (meaning free market principles) as replacing the interventionism and welfarism of the state, with economic measures of efficiency and effectiveness replacing

measures of rehabilitation as definitions of success in punishment. It is not a 'war' which has displaced welfare, merely a shift in what Foucault (1972) considers the 'speaker', with the primary discourse shifting toward economics rather than more traditional notions of social justice, medicine and psychiatry. Indeed, the concepts of the 'new penology' are economic in origin, taking concepts applied regularly within economics and translating them into the criminal justice system (Miller 2001). Ideas such as performance management and budgetary responsibility are commonplace within business, but are new ideas when applied to state controlled crime responses. As Garland (1996a) identified, the reduction of the state in the control of crime represents the responsabilisation of the community and non-government agencies to protect society from crime. This also serves to insulate the government from failings of the criminal justice system (such as recidivism) through their hands off management of the agencies responsible.

The 'new penology' represents a shift in personal responsibility, in that the state is no longer considered to be the primary provider of protection and the individual must take responsibility for their own actions (Field and Tata 2010). For Garland this represents the individual accepting responsibility for their part within the crime, both as perpetrator and as victim. Garland gives the example of the adoption of Homo Prudens as the archetype for a citizen, with those who do not protect themselves from risk being in some way blamed for the crime that befalls them. Miller (2009) argues that the 'new penology' also represents the primacy of 'positive liberty' (and the hierarchies of liberty), the freedom to be self-directed as long as that self-direction falls in line with the norms of society. Miller (2009 p.443) cites Isaiah Berlin *"If you fail to discipline yourself, I must do it for you; and you cannot complain of a lack of freedom, for the fact that you are [in court] is evidence that... like a child, a savage, an idiot, you are not ripe for self-direction"*. In this quote, we see Foucault's concepts of 'agency' at work, this time framed as being 'positive' and 'negative', with those decisions that fall in line with the norms of society being seen as positive freedom. For an individual to be granted

agency, they must act in accordance with the norms of society, for those are 'higher' norms granted special status by their general acceptance. When viewing drug policy through this theoretical framework, it is possible to see this notion of 'higher' norms at work, with those who accept the primacy of abstinence/recovery being seen as more 'worthy' of treatment than those who wish to continue to use. Similarly, under the harm reduction model, those that wish to offend whilst using drugs (or who are arrested for using drugs) are not permitted 'positive' freedom, rather the court strips them of this, imposing treatment on them even if the offence does not warrant a community sentence (Stevens 2010). Under the recovery model this is again demonstrated in the attitude to work, with those that choose to work (either paid or voluntary) being given enhanced status over those who 'merely' became abstinent in that they are given the status of 'recovery' whereas those unemployed may have this withheld (O'Neil and Loftus 2013). This moralising over the hierarchy of freedom is indicative of the influence of neo-conservatism, with moral norms and traditional structures (such as employment) being lionised and praised, and in effect society being 're-moralised' as a result of the policy (Lucken 1998). Despite being apolitical, the 'new penology' actually allows for a significant re-moralisation of criminal justice, with offenders (particularly drug users) being advantaged or disadvantaged by how their use of agency matches up to the norms of society. Those that make choices which fall outside of the preconceived notions of how someone in that position *should* act, are likely to be considered to be making bad use of their agency and so will be disproportionately sanctioned (Marquart et al 1999).

The 'new penology' also serves to allow the state to move away from personalised crime control and punishment, with actuarial risk assessments replacing rehabilitative treatment. The apolitical foundation of the 'new penology' allows it to function without any broader social goal or narrative of purpose; crime control is merely an output of efficiently run organisations. In this way drug treatment is merely a function of well-run treatment agencies, with efficiency being the main measure of success. In the case of recovery, we see this in

the positive output of being out of treatment which, as shown in Section 5.3 is not a measure of a person being drug free but merely a measure of a person being out of treatment (Mason et al 2015). This demonstrates a number of significant influences from the 'new penology' on drug treatment. Under harm reduction the key to successful treatment (within tier 2 services) was a person remaining in treatment for 12 months or being transferred into more intensive tier 3 or 4 treatment (NTA 2009). This signified nothing more than the person being in treatment. Whereas under recovery, this morphed into a person being out of treatment for 12 months, again not a measure of successful treatment but a measure of the efficiency of the treatment provider to get a drug user out of treatment. In both cases, the treatment itself is irrelevant; it is the absence or presence of treatment which indicates success. In the harm reduction model, the large increases in spending were justified by the large increases of people in treatment (Reuter and Stevens 2007). This was designed to create efficiency because longer stays in treatment were indicative of longer periods of law abiding and longer periods of illicit drug abstinence. Neither were actual measures of the success of drug treatment (for example quality of life, finding a home or family relationships) but were actuarial measures of efficiency based upon aggregate data of drug treatment. This mirrors Garland's (1997) ideas on the application of Homo Prudens to society as a whole, with aggregate drug treatment data being applied to all drug users and in effect 'making up' people who do not exist outside of this generalisation. Crucially, within this theoretical framework treatment itself is irrelevant, changes in practice effect nothing and it is the political will of the state that is paramount. The treatment provider is given agency, but they have to use it in accordance with the will of the state (rather than to provide successful treatment) or else their 'positive freedom' is removed. In the harm reduction model, the state's will is that as many drug users are in treatment as possible, whereas under the recovery model the will is that as few as possible return to treatment. In essence, there is no impetus to change treatment; it is the outcomes which are changed. The 'new penology' is demonstrated in both, whereby outcomes and throughput are more important than

effectiveness of the treatment, despite not showing a 'true' picture of how effective treatment is.

3.5.1 Measuring risk

Traditionally, when considering the risks that are being measured by the state it is the risk of reoffending which is discussed, yet this is not the only measure of risk assessed by the state. Marquart et al (1999) identify medical data and medical risks as being used to identify risk associated with prisoners in a way which is similar to medical risks associated with drug users. They identify three types of health risk which are assessed by the state:

- 1) Community: infectious diseases
- 2) Individual: drug use, smoking
- 3) Economic risk: delivering healthcare to the individual

(Marquart et al 1999)

In the context of drug users, we can easily see these risks being assessed within treatment and punishment. Questions about blood borne viruses (BBVs) are common within the assessment paperwork, and reduction in HIV transmission forms the backbone of the harm reduction model of treatment (Stevens 2010). However, these assessments of risk are relatively altruistic in their intent as they seek to reduce the harms associated with drug use, both for the user and the community as a whole. Yet when combined with drug-related punishments such as the DRR, we see that this assessment of medical risk is not merely confined to this kind of public protection. Indeed Foucault argued that methadone is a method of control of the body by the state, through the use of medication (Neale et al 2013). This increase in knowledge also represents an increase in surveillance by the state, with those of additional medical risk being subjected to scrutiny that other drug users would not. Questions about sexual health and bodily health are more forthcoming for those who have been identified with BBVs or drug addiction when under the care of the state (such as through probation). We can also see examples of healthcare risks being used to punish

those under the care of the state, as risky behaviour can be used to recall to prison, charge with an offence and is the foundation of the DRR. In cases where an offender is managed by probation, questions about BBV care (such as sexual health, injecting technique and even access to medication) will be commonplace and can even form part of the order itself.

Bayens et al (1998) even found that the use of health risks (in this case drug addiction) was used to 'recycle' the population, meaning that those drug users who entered the criminal justice system had their own health status used to keep them under surveillance. Contrary to what Feeley and Simon (1992) argued would occur, these groups suffer from more individualised state interference in their lives by the virtue of their risky health status. This increased surveillance has additional effects for the offender, with them less likely to be able to secure housing and employment whilst under higher levels of surveillance and as a result less likely to abstain from crime. Similarly, this focus on health risk is mainly concerned with the community level risk, with those under increased supervision monitored not for their own protection (as would be the argument under harm reduction) but to protect the community from them.

3.5.2 The 'new penology' and workers

The transition from rehabilitative to managerial has knock on effects for the staff too, with those that identify as rehabilitative in ideals being less likely to identify with the new regime. Those who are able to grasp the new standards of performance management, or who are from a background where performance management is the norm, will be better equipped to deal with the changes brought about by the 'new penology' (Cheliotis 2006). These employees will also be more likely to rise through the ranks of the organisation, meaning that the performance management practices are more likely to embed in management. This will likely reiterate the already existing management processes and create incestuous management processes whereby new methods of work are stifled. This is not to say that charismatic and well placed individuals would not be able to affect change from within, but this is much less likely in organisations where the principle ideology is that of performance

management. It is not only the employee who will learn to navigate the language of risk assessment, with the offender themselves having to learn the language of the punishment if they are avoid additional punishment. In their research on drug courts in New York, Miller (2009) found that the language of the court was used by the offenders themselves, with self-reflection, responsibility and self-esteem being principle languages. For offenders who did not speak this language the effects were disastrous, with them being much more likely to be sent to a 'regular' court whereby their particular needs would not be considered in their sentence and more punitive sentences were likely. Those who participated with the court language were seen as 'authentic' meaning that they would benefit from the special sentences the court had at its disposal for their case. For those who were less fluent, their experience was seen as being less 'authentic' despite them potentially having the same or even greater motivation for change. In terms of drug treatment, it is worth considering the role language has in the care-planning section of drug treatment as this is the period where 'motivation' is tested and treatment is designed.

3.5.3 The community

Another key feature of the 'new penology' is the outsourcing of crime control to the community as a whole, with smaller and smaller communities being targeted as contributors as the state recedes from public life. In terms of drug treatment this is clearly visible in the 2010 NDS in that the local community is named as a source of recovery capital for the drug user and a key component of recovery and maintaining recovery. However, it is also worth considering the incapacitative role that community services can have, with treatment services especially being capable of serving an incapacitative role for the state (Marquart et al 1999). It is widely held that community sentences have an incapacitative role, with offenders on community payback (service) orders, drug/alcohol rehabilitation orders and probation orders held away from offending because of the time these sentences take each week (Cavadino, Dignan and Mair 2013). If this is the case, it is possible that community treatment is also a form of incapacitation but for those who are outside of the criminal justice

system. As was recognised above, methadone can be considered a method of state control of the body through the use of medicine, but treatment itself can also be considered a form of incapacitation, with the user attending sessions of treatment instead of being out using drugs. In this way we can see more rigorous forms of treatment as being in some way incapacitative in their execution, than other less intensive forms of treatment. Methadone treatment can be seen to be a less invasive and involved treatment method than recovery based treatment, meaning that the state has less control over the drug user whilst within treatment. In this way it is possible to read the 2010 NDS adoption of recovery as an extension of state based incapacitation rather than as a real change in the manner in which treatment is delivered. Indeed, if you consider the reduction in levels of state support for recovering drug users, it is clear to see that treatment services can be conceived as incapacitative in their agenda, with truly rehabilitative treatment such as mental health treatment, economic welfare and employability skills all being cut at the same time as the state introduces recovery as a model (MacGregor and Thickett 2011).

3.6 The relationship between theory and practice

This research seeks to understand further the relationship between policy and practice within drug treatment. This chapter serves to demonstrate a lens through which this relationship can be observed. In the discussion above, these theories have been examined within the context of their original focus: the criminal justice system, but also the context used within this research: drug treatment. This has shown how the interconnectedness of the CJS and drug treatment goes beyond the use of drug treatment within the CJS, but also encapsulates the ideology of practice and the function of treatment itself. Whilst research into the interconnectedness of drug treatment and CJS risk assessment has been carried out before (Weston 2016 & Seddon et al 2012), this research seeks to understand risk assessment within the context of drug treatment alone. In this way it is useful to view the policies that inform practice, using the 'new penology' to discuss how managerialism, risk and incapacitation are utilised within the practices of staff. By doing this, it will be possible to see

how these practices inform organisational culture and staff beliefs. It is also important to use the theories presented here to look at worker formations of knowledge and how government measures of output and efficiency impact upon how workers themselves view their work and the treatment they provide. This chapter has demonstrated how managerialism and efficiency measures have been used within the CJS and also within drug treatment, giving a theoretical framework to discuss how workers use these measures but most importantly their understanding and opinions of the measures. By understanding their opinions of these measures, it will be possible to see the influence that government policy has on the beliefs and working practices of the workers themselves.

Summary

This chapter has served to expand upon the concepts surrounding the 'new penology' and has applied them directly to drug treatment. The reader was introduced to the concept of 'contradiction and volatility' within drug treatment and how this environment has been used to depersonalise treatment. By depersonalising treatment, the state has manoeuvred itself out of responsibility for providing treatment, instead placing the responsibility upon the user and the community. This chapter will serve as the theoretical backbone to the following chapters, offering a theoretical lens through which to analyse the interview data collected in the study.

Chapter 4: Methodology

4.1 Introduction

The purpose of this study is to explore how drug treatment workers form their narratives of treatment and addiction and how narratives from organisations and government influence this formation. In this chapter I will be setting out the methodological issues that have been present during the research process, which consisted of twenty-six semi-structured interviews from my three sample areas. I will start by defining the initial research questions that formed during the initial design phase of the project. Whilst these were not the finalised research questions, they influenced the choice of research methodology and this chapter would not be complete without a discussion of their influence. This will include some of the research narrative and discuss how the transition through the study affected the research questions. This chapter will also include the finalised research questions that will form the basis of the finalised study. An explanation of my role within the research as both an insider and an outsider and the issues this caused within the data collection process will also be discussed. Throughout this chapter I will be referring to the methodological approaches I took to the study as well as the data collection processes that were used at each stage of the research process.

4.2 The initial research narrative and an aborted start

4.2.1 The origin of the study

The basis for the original research questions came from a quote from Tom Kirkwood, the CEO of the abstinence based drug treatment charity 'Trust the Process' (TTP), interviewed by Gyngell (2011) in "Breaking the Habit". In this he argued that treatment providers that come from an abstinence background would be wary of bidding for treatment contracts because of 'Transfer of Undertakings (Protection of Employment)' law (TUPE). Because of this law any treatment provider taking over a service would be required by law to continue the employment of existing staff under existing terms and conditions. Any loss of employment could only be through redundancy and therefore the new employer would be liable for any redundancy costs (HM Government 2014). Kirkwood argued that this would

mean inheriting “a demotivated, poorly trained workforce unskilled in anything but harm minimisation” (Gyngell 2011 p.33). Kirkwood’s argument was placed within Gyngell’s overall argument as ‘proof’ that the government move to abstinence-based treatment over harm reduction/minimisation treatment was little more than lip service. Gyngell (2011) went further, arguing that the entire change in outlook by the government was stymied by these employment laws and that fundamental change in drug treatment was impossible whilst existing staff remained in post. Her argument that the drug workers themselves would hinder the process of change interested me as a worker who had been trained in the harm reduction/minimisation era of the early 2000s. It was my experience that workers held core beliefs on addiction, but these seemed malleable (my own beliefs had shifted throughout my training and working life) and to consider them a threat to progress was something I had previously not considered. This idea formed the basis of my research topic, but in order to progress, it would be necessary to generate some more concrete research questions that would enable the research idea to transition into an executable strategy.

4.2.2 The formation of the research strategy

The research design followed an inductive path (Hodkinson 2013), starting with a broader topic and aiming to use the research to generate a more refined understanding once complete. This approach has allowed me to use the results gathered to change the data collection method mid-collection and meant that I was not locked into rigidly testing competing hypotheses (David and Sutton 2011). By rejecting the deductive process of hypothesis creation and falsification it was felt I had mitigated (at least partially) against the risk of ‘masking’ other explanations that I had not considered when selecting my initial competing hypotheses (May 2001). However I did not approach the subject as a ‘simplistic inductivist’, without suitable hypotheses to test throughout the course of the research (Hodkinson 2013 and Silverman 2006) as this would not give me the structure needed to produce a compelling research plan. As a neophyte researcher I felt it would also be detrimental to my progression to enter the field without a plan. However it was clear to me

that by including just two variables in my design, I would not have the detail needed to write a set of compelling research questions and therefore would not have the structure I felt was necessary. There was also the risk that I would fall into the 'simplistic inductivism' trap and optimistically expect aggregate data to produce a complete and accurate picture of 'the truth' (if such a thing exists) (Hammersley and Atkinson 2007). Following a purely naturalist approach and expecting 'hanging out' with my respondents (Silverman 2000 p.62) to show me my answers seemed beyond my skills as a novice researcher and seemed little different than writing about my day-to-day work. By opting to introduce a third variable of government/employer influence to my initial research ideas I felt I could create a more persuasive set of research questions and allow myself some competing hypotheses by which to compare when working in the field. This would reduce the risk of expecting the data to map out my conclusions for me, whilst also giving me the flexibility that I wanted from the inductive approach (Babbie 1998). By introducing this third variable, it was felt that I would be able to better grasp the concepts of government influence over the narrative formation, as was the original research idea. It was my intention that this research would demonstrate whether influences that I considered to be 'overt' (such as mass media and policy documentation) would influence the views of treatment and addiction more than 'covert' influences (such as organisational/managerial pressure). By being flexible with my research questions during the study, I would be able to tailor my research towards influences that I had not considered in the design (such as public figures outside of government and non-governmental bodies) but that had emerged during the research process (David and Sutton 2011).

Whilst it is considered to be advantageous for novice researchers to draw on their own work or social lives for research questions (Strauss and Corbin 1990 and Silverman 2000), this introduced a level of bias to my initial research design. What became clear was that I had initially rejected Kirkwood's hypothesis that those who were trained in harm reduction

techniques would be less useful to a nascent abstinence-based treatment programme than new staff. It was my interpretation that Gyngell was using this quote to show that those trained in a harm reduction were not open to a new way of looking at drug treatment, a hypothesis that I also rejected. This rejection arose mainly through my own bias at wanting to seem open minded to new ideas. I also partly perceived that (at least at some level) their scorn was placed in my direction, given that at the time I was working within the field that they were criticising and was trained in the very manner they were critical of. However when I started to consider my own research questions, it became clear that by discounting their ideas I would be unable to determine how workers really form their narratives. By discounting the hypothesis that narratives are formed independently of government influence or that they are unchangeable by government policy I had not formed my research questions correctly. I had assumed to investigate the formation of narratives and how they were impacted upon by government, yet had failed to anticipate that they were not, or were indeed affected by another influence. With this realisation, a sketch of the initial research questions that would form the basis of my research was formed:

- Does government action (policy, publicity, employer action) affect the formation of narratives of drug treatment in drug treatment workers?
- How much influence does said government action have on the worker's actions?
- How malleable are narratives and do workers change their understanding of drug treatment based upon outside influences?
- Are drug workers' understanding of addiction and treatment fixed, or do they change throughout their working life? (This was particularly pertinent as it was my experience that workers in my sample areas did not remain in the profession for long).

4.2.3 Data collection

Given that I had my initial research topic and initial research questions, the next step was to determine what method of data collection would enable me to see how these variables affected narrative formation. This was important as the data collection method will likely

influence the final research questions themselves (May 2001). I settled on a qualitative methodology for the study partly because it seemed more difficult to measure the effect these beliefs had in a quantitative manner. This seemed especially true given the various roles that encompass 'drug treatment' and the personal construction of the treatment process. My own experience of official treatment figures was that they were problematic given that they are highly subjective and often failed to demonstrate the true picture of drug use in an area. A picture that seemed to (at least partly) be reflected country-wide in other research (Reuter and Stevens 2007). My main reason for adopting a qualitative approach was to use my position within drug treatment to break down the public/private divide of those who previously were unheard in academic research (May 2001), which was focussed mainly on policymakers and treatment recipients. This seemed an untapped resource, given that those creating and implementing the community treatment could be valuable sources on what influenced the formation of said treatment. This argument hinged on my own experience of working in drug treatment and reflected the personal interaction between client and worker. This relationship, whilst falling within the wider picture of community treatment, was therapeutic and therefore did not follow a fixed pattern for each client. This subjectivity in treatment was going to be the focus of the study (albeit indirectly) and so the logical choice for respondents seemed to be the workers themselves. Given that it was their narratives that would form part of the study, they would also be best placed to answer my original questions on whether any governmental ideological shifts would actually affect their narratives around treatment.

My initial research ideas focussed on the role of the employer and the state as primary influencers on the narratives formed by workers. The study of this kind of managerial/ideological change has historically been studied using qualitative methods and has been shown to offer valid insight into organisational change (Miller et al 2004). Given my own desire to reduce the public/private divide on the formation of community treatment and

the insight offered by qualitative techniques into the motivations and drives of workers, a qualitative approach to data collection was the obvious choice. Whilst I have opted for this method because of the 'depth' of knowledge yielded, I do not wish to subscribe to the reductive argument that a quantitative methodology would not have yielded 'deep' understanding or would in some way be 'shallower' in the understanding it produced (Silverman 2000). In part it is the depth of understanding yielded using a relatively small sample size which makes a qualitative approach more desirable. This is due to the desire to locate the research within my former areas of work and the limited number of respondents available to me.

I made the decision early on that I would focus on the role of workers in Eastshire, Midshire and Westshire as being the respondents in my study. This was in part due to Eastshire being a pilot area for the new abstinence based treatment as well as the government's flagship payment by results policy (PbR), whilst also maintaining harm minimisation treatment in the other areas. As a result, the sample areas would be ideal for considering the role internal narratives might have on the treatment provided when the narrative for that treatment is changed. That I had existing contacts within the treatment services meant that I would have ready access to the limited respondents as well as access to managers and local government contract holders. This access, as well as the limited number of areas working within the new model, meant that basing my research purely within these areas should not prove an impediment to attaining the research goals.

With the initial research design and the data collection method in place, putting them together would hopefully produce a coherent set of research questions with a logical and practical data collection plan. When looking at the research questions within the qualitative framework I had developed, semi-structured interviews seemed the best choice as the

primary method of data collection. They would allow me the flexibility I craved, with the structure that I needed as a novice researcher. Given that I wanted to retain the flexibility to use the initial data to alter my research questions, it seemed useful to be able to do this with the questions used in the interview (David and Sutton 2011). The research would also not be concerned with obtaining a standardised approach to data collection, opting for a more subjective viewpoint of personal and professional narratives. The interviews would also be conducted at the respondent's convenience and in non-standardised settings, meaning that structured interviews would lose some of their utility and making semi-structured interviews more applicable (May 2001). The decision to not use unstructured interviews was merely a concession based on my own inexperience at the formal interviewing process rather than a feature of the formal design, and as the research progressed the interviews would take a more unstructured form.

The preliminary research design was now complete, with the data collection method and research questions selected. Below are the preliminary research questions and how the data collection method would be used to collect the data:

- Does government action (policy, publicity, employer action) affect the formation of narratives of drug treatment in drug treatment workers? – Interviews with workers and local government employees to determine the level of influence.
- How much influence does said government action have on the worker's actions?
- How malleable are narratives and do workers change their understanding of drug treatment based upon outside influences?
- Are drug workers understanding of addiction and treatment fixed, or do they change throughout their working life?

As a piece of research design, this model showed clear signs of weakness when held under scrutiny. It failed to account for access issues which, as the time for implementation

approached, were becoming increasingly a problem. I had designed a project that was both too straightforward in design and had fallen perilously close to the inductive trap I had sought to avoid. The questions themselves were valid, but lacked any critical depth and needed an additional factor to mark them out as credible research questions. It had also become clear that my role within the industry was masking true criticality as, with the Gyngell hypothesis, I refuted potential routes of enquiry using my own experience as a justification. My own status as an insider (see section 4.3) was now affecting my capacity to be critical in my research design.

In order to start injecting criticality into my work, I started a reflexive journal, hoping that taking a critical approach to my own working life would help me gain the distance needed to re-engage critically with the research project (Bryman 2012). This journal assisted the critical process by differentiating between the 'work self' and the 'personal self' by forcing me to critically think about my own work and my interactions with others at the end of each day (Costley et al 2010). This also assisted in demonstrating the subjective nature of the work I was carrying out. The role I had given myself fit neither the positivist framework of a neutral focus group, nor the naturalist view of an unbiased social conduit of others' views (Hammersley and Atkinson 2007). By attempting to remain neutral within the research, I had neutered the study, robbing it of all criticality and reducing it to merely a study of Variable A on Variable B. If I were to complete this study effectively, I needed to address my role within it.

4.3 Definition of self as insider and outsider

Within this research the definition of my status as either an insider or outsider is important as this could affect data collection and would likely affect the analysis of the data (Taylor 2011). Before engaging in this research I worked as a full-time employee of a drug treatment agency, working in multiple areas within Eastshire, Westshire and Midshire. I retained this

post throughout the research design, but left before commencement of the research itself. As I write this I currently have over ten years of experience working with offenders in the community (including drug users) and 5 years of experience working directly in drug treatment. This experience was primarily within one geographical area, but I have spent time working in most areas within the sample. I am familiar with the drug treatment, offending and drug use landscapes in my sample areas and I feel that this positions me well for the research I have undertaken.

When defining my position within the research, I approached the design as if I were an insider, with my knowledge of the language and structure of drug treatment placing me ahead of other new researchers (Hucklesby and Wincup 2010). However, it became clear that this label of 'insider' or 'outsider' was not a mutually exclusive position, but a position on a continuum (Christensen and Dahl 1997 & Surra and Ridley 1991). This challenged my own interpretation of the insider/outsider roles as well as my concept of how this would affect my data. My initial understanding was that the insider role would offer greater subjective understanding than the objective outsider role (May 2001). Yet in light of this change in my understanding, this binary delineation was not appropriate.

I became aware that characteristics other than my occupation could be used to define the term 'insider' and that whilst I was an insider for the purposes of employment, I could still be seen as an outsider by others (May 2001, Hammersley and Atkinson 2013). This was not initially considered when the research design began, and the idea that characteristics other than employment could trump my own insider status was naively not seen to be an issue. Nor was it considered during the research design that my relationship with my employer could change, a result of which was a change in employment status that rendered me (by my own limited definition) an outsider. These realisations led to a major reconsideration of

my role within the research and are a part of what led to me adopting a more reflexive mind-set during the research itself.

At the outset of the research design I considered myself an insider, as I held the cultural similarities, experiences and shorthand that defined this position (May 2001). However, I had weighted these similar characteristics too highly and ignored those that defined me as 'other', such as: gender, race and status as former user. I had fallen into the 'deceptively simple' trap of seeing the two roles as absolutes and failing to see the characteristics that clash with the respondent (Hodkinson 2005). This emphasis on the 'ties that bind' is indicative of the subjective nature of the insider label, with my own opinion (at the time) being that work-based characteristics trump characteristics that others might consider more important (Cresswell 2009). That this was not the case became self-evident when reflecting upon the field notes at the end of each day during my preparatory research phase. That there were divides between different roles within the organisations became obvious, with statements about me "not understanding" (field notes 2013) because of my role standing out. That there was no uniform identity of 'drug worker' became evident, and led to reflection on my own labels and role within the research. This has become increasingly important within the research itself, with the research questions focussing on the way 'drug workers' form narratives. If there were no uniform definition of a drug worker, then how was I to answer this question?

Whilst it was clear that I was not the 'absolute' insider that I initially believed, I was still an insider to the industry itself. I shared socio-cultural locations with the researched workers and understood the process of drug treatment in a different way than a 'true' outsider researcher would (Hodkinson 2005 and May 2001). This status would provide me with perks unavailable to other researchers not existing in this "master role" (Burgess 1982 p.46) and

would afford me access to people and data that is historically difficult to attain (Hucklesby and Wincup 2010). Indeed, my role as insider had already assisted me subconsciously during the research design process, guiding me to avoid spending time developing research questions around data that I would not have been able to get access to (Hucklesby and Wincup 2010 & Hodkinson 2005). My insider knowledge of information sharing and data storage practices in the sample areas meant that I did not design the research questions using data that organisations would be unlikely to share with me. Nor did I design my research around the interviews of drug users themselves, as my experience was that access to this group was both ethically and physically difficult to gain (Hucklesby and Wincup 2010). That the study would not be funded was also a consideration; with payment for client participation is common in research on treatment, with those studies not participating in payment suffering as a result (McKeganey 2001). As a result of this, there was a risk that my own research would suffer, as well as the ethical issues associated with paying clients that I was also professionally working with. Whilst these factors were important in the design of the research, they were not the main reasoning behind excluding drug users/clients from the study, but in this my experience would play an important role.

Interviews with drug users have been a valued part of drug treatment research, with many studies utilising this approach to great effect in demonstrating the effectiveness of treatment (see Stevens 2010 and Gyngell 2011 for examples). Yet their involvement was not without discussion, with Hucklesby and Wincup (2010 p.22-23) and McKeganey (2001) arguing that there are ethical and practical issues with interviewing respondents under the influence of drugs or withdrawing from drugs. This is a wider issue outside of academic research, with the Police and CPS also considering interviews under the influence to be unreliable (Home Office 2005). My own decision to exclude those in treatment from interview was not based upon this issue, as I had no way to ascertain the intoxication of the staff I interviewed either (and many are previous drug or alcohol misusers) and did not consider this a problem when

interviewing them. As an active insider, I was already privy to knowledge about drug users in the area and to the rules of those working within treatment. I was also well known within the using community as a worker and would find this both difficult and ethically troublesome to conceal. This would undoubtedly affect the power dynamic between interviewer and interviewee, potentially affecting the truthfulness of the data collected as well as respondents' willingness to be involved (May 2001). Given that I also possessed power over the medication of the potential respondents (and this being a driving factor for most users), I felt I could not interview those actively in treatment without ethical and logistical difficulty.

My own experience had also taught me that drug users were not always truthful with those interviewing them. Indeed, Hucklesby and Wincup (2010) found that drug users experienced large numbers of questions on a daily basis and would achieve question fatigue, leading to only superficial engagement with the questioner. My own experience supported this, with respondents to questions (in a professional treatment capacity) often dodging the question or providing answers which were known to illicit a positive response from the worker in as expeditious fashion as possible. Given that I was already known to a number of the potential respondents, they may already have achieved question fatigue from me and may not differentiate between the interview questions I asked them on a day-to-day basis and those for this project. Because of this, I felt that there was a risk that I would not be able to get the level of detail I wanted with the data available.

As well as there being no true picture of what a 'drug worker' was, it is also true that the status of drug worker was translocal, with each locality in the sample operating under marginally different parameters based upon drug use in their own area. Similar to Hodkinson's (2005) experience of being a Goth, being a drug worker was a status that changed depending upon the locality that you work in. With smaller, more rural areas

providing different services (based upon geographical, socio-economic and drug consumption factors) to those in higher population urban areas. My own status was translocal as I worked in multiple areas throughout my time as a drug worker, giving me a perspective of smaller, more personalised rural treatment as well as larger, group based urban treatment. My knowledge that the role of drug worker changed related to geographical location meant that I did not consider utilising my role as insider to provide covert research inside one location. This would have been a simple approach to gain the data I wanted given my access to staff but would be unlikely to yield the data I felt was needed. I wanted to give a broad a view of how narratives are formed and to do this I knew I needed to include as many treatment hubs as possible.

Operating as an insider researcher within an organisation has potential issues which would not be a consideration for outsiders conducting the same research. My own status led me to consider myself initially to be a 'subcultural spokesman', (Hodkinson 2005) seeking to enlighten those outside of the industry as to how we (as insiders) see treatment (Hammersley and Atkinson 2007). My own writing reflected this mind-set with initial drafts and field notes talking about how 'we' see things. I found myself caught up in this narrative as I spoke to my colleagues about my research, with them hoping that they would finally be heard in the higher ranks of government as a result of this research. Throughout the planning phase, it became clear that both my colleagues and myself wanted me to work as a whistle blower, highlighting the issues surrounding meddling with treatment and budgets. As I continued with my research design, it became clear that my desire to highlight private behaviours had been perverted into a desire to 'tell it like it is' within the industry (May 2001). In light of this, I would need to reconsider my own motivations for the study; did I really want to do this as an academic exercise or was I just trying to vent the frustration shared by myself and my colleagues? Following this realisation I became more dismissive of talk with my colleagues about the research design, offering vague responses when asked about the

research questions. I provided them with enough information to keep them interested (they were my gatekeepers after all), but not enough that they knew the focus of the study itself or the questions I would be asking. I found myself increasingly using the language of academia, rather than couching my research in terms of the industry. The final stage of the design process occurred following my leaving my job, providing me with both objective distance from the finalised research questions and preventing me having to answer questions from my participants ahead of time. As I write now, this may have been an unnecessary step, as my former colleagues would soon be barred from having contact with me and so would not have been able to influence the design stage.

The initial focus on employment as the defining trait of an insider was now fading as it became clearer that my own traits affected my status on a person-to-person basis (Burgess 1982). This would turn out to be fortuitous, as my employment status would also change before the research began. In the second year of study my employer changed and I became subject to the TUPE process, the criticism of which had formed the impetus for the study in the first place. My new employer initially knew nothing of my impending research, but meetings with national management showed a commitment to help me achieve my goals. However, once engaged with local management it became clear that my research was not considered worthwhile and was treated as a barrier to my continued employment. This culminated in my having to make a choice between remaining employed and continuing with the research. My shared trait of employment was no more.

It was following this change that I truly realised what being an insider meant, with distance providing context to a continuum that had thus far remained a purely theoretical concept. I still felt as if nothing had changed, but would my former colleagues still accept me as knowledgeable in the area? I continued with the research design, still utilising the experience

and knowledge built up over my time working in the industry. I used insider knowledge to determine what data to collect, what people to approach and what questions to ask. All this in spite of not having the one trait I had previously considered all important. I was now better able to combine the theory I was reading with the experience I had accrued, something which I had read but felt difficult to implement (Hodkinson 2005). Distance, it seemed had provided me with the objectivity that I had previously struggled to find.

Upon returning to my former place of work I found that I had also not lost my shared socio-cultural status, with my former colleagues treating me in the same manner as if I had remained employed. Yet no matter how my ex-colleagues treated me, there remained a distance that marked me as outsider. This distance originated in me, with locations that had been my place of work for many years now feeling alien yet familiar. My ex-colleagues, by and large, treated me as if I had been on holiday with many remarking that I was back “so soon” (I had been out of the company for 6 weeks by now). Although this was not uniformly true, with former colleagues I had considered friends offering little more than a ‘hello’, my outsider status firmly fixed with them. In my own mind (if not in all my ex-colleagues) I had transitioned to the role of outsider-insider; I now shared the socio-cultural landmarks (although even these would fade over time) yet in my own mind I was no longer a part of this world. Throughout the ensuing research period this feeling of ‘outsiderness’ would not fade, with previously familiar places feeling foreign, and yet the conversations I had with former colleagues would re-ignite the feeling of community I felt as an employee. The criticality that I had felt upon leaving did not depart, leaving me feeling that I was viewing old haunts with new eyes, seeing theory in places where I would have seen friends and yielding information where I would have once seen routine. Roseneil (1993) talks about this need to get physical distance in order to gain critical distance in her research on Greenham women, a process which (despite a shorter period of time than hers) I feel has been essential to the success of this project.

4.4 Semi-structured interviews

It was decided from a fairly early stage in the research design that semi-structured interviews would be used as the primary method of data collection. This was in part to allow flexibility in the collection of data and to allow the respondent to drive the interview to the areas they feel are important. Given the subjective nature of the data I wanted to collect, this seemed to be the best way of collecting the data whilst also being sure to keep the interview 'on track'. By allowing the interviewee to drive the narrative of the interview I would be able to cover the origins of their own narratives without forcing them to discuss the origins of my own (May 2001). I hoped that the interview would take the form of a conversation rather than a formal interview, with the questions used merely as a method of making sure I collected the information I felt was necessary and to prevent the interview from going too far off track. This was a fine line, with the interviewee needing the space to get to the point of what they were telling me whilst I also needed to ensure that the interviewee didn't go too far off track and render the interview useless.

The interviews were recorded at the consent of the respondent and were transcribed at a later date. This process allowed me to concentrate on the respondent without needing to make notes (unless I particularly wanted to) and I felt allowed the interview to work more as a recorded conversation rather than as a formal interview. I utilised a standardised question to start every interview, which was used to collect biographical data about each respondent. This also served as an ice breaker, with the interviewee often talking uninterrupted for around 2-3 minutes about their own life. I utilised the data within this question to formulate the successive questions, with background used to form questions that would allow me to drill down into the influence their background had on their working lives.

As the interviews progressed and my own confidence as an interviewer grew, the structured section of the interview became mainly a method of collecting personal data in a uniform manner (as well as an icebreaker for the interviewee) and the resulting interview became more free-flowing and more akin to an un-structured interview. In part this move toward less structure could be attributed to my own status as a partial insider within the industry (although I had not worked within all the treatment centres, most respondents were aware of me) and thereby their familiarity with me. My insider status certainly helped with the interview process, with discussions not needing to be stopped for explanations or derailed by discussions of function (Hucklesby and Wincup 2010). Hodkinson (2005) argues that this insider status also allows the interviewer to better perceive when a respondent is embellishing the truth or is being evasive about an uncomfortable issue. Certainly this latter point was of use, with some respondents being uncomfortable criticising the working practises of their employer or of their colleagues. Although of the former, I did not feel any embellishment or untruth in any of the respondents and all 'rang true' to my understanding. Granted, this may be due to gaps in my own knowledge, as I could not know how every worker handles every case. However, as I could not spot embellishments in the stories of those I knew well I have assumed this to be the case across all interviewees. Whilst I am accepting that these stories are not fabricated, I am not considering these accounts to be 'true' pictures of what has happened or even truths beyond the context of the interview. The subjective nature of what I have asked has meant that I am merely accepting these interviews as being true *at the time they were conducted* and if repeated, may not yield the same results.

The location of the interviews has also been problematic, with a uniform location being impossible to locate. As a result, I attempted to interview the respondents in a place most comfortable for them. This meant interviewing in places of work, home, bars and even a university. The majority of the interviews were conducted in the respondent's place of work.

Mainly this was due to the support provided by one of the local treatment providers who allowed me access to the sites as well as access to their employees, who were encouraged to participate. By interviewing at the place of work there was the added benefit of having the respondent in a work frame of mind when interviewed, which was certainly a positive as most respondents reported “shutting off” when leaving work. By interviewing in the offices I also had ready access to potential respondents, meaning that I was able to recruit more respondents in the office.

Throughout the interviewing process I found that I was more comfortable interviewing in the work setting than in the home or neutral territory (such as a café or bar). Partly I feel this was (to begin with at least) due to my experience of working in these buildings; with the setting familiar, the skills I had developed interviewing drug users seemed easier to access. I believe that whilst these skills are not the same as those used by a successful qualitative researcher, they do at least share some of the same DNA. This familiarity and my capacity to fall back on these existing skills meant that there was less pressure to quickly develop the skills of a researcher and made the transition between the two skill-sets smoother. This was made clear to me in the interviews in bars, cafes and homes, with these interviews progressing well, but my own performance seeming more stilted and less sure than those within a professional setting. These settings were necessitated as a treatment provider declined to give permission for interviews to be on their premises. Eventually one provider refused to be a part of the study, causing staff who had already agreed to be interviewed to back out. When I approached them to ask for an explanation, I was informed that no reason for refusing would be given, they merely did not want their staff to participate.

By interviewing in the place of work, there were issues that had not previously been considered. The main issue was that of confidentiality, with staff questioning how

anonymous my study would be, especially as they had been introduced to me through their employer. That I was a former employee would be no help here and I needed to persuade some respondents that what they said would be kept in the strictest of confidence. The confidentiality and consent form they signed was helpful in that it gave an aura of authority to the interview and lent me a portion of that authority too. I also gave the respondent a potted history of my own employment as well as a verbal discussion about the aims of the study. They were provided with detail about the study beforehand (with a copy of the consent form – see appendix one) and were given my email address should they change their mind and decide to withdraw from the study. I encouraged those who felt uncomfortable with the level of confidentiality to consider withdrawing rather than worry about participating. Despite this, I have had no requests to withdraw.

4.5 Ethics

Ethical practice when working with or around drug users is a priority for all researchers, with the discussion around exploitation being especially important. As a former worker it was clear that accessing drug users themselves would be difficult, if not impossible and as previously discussed my insider status would introduce further complications to the power structure of the interview (Hucklesby and Wincup 2010). With this in mind it was decided to exclude drug users from the interview pool, yet this did not exclude all ethical considerations surrounding them, with my interview pool still including those who worked with drug users. One of the main cornerstones of drug treatment is confidentiality, with users encouraged to come into treatment based entirely on the fact that the treatment provider will maintain their anonymity throughout treatment if necessary. However it is common for workers to discuss cases with others if there are problems and as part of treatment. It became clear early on that workers have become used to using names and real-life cases to explain concepts and ideas to others. As a result I would need to further anonymise the interviews to ensure that no client-specific details could be gained from reading the study. This became further complicated when workers started to mention other workers and other treatment agencies,

as these discussions were rarely complimentary or confidential, meaning that further portions of the interview would need to be anonymised.

As is clear from reading this methodology, I have also chosen to anonymise the locations of my samples and the names of my participants. This was a necessary act as one of the treatment providers became reluctant to allow their workers to participate in the study, eventually becoming hostile to the entire process. I was informed that I would not be allowed to interview any workers from this area, nor would I be permitted entry to any of their treatment centres. Workers I contacted after this time were informed (by the employer) that they would be disciplined if they took part in the study and despite this, some still kindly volunteered their time (outside of work hours) to take part. As a measure of protection for those participants, I have changed the names of all interviewees and the areas in which they worked. This also necessitated that I redact or change the names of any service within the interview data itself and whilst this may impede the reader's initial understanding, it does not affect the meaning of the quoted material. As a rule I decided to anonymise all mentions of names and places in the interviews. This has still meant that some interviews have data within them that can identify the respondent, for example in my interviews with the commissioners I made clear that I would anonymise where possible, but as there were only two respondents fitting this description anonymising the data would not obscure their identity completely.

A further ethical consideration was the security and storage of my interview data. Under the Data Protection Act 2018 I am bound as a researcher to ensure that the data I hold is held securely and only for as long as is necessary (Department for Digital, Media, Culture and Sport 2018). In order to ensure my interviews were kept as secure as possible, all twenty-six interviews were downloaded from my recording device and encrypted as soon as the

interviews were completed. The recording device was then wiped and the encrypted interviews were stored on a password protected hard disk, which was kept in a locked cabinet at my place of work. Any printouts used in the data analysis stage of the research were also kept in the same locked cabinet and then destroyed once the analysis was complete. The transcripts of the interviews and the consent forms were also kept within a locked filing cabinet at my place of work. Anonymisation of my data meant that there was no need to access the original files once my writing up phase had begun. However, I have retained the original audio files and transcripts as there is further research that can be carried out with the data. Access to the original audio files may therefore be needed for context or to clarify material originally deemed inaudible in the original transcription process.

This research was carried out in accordance with Canterbury Christ Church University ethics guidelines and as such was evaluated for ethical clearance before fieldwork commenced (see appendix one). This involved independent review of the ethics application and the researcher needing to demonstrate that no harm was caused by this research. Ethical approval has been included within appendix one.

4.6 Foucault

Returning to the core concept of the research involved looking at the meaning of narratives and the role that society, state and self play in their formation. When looking at my own concepts of what makes up our beliefs and narratives I found that I wanted my own training and understanding to be responsible for their formation, yet I was also keen to see that state function had a role to play. As a counterpoint to this belief it was advised that I should start to read the work of Foucault and look at his work on narrative formation within subjects. By studying the formation of knowledge, I might gain insight into the processes that I wished to study in my own field.

Foucault's work helped to expand my ideas on the role of the state and organisational structure in the formation of treatment narratives, initially through his discussion on the role of discourse in the formation of knowledge. Foucault argues that discourse is a window through which we can glimpse the 'reality' of the object, or through which we can make sense of the object itself (Danaher and Shirato 2000). Implicit within this statement is the idea that we cannot make sense or see the truth of any object outside of the discourse surrounding it. This seemed to match with my own research, as the discourse produced by the state needs to be influential enough to change the manner in which we understand the nature of addiction and the role of treatment within it. Foucault further argues that the field that the subject occupies further serves to define and make visible aspects of the object. In this I need to be clear as to the definitions of 'object' and 'subject' that I am working under. Whilst not explicitly defined as such by Foucault, I am using the word 'object' to define the focus of the study itself (the role of addiction and treatment within this study), and the word 'subject' to define the person who is involved in the study (the worker in this instance). These are not the formalised versions of these words, but I felt that defining their use might lend some clarity to this section and indicate my own intent as to how they are used within this research. Foucault's definition of the object (using my notation) would be useful as he states that the object itself has no form outside of the discourse used to describe it (Foucault 1972). By creating discourse about the object we are able to interact with it; the ephemeral becomes the tangible and therefore the controllable. This description of the object allows the subject to perceive it and further to discuss the role this object serves, thereby contributing to the discourse that defines the object (Foucault 1972). In terms of drug treatment, the discourse surrounding the notion of 'recovery' produces a visible condition/status that can then be seen by the subject and commented upon, thereby deriving more discourse to further increase the visibility of recovery as a goal. For addiction, the discourse serves two purposes: firstly it renders troublesome any behaviour which is seen as bad for society. Secondly it separates addiction from similar, but legitimate, states of compulsive behaviour, such as gluttony or material greed. By creating a discourse around 'recovery' it is possible to

both demonise behaviour that could be damaging to society and lionise those behaviours that enhance conformity. When considering the non-discursive nature of addiction it is impossible to see the pre-discourse nature of the object itself, as objects can only be seen through the lens of discourse. For us to consider addiction outside of the discourse, we would need sight of the object, and the only method of making it visible is through the lens (or to reuse a metaphor 'window') of discourse (Kendall and Wickham 2003).

For Foucault the relationship between the triad of knowledge, power and subject is an interaction of equalised power, with none gaining primacy over the other (Kendall and Wickham 2003). This third notion of power is also important when considering the role of discourse of recovery on the worker, as the power is placed in the hands of those who wield knowledge against the subject, those designated as authority figures. In most instances this power falls with those with knowledge and the power to be seen as an 'authority' on the subject. In science and medicine this is an easy distinction, with those commentators usually armed with academic knowledge and social status designated as authorities on the subject (Foucault 1972). However in addiction and treatment this authority is less easily defined, with the political views of the causes of addiction (and thereby the lion's share of the discourse) often being seen as the defining features to be an authority figure on the subject. As seen in the previous chapters, the cause or cure for addiction has been contested throughout the history of addiction itself, with such diverse fields as medicine, law, psychopathology, economics and personal conduct seen as the authority and thereby designated as 'official' speakers (Reuter and Stevens 2007). That the power lies with these figures does not mean that addiction is a closed discourse. It can clearly be demonstrated that the change as to who is defined as a designated speaker means that innovation in thought is achievable in the field.

The relationship/location of the listener/subject is also of interest, with those listeners who occupy a location associated with the designated speaker more likely to agree and accept the ideas presented in the dominant discourse (Foucault 1972). In terms of this study, this would mean that a worker who is NA/AA focussed, or bases their work around abstinence, is more likely to be influenced by the dominant discourse of recovery than a worker who is more harm reduction or counselling focussed. This is not to say that they would not still be affected by the discourse, as the knowledge and power wielded against them may still affect their view of the object (Kendall and Wickham 2003). When considering the origination point of this research, the recovery community seems to argue against this, with the dominant opinion being that workers are part of a closed discourse and innovative thought from outside that discourse would be opposed or resisted (Best et al 2010, McKeganey 2010b & Lopez Gaston 2010). It is my aim that by showing the influence of the dominant discourse I will be able to demonstrate that the narratives formed by the drug treatment workers are part of an open and not a closed discourse.

This study will therefore look at the relationship between the workers and the dominant discourse of the time: recovery. It will also look at the sources the workers draw upon, meaning the subject areas, agencies and individuals that serve as 'speakers' for the workers. By addressing the relationship between the worker and the discourse surrounding drug treatment, it will be possible to see if workers exist within a 'closed discourse' whereby new information or information that is counter to their understanding is ignored. This is the crux of the argument by Kirkwood, that workers are a part of a closed discourse and as such recovery cannot be fully implemented until these workers are purged and replaced with workers that are open to recovery as a concept.

4.7 Discourse

It is difficult to provide a conclusive definition of discourse, with this term ironically meaning different things to different people. However it is necessary to provide a working definition of discourse for this project, as it would be difficult to show the relationship between workers and discourse if it meant all things to all people (Prior 2003). Fairclough (1993) offers a useful glossary of terms to be used by a researcher when conducting a discourse analysis, with definitions which whilst I will not be undertaking a discourse analysis, will serve to illuminate my own approach to understanding discourse. For this research I will be using the term *discourse* to refer to language used to signify a social practice, as well as to represent collectively the language around a particular subject or subjects. This will mean that the term 'discourse' will reflect both the language used around addiction and drug treatment to convey meaning and ideas as well as a collective term for the wider discussion surrounding addiction and treatment as subjects in their own right. Fairclough (1993) also defines the word 'text' as a product of a discursive event, meaning that whilst my interviews are audible in nature, I will be referring to them as 'text' in this work.

4.7.1 Thematic analysis

The method chosen to analyse the data taken from the interviews is a thematic analysis. This was chosen as it is in keeping with the inductive approach to research that I wished to take and also it allowed the data to generate the overall themes to be discussed (Caulfield and Hill 2014). I utilised Braun and Clarke's (2006) six steps of analysis in my analysis of the data:

- Step 1: Become familiar with the data
- Step 2: Generate initial codes
- Step 3: Search for themes
- Step 4: Review themes
- Step 5: Define themes
- Step 6: Write up

The interviews were separately analysed for each chapter, with un-coded interviews used as the starting point for each chapter. The researcher was then able to go through each interview, identifying areas of text that directly or indirectly spoke about the subject contained within the chapter. Whilst the chapter headings were written ahead of the analysis, these represented nothing more than the themes identified by the literature review and were adaptable if the analysis proved to change the overall themes. It was the coding of the data that allowed the crystallisation of the main subsections of each chapter. This process was assisted by the semi-structure of the interviews, with most following a similar pattern meaning that it was possible to compare sections of interviews and see directly the relationship between the interviewees and the development of themes (and subsequently sub-themes). Once all the interviews had been coded, it was possible to then analyse the coded data for themes, separating the coded data into themed groups and allowing the overall themes of the chapter to emerge. This is where the coding table would emerge, offering a tabulated example of the keywords and themes that had been identified.

Once the themes of the chapter had emerged, the data was then refined to show the varying perspectives the workers had on the themes identified. This would allow the researcher to demonstrate the major themes, but also areas of discrepancy or disagreement. This is then tied back into the main areas identified within the literature, thereby allowing the researcher to show support, conflict or provide explanation to the reader.

Coupled with the analysis of the interviews, the literature shown in chapters two and three were used to provide context to the statements made and the inferences drawn. Analysis of these texts was also used to show the ideational function of discourse over the materialistic function of everyday speech (Titscher et al 2000). Foucault argues that by showing the ideational background to the discourse it will be possible to glimpse the influence of

institutions and institutional apparatuses on the subject and therefore see their working on the individual (Foucault 1972). The ideated discourse outlined by Fairclough (1993) shares similarity with the Foucault's concepts of 'agency', where statements have meaning outside of their words and this meaning can be used to prevent others from being heard (Woofit 2008). Dominance of discourses is important to this research, as non-dominant discourses are more easily side-lined and disregarded by organisations leading to mono-discourse organisations (Miller and Fox 2004). By demonstrating the ideologies at play within the treatment providers and the workers, it will be possible to glimpse the influences that are present on the workers thoughts as well as their openness to new ideas and new concepts. This links closely to Foucault's ideas on closed discourses, with innovation prevented by the strength of the other discourses in the field. If workers really are an impediment to recovery being efficiently implemented, then there would be evidence of closed discourses within the workers' interviews. Through analysing the interviews, it would also be possible to glimpse the influences on the workers too.

In Chapter two it has been shown that there has been a transition in how drug users are seen. New Labour were shown to have taken a more social positivist approach (drug use linked to poverty and unemployment), whilst the coalition have taken a more classicist/new right approach (individual responsibility, return to 'normal' behaviour). These ideas are not mutually exclusive, but are in stark contrast to one another from an ideological standpoint. As a result it is unlikely that they could operate as complementary narratives of addiction within an organisation, making it unlikely for one individual to hold both these beliefs. The dominance of discourse allows it to have a regulatory function, with the definition of offender, victim and role model defined by the discourse surrounding them (Woofit 2008). By looking at the discourses that surround individual drug workers, it might be possible to see if this discourse has changed over time and therefore see what effect government reclassification will have had on the identity of the drug user as perceived by the worker. By starting the

interview at the beginning of the worker's career, it was hoped that the worker would utilise the interview as a life history and demonstrate the discourses surrounding them at moments in time (May 2001). This will also allow the researcher to understand the role that historical experience has upon the worker, with those that have dominant professional discourses (such as those with medical training) potentially less likely to accept alternative explanations for addiction. Analysis of the themes surrounding workers and their influences will allow the researcher to determine how closed to new ideas workers are and if this could truly be described as a closed discourse.

4.7.2 Who is speaking?

The idea of a designated speaker, or the role of authority figure, has dominated discourses on drug treatment, with the popularity of their ideas matching with policy documents and procedure. That the dominant discourse is often in lock-step with the policy of the time is important if Kirkwood's statement is to be taken to be true, as workers would continue with the treatment espoused by their own discourses rather than be influenced by government policy. This would be counter to the concepts outlined by Foucault, as power exerting knowledge on the subject should move their position even if this is only a small movement (Danaher and Shirato 2000). The power of the designated speaker (in this case recovery speakers) should move the workers away from their harm reduction training (and therefore its explanations), meaning that they should accept at least some of the recovery agenda. This can be easily shown within the analysis, with workers' interviews analysed for instances of support for the ideals of the recovery model. The importance given to particular speakers is also of concern as not all speakers get to be considered part of the discourse around the subject. Theresa May in the 2010 National Drug Strategy (NDS) (HM Government 2010a) outlines this perfectly when she states that the government will not consider the ideas of legalisation as the harms caused by the use of drugs outweigh the good this could do. This serves two purposes, firstly acknowledging the presence of outside discourses whilst secondly excluding them from the wider discourse, thereby marginalising them in the

national debate and reducing the power they have over the overall discourse. Whilst May wishes to keep the legalisation debate from being part of the current discussion on drug policy, this field is not a closed discourse, meaning that some discussion of legalisation will always leak out to the public and become part of the wider discourse (see Home office 2014 as an example this year). By analysing influences on the workers, it will be possible to see what influence the government has over worker perceptions of addiction and treatment and therefore their acceptance of recovery as a model. Similarly, by looking at the beliefs of the workers it will be possible to see if these reflect the ideals of 'non-designated' speakers, with views such as legalisation and decriminalisation deviating enough from the mainstream discourse that they may indicate an acceptance of non-traditional beliefs surrounding drug treatment.

4.7.3 What institutions are speaking/what is the site of the discourse?

These are two closely aligned concepts that Foucault (1972) believes are needed in order to understand the formation of the discourse. By looking at the organisations that are speaking it will be possible to see the context of the statements being made. Barker (1998) refers to Foucault's idea of the 'will of truth', whereby an institution actively supports a particular discourse, giving it credence and authority. In simple terms, if a doctor (or medical institution) is the designated authority figure, then the discourse will likely centre on medical issues. In the case of addiction, that addiction is a medical disorder and should be treated as such. Analysis of the institutions will be needed in order to show how the subject perceives the problem of addiction and the role of treatment. This has been undertaken by looking at the procedures of the treatment agencies and the worker interactions with such policies. Similarly, it is necessary to study the location of the speaker themselves and how their own position will affect the discourse they both produce and consume. For example in Gyngell (2011) there are a number of sources quoted on the role of abstinence in treatment. These tend to be from residential rehab units or other abstinence-supporting treatment providers and are therefore already part of the abstinence discourse. These then testify as to the

superiority of abstinence-based treatment over harm reduction, using abstinence-based discourse (in the form of rehab statistics) to justify their stance. In this example the individual is already located within the field of abstinence, thereby the discourse of this field is used to generate more discourse in the same field (Barker 1998). For the interviewees, they are located within a treatment model and as such their interviews must be analysed within the framework of those institutions. This will mean that interviewees must be considered a part of the institutions they work for, rather than merely as individuals. The worker is not merely a collection of their own beliefs, but also a professional persona, which may be influenced by the institutional beliefs they are exposed to. By looking at professional behaviour coupled with personal beliefs, it may be possible to determine the influence the institution has over the worker.

4.7.4 Who is the listener?

The location of the listener is as vital as the location of the speaker, with listeners likely to interpret the speaker's words through the prism of their own discourse (Foucault 1972). In this instance the role of the interviewer is key, making sure to gain sufficient background information about the interviewee so as to make their position clear. Much like the location of the speaker, the location of the listener is likely to affect the discourse they receive, the reception they give to that discourse and the filter through which discourse is consumed. This has been previously demonstrated in my own view on being an insider within the treatment profession, whereby I had interpreted the role of the insider to be employment based and uniform across all workers. My perceived location of 'insider' meant that the discourse I perceived to be most 'true' was that which showed my own characteristics to be those primarily associated with being an insider. My own location meant that I initially misinterpreted or ignored those discourses that highlighted other characteristics as being of equal or greater importance. Within the analysis of the data, it will be the position of the listener (the worker) that will affect their perception of the speaker and the discourse that surrounds addiction. If the worker positions themselves so that their own prism of knowledge

is counter to the speaker, then they will not be receptive to their ideas. For a worker to accept the concepts of abstinence and recovery, they need to be positioned as a listener in such a place that the speaker's words fit within their own framework of understanding. If, as Kirkwood (Gyngell 2011) implies, workers who are harm reduction trained are unresponsive to recovery as a model, then those workers are positioned there by their own beliefs. Acceptance of recovery would therefore demonstrate not just acceptance of the new model, but also that the worker is able to position themselves so that more than one view of drug treatment is possible and acceptable.

4.8 Demographics

The study itself consisted of twenty-six interviews carried out in a number of locations and over a three month period. The original aim of the study was to balance out the interviews between Midshire (a new recovery-oriented treatment model) and Eastshire (an established payment by results service offering a recovery-based treatment model), but this did not happen as there were issues with access in Midshire. Westshire (a pre-recovery service) was always going to be the least represented service as they had the lowest numbers of staff and were in the process of going through a change in service provider at the time of the interviews. Gaining a large number of interviews in this area proved to be an insurmountable challenge for the study and as a result, this area is disproportionately represented.

| Location | Interviews | Male | Female |
|---------------|------------|------|--------|
| Westshire | 2 | 1 | 1 |
| Eastshire | 16 | 7 | 9 |
| Midshire | 6 | 4 | 2 |
| Commissioners | 2 | 0 | 2 |

Table 1: Number of interviews undertaken

Within Table 1 it is possible to see that there is a heavier representation from Eastshire in the number of interviews and that this was almost equally split between male and female participants. Midshire and the commissioners represented a greater gender bias, with both commissioners interviewed being female. This was not something that could have been

avoided, with the only commissioners that were appropriate for the study being those interviewed and as such this represents a feature of the sample areas rather than any kind of gender bias. Within the interviews in Midshire, it was impossible to balance the interviews due to the sudden lack of access. However, on analysis there seems to be no noticeable difference between the genders in terms of response, so this was not viewed as having a negative effect on the data. The lower representation of the non PbR service does raise some issues with regard to the comparability of the two services, with the PbR service represented more in the analysis. However, as this study was not about the differences between PbR and traditionally funded services, this was not deemed to invalidate the results. If this study is repeated in future, the desired outcome will still be to equalise the interviews from the different areas.

4.8.1 The role of the interviewees

Within the study, it was always intended that the worker would form the bulk of the study, with their voices being the most prominent. This was because it was always the aim of the study to explore the relationship between discourse and the worker themselves. Their views on treatment (particularly recovery) and the discourse surrounding drug use was always the main focus. Similarly, the quote from Kirkwood that drove the research in the beginning was directed at the client-facing workers rather than the management of the treatment services or commissioners. However, it was felt that there needed to be representation of the other strata of management within the sample areas. As a result, I sampled a number of managers of both localities (generally a manager of a treatment centre), regions (a number of localities) and the two commissioners responsible for the sample areas.

| Role | Interviews |
|------------------|------------|
| Worker | 21 |
| Locality manager | 2 |
| Regional manager | 1 |
| Commissioner | 2 |

Table 2: Interviews per job role

Whilst this is not a balanced sample, it was never intended to be such, with client facing workers always intended to be the primary source of data, as well as being the most abundant to interview. In the analysis, a number of differences arose in the data between the job roles, meaning that additional interviews of management would be desirable, but not essential. In future studies, it would be desirable to interview more commissioners on how their opinions were formed, as this proved to be a surprising source of data and like workers, these also represent an underutilised source of data on the subject of treatment.

4.8.2 Workers and their knowledge

One of the key areas analysed in the study was the history of the workers, concentrating mainly on their careers prior to becoming a drug worker. As was highlighted previously, there were structured questions at the beginning of each interview designed to capture information about their experience before becoming a drug worker. The responses were varied, with workers identifying thirteen different areas of experience and some workers identifying more than one source of experience. These were then divided up into five broader themes, with some careers appearing in more than one theme. For example, a psychiatric nurse would appear in the ‘medicine’ and ‘mental health’ themes whereas a prison officer would only appear within the ‘CJS’ theme. These two factors have meant that the interview count does not match up to the number of interviews conducted, with some interviews not matching any of these themes not being counted in the table below and some being double counted.

| Origin | |
|---------------------------|----|
| CJS | 6 |
| Medicine | 10 |
| Mental health/counselling | 6 |
| Addiction | 6 |
| Generic social work | 2 |

Table 3: Interview count based on knowledge themes

Whilst it is clear that ‘medicine’ had the most interviewees, it was not overwhelmingly so, with ‘CJS’, ‘mental health/counselling’ and ‘addiction’ (which encompassed those with addiction and those with familial addiction) representing the joint second highest number of

interviews. Overall, there was an imbalance toward medicine and the CJS as previous career paths. However, this was a much lower percentage than was expected in the planning stage of the research, with my experience showing that the vast majority of workers had some kind of health background.

4.9 Revisiting the research questions

Looking back at the initial research questions it is clear that they are not substantial enough to allow explanation of the main themes. Taking into consideration the ideas and concepts outlined in this chapter it seemed pertinent to revisit these questions and modify them to include the additional concepts. Below are the finalised research questions that formed the background to the interviews:

- 1) Does the location of the worker within the field affect the formation of their narratives on recovery?
- 2) Do they perceive the dominant discourse differently or reject the dominant discourse completely given their position?
- 3) Who are the authorised speakers on addiction and drug treatment? Are they the same for all workers?
- 4) Are workers a closed discourse in terms of recovery ideas? Are they open to new concepts and ideas?
- 5) Do all workers subscribe to the same causes and treatments for addiction? Is there a consensus as to what 'works' in terms of treatment?
- 6) Is the narrative created by the treatment outcomes in line with the understandings of 'good treatment' held by the workers?

From these questions the initial questions for the interviews were laid out (see appendix four) and whilst these were not the questions used throughout each interview, they formed the backbone of the discussion topics in each.

Summary

This chapter served as an explanation of the issues and considerations behind data collection and interpretation. The change in status for the researcher between insider and outsider affected more than just the mind-set of the researcher himself, playing a significant role in the sampling numbers for the study. This change forced the researcher to re-evaluate his status and position within the research and also allowed further reflection on the research questions as a whole. Whilst the new outsider status of the researcher did inform the sampling numbers, it is felt that this has not affected the quality of the interviews and the overall number of interviewees (twenty-six) was seen as being acceptable.

Chapter 5: Managerialism, Payment by Results and the Development of Effective Treatment

5.1 Introduction

In chapters two and three Feeley and Simon's (1992) theory of the 'new penology' was used as a theoretical framework to discuss the development of drug treatment in the UK. The relationship with Garland's (1996a) theories of 'adaption' and 'denial' as well as O'Malley's (1999) ideas on the 'new right' were also introduced. Their discussion of the changes to penal policy were argued to be also applicable to UK drug policy and served as an explanation for some of the recent changes in focus, most notably harm reduction. This chapter will serve as an expansion of that concept, with theories surrounding changes to modern penal policy and Foucaultian concepts of agency and freedom being applied to the modern drug policy and interview data. This discussion will serve as the backdrop to my own research, with interview data being used to demonstrate the 'real world' manifestations of the theories discussed.

5.2 Adaption and Denial

5.2.1 Responsibilisation

As was identified in Chapter three the concepts of 'adaption' and 'denial' identified by Garland (1996a) can be observed within 21st century drug policy, with harm reduction and recovery both seeking to responsabilise the drug treatment sector. Garland (1997) argues that the neo-liberal states will use adaption in order to reduce their direct responsibility for crime. He also argues that in doing so the state also gains a raft of new powers through management of contracts for the new agencies responsible. This is visible within drug treatment and was a factor in the interviews with managers about treatment contracts. In terms of drug treatment, contract length can be identified as having an added effect for the service providers themselves, as the length of the contract will directly determine the type of work and how radical the changes they make can be. From the interviews with four of the managers, it can be seen that Garland's concept of adaption could be seen as an explanation.

But and also contracts time-wise is so small. We're only looking at between where the two-year contract, initial plus two years and we're really achieving what we're doing, which we have been. So by the time we've gone through the process of change for the contract, you get about a year of performing before you're getting ready to tender for the next one. And that is a tough thing. ('Danny' - manager)

...they're doing these contracts every couple of years, every three or four years you know you're spending at least a quarter of that time trying to bed in new ways of working and change all that sort of stuff so rather than giving 5 or 10 years which gives you a chance to really perform. So you're always like that ('Danny' - manager)

Here 'Danny' highlights an issue for managers of service centres and for locality managers who are in charge of bidding for new contracts. This constant rotation between services and service providers can cause issues for continuity of treatment and for creating any meaningful changes to the treatment offered (HM Government 2017b). In the quote, 'Danny' discusses the length of the contract as being around three to four years in length, meaning that the service only gets one year of running before the tendering process for the next contract starts again. 'Danny' discusses how as a worker and manager this is problematic, as the time taken to set up the new contract and the tendering process essentially take up two thirds of the contract time, leaving little time for assessment of the service before tendering begins again. Pre-2010, contracts being 3-5 years made sense as this was the usual length of a Parliament and therefore services would be in line with the formation and dissolution of a government. Since the passing of the Fixed-term Parliaments Act 2011, this is no longer the case and the contracts will no longer expire around the time of governmental change. Whilst this is not a deliberate phenomenon, it does have a consequence for drug users, as government focus on treatment may change (such as the switch between harm reduction and recovery) meaning contracts may be run with a treatment system that does not reflect the current government policy. There is also the issue that treatment methods offered by a service will be forced to continue to change as the contracts are updated, meaning a successful service may be forced to change because of contract changes. This also represents an unintended consequence of adaption, with services not given the time to

settle in and develop effective treatment due to the constant refreshing of contracts. Yet by having short-term contracts the state insulates itself against any negative consequences of the service not working, as it is a poorly working service which has caused the issue and not the fault of government policy (Garland 1996b). However, this approach also stifles innovation and true changes to working practices without serious disruption. As Danny argues, this also has a destabilising effect on both workers and clients, with employer changes the norm and employee stability low. This is especially problematic, as the move toward generic workers and lower pay in some services also made morale very low.

5.2.2 Aggregate people

Garland's (1997) concept of 'making' people from aggregate figures is also demonstrated within the research, with respondents (7/26 interviews) discussing the role of aggregate data being imposed upon the lives of individuals. In particular 'Danny' highlights the issues surrounding data from other areas being used to project how many drug users are in an area:

What I don't like is the fact that outcomes and numbers are measured on this Glasgow folder based on pro rata from the figures in Glasgow or anything like that. So we were told at one point we should be having, there's about 500 or 600 crack users drug one in [Redacted]. We were told it should be about two and a half thousand. There's no way there's two and a half thousand drug one crack users in [Redacted]. We don't have crack dens as such. We have heroin users that sometimes use crack. But because they've done this county collation from the Glasgow folder they'll then say you're not getting enough crack users in, what are you doing about it?

'Danny' highlights the issue of using aggregate data to project numbers of people within another area. Here figures from Glasgow are used to predict the number of primary crack users (drug users who identify their primary source of addiction as being crack cocaine) in Eastshire. This impacts both the service provider and the worker, with the provider being assessed on their capacity to bring new crack users into service, thereby putting additional pressure on the worker to identify and draw in those new crack users. The service itself will be deemed to be failing if it does not provide crack-using drug users in the proportions that

have been determined using the data from Glasgow. Yet from 'Danny's' experience this problem does not exist in Eastshire and there are not enough primary crack users in the area. This represents a problem with the application of aggregate data to an area, as in this case as a manager, 'Danny' will be forced to target services at a group of drug users who have been created by the data and in his experience do not exist. However, by defining users in terms of their primary drug use like this, the state had reduced the need to treat individuals and can now request aggregate treatment based on drug type rather than personalised therapeutic treatment (Miller 2009). This also serves to subsume less common, niche drug-using identities within the narratives of the most common, riskiest populations (Crick 2012). In my research, I found this aggregate treatment being discussed in all interviews (26/26), with many workers using the drug of choice as a shortcut to talk about types of treatment or discussing the need for 'personalised' treatment instead of generalised treatment. In the quote below, it is possible to see state desire for aggregate treatment through the measures of the outputs of a service.

I think for the most part. For the most part, when you've got boxes and people aren't square. (Laughter) ('Valentine' - worker)

Here it is possible to start to see adaption in the state's responses to drug use. 'Valentine' is looking at the Treatment Outcomes Profile forms (TOPs) that workers need to fill out periodically or when a client leaves treatment. 'Valentine' identifies that the forms have boxes of predetermined questions about wellbeing and other risk factors associated with drug use, yet they point out that the person themselves does not always fit the description the boxes create. In looking at the boxes though, we can see adaption, with the state abdicating responsibility for welfare to the treatment provider, but maintaining managerial control of the service (Field and Tata 2010). It is also possible to glimpse the 'new penology' too, in that these boxes are based upon actuarial risk of reoffending and relapse rather than any real measure of the effectiveness of treatment (Miller 2001). In fact the boxes generally refer to the user's life outside of treatment and are more a measure of the life of the client

than a measure of treatment itself. The measures on the TOPs form could actually be seen as a method of collecting and collating medical information that would not usually be collected by the state in the course of treatment, and actually represent the surveillance and risk assessment of marginalised individuals (Marquant et al 1999).

5.3 Treatment Outcomes Profile (TOPs)

Across the interviews it was clear that the measures calculated by the Treatment Outcomes Profile (TOPs) forms were seen to be a poor reflection of the 'true' picture of drug treatment. Certainly this was true of the worker interviews, with all workers highlighting issues with the forms and their measures during their interviews. There was a high level of scepticism, with the majority of workers stating that they would not consider something being described as 'evidence based' as meaning it had any real merit. Some (7/26 interviews) gave the response that it was their background which caused them to be sceptical:

I'm sceptical, yeah. Because you have to be as a nurse when you're working on evidence based practice. ('Robert' - worker)

'Robert' was atypical in giving a reason for their scepticism, with others just stating that they were sceptical of anything given as 'evidence based'. For Robert, the issue of trust stemmed from their background in nursing rather than anything taken from drug treatment work. This may be indicative of the professional identity of 'nurse' being used as a justification for scepticism, where the identity of 'drug worker' is considered inferior due to it being seen as a position not requiring professional qualifications and thus lacking the moral authority to object (Simons et al 2017). Most respondents (15/26 interviews) admitted they would do their own research or wait to judge based on performance rather than trusting the evidence base absolutely. The main argument for this mistrust is that the evidence is likely based on data taken from Treatment Outcome Profile (known as 'TOPs') forms, which they felt did not match the outcomes of the client (18/26 interviews) and were too easy to fake (23/26 interviews). Their perception of the forms themselves was that they measure areas of

treatment that are unimportant (in the opinion of the worker) or mask the true picture of treatment outcomes. In the following quote from 'Lee' we can see the general opposition to the TOPs measures:

I think not one of them are realistic. It's...I've called them, it's figures isn't it.

In this statement, 'Lee' was expressing a frustration with the TOPs as a measure of success, that they are unrealistic measures of success to generate figures to be assessed.

Some of the tick boxes are very ambiguous and if someone has disengaged you can refer them to specialist treatment in this area. And the specialist treatment will be [service provider previously stated as being poor]. ('Akash' - worker)

Here 'Akash' highlights another of the issues between the tier two and tier three systems, whereby it will be considered to be a positive outcome if they forward the client on to tier three services even though the client has disengaged with tier two services. In a previous portion of the interview 'Akash' highlighted that the tier 3 provider they would refer to was renowned for unsafe doses of methadone and poor quality service. In order for 'Akash' to gain a positive outcome for their agency however, they need to forward these clients on to a service they know is not only poor, but is actually a risk to the client's health. In this instance, 'Akash' is highlighting that the outcomes on the forms are driving the client into sub-optimal (and potentially dangerous) treatment, which is contrary to their professional judgement.

It's very easy to manipulate stats. So, no I don't think it gives a true digit scale of what [we do] ('Akash' - worker)

'Akash' is highlighting an issue covered in Section 5.4 where workers are expected to falsify data. This serves to undermine the validity of the data in the eyes of the workers and the applicability of it to the clients being treated and the service itself. It is also having a knock on effect, with workers less willing to trust 'evidence based' treatment due to their overall lack of trust in the evidence backing it up. Within the non-management/non-commissioner workers sampled, there was uniform acceptance that the TOPs form was a pointless exercise that

needed to be completed as a chore of their job. No workers felt that the form added anything to treatment, or was useful as anything other than a measure of the service. This is supported by 'Basil', who expresses frustration at the figures being 'just' a measure that you tick on a box.

I guess with the TOPS form, you just have a little tick on the box and then close it on the system. Whether it's important, I don't know.

In this statement, it is possible to start to see a disconnect between worker and statistics. Here the worker is expressing that they do not know the point of the activity that they are undertaking and they express an ambivalence to the outputs generated by their service centre. McCorkle and Crank (1996) critique the 'new penology' as changing little for the frontline worker with changes being minimal in their day-to-day work. This quote by 'Basil', seems to support this view, with the 'actuarial justice' of the TOPs form being of little interest to them and their assessment of the importance being very noncommittal. This ambivalence to the outputs can have a knock-on effect for the drug user though, as staff who do not buy into the outputs are unlikely to feel any negative effects, whereas it is likely that the client will be blamed or their motivation called into question (Gray and Salole 2005). In this way, the statement by 'Basil' could be seen as problematic, as treatment workers who do not work to the outputs may not produce successful outputs, which may have repercussions for clients attempting to re-access treatment. This is especially problematic in the context of introducing recovery, as successful buy-in from workers will be necessary for a sea change in treatment ideology to yield results. However, it is worth noting that those workers that worked in the Payment by Results (PbR) area were much happier that the outcomes reflected the lives of the clients than those in the other two areas. As is seen in Section 5.4, the staff working under this model were under much higher scrutiny in regards to their outcomes and as such were able to believe the results of their outcomes because they were independently verified by an independent assessor. In the interviews though, it became clear that workers were the least impressed with the TOPs as an accurate measure of treatment, with the level of

satisfaction improving as you move through to the commissioners. Compare the quote of 'Basil' (a worker), with that of 'Blair' (a commissioner):

And as such, me personally – and this is my biggest emphasis – the outcomes tell you something. They tell you some part of the picture doesn't it?

In this quote 'Blair' is expressing a faith in the figures to show some part of the truth of drug treatment, although their use of a question to end the sentence potentially indicates a sense of doubt. Whilst they are not admitting that the outcomes demonstrate a full picture, they feel that there must be some 'part of the picture' which becomes visible when the outputs are analysed. In this way we can perhaps see a portion of what Cheliotis (2006) argues, in that those who are adept at performance management (in this case have faith in the outputs of the service) are more likely to get promoted to positions of authority. Certainly, in my limited sample, it is the commissioners that have the greatest faith in the TOPs outputs (3/5 managers interviewed felt they showed at least something valuable), whereas the staff completing them are more contemptuous of their accuracy (none found them useful). Although it is worth mentioning this quote from 'Mary' (a commissioner):

I've never been quite a fan of it [TOPs], I would be honest. (Laughter).

5.3.1 Negotiating the outcomes

When discussing the outputs of the service, the commissioners ('Mary' and 'Blair') both mentioned that the statistics are not irrefutable and there remained doubt over the accuracy or effectiveness of the measures. Indeed the commissioning of services involves a negotiation between the service providers and the commissioners:

Yeah and we can say something like, "This is what it looks like. So what are your thoughts? Do you think this would really stick? Do you think this is actually what's going on?" ('Mary' - commissioner)

Here 'Mary' is describing the negotiation between service providers and commissioners during a tendering process, with the outcomes and performance measures being a key

component of that negotiation. As will be shown later, the outcomes of the PbR project were negotiated down so that they allowed the provider to earn a profit, as the initial measures would not allow this. In this way, we can see that the measures are not of the effectiveness of the treatment provided, but more of the efficiency of the provider, entirely in line with the 'new penology' (Feeley and Simon 1992). If they measured the effectiveness of the treatment, the negotiation would not need to be made, but as they merely measure the efficiency of the service, they can be renegotiated to make the service seem more efficient and as a result, more profitable.

In terms of trust for the outcomes of the service, 'Pat' gives a good insight into the perspective of the service provider:

And I think that's where Public Health England have just realised that nobody's really been auditing. I mean they've been auditing data accuracy but nobody's been auditing data quality.

Their impression from their work leading a service is that PHE have moved toward payment by results (PbR), in part as a method of dealing with the fraudulent TOPs forms. In this statement they demonstrate that there is the impression that fraudulent figures have been used for years because PHE (and their ancestors) have not audited the quality of the outputs produced by the service providers. That the data matched their expected outputs meant that the data had been assumed to be accurate. This is also recognised by the commissioners, with 'Blair' stating the following about PbR:

We scrutinise ourselves to death to an extent [to] the detriment that we measure nationally poorer than anywhere else. But I was thinking, on the other hand, it's about our individuals getting the best service possible. And I don't want to falsify somebody's discharge because at the end of the day, how long will that person sustain it anyhow isn't it? If it was a kind of half-hearted discharge, the person might, you know, will drop back anyhow at the end of the day.

Here they recognise that they are not doing as well statistically as other services nationwide, but they feel that the oversight they have of the figures means their output measures are more accurate. This is supported by Mason et al (2015) who also found that the PbR pilot projects performed worse in all areas than non-PbR providers. In their commentary of the results, they highlight that this may be because PbR providers are more 'risk averse', meaning that they are less likely to complete a client as drug free when they are not sure. As can be seen in the interviews below, it is the assertion of this research that it is not risk aversion that causes this difference, but fraudulent outcomes being recorded by non-PbR providers due to lack of oversight. Under PbR, it is the coming back into treatment which is the concern, given that the recovery model demands a six month absence in order to get a successful outcome and payment. By scrutinising the outputs of the service in greater detail, it is possible to reduce the number of people who complete treatment and come back into service. This will increase the efficiency of the service itself and will actually provide a more accurate measure of the effectiveness of the treatment as well as the efficiency of the treatment provider. This is echoed by staff too, with an example from 'Matt' demonstrating the difference in accountability and oversight that PbR has brought to treatment services:

I think all of the PbR ones were lower, but I think that's because there is a requirement to provide more evidence. So chances are before we were PbR we were probably signing people off as treatment complete, and actually, if it was...came under the scrutiny of PbR they wouldn't...that wouldn't have happened.

As highlighted in Section 5.4 there was a recognition of the oversight and scrutiny of the outputs in the PbR service centres, with workers happier to recognise the 'fudging' of the figures under the previous model.

Language formed a part of the issues with the output measures on the TOPs form, with workers aware that drug users are being surveyed in a power imbalance, meaning that the language used to describe treatment is often in the language of treatment rather than the

client. Drug users are often in the position of being of lower power given the location, the familiarity the worker has with the form and the general treatment dynamic, and as such have to couch their responses in the language of the treatment provider (Lopez Gaston et al 2010). In this quote a worker who used to access treatment themselves articulates the issue with asking a successful client about the treatment they received:

then there's ones that I think are possibly people-pleasing as well. They want to say the right thing because maybe saying something about us and our service whilst we're there in front of them. And they want to say it's good, maybe saying it's a bit better than what maybe it really is.

In this instance the worker is identifying the problem with workers being involved in the treatment evaluation. Here they identify that the client may be disinclined to provide honest feedback about the service they received in part due to the power disparity between the worker and the client (Peters et al 2015). The reverse of this can be observed in the following quote from 'Amelle', who feels that clients lie about their criminality in the forms:

There is a lot about criminal activities which we know they lie most of the time. There are not many who would say yes.

This is the same issue as the one identified above, with the client lying to the worker in order to tell them what they want to hear. However, this is an example not of the power disparity, but of a phenomenon identified by Miller (2009) and Malkin (2005) of offenders learning the language of the organisation (and most specifically the organisation's goals) in order to get what they want. In these pieces of research, the offenders learn the language of the drug courts in order to better navigate the system and to better generate favourable outcomes for themselves. In the two quotes above we are seeing this demonstrated in drug treatment, with users using the language of the TOPs form (no crime, no drug use) to better navigate the treatment services to their gain. Although, it is worth considering that poor reflection upon actions and behaviours is a symptom of drug use (Peters et al 2015). The first quote is perceived as being an altruistic act, but could easily be seen as an act of self-reward, with

the client keeping the service provider onside by giving generally positive feedback. There are further incentives to keep the provider happy, in that it will ensure easy access to treatment if there is a relapse, future employment in the industry or volunteering work as a recovery champion. All of these factors disincentivise the client from giving honest feedback. Similarly, the quote from 'Amelle' demonstrates that the clients are likely to provide false information in order to hide behaviour which does not fit in with the 'language' of treatment. In the context of treatment, it is unlikely that the client will lie about criminality at the beginning of treatment as this forms part of the 'reaching rock bottom' narrative, yet at the end any criminality must be minimised in order to fit in with the redemptive narrative of treatment (Cannon 2013). This incentivises the minimisation of criminality and explains the observations made by 'Amelle'.

'Mikel' however, believes that it is not just the clients who lie about their activities but also the treatment services and commissioners. The lengthy quote below demonstrates their belief that commissioners' own views on the services are tied into their role as commissioners:

There's an absolute terror of providing figures the commissioners won't like and there's a huge flaw built into the system in that the commissioners having chosen a service provider, then really their reputations, jobs, success is on the line. So they want to see that provider do well. So, it feels to me like the performance of the provider isn't impartially judged. We went to an away day last month and the commissioner who commissioned this service was there, and saying that after the end of the year, it was a roaring success and [they]'d only had one complaint, you know? That's just impeccable. But, it's just as well for [them], isn't it? Because when [they] commissioned the service, lots of people said to [them], "Well, you've made a bad decision." [they've] got a vested interest in this service doing very well and not being complained about. So if [they've] only heard of one complaint well super-duper.

In this quote it is clear from the language that the worker does not have a lot of respect for the commissioning process or the evaluation process of treatment agencies. The use of sarcasm throughout is indicative of the worker demonstrating their disdain for the processes discussed. The process, they feel, is prevented from being transparent and reflective by the

bias of the commissioners and the self-interest of the treatment provider. By shielding the commissioners from complaints, the treatment providers improve the impression of their own service being 'impeccable'. The commissioners also gain the proof they need that the service they chose is the right one, as it is not producing any complaints and is producing the outcomes they expected through the TOPs forms. In terms of Garland's (1996a) notion of adaption, this represents the government taking a step away from the hands-on role of drug treatment, so the commissioners can no longer measure the effectiveness of the treatment provided, merely the efficiency of the service. It is the responsibility of the 'responsibilised' treatment provider to deal with complaints and problems with the service; it is the role of the commissioners to merely measure the efficiency of the treatment provider as well as their financial efficiency (Miller 2009). The knock-on effect of this is that workers perceive less direct control from the state. In this instance that is perceived as the commissioners directly ignoring the performance of the service, but it could just as easily be perceived as too much distance from the service or a lack of care. Similarly, this is indicative of the 'new penology', with the measures of success being set so low (no complaints) that the service cannot help but succeed (Brownlee 1998). Also the measures of success are unrelated to the actual work of the service itself. Indeed, it would be hard to conceive of a service concerned with challenging behaviour and changing entrenched behaviours that does *not* receive regular complaints. Their absence is taken here as being indicative of success, but this could just as easily be seen as demonstrating the service is not pushing those in treatment enough.

5.3.2 Measures of success

When looking at drug treatment in the context of the recovery agenda, the most obvious measure of successful treatment would be the level of drug use the client states when they leave treatment. Yet in terms of the effectiveness of output measures, the TOPs form was seen as being an especially poor measure of drug use, relying as it does on the testimony of

the client at the point of exit. This highlighted a number of issues with data produced by this method:

You know, the TOPs really is just a piece of paper that tells you about the here and now, you know, the last four weeks of use ('Louise' - worker)

In this quote, 'Louise' highlights a limitation of the form, with only the previous four weeks of use being measured. This is problematic in terms of the completion of the treatment, but also at the periodic reviews the clients undertake. In both these instances it is not the full picture which is being viewed, but a snapshot of the time surrounding the form being filled out. In instances where the form is being filled out as part of the review, this may mean that a recent relapse is spread out over the previous four weeks, meaning that the intensity of the drug use is diluted. Or if it is part of the closure from treatment, four weeks abstinence could be considered as evidence of a drug-free lifestyle, when this is not necessarily the case.

I just got the distinct impression that my clients...some of them that were still drinking and there was a couple who wanted to control their drinking, I think they wasn't being entirely honest around the numbers that they was doing, where in fact I had evidence to show that it wasn't entirely honest. ('Simon' - worker)

The forms also rely upon the client telling the truth, meaning that when a client lies and the worker knows this, it can devalue the measures on the form and as a result any reliance upon the measures to prove or disprove anything.

It's a snippet of that moment in time. And it's a number and it's...I'm not really sure what it's supposed to reflect at what stage they are in their treatment. ('Christine' - worker)

Here, 'Christine' is demonstrating a disconnect between the 'true' picture of the recovery of the individual and the picture painted by the TOPs form. Whilst it would be foolish to assume the worker knows the 'truth' about the recovery of the individual, it is important to consider that 'Christine' considers the 'truth' of the form to be incorrect or in some way invaluable. Of particular interest is the distrust in the form, particularly because it seeks to quantify the

recovery process, something which academics have previously used as the foundation of quantitative research into the success of treatment (Neale et al 2013). 'Christine' also highlights the core of the 'new penology' in this statement, through the idea that they are measuring *something* but it is not abundantly clear what it is. Measurement for the sake of measurement.

Are they ticking all the boxes? But what about the other stuff outside of the box?
(‘Dora’ - worker)

This quote builds upon the scepticism shown by 'Christine', in that the form merely measures the outcomes measured on the form. It does not measure the growth of the individual and most crucially, it does not measure their recovery capital (a key constituent of the recovery process). If this is to be the measure of the success of recovery-based treatment, then it needs to consider the actual measures of recovery. Otherwise it is merely an example of the 'actuarial justice' identified by Feeley and Simon (1992). This concept of measurement for measurement's sake is best shown in this quote from 'Mikel', where he talks about the minutes of a meeting:

I mean, I was in a meeting recently. I was examining the minutes of the last meeting, which I had chaired and the chair of the current meeting asked why the previous meeting had only lasted 35 minutes. I said, "Well, there was a very limited attendance and there was a limited amount of stuff that people brought." And that person asked the minute-taker, in future, to make sure that the meetings recorded are substantially longer than 35 minutes. They didn't ask her to change that one, but in future, we don't want any 35-minute meetings. They like to see that meeting last two hours, that should be a two-hour meeting. So feeling able to say that to your team suggests to me that you've got an unhealthy relationship with objective fact.
(Laughter)

Here 'Mikel' is demonstrating their frustration with managerial practices in Midshire, whereby the content of the meeting is not considered to be important, but rather the duration of the meeting. It is not the quality of the discourse or the usefulness of the meeting which needs to be measured, but the duration of the meeting, as that indicates the usefulness and importance of the meeting to management. This is another example of what Cheliotis (2006)

describes as the long-term effects of the 'new penology' on an organisation. By prioritising the things an organisation *does* rather than *achieves*, the organisation builds this into their management structure. Those who are comfortable with this practice will rise to positions of power more easily than those who do not. In this instance, the manager is so comfortable with the organisational practice of being judged on what is done rather than achieved that they are happy to ask a worker to ensure the meeting lasts longer rather than ensuring the meeting sufficiently covers the material effectively.

5.4 Payment by results

As highlighted in Chapter one, I was sceptical about the role of PbR in drug treatment, feeling that it would introduce an unnecessary financial consideration to what I considered to be a welfare service. It also represented (to me) the height of the 'new penology', with services being judged not on their actual effectiveness but on measures of recovery defined by the state rather than the individual. In the interview design, I sought to include a discussion of the outcome measures used by the various service centres. This invariably led to discussions about the method of recording those outcomes, the TOPs form. One key area that came out from this discussion was the workers talking about the pressure to produce 'good' outcomes for the service and how this manifested in faked or fraudulent TOPs forms. Most workers (23/26 interviews) would acknowledge that this was something which happened, but not all admitted to doing this themselves.

We use to say we would either have a real treatment, completely drug-free or a fake treatment, completely drug-free. So, and the fake ones were typically those that had...were drug-free last time we saw them but have vanished ('Freya' - worker)

Here 'Freya' identifies the key components of the process, whereby pressure was placed upon workers to rank someone on their closure TOPs as a successful closure despite the client having dropped out. Again, this demonstrates the managerialist measurement of what the organisation does rather than achieves, in that the success of the treatment (i.e. not

having the client come back into treatment) is not considered as important as merely getting a successful completion.

And I know that, obviously not myself, but I know that there has been false things put on there by people. ('Christine' - worker)

There's a lot of leeway for key workers to manipulate TOPs. So, you know, I don't always think that the outcomes represent how a client really is, not always. ('Hector' - worker)

Both of the above statements by 'Hector' and 'Christine' are indicative of the discussions in the interviews, with all workers identifying issues with the truthfulness of the data on the TOPs forms, or the pressure that is placed upon workers by the provider to get a positive outcome. Within the interviews no worker countered this narrative of pressure to provide positive outcomes in the TOPs, although the pressure to falsify outcomes was recognised by the commissioners ('Mary' and 'Blair') within their own services. Both admitted that the official treatment outcomes figures nationally indicated some falsehood within other services.

This pressure to achieve a 'positive outcome' can also lead to conflict between agencies, as there are conflicting definitions of what constitutes a 'positive outcome' for a drug user.

But also you got the conflict as well, not payment by results, but between probation and treatment services for DRRs, for instance. So a successful completion for probation is somebody that attends a DRR so they can continue to use any substance right the way through it and still be seen as a successful outcome. Whereas for treatment agencies who're still using that substance, it's not a successful outcome ('Violet' - manager)

Here 'Violet' identifies the issues with working with probation on a Drug Rehabilitation Requirement (DRR), as the probation order requires drug testing and treatment attendance throughout the sentence but has no longer term goals. This means that a client can successfully complete a DRR, but fail to successfully complete treatment with the treatment service running the DRR. This is further complicated when the service is under a PbR

system, with the pressure to gain a positive completion being compounded for the worker by the addition of financial incentives to successful treatment.

It does, but I think there's always been that pressure. But I'll tell you that with PbR, it's just sort of...maybe it's just compounded it a bit because there's money attached to it. ('Matt' - worker)

As shown in Section 5.4 there is a perception of pressure to achieve positive outcomes for the workers in a PbR setting, with the finances of the service being directly related to the outcomes of treatment. Yet in non-PbR services the reported instances of fraudulent TOPs forms was greater, in part because of the lack of oversight outside of the treatment services. As highlighted by 'Blair', there is an added incentive to scrutinise the outcomes from a PbR service as the payments are directly linked, whereas a non-PbR service would not need to be scrutinised in such a way.

I wonder what we would find if we did 100% audit of each of these discharges. But I think it's sort of give and take of the benefit [of the doubt] ('Blair' - commissioner)

By giving the benefit of the doubt to the services, the commissioners also give discretion to the managers and workers to adjust their outputs to reflect more positively on their service. It is worth noting that none of the workers suggested that they falsified the outcomes on their forms through their own choice, rather it was because of organisational pressure. The nearest to suggesting this was 'Steph', who suggested a practical reason for the changes:

I have to say that to them as well because I'm doing the nought to twenty scenario. They sit there. They're pondering. And I say, "Okay. We can only go this moment and today." Otherwise, we'll never get through the form because they sit there.

Here 'Steph' highlights the practical issues associated with the form in that quantitative values are used to evaluate wellbeing. Without any explanation of what the different values mean, the client is expected to assign a value to their feeling of wellbeing between zero and twenty. As 'Steph' indicates, it is sometimes in the workers interests to guide the client or else the process will take a long period of time. This is echoed by 'Hector', who

demonstrates the ways in which the measures are not accurate and are changed by the worker:

I mean with the TOPs...I mean this is anonymous, isn't it? (Laughter) With the TOPs, there's always an element of sort of coercion with regards to the sort of answers you're getting from clients or often, you know, there is. And if your client might...you know, you say, "How do you feel zero out of 20," and he says, "Oh, I don't know. I'm not sure." And, you know, you can say, "Oh, 15?" Do you know what I mean?

(Later in the interview) You can manipulate scores and you can...I mean, you could probably even adjust, you know, days drinking, units drunk, and all that sort of thing, you know. If they say...they might say "Oh, yeah, only two cans." And, you could think, "Oh, two cans." What's two cans of weak lager and put it down when really it could be two cans of super strength. He could be halving the amount of units.

In both these quotes, 'Hector' demonstrates that the measures in the TOPs form can be influenced by the worker themselves. Despite this agreement that there is organisational pressure to get positive results, the workers do not always feel they have to falsify the results.

Do I feel there's a pressure [to falsify]? (Pause) I don't ('Dora' - worker)

Because I think that because there is a pressure to get people out of treatment in a positive way, I think that, you know, I mean like for me, I think you have to...you always have to keep your integrity. ('Matt' - worker)

In these statements, we see two workers with different responses to the pressure to get positive outcomes. In the first, 'Dora' simply does not feel the pressure, whereas in the second, 'Matt' feels the pressure to get people out of treatment, but does not falsify records because they feel that their integrity is at stake. Although 'Matt' does follow this up with the following statement, indicating that it may not be integrity that is motivating them, but rather apathy toward their service:

also I couldn't bring myself to fudge a figure or anything like that to get a good outcome. I don't care really. If there's no...if our outcomes are not good, then our outcomes are not good.

For those that do feel pressure to edit their forms to make for more positive outcomes (18 interviewees), there is a general acceptance that it is wrong, but 'part of the job' as shown in the statement by 'Freya':

So, it's yeah, which I always feel uncomfortable with doing.

This problem is also recognised by managers, with 'Pat' arguing that the problem does not lie in the organisations, but in the definitions of positive outcomes changing:

So, when you say treatment complete, what is your definition of treatment complete? Is it if somebody said, "Thank you very much. Eleven sessions was enough for me. Do you mind if I don't come back for the 12th?" which is... all that sort of stuff. Or do you just say, "Oh, they didn't come back so they obviously worked." It's difficult. I know... you know...through the years I've worked in treatment system that other agencies have completely different definitions of what is a positive outcome and unfortunately that's what commissioners are looking for, positive outcomes, the new payment by results, the new performance indicators, they're tightening up on that.

Here 'Pat' identifies two key areas of problem: the changing definitions of success from organisation to organisation and the desire for commissioners (and by virtue, the state) to see positive outcomes from the services. This represents some of the key issues with a 'new penology' approach to drug treatment; the outcomes are important to the manager as the service is being assessed on them, but they do not represent the actual achievements of the workers. This means that the outcomes have no real meaning and the worker disengages with the measurement, leading to apathy or contempt for the measurements of the services they work in.

5.4.1 Evaluation

For those who worked within the PbR service, this distrust of the data was reduced by the evaluation process associated with PbR. As 'Joan' put it:

Well, because we're working in this area within a PbR model, I'd say we're really fucking accurate. (Laughter).

In terms of support for the service, those within the PbR model had much greater optimism for their service as well as greater trust in the measurements used to assess the usefulness of the service itself.

I like PbR. It helps us to be accountable. I think it helps us to collate more evidence to prove that someone has treat...has completed treatment ('Matt' - worker)

actually I think that's one of the benefits from payment by results is that actually the treatment outcomes are true with payment by results. And I think with payment by results as a practitioner, it makes you concentrate on the areas that are doing the most critical for that individual to be able to get that payment. So although you are payment-driven.....actually everything you've done is evidenced because you have to provide all the paperwork. ('Violet' - manager)

In the interviews, it was this accountability which was highlighted by the workers (15/26 interviews) as being key to their optimism and belief in the service. This served to help protect the integrity of the service, but also served an additional purpose as 'Joan' highlights:

In terms of whenever we have an audit or death or something like that in an investigation just they, everything seems to pass with flying colours and I think it's because of the PbR mechanism that the whole way along those boxes have be ticked otherwise, you're not going to get a payment then you're going to be pulled up in supervision because (laughter) the evidence wasn't there and you can't close that person.

As 'Joan' states here, the additional level of scrutiny that PbR brought to the service also served to improve worker protection in cases of client death or external audit. In both these cases workers would be scrutinised individually and their paperwork assessed (NTA 2011). By increasing the audit quality of regular working, the service actually helps protect its workers from the negative effects of poor quality record keeping. Although, it is worth noting that one of the commissioners interviewed questioned the level of scrutiny and whether this was appropriate for the services they commissioned.

because literally, each discharge is scrutinised. So whereas...I think this pose the question because we're micromanaging almost each discharge. ('Blair' - commissioner)

The introduction of PbR to services was seen by workers as being intimidating and even counter-productive. As outlined in the introduction of this thesis, I had a number of doubts about the services being delivered under PbR and whether this would increase the level of fraudulent completions I experienced pre-PbR. The overriding level of change PbR brought to the services was best exemplified in this quote:

When it first came out there was all the big horror. "Oh, payment by results." And yes, that first year, it's a complete culture change for everybody, do you know what I mean? It wasn't just about putting in a new model. It was a new team of people, a new organisation. You can think of all the things that you shouldn't put together in one thing and it was [Redacted Service], do you know what I mean? ('Mary' - commissioner)

Despite the initial scepticism, the workers seemed in favour of PbR, with nine interviewees citing it as the best service they have worked in and the model working well for them. In particular the levels of scrutiny were highlighted as being a positive, with the pressure to give false positive outcomes removed and the pressure being to produce well-evidenced, positive outcomes instead even if this meant lower numbers of positive outcomes compared to other services.

I think all of the PbR ones were lower, but I think that's because there is a requirement to provide more evidence. So chances are before we were PbR we were probably signing people off as treatment complete, and actually, if it was...came under the scrutiny of PbR they wouldn't...that wouldn't have happened. ('Matt' - worker)

We don't falsify figures or anything, but you know, that...and the way the PbR is here, it doesn't leave room for manipulation. Do you know what I mean? And so you could say that somebody's been drug-free right the way through, but actually that's not enough. You have the evidence that they have been. ('Violet' - manager)

These two quotes highlight the increased scrutiny of outcomes as being a catalyst for good working, with both workers highlighting that positive outcomes were being better evidenced and therefore 'truer' than under the previous models of payment. This is supported by a commissioner, who highlights that they consider this model to be a 'true' model of measurement:

It's the true reflection of what was going on. And I'm not saying that reporting was wrong before. But I think it just wasn't as thoroughly checked whereas now, it is.
(‘Mary’ - commissioner)

It is interesting to see that ‘Mary’ identifies the superiority of the PbR model as being a ‘truer’ representation of the success of treatment whilst also refusing to admit that the previous models of reporting are inadequate. In this statement we see levels of truth, with the PbR results being given a higher value of truth than the other models, but a refusal to acknowledge that the others are in any way inadequate. When looking at the PbR model, it is possible to see Garland’s (1996a) ideas of reduced state accountability, yet increased state power. Here, the state has commissioned a service and merely operates in a management function (through the commissioners), yet there is now an increase in the power that the state has over the drug user through the bureaucratic measures of ‘proof’. As discussed in Section 5.3, the proof of treatment or motivation that the state now demands is a method of further controlling the actions of marginalised drug users who have been categorised as high risk. Under this model, the worse an addiction is, the higher the assessed risk of the client and the more funding available should they complete treatment (Mason et al 2015). This incentivises the treatment agency to provide more treatment methods to the client and to evidence them for the closure of treatment. This serves two purposes: it increases the chances of successful treatment, but it also decreases the free time of the drug user and is in effect a form of incapacitation based upon perceived risk. This is a form of incapacitation through the use of treatment, meaning those designated as highest risk (those with the severest addiction to the most destructive drugs) are those the most incapacitated by treatment. In essence, by providing more treatment options, the recovery services increase their ability to incapacitate the drug user and prevent crime. By emphasising the need for evidence of changes in behaviour, the state is actually increasing its power over the free time of the drug user and in essence increasing the amount of incapacitation the user experiences. This also further demonstrates Marquart et al’s (1999) idea of health risks and medicalisation as a method of determining risky individuals.

I think you have far more evidence and lots of things that have to be evidenced about their recovery. So you do get the bigger picture of where they're at in their recovery rather than just them telling you and you writing on your case notes and offer groups and things that come up, things you put on case notes and stuff which quite often are very good. But having an evidence of things i.e., hospitals and social services and all that kind of stuff. I suppose you get more evidence in that respect. ('Christine' - worker)

In this quote 'Christine' identifies the types of evidence that can be used to demonstrate a client has improved their quality of life and their recovery capital (a key component of gaining a positive outcome). The examples they give, though, are for hospital appointments and social services engagement, areas which are not traditionally a part of drug treatment. Whilst it is easy to see why they form part of the recovery capital of a client, this further demonstrates an increase in the power of the state, with the state collecting increasingly greater levels of information about the life of the client through the guise of 'treatment' (O'Neill and Loftus 2013). This also represents the increased influence of neo-conservatism in the recovery agenda, with increased responsibility for one's actions being a key component of both neo-conservatism and the recovery model.

Whilst all the PbR workers interviewed expressed that they were not pressured to get positive outcomes without evidence or to falsify their outcomes (as was the case in the other models interviewed or when PbR workers discussed previous models), this did not mean that there was no pressure for outcomes.

We did use...we did used to have a board on the wall which did have everyone's outcomes for the month. It wasn't anything to do with payment, but you know, if someone had got a positive outcome, it would be up on the board and all that sort of thing. And, yeah, I didn't like that at all... ('Hector' - worker)

Well, I would say it would put another pressure, but it's an aspect of the job that has to be considered... ..because service depends on it. So whilst we're not on a table of who gets most, it is...that has to be something that we are working towards with our clients. Do you know what I mean? ('Valentine' - worker)

Here 'Valentine' and 'Hector' discuss the pressure to gain a positive outcome within a PbR service. 'Hector' highlights the board which they feel is a tool to increase the pressure on workers to achieve a positive outcome through peer pressure, a technique which 'Hector' states they do not like. Interestingly, 'Valentine' states that this kind of technique is not something they noticed and that the pressure is actually a positive effect as it focusses the worker on the recovery of the client. 'Valentine' also recognises that this is a part the workers have to play in order to fund the service itself; that it is a pressure to keep the service in business rather than a way of judging performance of the workers. In a further response 'Hector' said the following:

You know, I have a sort of list and it had everyone's name on and how much money we'd all earned.

This indicates that the pressure felt by 'Hector' to earn more money may stem from internal pressures. That 'Valentine' stated that there isn't a table of who earns the most, yet 'Hector' has a copy, indicates that the information is available but only if asked for. In fact, in a follow up question 'Hector' admitted that they asked for the information to see if it was available. This indicates a divergence of responses to the pressure exerted by PbR, with some workers able to separate their role as a revenue generator from their role as a treatment professional and others not. Kolind et al (2015) discuss 'conflicted staff' and 'late modern hybrids' in their discussion on the role of prison officers in Nordic prisons, and this idea shares some similarities with the workers in a PbR service. In their discussion 'conflicted staff' are identified as being staff who want to help prisoners, but are only able to see the prisoner as the source of any barriers to progress. In this way they are similar to 'Hector', who sees the PbR framework as an impediment to improvements with the client as there is always pressure on the staff to achieve a positive outcome within the framework of PbR and not necessarily what is best for the client. In 'Valentine' however, we see a reflection of the 'late modern hybrid': a type of staff who are able to internalise and integrate new ideas (particularly 'new penology' ideas) into their occupational identity (Kolind et al 2015). By

expressing their view that PbR is a way of refocusing on the client, 'Valentine' is expressing their internalisation of the goals of the treatment service. They are expressing, through their work, the ideals given by the service for the use of PbR in the first place. Interestingly, this internalisation is not shared across management, with 'Pat' expressing the following about the service they manage:

I do. I think...yeah. Obviously there's a financial implication to payment by results which I think clouds everyone's thoughts about it.

This is interesting in the context of this research paper, as one of the central issues identified in the methodology was the criticism that recovery would take an entirely new set of staff in order to be implemented correctly. In this case it is possible to see two different approaches to the internalisation of organisational values, with 'Hector' viewing them as a barrier to treatment and 'Valentine' seeing them as a method of refocussing workers priorities. In Chapter six this will be discussed further with direct reference to the recovery agenda and the goals of abstinence.

5.4.2 Payment by Results and treatment

One of the criticisms levelled at PbR by the workers was the possibility for the treatment to get lost in seeking the payment. Certainly, as we saw with 'Hector' in section 5.4.1 it is possible for the workers, particularly those who have not internalised the organisational norms, to feel distracted by the payment portion of PbR.

That's human nature and because you're always thinking, so why we did it? Are we doing this for the client? Are we doing this for the figures? ('Steph' - worker)

As this quote by 'Steph' highlights, workers can become focussed on the motivation for their actions, with 'Steph' wondering if the PbR portion of the contract reduces the client focus. The focus on goals for the service is cited as being a cause of this self-reflection, with workers citing the absence of goals as being a driver for their concern.

And in terms of our PbR contract, we have to, so we get targets around people sustaining treatment for 12 months, sustaining abstinence or recovery for 12 months after leaving treatment. So we never had targets around after people were close before. And it's now being reduced to six months. ('Joan' - worker)

Here 'Joan' is discussing the absence of goals for the service being replaced by fixed goals of 12 months of absence from treatment. It is worth being clear that 'Joan' is referring to the absence of goals under the previous model with regard to being 12 months out of treatment and not the absence of goals entirely, with all six service centres interviewed being subject to a form of outcome-based measurement. However, in light of that information 'Joan' is highlighting their *perception* of the measures they are being judged against, with the older measures of the client merely being drug free at the point of exit not being seen as a *measure*. In terms of the treatment being offered, it is the outcomes which drive the treatment, with clients who wish to use drugs occasionally no longer being considered a positive outcome.

That's why I have loads of heroin clients, which are still using one. And that's it. There is no payment because they're using once a month, and they were using every day which I think, yes, it's a good result, but it's nothing. You would not have any payment for that. ('Amelle' - worker)

That is going to be as in dropped out; it has to be the closure. I think, well, the client didn't drop out; he'd finished. He was using every day, so there is something good about it, but we have to put dropped out because there is no other way to put it. ('Amelle' - worker)

In part this is explained by the shift from harm reduction to recovery, with the emphasis on abstinence that sticks rather than merely abstinence at the point of closure. Also, the additional scrutiny on completions which are a crucial part of the PbR model serves to 'trap' these clients in treatment; although unlike those 'trapped' by methadone, treatment in this model has a fixed end date (Mason et al 2015). As shown previously, the forging of figures in order to get a positive outcome was part of the non-PbR models, with the worker able to fill the form out as "drug free" once the client stated they had reached the end of treatment. In

the response to those trapped clients, we can see a glimpse of the neo-conservatism argued to be a part of the 'new right' by O'Malley (1999). Authors from the recovery model argue that there needs to be more morality within drug treatment, with drug use cast as being immoral and shaming. For authors, such as McKeganey (2014) and Gyngell (2011), it is perfectly correct for clients who continue to use drugs whilst in treatment to be removed from treatment until they are 'ready' to engage with treatment. This remains a problem for PbR services: what to do with clients who wish to use drugs post-treatment, especially in services with fixed-term treatment contracts.

A further criticism of the PbR service was that it was 'whole person' focussed, but that the services offered were generic and based upon what worked in other areas.

So it does work if you are white British male between 25 and 30. So fair enough thank you very much... Worked with the Asian community, worked with the Eastern European co-.... So we went for certainty it works, but as I said it just...you know, there's a small sample, yeah. ('Jasmine' - worker)

Here, it is possible to see the 'new penology', with services not offering individual therapeutic treatment, but treatment that can be 'proven' to work on the aggregate. This could be argued to be an extension of the 'de-politicising' of social policy through the application of science, by applying techniques which can be proven to 'work' on the general population (Gstrein 2018). 'Jasmine' identifies the issue that a lot of 'what works' is taken from other service centres, with treatment methods applied without consideration of whether they are right for the person they are being applied to. It is better to apply something that works to the masses than individualise for the person. This can also be seen to be a positive, with new ideas and new avenues for treatment being explored.

And because X, Y, Z's got to be done, you can't miss out Y. Whereas before, I am...to be honest, I don't think there was ever a big urgency on getting people into education or work or...do you know what I mean? Because it was never recovery focused. And that is the thing with PbR, it is about recovery focus. So it means the whole person has to be looked at. ('Mary' - commissioner)

Here 'Mary' highlights the benefits of the PbR model, arguing that it is the whole person who is being treated and not just the addiction. Other workers (7/26 interviews) were more sceptical, however, offering a dim view of the aggregate treatment method, arguing that whilst the individual is being looked at in more depth and in more areas, the treatment is no longer personalised to their needs and is provided in a generic manner to all.

They have no choice. It's [group] work or nothing. And It's almost like I don't know. To me, that initial step I guess where I'm coming from is that's a really anxiety provoking time for those people. Perhaps they're ashamed, embarrassed to be there. ('Pat' - manager)

Here 'Pat' discusses the issues associated with the 'one size fits all' methods of treatment, where clients new to treatment may be forced into group work because it has been 'proven' to work rather than because it is the best treatment option for the client. This is not a phenomenon that is limited to the PbR services, with workers from all types of service demonstrating scepticism at the benefits of treatment or the reasons behind the implementation of a particular treatment model. It was a common thread throughout the interviews that workers felt their professional discretion was being sacrificed through fixed treatment programmes and that individualism was being lost in the desire to find treatment that worked for everyone (10/26 interviews). The most scathing response was given by 'Robert', who when asked about what the purpose of modern treatment was, they responded: "*It's not about clients*".

5.4.3 Moved goal posts

Within the 'new penology' the outcomes being measured are important to consider as if a service is working under the 'new penology' the outcomes will not represent what the service 'achieves' but merely what it 'does' (Feeley and Simon 1992). In terms of the services covered for this research, the outcome of their treatment is to reduce the effects of addiction on the drug user. In areas with a PbR component, the outcomes are determined as part of the tendering process and, as shown in section 5.3.1 are as such negotiated in part between

the commissioners and the tendering agencies. In this we can see the 'new penology' at work, with the outcomes of the services being changed to represent what is 'done' by the service rather than what is 'achieved'.

And in terms of our PbR contract, we have to, so we get targets around people sustaining treatment for 12 months, sustaining abstinence or recovery for 12 months after leaving treatment. So we never had targets around after people were close[d] before. And it's now being reduced to six months. ('Joan' - worker)

Here, 'Joan' is discussing the contract their service works with and the outcomes they are being assessed against. It is interesting to note the move from 12 months being out of treatment to 6 months, as this is a significant change in the outcomes for the service. The reasoning for this was given by 'Blair':

And the six month was always, again, they looked at when did people represent and the majority represented within six months.

This statement is significant as it represents a realignment of the measures for a service to be representative of what is 'done' rather than what is 'achieved'. In this statement, it can be argued that the commissioners are moving the measures of successful treatment in order that they fall in line with what the service is already producing and not what the service *should* be producing. Surely, if a service is promoting treatment that is new and promoting lasting recovery, the outcomes should not be in line with the models that preceded it? In their review of PbR pilots, Mason et al (2015) found that PbR pilots reported significantly worse treatment outcomes than non-PbR sites, meaning that the client was less likely to complete treatment drug free and more likely to drop out. As explained above, this may be indicative of the measures rather than the quality of treatment, with non-PbR services found to be 'less risk averse' in Mason et al (2015) and more likely to encourage fraudulent completions within this research. This has an added effect for the providers, with their national outcomes forming part of their professional reputation, and the risk of those engaging with PbR being seen to be less effective than those who do not (Cheliotis 2006). In terms of this statement it

is possible to read a number of different reasons for the change in outcomes. Firstly, and the reason given by 'Blair', is that the change was made to ensure the profitability (and therefore viability) of the service. It was made clear to me in a number of the interviews (and my own experience) that PbR put significant financial strain on the organisation running the contract and that if the service was not financially viable the providers would not be able to bid for further contracts. In this way it represents a further development of Garland's (1996b) ideas of 'adaption', whereby the state is no longer insulating itself from criticism about the failure of the service, but also now insulating itself from the financial success/failure of a service. Under PbR, if the service does not make money, it is the provider who has not succeeded and not PbR which has failed. In this way it also represents the 'new penology', with success and failure being recast to fit the service being provided. By renegotiating the measures, the state (in the form of the commissioners) re-frame failure as success by recounting those who returned to treatment in the 6-12 month period as successes. This has nothing to do with the actual achievements of the service, but merely what the service 'does'. In this way the service can be rebranded a success without actually changing anything about service delivery or treatment.

5.5 Statistics and measures post-2010

Overall, it is possible to view the changes made to drug treatment by the 2010 NDS as a continuation of the managerialism introduced under new Labour in the harm reduction era. Worker perception is of an increased concern with outcomes and statistics.

And I think since the start of 2010 drug strategy, I feel that real emphasis on outcomes. ('Blair' - commissioner)

From the results presented here, it is possible to see elements of Garland, the 'new right' and the 'new penology' present within the current drug treatment system and in all three of the service providers researched. What this represents is further change in the purpose of drug treatment. Rather than being a service whose aim is to cure those afflicted with drug

addiction, services are now in the business of dealing with the risk associated with drug addiction (Marquart et al 1999). Instead of working to cure the ills of addiction for the individual, the services now work to manage the risk to society of drug users as a group. In the harm reduction era, this was through the process of collection, whereby drug services sought to collect drug users and incapacitate them in treatment. In the recovery era this has morphed into the reverse, with treatment services aiming to keep users out of service for as long as possible, yet incapacitating those in treatment more severely. It is possible to see the perceived motivation (economics) for this change in the comments of the commissioners:

Well, nationally, it's six months but the weird thing was, for the national pilot. It was a year.

In this quote one of the commissioners interviewed discussed the difference in the positive outcomes for treatment services, with PbR services expected to keep clients out of treatment for twice as long as non-PbR services. Although, as was shown above, in a move which demonstrates the 'new penology' at work, this was renegotiated down to six months in order for services to make a profit rather than because six months represented effective treatment.

Well, you might be lucky this year because of that but you might be for the next few years really unlucky with your outcomes. And so, tough luck, we won't pay you any money

This represents an overall change in the funding for drug treatment, with workers (15/26 interviews) identifying the changes in government funding as being a catalyst for the PbR model.

it's the political system changing everything that we have to do to do cheaper, cheaper, cheaper and the most effective therefore is pressure. ('Jasmine' - worker)

Within the interviews this was identified as a key change, with employment and societal responsibility seen as being new measures of success (8/26 interviews). Overall treatment was shown to shift from preventing criminality to preventing economic harm. In Chapter two,

the discussion of the movement of the designated speaker was discussed in relation to the shifting of discourse from medical to criminal justice. This represents a further shift away from public health being the motivation for treatment, although this is a shift toward economics and morality rather than a movement towards further criminal justice involvement. Although criminality and harm are both harms to wider society, this change represents a switch in public perception where in the age of austerity financial harms were seen as more damaging to society than crime. This represents not a change in treatment itself, but rather a change in the risk associated with drug use and the discourse surrounding the motivation for providing treatment. It is now economic harm rather than criminality which is measured and by which the drug users are divided. However, this still represents the 'new penology' at work, with drug users still being treated not for their addictions, but for the risks they pose to society as a whole (Miller 2001). In the expansion of output measures and the change in focus for risk measures, recovery represents not a change back to the 'old' penology, but rather an expansion of the 'new penology'.

However, it would be remiss to view this as a negative outcome. Most workers (21/26 interviews) cited optimism at the change to PbR and highlighted the benefits that the new system brings to drug treatment as a whole:

So in my experience actually, PbR in that respect has been a real catalyst for change. I was very tentative around the idea of PbR. I'm still not convinced that it works as a model but it has brought in some real positives in terms of how we do things. ('Joan' - worker)

The quote from 'Joan' highlights the overall sentiment of the workers themselves, with them viewing the changes to treatment processes as a success rather than a burden. However, it should be remarked that the changes seen as being positive could have been implemented without the need for a PbR system. The additional scrutiny of outcomes and the change in focus to post-treatment support could easily be introduced within the traditional funding

framework and may even be more successful given the stable funding this model generates. What is also personally interesting is that these changes have yielded some additional benefits which I did not foresee when I started the research, most notably that the service offers better insight into the warnings of a client dropping out.

It happens less now, I think, because we offer so much more that it tends to be picked up on. So, if they've vanished, they might miss three appointments in a week whereas, you know, before if we were offering them once a fortnight three appointments was six weeks. So, it gets flagged up much quicker ('Freya' - worker)

These benefits have associated effects on service user engagement too, with workers (9/26 interviews) feeling that users were more satisfied with the service than they had been with other treatment schemes.

And the client has remarked you know under [Redacted] contract is the best service they've ever had because of the accountability that we have to this assessment process and outcome process. ('Danny' - manager)

Interestingly, this satisfaction is attributed by 'Danny' to the improvements in service processes brought about by PbR rather than a satisfaction with the changes brought about by the recovery model. In the next chapter, I will address worker impressions of the recovery model, what it means and their impressions of the viability of its use in drug treatment.

Summary

This chapter sought to demonstrate the linkage between the 'new penology', 'new right' and Garland's concepts of adaption and denial and the current model of drug treatment. Using this theoretical framework, it is possible to see elements of these theories within the interview data and the various models of treatment in the sample. The results presented here demonstrate that there is a clear movement toward actuarial measures of risk, highlighted in all three theories. Also, it is possible to view the further domination of economic language and neo-liberal ideology in the interviews, representing a change in the discourse and a further movement away from the medical model of treatment. However, this

chapter also demonstrated the additional benefits to both staff and clients that PbR services have provided, benefits that were surprising for both staff and the researcher. There was shown to be an interrelationship between PbR and worker acceptance of definitions of successful treatment. However, this was not necessarily seen to be related to PbR, but rather better measures of treatment outcomes, with workers better able to engage with definitions that were robustly measured.

Chapter 6: The Interrelationship Between Harm Reduction and Recovery Within Worker Knowledge and Practice

6.1 Introduction

As identified previously, research on drug workers was mainly concerned with trained counsellors and therapists from the USA or Canada. Whilst this research is still useful, it does not reflect the UK worker population, with workers originating from a number of backgrounds and workers not being seen as a skilled workforce (Polcin 2014). Within this sample I interviewed workers with a number of backgrounds, with many (6/26 interviews) coming from a nursing (either physical or psychiatric) background. However, their previous careers were in no way homogenous, with previous careers as translators (1/26), bankers (1/26) and criminal justice workers (6/26) mixing with those with experience of addiction either in their families or personally (6/26). This variety of backgrounds makes finding a consensus of opinion difficult and is the foundation of my opposition to workers' ideology being represented as a homogenous whole.

In Chapter two the lack of consensus surrounding definitions for 'abstinence' and 'recovery' were discussed. In this chapter these concepts will be discussed further, particularly within the context of worker understanding of these principles. It is hoped that this chapter will serve to enlighten as to the perspectives of this group and to critically discuss some of the perceptions that are currently held within academia as to the beliefs of drug treatment workers.

6.2 Worker definitions of treatment

6.2.1 Harm reduction

There is a perception within research in the UK that drug treatment workers are harm reduction focussed and resistant to recovery and abstinence as foundations of treatment. Indeed, this is a core argument for the progression to recovery as a model and an argument for not using TUPE to transfer over existing staff to new recovery treatment centres (Gyngell 2011). However, this is a viewpoint that was not supported within the data for this study. This

research found that this was not uniformly the case, with twenty-four of the workers interviewed offering a sceptical view of methadone and substitute opiate prescribing in general, often conflating the two concepts when discussing them.

(on whether methadone causes deaths) *Yes, definitely* ('Akash' - worker)

(later in the interview) *Personally, I feel that we are another form drug dealing if we're giving out methadone to people who are using them on top. It's actually making it more dangerous because they'll use them on top and again building up tolerance level of something that's really high and have a massive Methadone experience. I don't really think that we should necessarily give a Methadone script. What we should offer them is something that you can't use on top* ('Akash' - worker)

I don't agree with long-term maintenance methods on script and actually I'm probably astound when I'm not sure if treatment works too. ('Violet' - manager)

(Later in the interview when discussing the harm reduction model) *It's almost like we're colluding with him. I think it's almost like we've developed a co-dependency on the client and seem that we've become the dealers, if you like.* ('Violet' - manager)

Here 'Akash' gave their opinion on the role of methadone and the dangers associated with it. By far the most negative on methadone, 'Akash' demonstrates that they feel the prescribing of methadone leads to death and does not prevent overdose death as is stated by harm reduction proponents (Csete and Wolfe 2017). Whilst these are outlier opinions, 'Akash' and 'Violet' do offer opinions counter to the perceived logic that workers are generally harm reduction fundamentalists. Most interestingly, both these workers were working in a harm reduction locality rather than the recovery-based localities of all other respondents. Whilst a small sample size, this could indicate that working within a harm reduction environment does not mean the worker will internalise the ideology of the treatment. Another outlier opinion was that of 'Joachim', who stated the following:

I don't think you should stop. We don't want to stop people getting off it but I don't see it's a bad thing to stay on it I guess.

Here, 'Joachim' represents the traditional view of a harm reductionist, who sees long term methadone prescribing as being a desirable outcome. This is the stereotype of a drug worker that is represented within the literature, motivated by harm reduction and happy for drug users to be on methadone in perpetuity based on their own philosophy (Buchanen 2010, cited in Weston 2016). In their paper on breaking the myths surrounding recovery, Best et al (2010) offer the example of insulin being to diabetes what methadone is to addiction. This is presented by the authors as a weak argument as the two examples are non-comparable, given the guarantee of death should a diabetic give up insulin. 'Joachim' offers a similar argument to that criticised by Best et al (2010) in defence of their perspective on methadone maintenance.

Well, this whole sort of methadone maroon and parked on methadone I think is a very strange thing. I mean I guess that will help but that's what being parked on asthma inhalers or something like that. You have a check-up every so often. I have asthma inhalers, and every year I've gone over check-up and they ask me how I'm doing and they change the inhalers and they draw blood. Methadone maintenance is no different.

'Joachim' actually gives a slightly better example than the one given in Best et al (2010). By comparing to asthma, Joachim removes the guarantee of death and introduces the concept of risk. By medicating with asthma inhalers, asthmatics reduce the risk of a life-threatening attack. Methadone maintenance allows a user to reduce the risk of a life-threatening relapse. However, this argument would be stronger if it were in favour of naloxone, rather than methadone, as this is a drug which can prevent overdose whereas methadone merely reduces the risk. It is worth noting that both 'Akash' and 'Joachim' are outliers in their perspectives on methadone maintenance, with all other workers falling in between the two viewpoints, seeing benefits to both abstinence and maintenance. Indeed, despite being the most pro-maintenance of the sample, 'Joachim' does not see any purpose in forcing someone to remain on methadone if they wish to detox:

(on forcing someone to remain on methadone) I'm involved in it but none of that [is] happening. It will be insane.

Although they take a more fatalistic approach to treatment, demonstrating the opinion that drug addiction is a lifetime addiction that is difficult to conquer.

And clearly getting off methadone or rid of any substitute prescribed, getting off of it is better than staying on it if you can do that. But that's true for all sorts. Getting off insulin is better than being on insulin, but being on insulin is better than having diabetes. I don't see being on methadone.... People I know are [on] methadone...see it as a lifesaver. And you could...perhaps you could put an amount of work in it and you can get off of it but most people ended up on the long-term maintenance prescriptions and tried hard to get off.

In this way 'Joachim' is taking an approach to addiction which is similar in outlook to that of Alcoholics/Narcotics Anonymous (AA/NA) in that addiction is a lifetime battle (Kelly 2017). 'Joachim' merely sees this as a battle which is better fought using opiate substitution rather than abstinence. A more common opinion was that medicating *alone* is not enough and that clients will require more in the way of treatment than just methadone.

What did all you're doing is medicating. So that's not dealing with the addiction. All that's doing is fake. In my view, it's dealing with the body's physical dependence on that substance. The prescription, the methadone or the Suboxone, is not making any difference. ('Violet' - manager)

Whilst more sceptical than most on the benefits of methadone, 'Violet' represents the general consensus of workers interviewed (24/26 interviews): that methadone alone is not enough and that it merely treats the symptoms of drug addiction rather than working as a cure. Certainly, the concept of 'parking' people on methadone seems anathema to the workers interviewed, with 100% of interviewees agreeing that abstinence would be the ideal goal. However, they identify that there is a difference between 'parking' someone (in that they are precluded from change) and those who are incapable of achieving abstinence because of longstanding problems.

I think for some people looking abstinence is too far ahead and actually looks like not achievable because they haven't had that for such a long time. ('Violet' - manager)

I think there's a slight of hand going on there because it fits their political agenda. I don't think it's good enough just to park everybody on methadone and forget about

them. It's good to aim high if you can, but I think you've also got to realise that there is a significant minority, minority, but significant minority who are very, very damaged by drug use in early life and [Methadone] maintenance is perhaps optimal. ('Mikel' - worker)

This concept of balance and individualised treatment permeated all of the interviews, with workers pushing for truly individual treatment to be the norm.

I can't imagine how you think that a person in their late teens or early 20s who has been using drugs for a few years is going to need the same treatment as someone who is 45 and been using drugs for 30 years. Although they might. I can't see it. It's got to be individualised. A drug use is a mentally individual thing. You can say there are parallels or that sort of thing but people's lives are very individual. ('Joachim' - worker)

This individual-centred attitude does not fit with the harm reduction model of treatment for the many (Reuters and Stevens 2007) and fits more closely with the recovery model of treatment, where self-determined goals and individualised treatment are desired (Kaskutas et al 2015). Yet this is the overriding theme of the discussion of what treatment should be, even for those workers already within a recovery locality. When considering the place of abstinence too, the workers offered a vision of blended treatment, with workers encouraging clients towards abstinence, but with the safety net of harm reduction to prevent unnecessary harm.

I think there is a place for harm reduction. I think there's a higher.... I think that we have a duty actually to edge towards recovery and help these people that have a health issue. ('Simon' - worker)

I think the thing that surprises me is that for an alcohol dependence, we will do a medicated detox be it in the community or be in a detox centre hospital for 10 to 14...third...three weeks and then they're physically off the alcohol. Why do we give people a prescription for a drug addiction for weeks, months, and years? ('Violet' - manager)

So, if your motivation, say, you want to come off, then we will help you to come off. And that we help that person to be more ambitious because I think that's what was lacking before. ('Blair' - commissioner)

These quotes all represent the blended approach which typified the interviewees (26/26 interviewees), with a measured approach between harm reduction and recovery, and abstinence and maintenance prescribing. The interviewees demonstrated that they had issues with the previous harm reduction model, with many citing that there was not enough done to encourage detox for those that might have been able to do it. 'Mikel' felt that this was about balance in treatment, with those who could achieve abstinence needing to be encouraged, but those with more complex needs being treated more carefully, offering them treatment that offered small increments of improvement rather than rushing them to be abstinent first. In many ways, this represents further expansion of the management of 'risk' shown in the 'new penology', with risk here being the risk of drug use or the risk of further harm. Harm reduction techniques were used to manage the risk associated with or to the client, but once this risk was deemed to be acceptable, the movement to recovery was instigated so as to prevent the 'risk' of the client becoming trapped in treatment and thus unable to recover.

So I think there was a minority of people that could have done better and weren't challenging enough. But, it's an important job to separate those out from the ones who have got limited potential. Very complex needs who need and will always need loads of support. We've got to be really careful not to punish them. ('Mikel' - worker)

It is possible to see that there is a plurality to the drug worker impression of methadone and substitute prescribing which is not replicated in the literature, with workers often characterised as being overly medically focussed (Best et al 2010). Despite workers having differing levels of support for both recovery and harm reduction it is clear from the interviews that there is broad support for both being part of the treatment regime in a service. It is not yet clear however, what recovery means for the workers themselves.

6.2.2 Personal definitions of recovery

As has been shown previously, there is an impression within the literature that drug workers are harm reduction focussed and ideologically opposed to abstinence as an end goal (Best et al 2010 & Lopez Gaston et al 2010). This research argues that this is not the case, with

workers generally disapproving of methadone maintenance without end (24/26 Interviewees) and all workers (26/26 interviews) supporting abstinence as an end goal. As such, this section seeks to address the issues of personal ideology when it comes to recovery and to understand if there is a hegemony of medicalised ideology (as a method of dealing with the stress of everyday treatment) or if there is actually a plurality of personal ideology within the workers sampled. Understanding this will also help to determine the level of acceptance of the recovery agenda within the workers, a key criticism of treatment workers and a previously identified barrier to recovery truly being implemented within the UK (Best et al 2009). In this research, the semi-structured nature of the interviews allowed the respondents to speak about areas they felt were important and tangential relationships which would be impossible to anticipate even with the researchers experience in the field (Silverman 2000 & May 2001). It was felt that by taking this approach it would be possible to get a number of opinions on matters related to current drug treatment and therefore recovery, without constraining the respondents to talk merely about the recovery agenda.

In Chapter two, it was argued that one of the defining features of recovery as a model is that it has no formal definition. It can be argued that the UKDPC (2007) definition is considered to be definitive, as this is one of the most commonly cited definitions of recovery along with the Betty Ford Institute Consensus Panel (2007). In their 2010 update the latter recognised the UKDPC definition as an exceptional definition of recovery, encompassing areas of recovery that were not covered in the original BFI definition (Betty Ford Institute Consensus Panel 2010). As outlined previously, one of the key areas of contention for this author was in the decision to allow medically assisted recovery to be defined as recovery, as this seemed to be the antithesis of how the recovery agenda was discussed in the UK. It was also argued that this part of the definition was ignored in the drafting of the UK government's definition for their payment by results (PbR) scheme or for the 2010 National Drug Strategy (NDS), which both used abstinence from Class A drugs as a key component of recovery (HM Government

2010a & Mason et al 2015). In this research it seemed important when discussing recovery to differentiate between the personal definitions of recovery held by workers and those they worked within. The importance of personal beliefs was introduced into the project by Gyngell (2011) and her belief that recovery would only be achievable if drug workers adopted recovery as their own treatment ideology and that to fail to do this would be to fail recovery as a goal. This is echoed by Best et al (2010) who argued that the Drugs and Alcohol National Occupational Standards (DANOS) accreditation programme was a good way to introduce being recovery focussed to workers, as they need the accreditation to complete their training. By making the DANOS accreditation recovery focussed, each newly qualified worker would enter the workplace already recovery and abstinence focussed and would be able to help change the occupational culture of the organisation. This represents a method of controlling the discourse that the workers are exposed to in their initial training, ensuring that the recovery ideology is presented and the medicalised discourse of harm reduction is minimised. During the course of the interviews each of the respondents were asked what recovery meant to them in order to separate out their own beliefs from the operating procedures of their locality. 'Blair' highlighted the initial issue with defining recovery in their response:

Yeah. People haven't really defined it, isn't it?

This response is typical of the sample, with all respondents giving a slightly different definition of what recovery is and most struggling to articulate what it means to them. Broadly though, there were those who felt recovery was tied to abstinence (13/26 interviews) and those who felt it was something else, although abstinence formed a part of it. Although it is worth highlighting the response of 'Pat', who felt that recovery as a word should not be applied to drug treatment:

That's the word I don't necessarily.... I just think we overuse it. To me, if I [hear] recovery, I would expect to come up with Green Flag, AA. RAC. It just means my car's broken so I need help... I really don't know. I've really not given it any thought

but the fundamental use of the word recovery doesn't mean what it's there for at the moment.

Whilst 'Pat' doesn't dismiss recovery as a concept, they state that the word is over used, indicating that to them, because the word has no strict definition, it does not mean anything within drug treatment. It is essentially a buzz word, meaning nothing. They also state that the word does not mean what it "is there for at the moment" indicating that they feel there is an opacity to the concept of recovery. Indeed they have their own word they like to use instead:

I like the word well-being. I like well-being. Yeah. You know, well-being centre... well-beingness, I quite like that. I don't know why.

Despite feeling that the word lacks definition, 'Pat' identifies one of the core concepts of recovery: that of wellbeing (UKDPC 2007 & HM Government 2010a). This was a common theme throughout the interviews, with all interviewees identifying some form of change in wellbeing as being key to recovery:

It's improving their health and their life by reducing drugs and alcohol, and/or... Yeah, you can have recovery start with reduction and some would say it ends with stopping, with abstinence. ('Valentine' - worker)

It's about allowing them to have...to maybe see that they have a wider choice of maybe greater opportunities that have been constrained by their own backgrounds history and whereas drugs and alcohol have helped them survive. ('Dave' - worker)

You know, but it's for them to find out and to discover. It's not for us to tell them, its maybe for them to tell us. And we'll help them get to where it is that they want to go once they've decided. ('Simon' - worker)

Recovery to me means proving someone's well-being.... So recovery to me means someone's whole well-being and addressing if they want to it's here. ('Steph' - worker)

Well it's about... I mean for me, I think it's about making certain changes in your life...It's just that being – actually just being a normal person. ('Tim' - worker)

This version of recovery is supported by the experience of drug users themselves, with changes in quality of life often accompanying the designation of 'recovery' (Best et al 2012).

This definition of wellbeing as recovery does not exclude abstinence, with workers identifying that abstinence even for a short period is a vital part of the recovery process.

To recover is to kind of...for me, it's about moving on from and growing from a place of difficulty around their drug or...and/or alcohol misuse. So it doesn't...it's not exclusively abstinence. It's moving on from a difficult time of using. ('Matt' - worker)

I don't think recovery...recovery is different for everyone as well. Recovery is, I say, is not necessarily abstinence or being drug-free. It's about being able to cope with a normal life. ('Mary' - commissioner)

If somebody says to me, "I want to carry on doing my drinking socially," I encourage them they have at least six months abstinence that they can compare the two lifestyles with. ('Louise' - worker)

I would say it's...maybe it's the journey that the client has from being a drug user to live a long standing life of drug-free.....with the support of everything in the community. ('Amelle' - worker)

In these examples we see acceptance of 'abstinent and non-abstinent' recoveries (Witbrodt et al 2015), both of which are acceptable under the UKDPC (2007) definition, but are not acceptable under the PbR recovery scheme (Mason et al 2015 & Jones et al 2017). This poses a potential problem for services, with workers potentially willing to see clients as being in recovery and wishing them to be free from service, but unable to close them as they will not satisfy the criteria to complete a payment. This was highlighted as being an issue in Chapter five, with workers highlighting that services prevent clients from successfully discharging when they are using a small amount as the discharge process does not allow it.

The interviewees (16/26) identified that the process of recovery involves more than just improving wellbeing, but also engagement with society again in a more meaningful way.

The whole holistic...it's not just getting them off their scripts. They need something else as well. ('Jessica' - worker)

To me, recovery is a number of things. It's not just the drugs and alcohol. It's not just getting a prescription or getting a detox...To say they were fully into recovery, a healthy lifestyle, a healthy part of the community, valuing themselves as a person and being valued by the community as a person and being drug and alcohol-free and being happy really to just be who they are. ('Louise' - worker)

That's a funny one, isn't it, recovery? Recovery can mean anything... And what is normal? And is my normal the same as someone else's normal? Might not be. ('Dora' - worker)

the way I see it is that we are such a small part of what they need or what they might want or what they might have to be able to do it, to get to their recovery and maintain it. Because they have, you know, a whole life outside of this building which we're nothing to do with. And in theory, we should only be a part...a very small part in the life for a short period of time. So, they need to have other things in place, you know, whether that's simple things like having...walking a dog or you know having their kids or their parents around its way more important than what we do. We can offer them certain things but we don't...can't ever offer them enough that would get them to recover in isolation I don't think. ('Freya' - worker)

This represents an absorption of the government's narrative on recovery, with a return to productivity and engagement with the community being seen as central to the process of recovery (HM Government 2010a). It also represents an acceptance of one of the core components of recovery, that the community (particularly the recovery community) plays an important part in the recovery of an individual (Best et al 2012). This also represents a further acceptance of the UKDPC definition, which identified citizenship as a key component of recovery (UKDPC 2007).

Another core component of recovery is that goals and successes should be measured and set by the client themselves, and again this is accepted by the workers in the interviews (19/26 interviews).

It's determined by the individual of how they constitute their recovery with a view to aiming towards abstinence, going forward. ('Blair' - commissioner)

It doesn't to me. It means someone making the changes they want to make. ('Hector' - worker)

Well, I suppose recovery is being abstinent from all illicit substances and it's about how...how you go. There's obviously recovery that it was...recovery you're going on a journey. So, it's about knowing the destination. So, actually knowing where you're going or what you want and getting the stuff to help you to get there. ('Violet' - manager)

(Pause) Do you know, there are some clients that are quite happy to just dabble and dabble now and again, and that's what they want. ('Dora' - worker)

For me, a successful treatment outcome is actually someone achieving the goal that they want. So my hope would be abstinence for them, but actually it will depend on what it is they want. But I think for them to be able to live a fully integrated life in the community, I don't know. I don't think it's work, because working is not realistic, you know? ('Akash' - worker)

Because there's that perception that it's about being well and it's about being normal. And actually, recovery for an individual isn't about being well and being normal. It's about being somebody that they want to be. ('Robert' - worker)

There are differences here though, with 'Blair' and 'Violet' using abstinence as the end goal that the client should be aiming for and any changes along the way should be to achieve that goal. 'Hector' sees the process of recovery as being entirely client focussed and client set, whereas 'Dora' and 'Akash' form the mid-point of these views, in that abstinence should be the goal but the client should be able to set their own recovery. This exemplifies the conflict between abstinent and non-abstinent recoveries and allows us to describe two distinct subcategories of worker. In this, workers were split down the middle, with 50% feeling that the definition of recovery must contain abstinence of all drugs at its core and expressing this within their answers:

I think you should be completely drug-free. ('Jasmine' - worker)

(on recovery being tied to abstinence) *For me, yeah.* ('Louise' - worker)

Recovery is about becoming abstinent and remaining abstinent. ('Akash' - worker)

But I do think, I think abstinence actually is the only way. ('Violet' - manager)

(On whether recovery means abstinence) I would say, primarily yeah. ('Simon' - worker)

So I think recovery needs to be long term. You're always in trouble. An alcoholic is always considered to be an alcoholic. ('Basil' - worker)

These quotes demonstrate the idea that for half the sample abstinence is the main component of recovery: for an individual to be in recovery they must be drug free. Yet as highlighted in Chapter two, it is impossible for us to determine the level of 'drug free' that is acceptable. This is a weakness of this particular study, in that in the research design it was not considered that the researcher should ask what level of drug free is required by the worker. For the purpose of this analysis, it is assumed (based upon researcher experience) that the term 'drug free' refers to being abstinent of illicit Class A drugs (or the primary problem drug if not Class A) and not being maintained on opiate replacement medication. This is based upon the terminology used in drug treatment at the time of the researcher's employment in the field and it is in line with the government targets in this area (Mason et al 2015). It must be recognised though that this study failed to define the terminology within the interviews, and the definition rests almost entirely upon the experience of the researcher.

There is also recognition within the interviews that recovery does not just refer to recovery from substance misuse and that it encapsulates the wider state of the individual as a whole.

recovery is a big word and recovery from substance misuse is one thing. Recovery from life experiences is something else. So somebody recovering from their addiction could be very short-term... And you're now leaving the service, but there again could be issues of historic abuse, domestic abuse, trauma... and trauma for a variety of things that people are leaving the service with still. And they may haven't even started that recovery because they've done their recovery from substance use, but the other part of the recovery only just starts when they walk out this door.
(‘Christine’ - worker)

(On if recovery is as simple as being drug free) No. If it does, then we don't disservice in my opinion. Because, again, if it was that simple then I don't think drug problems would exist to the level that they exist because it would be much...it's much more sim...much more simple and wouldn't need us, wouldn't need money and wouldn't need, you know, support and all the different things that we can offer and our other agencies offer to get people. (‘Freya’ - worker)

This recognition of drug use being a compound problem represents the acceptance that drug use is a symptom of other personal issues that may be underlying the drug use and that drug treatment is not the sole problem to be solved. This also represents an acceptance of the mental health definition of recovery, whereby the absence of mental illness is not a defining characteristic of recovery, but merely a portion of the journey (Pauly et al 2017). In the quote below, ‘Christine’ demonstrates a further component of this definition, looking at recovery not as something that happens ‘from’ addiction, but something that happens ‘within’ addiction.

Recovery is a process. And it's about somebody getting to a stage that they're happy with. Recovery's a tricky one, isn't it? Because recovery to some people is to be abstinent and that's kind of a recovery model or whatever. But a recovery may be actually I need to recover from a six-month period and get back to how it was six months ago.

In the interviews it is clear that there is a differentiation between two major ideologies within the workers: those that see recovery as having abstinence as an end goal and those who see it as an aspirational ending to a journey. Whilst this is a subtle difference, both are shown to be acceptable goals for recovery. This differentiation also represents the conflict between the forms of recovery seen in UK drug policy, with abstinence as a core component of UK policy, yet medically maintained recovery accepted as the definition by some recovery

advocates (UKDPC 2007, Betty Ford Consensus Panel 2010 & HM Government 2010a). Yet they both meet the essential criteria of supporting recovery. Perhaps the most simple definition that encompasses recovery comes from a worker in recovery (who I will not identify for ethical reasons):

Freedom. I mean keep it simple. Freedom from the ball and chain that addiction is. Freedom from belief systems and certain types of thinking that can keep you quite miserable maybe. It's a change of thinking, change in general. So freedom and change.

6.2.3 Recovery in practice

In section 6.2.2 personal definitions of recovery were discussed and two types of recovery were defined: abstinent and non-abstinent recovery. These two definitions are important, as they represent the total of worker opinions on what recovery means to them, but this is not necessarily the ideology that they treat under. It is the treatment provider who tenders for contracts and thus provides the treatment framework (and ideology) for the area (Best et al 2013). Within these areas the locality manager is also responsible for the implementation of the treatment in their area in line with local needs and the overall treatment framework outlined by the provider. Under this model it is possible for the worker to experience differing interpretations of the framework, particularly given that the definition of recovery is opaque. As such, it is important to discuss the workers perceptions of the treatment services they have worked for. To that end, this section will look at the role abstinence and non-abstinence play in recovery within their services.

...since the changeover in April, there's been a big push to get people out of recovery. We're not maintaining people. We're not maintaining anyone. ('Hector' - worker)

For me, recovery is, well, from our agency's point of view, it's about working towards and achieving and maintaining their abstinence. ('Freya' - worker)

I think for me, it's determined by...the government proposes total abstinence. ('Mary' - commissioner)

I know what the government means by recovery. It's abstinence. ('Blair' - commissioner)

These quotes all highlight the organisational push for abstinence from illicit and prescribed (by the service) drugs experienced by the workers at different levels. The commissioners identify that the impetus for getting clients out of treatment and into abstinence is from the government and this matches with the stated goals in the 2010 NDS, where abstinence is identified as a core principle of recovery. This demonstrates the movement within drug policy, with medicalised treatment waning in favour of more moralistic, economically focussed recovery. Workers are experiencing this change in focus too, with 'Freya' and 'Hector' both identifying that their PbR service is focussed on abstinence as a treatment outcome. This change is also highlighted by 'Matt':

But abstinence does tend to work for a lot of people a lot of the time. But it's a big goal to have and I don't think people can really commit to that unless they, you know, have really made that decision. So I would always be advocating abstinence. And I think that [treatment provider] are also...they're very keen on abstinence as well which is good because I think like in the eight years that I've been doing substance misuse, maybe like about maybe five, six years ago, abstinence felt like it was a bit of a dirty word. It was all about harm reduction.

'Matt' articulates the change in focus for treatment services, describing recovery as a "dirty word" under previous providers who were focussed on harm reduction. Here it is possible to see one of the benefits of the partnership working process that was outlined in Chapter four, with government ideology clearly articulated to the frontline worker through the working agreement of the partner agency. By working with the provider directly, government is able to articulate their ideas on drug treatment, but are also able to allow innovation in treatment design (Thomas et al 2016). This does cause a problem though, when the personal definition of recovery is at odds with the ideology of the service.

(On whether recovery mean abstinence now) Not with my head but that's what it is outside. That's what it means in treatment circus. That's what it means to politicians and the powers that be, all these organisations. ('Joachim' - worker)

...well, it seems like to management and drug services in general at the moment, recovery means total abstinence. ('Hector' - worker)

(Pause) I think the services, yeah, obviously want clients to be drug-free. And to hope that they will stay abstinent from using any substances. ('Dora' - worker)

This is particularly problematic when treatment outcomes are added to the picture, as this introduces a stress between the personal understanding of recovery and the government measures of recovery. The worker is therefore caught between keeping a person in treatment that they feel has recovered and the need for successful outcome to keep the service funded.

(on personal beliefs vs working practices) you know, we have to work how we're told to work sometimes. ('Hector' - worker)

Staff that had been in the area for a period of time, they know how it works. And they can't change it so they might as well just go with it. ('Akash' - worker)

I think it's becoming robotic rather than it being person-centred. And we try to make it as person-centred as we possibly can, but we get such a lot of pressure on us to perform and have outcomes. ('Christine' - worker)

This demonstrates the 'professional identity' discussed in Chapter two whereby the worker adopts the values held by the organisation and incorporates them with their own personal attributes (Simons et al 2017). In terms of acceptance of the organisational definition of recovery, workers in Eastshire were much more accepting (93% acceptance compared to 0% in Westshire and 50% in Midshire), in part due to their acceptance of the link between payment and recovery.

The recovery agenda...so from a professional point of view, they've decided this is a definition of recovery. For me, with our clients are they making progress, are they where they want to be? And interestingly from an NDTMS point of view, you can't shut down someone who's occasionally using heroin. They have to be shut down as incomplete...You can if you're occasionally using amphetamine. You can if they

were casually using alcohol. So there's all that sort of anomalies. And what I have found when I've worked with clients in the past and when we worked with teams here is we, we are trying to get users to discover what recovery is for them. Because we can put it in a box and say this is recovery but our clients are...sometimes when these things are designed and you get service designs and the NDTMS and so on. They start from A. They go to B. They're very robotic. And they should do this and this. They should be doing this. And actually human beings are transient. They go up and down emotionally and so on. So I think recovery is very different for different people. ('Danny' - manager)

Here 'Danny' demonstrates the issues they have with the NDTMS definition of being 'drug free' in that you can be using drugs on top of your prescription as long as the drug is not your primary drug. However, rather than fighting this definition 'Danny' has accepted it and is instead allowing the client to discover their own meaning of recovery. Here, for 'Danny' their own definition of recovery is less important than the discovery of recovery by the client. This matches the research by Eversman (2010) where workers were found to be largely similar in their outlook on treatment and treatment outcomes. However those interviewed in Eversman's research were primarily in recovery and it is unclear as to how this affected their similarities in ideology with their (recovery oriented) employer. In this research, it was the workers from Midshire who were less likely to accept this definition of recovery and as a result less likely to accept the occupational ideology.

If you don't do this, you'll lose that. You don't follow the model to the letter you lose your job. And I think that's becoming a stronger influence in treatment which I think is actually kind of taken away from the effectiveness of treatment. ('Dave' - worker)

If I did that at [treatment service] and but the bosses found out.... Actually, I'm trying to help this person get back to controlled heroin use. They go bonkers on you, don't they? I don't know. ('Joachim' - worker)

Here we see the difference in approach between the two agencies, with the workers from Midshire being forced to accept the change in organisational ideology rather than being encouraged to accept it, as is the case in Eastshire. This perception of being forced to change as opposed to change being part of the new working practices seems to motivate the workers in different ways. By being forced, 'Dave' and 'Joachim' are in direct conflict with

their employer and are resistant to the change. In introducing the change in philosophy as a way to keep the service running, 'Hector', 'Akash' and 'Christine' are more relaxed in their acceptance of the change. In this way it is possible that PbR can actually assist with ideological organisational change, as there is a perceivable change in the funding of the service which is tied to the ideology. It is the financial component of the service which has changed (the outcomes) rather than being a fundamental challenge to the workers perception of what they do. This allows an easier transition for the worker between their previous professional identity and their new one. This acceptance of professional identities has practical uses for the worker too, with successful client engagement linked to how helpful a worker and service are in helping the client to meet their own goals (Fiorentine et al 1999). This will also help workers with the transformation into recovery based workers too, with acceptance of the self-directed nature of recovery being key to changing a worker from a director of change into the facilitators of self-directed change (Best et al 2010).

It's about being honest from the start, from that very first conversation that that doesn't happen anymore, that they can't come here and just get a script. What this service offers is recovery. And they...some of the clients will buy into recovery because they might want it ('Valentine' - worker)

What 'Valentine' offers here is a clear outline of the expectations of the service and what it can deliver for the client. They are outlining the organisational expectations for behaviour and defining the boundaries of the therapeutic relationship. By doing this, the workers are able to allow the client to define their own recovery within the context of the organisation's goals; the worker is expressing the organisational ideology to the client so that they can make the choices that best suit them, but within the context of the organisation. In this it is possible to glimpse Foucaultian 'agency' at work in the relationship between provider, worker and client (Garland 1997).

6.3 Motivation

Treatment motivation or the motivation for change is a key component in the recovery agenda (Cosden et al 2006). Proponents of recovery will lambast harm reduction, and substitute opiate prescribing in particular, as stunting the growth of recovery and preventing a significant proportion (49.9% according to NTA 2007) from achieving their goal of abstinence. This is certainly supported by half of the respondents in this research as shown previously by their attitudes to methadone:

(on substitute prescribing) But by for settling for [okay]. And that paralyses people and keeps them trapped. I think there's an element of truth in that... ('Mikel' - worker)

Motivation is further complicated when viewed within the context of treatment though, with treatment cohorts usually mixed between those volunteering for treatment and those within quasi-compulsory treatment (QCT). My own experience of this is that those who are placed in QCT are usually engaged with treatment or have been recently, and as such the order serves as little more than a forced return to the status quo. This research is looking into the relationship between recovery and the drug treatment worker, and as such it was felt that motivation and worker opinions on motivation are important.

I think people.... No one comes in to drug treatment unmotivated. They come for a reason. They come because there's something in their life that they're unhappy about. Now, if the reason they come in is because they're unhappy because they can't seem to have enough money to buy the drugs that they want, then I think that's slightly dubious. I don't think we should be doing that. ('Joachim' - worker)

This quote represents the baseline of motivation for the worker: the idea that someone has entered treatment, that by entering treatment in the first place they have demonstrated some kind of motivation to change. However the definition of motivation is (much like recovery and abstinence) poorly defined, with some workers identifying it as a desire to make a change no matter how small and others identifying it as wanting to be drug free or abstinent.

(On whether motivation means a desire to be abstinent) *Probably yeah.* ('Basil' - worker)

When things go right for a client, and the client's open and susceptible to changes and willing to change, then, I think moving through the service can be really smooth for them. And it can work really well. So, I kind of think a lot of it depends on the client. ('Dora' - worker)

In these two quotes it is possible to see this difference of opinion at work, with 'Basil' looking at motivation as springing from the desire to be abstinent, whereas for Rod, the desire for change will sweep the client to abstinence as they are now more open to change. In terms of academic research, the link between motivation and treatment outcomes is generally accepted as anecdotally true and is a motivator for McKeganey (2011b) for the withdrawal of treatment for those who do not wish to be abstinent. What this represents in this research is a further example of the difference between an abstinent and non-abstinent recovery for workers, with motivation being assessed according to the workers' own definition of a suitable end point to treatment. As such their own impression of what a suitable end point is drives the worker's perception of the motivation of the client at the point of entry.

6.3.1 Developing motivation

My own experience of working in drug treatment demonstrated the value of motivation in successful treatment and this is supported by research in the area and government policy for treatment (HM Government 2010 & Best et al 2013). This was supported entirely by the workers, with all workers (26/26 interviews) believing that motivation was a key component in treatment.

So I think that initially when you're seeing a client, well, not even initially, the whole time that you should be using motivational skills and plugging them into the recovery community because they can't do it on their own. And it's just sort of enforcing that belief that we have as a treatment service that they can't do it on their own. And so I think that motivation is vital. ('Matt' - worker)

It is widely accepted that a client cannot maintain motivation to change throughout their treatment (Miller and Dunlap 2011) and that it is the worker who is responsible for the development of motivation throughout the treatment episode. Workers themselves see this as part of their role, with the cultivation of motivation and the desire to change a significant portion of their job.

Oh, I think that's the first thing yes. Motivation form is quite important and the maintaining of motivation and them seeing the changes to realise, yes, it's changing and it's changing for the positives. Yes, motivation is 99% important. ('Amelle' - worker)

I think that's my rule is to assist clients to recover. I'm not sure if recover is the right word. I think treatment's more accurate. They might not be recovering something they've never had before, to be honest. ('Dave' - worker)

The first, the most important thing you have to do is build a relationship. And the second thing that I believe is that all these things that we provide, all this stuff we provide is all about doing one thing and that's about giving the client, the service user, whatever you want to call them, the belief that they can change. ('Joachim' - worker)

It is important. It's important that not necessarily on our first session, but it's important that, you know, in the early stages of their recovery, they will develop some motivation. And you know, we work on people's motivation with motivational interviewing and all that. If someone comes in and their...you know, their motivation is fluctuating, you know, you'll be working on that. You know, but for someone to have a successful outcome, for someone to successfully go through treatment, you know, they're going to need motivation. So, if you're working with a client who, you know, has got little motivation for change, then you think, "Well, you know, what's the point?" ('Hector' - worker)

So that's key for me and I think that our job is not difficult because we should only be working with people that have some sort of motivation. Their motivation is very, very fragile job so they can come in one day and be like "Yeah, yeah, I want to stop," and then a week later whilst they're in treatment maybe not. ('Matt' - worker)

Within these quotes we can see the broad description of their role as being to motivate and encourage the client to change. In many ways this is the same function that the recovery community is supposed to provide, with workers replacing fellow clients as the support

structure and cheerleader (Kelly 2017 and Best 2017b). These two areas should not be seen as mutually exclusive though, with both serving as valuable assets in the recovery of a client. Indeed, this was demonstrated by the links with the recovery community in Eastshire, with the recovery community having a place within the treatment centre so that clients can speak with recovery champions immediately following their meeting with their keyworker.

...they don't need to be completely motivated because the kind, the power of the recovery community and the things that they do, what we often find is that someone will come in for a key working session, come down here for a coffee and you kind of go, "Hi." And they go, "Ugh. Just had a terrible key working session. Like your workers told me all the stuff I don't want to hear." And then you go, "Oh that's sad. Come talk about in [Recovery group]." And someone will come in and then come back the next week and come back the week after that. It's quite an intrinsically motivating thing without someone having to you know come in an incredibly positive mood ready to make changes. It's more about finding somewhere that people are accepted as long as they're not under the influence at that point... And that there's quite a visible demonstration that recovery does happen. ('Joan' - worker)

This was seen to be important for the client, as motivation is mercurial and can change at any moment. This was a trait recognised by all workers, with the maintenance of motivation seen as a key skill.

I think initially, motivation is important but also, I do think that motivation in human beings it kind of, it's a bit fluid. ('Simon' - worker)

a lot of them come in and recovery is like just unattainable, it's just something they're never going to achieve. You know, let's start small, real smart goals. Let's start something...let's just put in your care plan that you ought to be on time and then come to your first four appointments with me. Let's keep it real. ('Louise' - worker)

(Later in the interview) And when they start to see they can achieve something, no matter how small because, you know, it's still an achievement. The motivation does grow. And I'm a great believer in celebrating success however small that may be because for somebody it's their world. ('Louise' - worker)

it's unrealistic to say that you're going to be motivated, highly motivated.....all of the time. And I try to put across a bit of balance, you know. You had to be a little bit more gentle with yourself. Motivation is good, it's easier that way but it's not always going to be there. ('Simon' - worker)

It's got to come for them, yeah. You can challenge it. You can kind of challenge their belief systems around it and challenge their thoughts and their behaviour in quite a gentle way without being too aggressive about it. ('Christine' - worker)

The two quotes above from 'Louise' demonstrate an approach that was used by a number of workers (10/26 interviews): incremental gains. In this method we can see the combination of harm reduction and recovery at work, with the workers using harm reduction principles to keep the client safe from overdose and in treatment, but working toward recovery as an end goal. This is in line with the advice given by Public Health England (PHE) (Day 2013) in their guidance on achieving recovery, with small incremental gains used to build confidence and move toward larger changes. However, 'Louise' does not advocate having larger overarching goals (such as abstinence) as is the recommendation in the PHE document. Instead, 'Louise' and the other interviewees advocate using harm reduction strategies to keep the client safe, whilst building on the successes these small changes bring to build to larger goals. There is evidence that substitute prescribing is a good method of keeping people in treatment who would otherwise drop out (Roberts 2014), meaning that the method employed by workers here is designed to keep clients in treatment whilst building their motivation to move on to abstinence.

I think harm reduction is part of recovery. But for me, recovery is like a step on. So you can give...you can provide harm reduction advice and support for someone but they're not in recovery or reaching recovery. ('Matt' - worker)

You know, but it's for them to find out and to discover. It's not for us to tell them, its maybe for them to tell us. And we'll help them get to where it is that they want to go once they've decided. ('Simon' - worker)

It's not about me. It's about their needs, the amount, and what they want but we want it to be realistic about what we can offer. So for those clients, they probably know. They know services have changed recently but we've got passed that now so people who have exited and coming back again within the same service in the same service model, the recovery model that's being delivered. ('Steph' - worker)

When looking at the literature, this is not a popular method with recovery advocates, as this is seen as diluting the principles of recovery and not embracing the ‘true’ meaning of recovery (McKeganey 2011b). Yet this is also supported by PHE (Day 2013) with a section in their ‘routes to recovery’ being devoted to harm minimisation techniques. Crucially though, this is the shortest section of the document and contains very little detail on what should be done with the client, beyond looking at the risks associated with behaviours. In the section on opiate prescribing, there is little present on the benefits of methadone/Suboxone and these two drugs are treated in the same manner as heroin. There is no discussion on how to assist the client with detoxing from opiate prescribing, nor in helping them decide when it is time to detox from prescribed medication. It is merely stated that opiate substitution is used for stabilisation and no further information is offered. This is also the only section of the document where methadone or Subutex (or Suboxone) are mentioned, indicating that the routes to recovery highlighted here are very much abstinence focussed. This is contrary to the recovery process outlined by the workers, whereby harm reduction and opiate prescribing is very much a cornerstone of the recovery process.

We focus a lot on harm reduction and minimisation as well as abstinence. We do know that we’re striving towards abstinence. (‘Louise’ - worker)

Yeah, I’m happy to work with people on harm reduction. So obviously, we need to look out crime reduction. We need to look out for the spread of diseases that sort of thing. But for somebody to have a fully integrated life within the service, I think that it needs to be abstinent (‘Violet’ - manager)

But I think really if our one aim is to try and safeguard the clients and help them achieve the recovery that they want (‘Freya’ - worker)

Here there is a difference between the government understanding of the recovery process and that outlined by the workers. Under the government’s model (outlined in Day 2013), substitute prescribing is a means to reduce harm only and is not considered to be part of the movement to being recovered. It is better than using illicit drugs, but is not part of the

recovery process beyond moving the client off of street drugs. In terms of other government recommendations though, the use of substitute prescribing is very much part of the recovery process, with the UKDPC (2007) definition of recovery including the concept of non-abstinent recovery. In their responses, the workers interviewed generally seemed to favour harm reduction as a stepping stone to help build motivation for abstinence, but their definitions of recovery did not preclude them from considering those who were managed on prescription medication as being recovered.

6.3.2 Forcing change on the unmotivated

One of the areas discussed with the interviewees was whether motivation could be forced upon a client. This was discussed because of the importance of QCT under the harm reduction model used by New Labour (Stevens 2011a), as it was felt that this would be a measure of the acceptance of the underlying principles of harm reduction over the personal direction espoused by recovery. It was highlighted that QCT represents a serious issue for the workers, and their management of it is one of the more challenging aspects of their jobs.

...probably my biggest battle that I have to fight with clients that get these orders that don't show any expression of motivation. They're not even in the contemplation stage. They just haven't got a problem or they just haven't got used alcohol or drugs. ('Matt' - worker)

The majority of clients, they show very low motivation because of the drug they used or the alcohol. Majority of them do it because they are compelled to do it probably by agencies over their families. ('Lee' - worker)

They're there for different reasons and find motivation. So I don't think it is important right at the start because we work with court orders, people coming through social services et cetera, et cetera and so on. ('Danny' - manager)

For QCT cases, the job of the worker is made more difficult because they often need to cultivate the initial motivation that would already be present in those who presented to treatment themselves. For the workers interviewed (26/26 interviewed), motivation is required in order to achieve recovery and a measure of that motivation springs from within

and cannot be developed by the worker. Yet it is one of the principles of QCT that motivation is unimportant, with the mere presence of the drug user within treatment offering positive gains in terms of life expectancy and health (Fiorentine et al 1999 & Monaghan and Yeomans 2016). This was rejected by the workers, with all highlighting the importance of motivation for the recovery process.

Yeah. Well, I just think if you want to give up and you can tell the people that want to stop doing it, you can see how motivated they are, and it doesn't work if you're not. ('Jessica' - worker)

They need to really want it for themselves and then everything else falls into place around that. I'm a great believer of that as well. ('Louise' - worker)

(On motivation) Quite important ('Tim' - worker)

I think a lot of it is down to the client. Not always, but a high percentage of the time, I think it is down to the client's attitude to change and willingness to change. And really, where they are in their own life. If they've got loads and loads of chaos in their life, it's too difficult for them to change. ('Dora' - worker)

It cannot be concluded though that QCT was not useful, as for the interviewees it represented an opportunity to demystify treatment and to 'sell' it to the client as a change they can make.

I think coercion works. The reason I think coercion works is, I experienced that when I worked in day programme, so within DRRs then. I think the way coercion work is that it often makes people realise that the treatment isn't this terrible thing that they envisage it's going to be. So I think sometimes if you make somebody go...not all the time, but actually sometimes people are just too scared going through that door or decide that...made a prejudgement that that's not for them. But actually once they try it, they realise that actually it isn't all that bad. So, yeah I do believe coercion does work to a degree. But there needs to be a cut-off point when you can coerce somebody and say, 'Come in. You've got to try.' But actually if they're still not willing to do it, then.... ('Violet' - manager)

You can lead people to it. I mean, I think that you see people do well when they are asked that are really cocking it up and are dragged kicking and screaming, but actually do make the most of it and surprise themselves and everybody else. So definitely, we have to go towards that. We have...you know, I think there are opportunities to kind of seduce the client into engaging with treatment against their own expectations. ('Mikel' - worker)

Here 'Violet' and 'Mikel' highlight the positives of QCT (in the form of a DRR) whereby the client is able to see the positive benefits of treatment and the staff are able to use their skills to cultivate motivation for change in the client. Whilst research into the success of QCT suggests that it is similarly effective to voluntary treatment, it can be argued that it allows workers to utilise their skills to engage those who would not usually be in treatment, into treatment (Stevens 2010 & Shaub et al 2009). What can be seen though, is worker reluctance to be involved in forcing someone into treatment and a lack of belief in this being a viable strategy.

I mean personally, no, I wouldn't want to try to force someone. ('Simon' - worker)

Can you force someone?... I don't want to force anyone to change. So I think that getting them on an order or getting them into treatment when they are not motivated at all is I think that that is counterproductive because they would then associate this place as something where we're trying to offer them this gift of recovery, and the more you offer something to someone that they don't want, it's not relevant to them. ('Hector' - worker)

By refusing to force anyone into treatment, the workers again demonstrate their commitment to personal motivation as a core driver of successful treatment. This fits again with them embracing the message of recovery, which also embraces the idea of personal motivation and growth being a portion of the recovery journey (Best et al 2013, Neale et al 2011 & Jarvinen 2017). This also represents an acceptance of the government's own definitions of recovery in the 2010 NDS, where personal motivation and personal growth are seen as key indicators of recovery in an individual (HM Government 2010a).

6.3.3 Testing motivation under recovery

As was highlighted in Chapter one, the source of much of my scepticism for the recovery model stemmed from a policy implemented close to the end of my career as a keyworker. This policy sought to 'test' the motivation of incoming clients to see if they were ready for recovery. The rationale explained to me was that a client who truly wanted to recover from drug use would be able to attend appointments set in advance, even if they were using,

because they were 'motivated to change'. This struck me as counterintuitive, as previously we had accommodated the chaotic lifestyle of the active drug user because it was expected that they could not manage their lives effectively. In the interviews, I found only one worker who agreed that motivation should be tested at the entry point to treatment.

It's important to test their motivation because part of the journey of recovery is having...is building up self-motivation and self-confidence and a desire to move forward as part of recovery. And sometimes clients themselves presented asking for a drug worker. But what I do a lot of the time is I would give them a date to come to the office and then say, 'If you go into the office in that date or the next day for example, then we'll triage you then.' That's just a whole test of motivation. And 9 out of 10 times they don't come. But then it saves my energy of chasing them up make sure... If I did the triage myself then I'll have to chase them up, do home visits, and the appropriate services. And that's all for someone who doesn't necessarily want to engage in our service, that's time wasted for me. I'd rather work with someone who actually wants to engage. ('Akash' - worker)

What 'Akash' expresses here is the very principle that my own employer expressed to me: that motivation must be tested to ensure it is real. Lancaster (2017) argues that the drug user in treatment is simultaneously both a responsible actor, in terms of their addiction, and an irresponsible actor who needs to be surveilled and controlled. Wincup (2017) also makes the argument that the very reason behind QCT is that a drug user is incapable of acting responsibly because of their addiction. Certainly, 'Akash's' response can be seen to be an example of clients being treated as being responsible for their own treatment.

6.4 The recovery community

Another aspect of the recovery ideology which has been highlighted as key to their definition of recovery by the government (HM Government 2010a) is the recovery community, a network of ex-users who provide support within the community for those who are attempting recovery (Kurtz 2017). This can take the form of any or all of the following: structured support organised in treatment centres, AA/NA/CA groups (either within the treatment centre or without) or informal support groups that are client led and client organised. The importance of this additional support ties into recovery being about more than just removing the drugs from a person's life, but also the rebuilding of the individual to 'normalcy'. Kelly

(2017) uses the analogy of a burning building, with the extinguishing of the blaze being the removal of drugs, but the rebuilding of the building is recovery. The government recognised the importance of the recovery community as being key to improving the prospects of recovery within the 2010 NDS, promoting the introduction of recovery champions: recovered individuals who are now in place to offer support in an official capacity. These positions can be paid or voluntary, but are considered a return to 'work' by the government, thereby satisfying their criteria that recovery include some form of employment (Pauly et al 2017). Treatment is often criticised for not embracing the recovery community enough by those within the recovery agenda, with workers often singled out as barriers to engagement, especially for AA/NA style 12-step interventions (Best 2017, Lopez Gaston et al 2010, Eversman 2010 & Best et al 2010). When starting this research this was a view that fitted with my own experience, with workers at best ambivalent to 12-step approaches, but not for the reasons cited within the literature, but because they were often sites of drug dealing and relapse in the areas I worked. In the interview process though, it became clear that this was not an opinion shared by many of the interviewees, with the 12-step principles and recovery community being explicitly mentioned and considered to be important for around 20% of the sample (5/26 interviews).

(On motivation outside of structured key work) In terms of what I do, they don't need to be completely motivated because the kind, the power of the recovery community and the things that they do ('Joan' - worker)

we've used our building for things like AA, NA, all that sort of stuff so they're definitely very helpful but they're very one way of working. But you know we will support anyway that helps people get recovery. ('Danny' - manager)

In terms of approaches, Eastshire engaged more with the recovery community, hosting events every day that allowed clients to meet and chat about their recovery and regularly hosting AA and NA meetings. Midshire utilised peer mentors to help clients to engage with the service and to provide encouragement and support akin to a 12-step sponsor. Westshire offered nothing in the way of peer support, but was in the process of changing to a recovery

focused treatment model and would be adopting peer mentors to assist with engagement and outreach. In each service, there existed some form of recovery community that was (or will be) actively utilised by the treatment provider to bolster treatment and as such, my own opinions on the usefulness of 12-step programmes and the recovery community were refuted. Similarly, the workers' positive impressions of 12-step programmes, recovery community and peer support were not indicative of the (granted limited) literature on the subject, skewing more toward positive. In the services interviewed it seems that there are good relations with the recovery community and some good work being done in partnership.

6.4.1 In-recovery and non-recovery workers

As demonstrated previously, research from the US and Canada (where in-recovery workers outnumber their non-recovery brethren) shows that in-recovery workers will likely recommend treatment that most closely fits with their own experience of successful treatment (Simons et al 2017 & Culbreth 2000). Whilst it would be foolish to transpose this research to the UK, given the difference in worker recruitment, it is worth considering that those workers who were in recovery or who had family members in recovery (6/26 interviews) in this sample did not differ from the rest of the sample in their support for 12-step treatment or abstinence as a goal. This may indicate that the diverse recruitment experience of the UK in some way mitigates the personal experience of the worker. This may also mean that diverse recruitment also helps workers to adapt to the professional identity of 'drug worker', as there is less homogeneity in the background of the workers. However, there was a perception of difference between the in-recovery and non-recovery workers. Some workers (4/26 interviews) did feel that their colleagues who were in recovery were more likely to be overzealous in their determination of what makes the correct treatment for the client.

We're using a lot more peer mentors, and I think in one part that's a good idea. And also my experience with peer mentor is that they tend to be quite zealous about what is the right way. Because what worked for them maybe didn't work for everybody else. ('Dave' - worker)

This is refuted by one of the workers, who offers their own interpretation of the zealousness of recovering workers when they say:

My experience is always in the back of my mind and it kind of like walks alongside me, but I'm never...I never judge or swayed by my experiences because I do treat people very individually. (Worker not identified for ethical reasons)

In this instance the worker discusses the role they play as a treatment provider, giving the treatment they offer primacy and using their experience as an additional source of knowledge to supplement the treatment they offer. They also discuss the client as an individual, which again is counter to the evidence offered by Duryea and Calleja (2013) and Simons et al (2017) that in-recovery workers are less likely to offer individualised treatment.

When looking at the interviews, what is startling is the absence of real opposition to AA/NA principles amongst the interviewees. Even the most resistant interviewee could at worst be described as ambivalent to AA/NA principles.

anybody who gets involved with 12-step work has to stop feeling like that. They have to do that. And it's all right if it works. ('Joachim' - worker)

There still exists a reluctance to grant peer support workers equal status as drug workers and this was supported within my own research, with all workers who discussed peer support worker status (7/26 interviews) seeing peer support work and AA/NA support being *in addition* to formalised treatment. For 'Pat' this seemed to be an obvious side-effect to treatment, with people being pulled into working in treatment following a successful recovery.

I think historically, drug services have always sucked them back in because they think there's this added value by having ex-users in service.

Here 'Pat' sees a mutual benefit to this approach, with the former client gaining employment and the service gaining a perceived benefit of additional experience of addiction which is not readily available in the non-recovering worker population. Duryea and Calleja (2013) argues that the pull for recovered drug users into treatment is based upon a gratitude for the treatment leading to their recovery. Research by Bauld et al (2010) for the Department for Work and Pensions (DWP) found that recovering drug users sampled were only able to find work within the drug and alcohol setting and that it was often the only route to employment for those with previous drug problems. Yet as an employer 'Pat' does not see this as being healthy for those employed within the service:

My personal opinion is we hold people in service, we give them the opportunity to do volunteering in peer management, and then we almost suck them back in as workers. My personal opinion is I don't think this is healthy.

Similarly, 'Jessica' finds that there is added risk to the recovery of the individual by working as a volunteer or peer mentor.

If I was in their position. I think I would want to stay well clear and do something totally different. But I think what they think is, they've been there, they've done it, they know everything, and they want to give their knowledge to other people. But I think...I think it is just hard, hard work to be around that all the time...And I think people do generally relapse quite a lot when they do come back into, when they do that kind of job as well.

It can be argued that working within treatment is a potential issue for those with existing drug or alcohol problems, as those who are in-recovery usually seek to avoid those who are actively using drugs (Pauly et al 2017). Yet this is not shown in research into in-recovery counsellors (in the US and Canada) or the limited research into workers in the UK, with research failing to address this issue. One of the arguments for AA/NA based meetings is that they allow the client to build a new identity away from drug users (Best 2017b & Neale et al 2011b), but there seems little research into what happens when that person builds up a therapeutic relationship with drug users or begins a social relationship (as would be the case as a peer support worker). If the UK is to adopt a recovery-based model as their system of

treatment, it would seem prudent to research any potential harmful effects that relying upon in-recovery staff may have on those staff members.

'Pat' was one of only two workers who offered comment on the workers employed in their service, with the majority not offering any comment on the matter. During the interviews, this did not form a part of the questioning process and as such any comments came from worker driven discussion. The only other worker who offered commentary on the recruitment of workers was 'Mikel', who discussed the varied areas that drug workers were recruited from and how they felt this was weakening the therapeutic relationship.

The fact that we're increasingly recruiting from the prisons, that recruiting staff from the prisons putting them straight in front of the line, you know, I think with very limited experience, without that kind of understanding of the therapeutic relationship. The fact that we're getting into the Department for Work and Pensions, that's all going in the wrong direction, I believe.

(Later in the interview) Having got in a mess with drugs doesn't make you expert by anything at all, really. ('Mikel' - worker)

'Mikel' is offering another angle on the experience or expertise debate, offering that workers without experience in the therapeutic environment should not be employed as drug workers. Crucially, this would exclude workers with a criminal justice (the joint largest original employer in the sample) employment history, but would not exclude those who have been part of the therapeutic relationship, recovered drug users. This may however reduce the efficacy of the recovery process, with criminality and employment being key measures of recovery within the government model.

6.5 The relationship between workers and recovery

Contrary to the picture painted in research in this area, there seemed to be a positive relationship between the workers and the recovery ideology, particularly in Eastshire where the relationship was most strong (15/16 interviews). At the end of every interview, the

workers were asked if we had ever got treatment right and if not, what they would change.

Workers from Midshire were the least optimistic, with them all stating that treatment was not the best currently.

And I only see the client once every four weeks if they sign up to a high intensity contract, once every six weeks if they sign up to a low intensity contract. Actually I'm not sure I get to know what's going for them...And a [key] working session is not sufficient to begin the development of an effective working relationship with your clients. It's entirely insufficient. ('Dave' - worker)

Well, the service is recovery agenda, so I think...I don't know. I suppose.... Well, what I hear is that they want everyone to be reducing and off their scripts. ('Jessica' - worker)

These statements are representative of the opinions of the workers in Midshire, with 66% (4/6 interviews) stating that the treatment provider was pushing to limit the number of key working sessions and trying to prevent clients from being on a prescription. Despite broad support for the goals of recovery, they did not feel that Midshire had the best treatment model they had known. This may indicate that the issue lies not with the concept of recovery, but with the service provider interpretation and implementation of recovery, as this was not the case in the other areas sampled. In this case, it is expected that workers who are able to adapt their viewpoint to this ideology will stay, but those who do not will leave, as workers are unlikely to work in services that they do not share some of their ideology with (Eversman 2010). My own experience was that a number of potential interviewees did leave Midshire during the interview process, citing ideological opposition to the treatment model, leading to further issues with sampling.

In contrast, workers from Eastshire were much more complementary about their treatment programme, with over half (9/16 interviews) agreeing that this is the best service they have been involved in:

God, these last 18 months, everything I've been involved in, it's been such a positive. You know, the recovery capital, the recovery community that we're trying to evolve...right here right now, I think we have got it right, but we've got to move on. There's a lot of improvement and there're always going to be other doors to open. But I think at the moment, for me, yeah. It's good. ('Louise' - worker)

Well, at the moment yes to the extent this is the best it's been. I don't think it's the best it can be. ('Danny' - manager)

Really, when I come along here, I really liked what was happening, it's what attracted me to this, we're trying to bring rehab out to the community ('Simon' - worker)

This represents further examples of the workers engaging with the ideology of recovery and the adoption of organisational ideology within the workers. It is worth considering that a difference between Midshire and Eastshire is that Midshire was much further through their contract at the time of the interviews. This could have an effect on this measure, as workers will have had longer to acclimatise to the new model and workers who are opposed to it may have left. Yet it was not identified by the workers, managers or commissioners that Eastshire had gone through a major change in staffing, so this may not be the case. Further research into this area would be worthwhile, as research into drug treatment regularly highlights high turnover of staff, low staff satisfaction and high staff stress levels as being endemic (Whitter et al 2006 & Best et al 2012). If it can be shown that PbR has a beneficial effect upon the staff acceptance of change or that soft enforcement of ideology change assists changes in treatment model, this may have beneficial effects for those receiving treatment, given the linkage between staff and client (Fiorentine et al 1999).

This chapter has been about looking at the relationship between the worker and recovery as an ideology rather than a practice, testing their engagement with the core concepts as a measure of their belief in recovery. This has been to challenge the narrative that drug treatment workers are medically focussed in their treatment and resistant to the use of

abstinence as an end goal for clients. In terms of engagement, it can be seen that the workers sampled were supportive of many of the recovery goals, with all supporting abstinence as an end goal for those clients that could achieve it. What was clear from the interviews was that the workers felt there needed to be a balance struck between psychosocial interventions, biomedical interventions and community outreach, with 'Matt' describing the preferred model the best:

I remember I went to a talk about it probably about a year and it talked...there was a guy from the National Treatment Agency it was then and he talked about what treatment should look like and that it was kind of like a three-pronged approach that there was biomedical part of it which would be like prescribing medication and then there would be the psychosocial aspects that would be the key working counselling group work and then there would be the social supports. That'd be your fellowship meetings and your peer support. And that really struck me. That really kind of made a lot of sense for me because that is what it's about.

This approach represents a blending of the recovery and harm reduction models, with biomedical approaches used to stabilise the drug user and then recovery principles used to guide the client to abstinence. Again, this represents the blending of the moralistic approach of recovery (being drug free is 'normal') with the medicalised discourse of harm reduction (addiction is a disease) that is present in the drug policy movement of the past decade. It also demonstrates the risk mitigation approach favoured by neo-liberal policy, with the risk of offending and drug use being reduced through harm reduction and then recovery taking over to prevent the risk of entrenchment in treatment. Workers in this study (26/26 interviews) engaged with the end goal of abstinence for those that can achieve it, and half the sample stated it should be the main goal of treatment. This indicates a wholesale adoption of one of the key principles of recovery as a treatment model. They have also demonstrated that engagement with the recovery community *in addition* to treatment is a valuable component to treatment, another key component of the main definitions of recovery. This is entirely inconsistent with the research thus far, with workers usually presented as roadblocks to the true acceptance of recovery within treatment agencies (Best et al 2010). As this chapter has discussed, this area of study is under developed and as such the conclusions drawn from

the literature are similarly under developed. Whilst this research is not a wholesale debunking of the concept that workers are a roadblock to recovery, it does shed doubt on this being an accepted principle. As such, it would be recommended that further research be carried out in this area, as this may yield further insight into the level of acceptance of recovery as an ideology and the understanding workers have as to the meaning of recovery.

Summary

This chapter looked at the relationship between the worker and the meaning of recovery. It highlighted a number of key areas: abstinence, motivation and the recovery community as areas of measure. It was found that in many of these areas, particularly the area of abstinence, the workers were in agreement with the recovery model. Indeed, it was shown that the workers themselves were strongly in favour of abstinence being an end goal for clients that could achieve it. This demonstrated that workers themselves were in line with the literature surrounding recovery, arguing in favour of the principles of recovery rather than against them as the literature would show.

In terms of the recovery community, the workers were broadly in favour of the community being a part of the treatment process, but the issue of primacy between experience and expertise was raised and this is a diversion from the recovery agenda. Whilst a small number of the workers identified that AA/NA principles were good for some clients, there was not overall support for this method of support and this was in line with the literature. Here workers favoured the medicalised discourse of treatment over the more moralistic approach of AA/NA, but they were not closed off, with workers engaging with the discourse rather than being ignorant or dismissive of it. Overall, this chapter demonstrated that there was a broader acceptance of the recovery principles and there was a split in support for the principles of abstinent and non-abstinent recovery between the workers, but all showing broad support for the concept of recovery as an end goal. It was identified that there were a

number of areas that could be researched further, and that further research into this area may yield further knowledge on the interaction between drug workers and the recovery agenda.

Chapter 7: Worker Perception of Drug Policy Influencers

7.1 Introduction

In section 4.6 Foucault's concept of "the speaker" was discussed, particularly in terms of this research, and in Chapter two the history of treatment was used to outline how the designated speaker within drug treatment changed with the various methods of treatment itself. This notion of the designated speaker was used to demonstrate the value that being the dominant voice on addiction has within government policy, with policy of the time often following the advice of the dominant voice. It is the position of this research that the current 'speaker' within treatment (the dominant voice) is that of the client/drug user and that this is also the dominant voice within the recovery model. Within all the models discussed in Chapter two, workers have never been a dominant voice, often being overshadowed by state institutions that have been given primacy, or by employers who dictate treatment models to them. This is recognised within the literature, with Polcin (2014) identifying that workers within drug treatment often consider themselves lacking in sufficient power to influence wider political narratives on treatment. Similarly, Ritter et al (2018) argue that 'non-elite experts' (such as those administering treatment) are often barred from policy discussion, certainly a description that could be applied to the average drug worker. Whilst this research seeks to provide a voice for workers on their treatment models and wishes to discuss the relationship between the worker and the state in terms of drug policy, it also seeks to find out which areas are influences for drug workers themselves. By doing this it is possible to see if workers exist within a 'closed discourse' where new ideas and new concepts are repelled, or within an 'open discourse' whereby new ideas are amalgamated with existing notions in an ever-changing narrative. This chapter will examine the influences that workers identify for their beliefs and what they consider to be good and bad influences on the drug treatment discussion.

7.2 Influence of their previous career/discipline

When research engages with drug treatment workers, one of the dominant themes (particularly with regard to recovery) is the primacy workers give to their previous training or

the models they worked within before becoming a drug worker (Lopez Gaston et al 2010 & Best et al 2010). The concept of 'cognitive dissonance' certainly supports this, with workers in general shown to refuse to believe or to disregard information that is contradictory to their beliefs, especially if it challenges their belief that they are a 'nice' or 'good' person and even if this information is vital to their wellbeing (Akerlof and Dickens 1982). This impression could be, in part, due to the lack of professional recognition for drug workers within the UK, with the position being seen as a 'rendezvous' career that attracts workers from a number of backgrounds. This is reflected within this research, with thirteen different entry points identified within the sample. There were two dominant disciplines that half of all workers originated from (at least in part, with some workers identifying more than one career before becoming a worker), with 38% (10/26 interviews) of the sample originating from a medical background (both mental and physical health) and 23% (6/26 interviews) citing prior criminal justice experience. These were not mutually exclusive backgrounds with workers highlighting a number of career paths before entering and some (5/26 interviews) identifying personal experience as their main source of prior knowledge and no relevant professional experience. In essence, this encapsulates the 'expertise vs experience' debate highlighted in section 2.5, whereby workers are seen to value expertise over experience. Certainly, the research in this area supports the hypothesis that experience is the equal of expertise (Culbreth 2000 and White 2009), yet my own experience of the field found workers placed far more value on expertise than experience. Before the interviews, I expected there to be a consensus that the workers used their own experience in their treatment and framed their understanding of addiction within the parameters of their prior careers. Whilst not exactly a closed discourse, I expected to see primacy given to their originating subject/career. Certainly I used my own previous career (criminal justice) as the lens I viewed addiction through, yet this is not what I found within the sample, with all respondents acknowledging that their previous careers only provided some of the knowledge they needed to understand addiction.

Well, yeah, yeah. I mean I look at it...what's making people tick more than what those things and.... Yeah, I guess. I'm not.... I used to be doing more work with sort

of psycho-dynamics stuff that sort of [treatment] going back. So I don't think you need to keep peeling off the layers of the onion to get to the middle because then you just end up at the centr[e] of an onion. So in times then, you're going to look forward but we are all shaped by what's happened to us in the past. Are we all or what nature or nurture, it don't matter. It's something from the past will predict our futures. Yeah, I supposed I do coming from psychiatric. ('Joachim' - worker)

Well, that's an interesting question. I mean you can't be divorced, can you, from your own social context, you know? I can't help but be aware and have opinions on the social environment and the political environment in which we live. You look at some of the clients that we meet having worked in [REDACTED] and in [REDACTED] are at the bottom end of the socioeconomic pile and have been, come from families that have been at the bottom end of that pile for generations. Choice is hugely limited. You meet people who might be well-educated about drug use now, but who, men, my age, who when they started using in their teens, 30 years ago, weren't well-educated, didn't know about...didn't know what heroin was really, you know, that kind of stuff. So, yeah, I think I certainly do draw on a socio-political perspective when I'm...yeah, when I'm assessing and planning for the clients, yeah. ('Mikel' - worker)

I think...I don't think...I think it probably does in a respect that my knowledge and I understand how easy it is to become homeless and the support that's needed I think and maybe subconsciously it does...So, but I'd like to think I take a sort of quite holistic approach when someone comes in. So you're looking at what their needs are and thinking how can we support them? ('Danny' - manager)

No, I think I look at it more of I take the whole environment into consideration. ('Jessica' - worker)

That's a good question. I believe that there is a susceptibility to addiction. So, genetics plays a big part. However, I still sit on a fence because obviously economic and social background has a huge role to play in that. So, if you have a susceptibility to addiction but you're stressed vulnerability doesn't lead you to your first experience of alcohol or drugs or whatever it might be, then, I believe you could possibly, you know, you could live a normal life. So, I think that the two hand in hand with one and the other, the two meet and then, that kind of brings you to that addiction, abuse...Coming in, it's easy to sit on the fence coming in, and taking everybody observes, everybody else's opinions and theories. I'm a little bit frustrated that I can't be more certain of one or the other, but I do believe that they both have such a key role to play. So, I think over the years, I've searched for an answer, and every time I searched for it, I come back to the same theories. ('Robert' - worker)

These workers all serve to show that whilst influenced by their past careers or learning paths, the workers sampled demonstrated that they were not blinkered in their ideas. Rather, they absorb information and explanations from a number of sources as well as disciplines.

This means that rather than ignoring counter explanations, as is expected when a view is challenged, the workers will internalise the explanation in order to utilise it in treatment in the future.

I think before I came into the job, I think it looked fairly black and white as why people use drugs. And then once you're in it, you realise that there's no real black and white in drug use. It's all grey areas because it's so personalised. ('Freya' - worker)

The personalisation of addiction is a theme that has run throughout this research and appears here as a representation of why alternative explanations of addiction (such as abstinence and recovery) can be accepted by the worker without ideological conflict. Acceptance of addiction as a personal issue was universal within the sample, meaning that all workers accept that there is no overall reason behind the majority of addiction. By accepting this, they could be more open to theories of addiction that run counter to their existing knowledge on the subject and as a result become more rounded in their approach to treatment methods.

As was demonstrated in section 2.5.1 workers are not a mono-culture, with a number of disciplines being represented and discussed favourably by workers in terms of their role in treatment. These disciplines were used as a starting point for a drug worker, a place that can be used to start from and then build upon.

So I guess my sort of...I guess my kind of thoughts and feelings around drug treatment are coming from quite therapeutic talking therapies type place. ('Matt' - worker)

(On using their previous work skills) *Yeah. I'm absolutely sure, I do, yeah.* ('Mikel' - worker)

So something is used because I've got a lot of information's and based on my experience, I was able to weigh the pros and cons, you see. ('Lee' - worker)

My experience is always in the back of my mind and it kind of like walks alongside me, but I'm never...I never judge or swayed by my experiences because I do treat people very individually. ('Louise' - worker)

I find the medical stuff quite interesting, but I've...I'm still learning from all the other things, and all the new things that is coming out. And now I'm doing lots of group work, so that...I find that quite interesting. ('Amelle' - worker)

Totally, completely naive. Because it's not a one vast thing because if it was, just about a medical approach, we would fill them all with medication and send them out the door and we would probably dispense it out of a machine and we wouldn't even be here. ('Freya' - worker)

And even [the] medical model is important, psychological model is important. But the...I think everybody has.... Trying to answer this question succinctly. I think everybody has a value to bring to the table ('Dave' - worker)

(On if their experience informs their treatment) *Yeah. ('Violet' - manager)*

Because I'm very interested in the criminal justice point of view. But definitely from the beginning I looked from the psychology point of view of the problem. ('Jasmine' - worker)

The quotes above offer insight into this process for the workers, with all highlighting the value they perceive in the various backgrounds within treatment. This represents not just a desire for continued personal development within the drug treatment workers, but an acceptance that their own background is not the only source of 'truth' for addiction. The desire for continuous professional development is also important as it is something that can be considered to be a component of a profession rather than a job. Research has previously shown that a reason behind workers staying out of the political discussion surrounding drug use and treatment has been their perceived lack of status as a 'profession' (Polcin 2014). In this way, workers are silencing themselves and preventing their experience from being heard in the wider discourse surrounding drug use and drug treatment. Within the sample, it was clear that all workers had opinions on what made good treatment and what should be

acceptable practice on drug use, but were not active in expressing these feelings publicly. If this is the case nationally, then workers have silenced themselves and their absence from the discourse is related to their perceived status.

Whilst the workers identified that they branched out into other areas of knowledge once working, a small number of workers (3 interviewees) identified that they would still use their background at the forefront of their treatment model. This meant that they would utilise the skills learned in their previous work primarily, meaning that a client would get that kind of treatment first.

Not necessarily counselling. I think initially I went along the counselling road, but then doing psychotherapy and more about behaviour and changes people's behaviour and looking at the behaviour around addiction, I found that that was a bigger part of changing people's behaviour around substances. The talking therapy of counselling is not necessarily going to work for everybody. So I think psychotherapy and counselling, it's good to have knowledge of both and various dynamics of therapies about changing people's addictions and the way they think and feel about themselves. But ultimately for me, somebody who comes into a service with addiction, it's about removing the substance, it's changing the behaviour and the thinking around their addiction and then dealing with the underlying issues after that. ('Christine' - worker)

This quote from 'Christine' emphasises this approach, with the worker approaching all clients from a psychological perspective before dealing with the other issues addiction causes.

Whilst 'Christine' acknowledges that there are other areas of treatment that are needed (removing the substance and the 'underlying issues') it is the psychological approaches that are seen as being the primary focus of their treatment. This quote represented my own experience of treating clients and as such, I was expecting to see this as a more dominant opinion demonstrated by the respondents. It is possible that the semi-structured nature of the interviews actually served to minimise the number of workers that held this belief, with questions seeming to be critical of this approach rather than seeking the truth of their approach. Certainly, the other two respondents that admitted this approach did not express their belief in such straightforward terms.

I don't think it changes the treatment or what have you because they're specifically coming in for whether it's alcohol, drugs or what have you. They kind of know what route they want to go down, which is good. But I do tend to look at the other issues more with them, the psychological issues that some of them have got. ('Dora' - worker)

(on dealing with a client) I suppose I still sort of follow the old school stuff...the old stuff I was talking [about] ('Joachim' - worker)

Here, both workers recognise their focus on their primary discipline but are less direct in their discussion of how this impacts upon their methods of treatment. It could be argued that their downplaying of this approach was due to the questioning of the researcher and as such does not represent the true feelings of the workers involved. In their answer, 'Joachim' states that they see the value in the 'old stuff' of treatment, by which they mean the therapeutic relationship between worker and client. This is again represented across the sample, with the building of a successful therapeutic relationship seen as key to successful treatment in all interviews.

Yes and no. Originally I did. I think now, after working for a period of time I think you can't just work in that background entirely. You have to work from a therapeutic background as well. I'd say, yes it's a mix really. ('Akash' - worker)

In this sense, the therapeutic relationship does represent a discipline achieving dominance within the sample of workers. As was demonstrated within the previous literature, this dominant voice is medical in nature, but stems from psychiatric medicine and mental health treatment rather than from physical medicine as was previously suggested. As shown in Chapter two, this is consistent with the expansion of treatment since the 1980s, with psychiatric medicine taking over from physical medicine as the primary provider of treatment and thus the primary provider of organisational discourse. However, this may also be particular to this sample, with 50% (13/26) of the sample having experience of social work, medicine, mental health and counselling where the therapeutic relationship is a key component. It is also worth considering that six interviewees also come from a background

of either familial or personal addiction and as such will be experienced with the therapeutic relationship. Overall, this meant that nineteen of the twenty six interviewees were familiar with the therapeutic relationship before starting work in drug treatment. Whilst the majority of workers utilise their background learning within their treatment of clients, it is worth noting that this is not uniform, with three workers interviewed coming from no connected background and merely ending up in drug work through chance.

It was more or less something I fell into. ('Amelle' - worker)

7.3 Rational discussion about drug use

Early in the interviewing process an interviewee mentioned that until we have a rational discussion about drug use in general, it will be impossible to have a rational drug policy. This struck me as a succinct way of discussing the discourse surrounding drug treatment and drug use, particularly the material that is produced by government. This would also serve to allow me to probe how open the discourse was surrounding treatment, with workers being able to express freely what they understand to be the main influences for treatment and what voices should be heard. Sadly, this transpired to not be the case, with very little response from the workers. In the resulting twenty three interviews I asked this question directly, most commonly (19 interviewees) drawing a simple answer of “no”. The most interesting distinction between two answers were from the commissioners:

I think we do to a degree because we get policies laid down to us that we've got to adhere to. ('Mary' - commissioner)

No. I think it's all politically driven. ('Blair' - commissioner)

These two responses represent very different perspectives on the rational discussion, with 'Mary' seeing the response from government as being the foundation of the rational discussion and 'Blair' seeing this a purely politicised discussion. That two commissioners can view the interaction between treatment and government in such different ways is

interesting and further serves to puncture the belief that there is a mono-culture within drug treatment. This is also interesting in that this is not a view shared by the ‘on the ground’ workers, with commissioners often portrayed as arms of government policy and being generally indistinguishable from central government (see section 5.3.1).

If you're talking about policies, you really have to talk to people on the ground level really. People that discuss things like policies and laws and anything to do with that are management and above. They haven't got a clue what happens on the ground floor. They don't really know what happens. They just look at the stats and say, 'Well, that's working,' and it's not actually working. ('Akash' - worker)

‘Akash’ demonstrates this feeling in this comment on the formation of policy, arguing that “management and above” are involved in policy decisions and policy discussion. That ‘Akash’ sees management as taking a positive view of all policy is not in keeping with the evidence here, with two commissioners not agreeing on the rationality of current policy. However, this does support the idea that ‘non-elite experts’ are often barred from policy discourse (Ritter et al 2018) and represents a feeling of political isolation by virtue of being a worker.

So my answer is no I don't think we have an open discussion but I'm quite happy that we don't. That's fine with me. ('Pat' - manager)

‘Pat’ is a regional manager and they do not agree that the discussion around drugs is rational. However, they are happy with the status quo as it prevents misunderstanding of the national view on drugs.

So I'm not sure there are always getting it right and I'm not sure the places like Holland and Portugal are getting it right because they're making there. Holland's obviously...their cannabis laws are different and Portugal, you know, they seem to think their substance misuse is okay and they sort of encourage it. I don't know. I don't like this idea of shooting galleries. ('Pat' - manager)

‘Pat’ argues that the lack of rationality is okay as long as there is consistency in its place. That consistency allows the user and treatment in general to better deal with the issues of drug use. ‘Pat’ further describes the battle against addiction and illicit drug use as a “losing

battle” and their preference is for there to be a consistency in the narrative surrounding drug use (particularly the illegality of drug use) rather than a truly rational discussion. This prompts a further discussion: would it be more useful to have a consistent message about drug use, or one which is rational? Certainly it can be argued that there is little political will to have the latter and much to be valued about the former.

7.4 Research outside of work

Whilst the workers within the sample recognised that they needed to draw on a number of disciplines in order to be effective workers, it is important to also consider how much time they devote to researching their field. Section 6.2.1 discussed how it was important to discuss the perception that drug workers were resistant to the ideas of recovery and how there existed a belief that workers who were trained under the harm reduction model would need to be removed if recovery were to be implemented correctly. This indicated that there was a belief that workers existed in a closed discourse, impervious to outside ideas and immovable in their beliefs. This was not seen to be the case in section 2.5.1, where workers were shown to have widely disparate ideas and beliefs. In order to address this issue, the workers were asked about their research habits in order to determine how much time they spent and what sources they found useful for researching drug treatment.

Yeah. I think it's quite important that everybody in this industry to keep up to date what's going on when there's legal harm or hidden middle-aged drinkers Panorama programmes. There's always...in every given month, there's going to be something and I think we do need to keep abreast a bit because it's just one of those.... In our industry, it's constantly moving especially around the things like [legal highs]. ('Pat' - manager)

I tend to watch documentary. I don't tend to read so much. ('Basil' - worker)

if there're changes from government or money or...you know, there's new ideas around it and thinking, then I would be looking at that as well. ('Valentine' - worker)

Just ear to the ground, the internet, that sort of thing. Yeah. And obviously, you know, when the last drug policy had come out, you know, that's available to access online and you know. ('Hector' - worker)

Yeah, of course, I'll read stuff. Yeah, yeah, yeah. ('Joachim' - worker)

Within the sample, all workers identified that there was a responsibility for them to stay abreast of the current trends in drug treatment and drug use. The internet was highlighted as a useful tool to ensure that the worker stays up to date with any trends, as were documentaries on TV. However, not all workers felt that they were responsible and kept up to date with treatment changes.

No, no, no. I have done in the past, but now, now I'm obviously...I'm working in drug and alcohol treatment, I do quite value my own space as my own space as part of my recovery really...I don't really do no research in my private time, no. (Unnamed in-recovery worker)

I haven't done recently but I mean throughout my recovery, I've read up on all sorts of different aspects of like dry drunk syndrome or grandiosity or perfectionism, co-dependency, you know, et cetera, et cetera. There's all different facets of human nature. Just to get a bit of knowledge, awareness, self-awareness like I said earlier but to understand other people and people that are coming in. So I can give a bit of knowledge that I think, learn, teach even, a bit more. (Unnamed in-recovery worker)

Here, two of the workers who are in recovery identify that now they are working within drug treatment, they are no longer actively researching drug treatment techniques. The first worker clearly states that this is because they value their space as part of their recovery. This ties into the discussion on peer support workers in section 2.5 and further demonstrates the need for research into the effects of working in drug treatment whilst in recovery. This demonstration of separating work and home as a method of self-preservation was demonstrated by non-recovered workers as well.

Yeah. I mean previously I used to get supervision with the previous provider there [is] no supervision and also the self-care is down to me more than what I have or give back to the organisation in that respect. And what I hear and what I see sometimes could be really stressful and could be very distressing and could be very frustrating. And I've got to be careful I don't take that home with me. ('Dave' - worker)

Here 'Dave' is discussing self-care as part of the discussion on what the change to the recovery model has meant to them. They quickly identify as a problem the reduction in pastoral care that has been a result of changing models (and providers) and the damaging effect that this may have on workers. In this way, 'Dave' is highlighting a similar issue to those in-recovery workers, that they have sacrificed staying up to date for the sake of their own wellbeing. As a result, it could be argued that a reduction in pastoral care could be responsible for the reduction in interest from workers in continuing their research outside of work hours. Again, this is an area which can only be explored with further research.

This was not the only reason given for non-recovering workers stopping their out of hours research.

Less than I did. Bear in mind that I'm retiring in two years' time. I've been doing this for 30 years and my head's full of it. There are things that I read. I certainly do read things. I mean, for instance, when...I read though quite thoroughly the William White Recovery-Oriented Methadone Maintenance paper because it interested me but I think I do what lots of people do. What I do is I know what I believe and I read the things that agree with me. (Laughter) I sort of think that it's a bit like politics. Nobody sits there and thinks, "Oh, I mean which party I'll follow." I think I believe this is, "Oh that's the party I will go to." It's a bit like that. I believe that this sort of treatment to that because I tend to read that. So it's sort of psychiatric kind of lit you know it's that sort of thing. But I mean I do, yeah, always have an interest on heavy stuff. I don't read the paper anymore but I'm on the BBC website, loads of stuff in the health side things and opinion there, I follow it up. ('Joachim' - worker)

(On doing their own research) *No. I used to. (Laughs) ('Christine' - worker)*

We don't get any journals here. When we used to work for [previous provider] we used to get a lot of journals delivered and we would all sit down and, you know, flick through them and talk to each other about different things. I used quite a lot reading Black Poppy's. I found that quite interesting but we don't get any of that here. ('Hector' - worker)

I haven't done it recently, since starting this role. And I've kind of been concentrating on nearer to home policies procedures and that kind of thing. So, I've not really had the time to kind of research that. I think I probably just resigned myself to the fact

that actually, I'm going to kind of sit on the fence and say with both aspects comes the problem. Yeah. ('Robert' - worker)

Given here are some of the reasons for not continuing with research outside of work, with workers offering a number of different reasons behind their decision not to continue to research despite this being seen as good practice. Some can be attributed to changes in provider and reduction of funding for treatment centres. The lack of journals and the desire to research internal policies can be attributed to these changes, with both examples being linked to the finances of the treatment providers and the changes to the working environment brought about by changing employers and models of treatment. Magazines and journals were highlighted by two respondents as being of particular use to them and as can be seen in section 7.4 magazines and academic journals were seen to be a good influence on the discourse surrounding drug use.

Like I would read something DDN today. What's the other one I read? There's all sorts of stuff I read. I mean I go online quite a lot so just interested on keeping an eye on. ('Danny' - manager)

Throughout the interviews, documentaries are seen as being a good way of keeping up with current trends in drug treatment. However, they were not seen as being a 'true' picture of drug use, with workers viewing them as something to watch to see how people view drug use from the outside rather than as a method of professional development.

I think those programmes tend to buy on the oh woe is me for the drug user and how difficult drug treatment is for them and that nobody's helped them and they're homeless and nobody's ever tried to do anything for them. And oh, nobody will prescribe the methadone so I think...well, I actually I know that that's not true. ('Violet' - manager)

(Later in the interview: on why the research) *Because I'm interested in the public perception.* ('Violet' - manager)

Yeah, yeah. I do watch a lot of documentaries actually. There's always documentaries about drugs...All they do is they highlight drug users being a victim all

the time. And they are victims in a sense especially some of their backgrounds, but it's still a choice. ('Akash' - worker)

'Violet' was by far the most negative on the benefits of documentaries, with other workers viewing TV documentaries as being irrelevant to their work (20/26 interviews). Yet 'Violet' identified documentaries as being a good way to keep abreast of public opinion on drug treatment and drug use. Again, 'Violet' and 'Akash' represented the extremes of views on this, with no other workers seeing this as being an issue.

No. I should do. I should do more than what I do. In saying that, if there's something where I kind of think, "God, that's different," or "I didn't know that". Like if I see something on TV, you know, I might watch that ('Dora' - worker)

It's not something I actively do on a regular basis, but yeah, I do. Anything, any documentaries on TV, or you know. I make sure that it's valid, I'm interested, I want to watch it. Anything in the media that comes up, you know... ('Valentine' - worker)

So, yeah, I would draw it from Internet research, books, television programmes, trainings, conferences, all those sorts of things. (Pat - manager)

The last one I watched, I really did enjoy was that Russell Brand one a few months ago...But, you know, no matter how you see people whether they're a celebrity, footballers, actors, and actresses, whatever you know, drink and drugs can happen to anybody. And it's how you deal with it. And just because they've got money doesn't make their treatment any easier than yours or make yours any harder than theirs. (Overlapping Conversation) That's what...I quite like the message I got from that. ('Louise' - worker)

If something happens to be on and I flick over and there's something on, I think, "That's interesting," then I might watch it. ('Mary' - commissioner)

These quotes highlight the opinion that documentaries serve a purpose to the workers of informing them of the opinions outside of treatment rather than being a form of education about treatment. In this way, documentaries serve to educate the workers as to the opinions of the masses, rather than to educate the masses as to the opinions of the workers. Despite the workers seeming to be interested in the programmes themselves, when asked about

good influences on the discourse surrounding drug use, none mentioned documentaries as a good way of influencing the public. Despite their relative unity over watching of documentaries, the workers sampled were less unified in their opinions on the outputs from the government.

And, I'll do it anyway, you know. If there is any policy change, I want to know about it. Do you know what I mean? ('Hector' - worker)

(On government drug policy) *I've not read them.* (Laughs) ('Christine' - worker)

It's very much I would say driven by PHE. So they churn out a new guidance and I'll never know how much—why there is being consulted with. They always got sort of working groups and stuff. ('Blair' - commissioner)

Both 'Blair' and 'Hector' discuss the role of government as something that must be engaged with by the worker as part of their role. 'Hector' states that they "want to know about it", meaning that they feel this is part of their role as a worker, whereas 'Blair' sees this as an impossible task. 'Blair' highlights that Public Health England (PHE) "churn" out a lot of material and that it is impossible to keep abreast of all changes and ideas coming from central government.

It all fell into probably one big coincidence that I was reading these government papers that we're talking about. Now, we're looking more at social capital and recovery. ('Blair' - commissioner)

Later in the interview, 'Blair' highlights this further stating that it was "coincidence" that social capital was a focus within the tendering process and that they were reading material on it at the time. Here it was sheer chance that the commissioner was reading material related to government policy, not because they do not keep up to date, but because the sheer quantity of material is too much to follow. This brings into question the value of magazines and journals that can be used to help curate the wide output within the field and present it to the worker in a manageable format. This also prompts the question of: what is an appropriate

level of reading for a worker to consider themselves 'up to date' on government policy? Again, this ties back to the lack of professional recognition within the role, with a more professionally accredited role being more likely to have a structured level of CPD. This was highlighted by the interviewees, with 19% (5/26) of interviewees discussing the role of education as a driver for further research.

I used to because I was doing a drug and alcohol counselling degree. But I'd finished that couple of years ago and I'm doing a counselling degree so it's just counselling, yeah, that I'm looking at. ('Matt' - worker)

I mean I must admit...because I'm not doing any further education at the moment, I have I don't know if I would use the word lazy. I have limited my reading recently. I think sometimes when you're doing some kind of further education, it expands your mind and it makes you hungry for information. ('Pat' - manager)

'Matt' and 'Pat' both highlight the benefit of education as a driver for researching treatment methods. Both workers see education as being a way for a worker to incentivise researching treatment and to develop knowledge in their field. This was highlighted by three other workers in their interviews.

No, I've just done a diploma in substance misuse management and there's always lots of different arguments and the one that I believe is the one, the environmental one, not the medical. ('Jessica' - manager)

Yeah. I do, yeah. Yeah. Especially, I've recently done a course at [REDACTED] Uni. I got a certificate and then a diploma in substance misuse management. ('Hector' - worker)

In fact, I'm just finishing a free online course by...through King's College. They're running a six to eight-week course in addictions. So a little bit of some basics, but it's also about discussions and it's also about the future and research. ('Amelle' - worker)

All three of these workers were responding to questions on their background and how they developed their knowledge beyond their backgrounds. What this highlights is the valuable role education plays in the development of knowledge for a worker. Indeed, this was

highlighted by Best et al (2010) as a way of boosting support for recovery with workers, with the DANOS accreditation being used as a way of ensuring recovery was part of every workers development. However, it must be noted that continuous education is not an answer to ensure all workers remain up to date.

And there was a time, I remember a time we used to go at conferences and you go away with at least one thing you think, "I can go back and implement that." Now, it seems to be stuff you kind of heard of before seems to be. ('Mary' - commissioner)

As this worker demonstrated, there are finite ideas and methods for the worker to implement, leading to a feeling of 'being here before'. Certainly, in my own experience, it felt as if ideas were recycled routinely, with ideas that were popular at the end of my (relatively short) career being similar to those at the beginning but that had previously been discarded as not working. If education is the key to ensuring workers remain current in their knowledge, then it is important that academic research in the area of drugs is adequately disseminated to workers. This was previously done through industry periodicals such as Drink and Drugs News (DDN), but as was mentioned by a worker in the interviews, access to these magazines has been curtailed by the cuts to funding.

7.4.1 Separation between work and home

Within those workers who said they did not research as much as they should (13/26 interviews), there is a trend of keeping home and work separate. Similar to those in-recovery workers identified above, there exists a mind-set of ensuring that work and home remain separate in order to maintain personal well-being.

Sadly I have to say when I go home I leave my work behind, it's [behind me]. So it's become much more stressful as my role has changed. I will endeavour to keep up through DDNs. And actually if there's a news report or a documentary at home then I do tend to watch it. But I'm careful, to be honest, to keep my home life separate. ('Dave' - worker)

Yeah, I do. Yes. I know some guys who don't, you know, their laptops at ten in the night I don't do that. When I get home, I just got to say, "That's it. That's it, I'm done." When Friday comes especially...5:00 that's my weekend. ('Basil' - worker)

If something happens to be on and I flick over and there's something on, I think, "That's interesting," then I might watch it. But I won't watch it because of work. I'm very much...for years I did here, it was like I wouldn't work at home and those sorts of things. But now, I come in, I do my hours, I go home. ('Mary' - commissioner)

No, TV is my downtime. I'm not going to mix the two together. (Laughter) ('Matt' - worker)

For those that expressed a desire to keep work and home separate (8/13 Interviews), there exists a barrier between work and home for their own or for their family's benefit. 'Dave' particularly recognises the harm that bringing home work-related experiences can have on a worker and they identify that the removal of work-related counselling has had a negative effect on their own health. As a method of coping, they have erected this barrier between work and home as the therapeutic supervision they relied upon is no longer available. However, this was not the only reason for building this barrier, with some workers expressing a desire to merely keep work separate because it is not their main focus.

It's not my only interest. ('Steph' - worker)

I wouldn't say I've ever gone out of my way to watch something on TV. ('Simon' - worker)

There are times when I will run a million miles. I'm slobbing on the sofa on a Tuesday night, I won't want to watch a documentary or listen to Russell Brand or whatever it is. But, on the other hand, I do look at Quality Press online. I do pick up articles in that way. ('Mikel' - worker)

All three of these workers identify that they do not bring work home with them because they have other interests or are otherwise disinclined to consider work outside of work time. This is an important issue within the sample, with all workers identifying that they should be researching drug treatment outside of work time. Again, this emphasises the lack of professionalisation of the role, where this type of activity would usually be considered

continued professional development. In this way, the workers themselves have bought into the narrative that they are not part of a profession and are doing the job because of an interest in the subject rather than because it is a career.

Yeah. Sometimes, I will. Often if, you know, if I think my wife will enjoy it or can stomach it (laughter) I might have it on. If not, if it's something that she's really not going to watch, you know, we're watching TV together, then I won't... I'll leave it.
(‘Hector’ - worker)

This quote from ‘Hector’ highlights another issue with this approach, in that by forcing workers to keep abreast of the subject at home, this can force the worker’s career onto family members who may not be interested. Given the subject matter, this may not be accepted by the family, thereby damaging the chances of the worker to develop their own knowledge. This move to de-professionalise the role of worker was identified directly by 19% (5/26) of the respondents, with them identifying methods of professionalisation that were present and are no longer there. These generally took the form of magazines and journals that could be discussed in team meetings and professional self-care, such as discussion groups and compulsory peer support. The removal of these resources is identified as being part of the austerity-based cuts to social care, but there is an argument that in seeking to equalise the status between peer support workers and workers the recovery model has inadvertently advocated for the de-professionalisation of existing workers.

7.5 Good influences on treatment

As part of the interview process, the participants were asked who they felt were good influences on treatment or the discussion surrounding drug use. This was designed to look at the influence the various commentators have on the workers themselves. Whilst all interviewees were able to give at least one influence that they liked, there was not the level of response that I expected, with some workers having to be prompted to think of anyone.

I think it was back in 2006 or maybe early 2007 and it was Monty Don. And, it was him rehabilitating people. I think...I’m not sure if they were just out of prison, but they were on community orders or they were on probation orders. And the order was...or

part of the order was that they work on his small holding and it was like the therapeutic value of, you know, of being at one with nature and seeing, you know, basically seeing things grow and just.... Do you know what I mean? ('Hector' - worker)

You're making me laugh now, but the only person who I noticed, two of them is Nikki Sixx... And Russell Brand...And, yeah, Nikki Sixx. I read his book, Heroin Diaries, and I think every single person, not only drug user, but everybody who is interested in it and worked with a drug user should use it. It's like a bible. It's a very, very good book. ('Jasmine' - worker)

Celebrities were chosen less often than was expected. The interviews were conducted around the time that Russell Brand had completed his documentary on drug use for the BBC. He had also visited some drug treatment centres in the South and so was a 'current' voice on addiction, particularly in the sample area. However, he was only identified by two of the interviewees as being a positive influence on the discussion surrounding drugs. He was also criticised by the same number as being a bad influence on the discussion.

So, Russell Brand, for example, will go on about how he thinks drug use should be legalised and that would solve all problems. I beg to differ. ('Freya' - worker)

people like Russell Brand stick their little heads above the [parapet] and opine because a lot of people think, well, he knows all about it; he's taken heroin. And I think you've got to be careful about that. ('Mikel' - worker)

The response from 'Freya' is very interesting as it is very different to my own understanding of Brand's public opinion on drugs, which is centred around NA/AA notions of recovery and abstinence. This likely means that 'Freya' has likely not actually listened to Brand's ideas, but has based their ideas on what his opinions are on their perception of him as a celebrity. 'Mikel' is much more direct in his criticism of his ideas and this represents another example of the 'experience vs expertise' battle within treatment that is discussed in section 2.5

I'd say the Advisory Council on the Misuse of Drugs. You know, generally what I read from them seems fairly sensible. ('Hector' - worker)

And then you had, was it Professor Nutt who kind of said some off the wall things.
(‘Freya’ - worker)

The two quotes above represent opinions on ‘official’ discussions on drug use, with both workers seeing different sides to a similar discussion. These interviews were undertaken after Professor Nutt left the ACMD, but the publicity surrounding his leaving clearly placed him in the mind of the worker. Again the interviews represent a difference in perception of the speaker, with ‘Freya’ seeing Professor Nutt as a controversial figure and ‘Hector’ seeing the ACMD as a good influence on the discourse. Whilst these two figures are not the same, it is interesting to consider that ‘Freya’ sees Professor Nutt as saying “off the wall things” whereas ‘Hector’ perceives the organisation most closely associated with Professor Nutt as being a good influence on discourse.

I mean for me personally I would say around this area NA seems to be. It is far more popular down here with clients than AA or CA. (Unnamed in-recovery worker)

I mean I think there’s NA and there’s AA which is a lot of people that I’ve spoken to are not keen on AA for reasons of their own, and CA and I think they’re great. It’s not for everybody. (‘Christine’ - worker)

Both the above workers name the various ‘anonymous’ groups as being good influences on drug treatment in the local area, although ‘Christine’ notes that they are “not for everybody”. The in-recovery worker citing NA as a good influence on treatment is in line with the research into drug workers in the US and Canada, with in-recovery workers being found to favour NA/AA more than their non-recovery peers. What makes this interesting is the support NA/AA garnered from ‘Christine’, meaning that again workers are not immune to the ideas coming from NA/AA, contrary to existing opinion.

I know people, lots of people do look at DrugScope to see what is going on. And their conferences are usually we attended. And people like that, really, like the Alcohol Learning Centre as well. I think we used that as a reference point and to find out what’s going on around the country. (‘Mary’ - commissioner)

The only agency...I think the stronger influence for me is DrugScope on challenging...they were the biggest challenge in PbR. They’re sort of the service

users and providers in all this. I think...well, it's a bit of a shame as the providers have lost their voice. ('Blair' - commissioner)

Interestingly, both commissioners raised the same charity (DrugScope, now DrugWise) as a good influence. Whilst it would be impossible to draw conclusions from this, it is interesting to consider that both felt the influence of DrugWise was a positive one on drug treatment discourse. It is also interesting to note that the other workers did not see this group as a good influence, perhaps indicating that their appeal lies in the broader application of drug treatment to a population, rather than the specific application of treatment to the individual. This was not addressed in the interviews though, so remains speculation.

The narrative that inspired this research is that drug workers are medically focussed in their understanding of treatment, meaning that I expected to see many of the workers say the National Treatment Agency (NTA), NHS or Public Health England (PHE) were good influences on treatment and the narrative surrounding drug use. This was not the case, with only two workers (2/26) citing these organisations. This is unexpected, as the sample has ten interviewees (10/26) from a medical background, all of whom had professional ties to the NHS and identified as medical professionals.

I haven't seen anything recently that would suggest otherwise. But I think the RCN and the NHS and everybody seems to be taking a bit of a back foot because of their sector. And I think with so many other organisations taking over from the NHS now, I don't think it's quite as high on their agenda. The NHS seems to be working towards this kind of payments by results. I think the foundation trust data's and that kind of stuff. And I know there are a couple of the NHS, or one of the NHS Trusts that used to provide substance misuse has just lost contact, and I'm not sure whether that's because of lack of input really. ('Robert' - worker)

But I think it's like...well, it used to be the NTA because that no longer exists, its now Public Health England... But they don't...Public Health England don't release statements and documents, really. Not like the NTA used to. ('Mary' - commissioner)

Both these statements are interesting as they demonstrate the perceived retreat of the medical profession from the narrative surrounding drug use. This represents a perception from the workers that the medical profession is in retreat as the dominant discourse. Of particular interest is the quote from 'Mary' who states that PHE does not release material "like the NTA used to". This is in direct opposition to a previous quote from 'Blair' where they state that PHE releases so much material that it is impossible to keep up to date with. Here we see the how the position of 'the speaker' is personal and not necessarily linked to their actual status within drug treatment discourse. In this instance, it is the perception of 'Blair' that PHE is "churning out" large quantities of material and yet 'Mary' sees this as a reduction of the output when compared to the predecessor (the NTA). Without further research, it would be impossible to determine which is correct, but what is more important is that they both perceive this to be the current situation. In the case of 'Mary', this means that PHE is less prolific than the NTA and for 'Blair' this is not correct. This is despite both interviewees holding the same post (and working together) and therefore being exposed to the same material as part of their work. Despite these shared traits, their perspectives of medicine (most specifically PHE as a voice of government) as 'the speaker' are radically different, meaning that personal perception of the dominance of a particular speaker (and thus the position of the listener) cannot be ignored. In this case it is the positioning of 'the listener' which is the dominant component and is directing their view of the object, rather than 'the speaker' directly influencing them.

Another source deemed to be good for drug treatment was academia, with academic material singled out by four workers as being a good influence on treatment and the discourse surrounding treatment.

But I do read some academic books if I could come up every now and then. A couple of drug workers have given me academic books... I try and read academic ones because...academic journals, because you can't trust anything else. ('Akash' - worker)

And obviously, people that write academic papers can be persuaded when you're reading those. You're thinking, "That's it." Then, you read another one, and think, "Well, actually, it isn't." ('Robert' - worker)

Within these interviews Professor Alex Stevens was an academic named directly, but this was through a shared acquaintance rather than any familiarity with their work. Another worker cited William White as a good influence and that they had read his work on methadone-maintained recovery. There did not appear to be a broad familiarity with academic studies or academics within the field. Even those workers that were strongly in favour of the recovery model did not cite any academics or studies associated with the model. This is in spite of strong support for this study amongst those interviewed, with many expressing their support for academic study of drug treatment in the pre-interview meetings.

In terms of the government itself, there was little support for them as a 'good' influence on treatment.

(On the government) I don't believe they got any understanding at all of drug and alcohol treatment. Or if they have, they're certainly gun-shy because they're cutting funding left and right. And I know that's the thing all over, but... ('Tim' - worker)

This is the only quote where the government are mentioned in terms of influencing treatment, but it is not as a positive influence. 'Tim' uses this question to highlight that the government are seen by them as being a poor influence on treatment as a whole and that the cuts to treatment budgets highlight this lack of understanding. That government is not seen as a positive voice for treatment is a poor indicator for the acceptance (or even acknowledgement) of the 2010 National Drug Strategy. However, as noted in section 3.2.2 this may not be important for the government to change the method of treatment. As Garland (1996b) highlights, the government have the mechanism of measurement by which to change treatment. Merely by changing the outcomes on the measurement forms, treatment

itself will have to change. Worker acceptance is thereby rendered irrelevant and government influence over workers is similarly irrelevant.

7.6 Workers and the speaker

This chapter sought to investigate the relationship between the worker and the designated speaker within drug treatment discourse. I had expected there to be much more to discuss when I designed the interviews, as my experience was that workers were very opinionated about the influences on treatment. However, this turned out not to be the case in these interviews, with many workers (12/26 interviews) struggling to think of any good influences on treatment. However, there are some areas where it is possible to see the relationship between discourse and worker practice, particularly in terms of their relationship with their previous careers, with workers disproving my previous hypothesis that they would stick closely to their original fields. This demonstrated that the workers themselves were varied in terms of which speakers they listened to, with the government and state agencies proving to be poorly considered by workers in general. What was demonstrated was a plurality of knowledge across workers, with an enthusiasm to learn new fields and new ideas: an open discourse. It was clear though that there has been a change to the working practices in drug treatment that has negatively affected their ability to learn at work. Continued professional development is distinctly lacking within the areas surveyed and this is in keeping with the perception of drug work not being a true profession. Similarly, the workers identified that the cutbacks resulting from austerity had effected their ability to develop their own knowledge, with the usual sources of information (journals and magazines) no longer being available to them at their place of work. These cuts also effected their ability to share knowledge within the agencies, with meetings and group discussions no longer the norm. This has the added effect of forcing the workers to learn outside of working hours, which whilst not an issue when they are in education, places a burden on the worker to merge their work and home time. 'Dave' identified that this means the worker needs to compromise between their own wellbeing and their desire to learn new information and techniques. For those in-recovery

workers I interviewed, this was not seen as a choice they could make, with their recovery also seen to be at stake. This further poses the question of the effect working in drug treatment has on the recovery of a worker. Certainly within this sample, the choice was made to preserve their recovery and rely upon pre-existing knowledge rather than risk relapse and merge work and home. If this is considered in regard to the future of treatment this bodes poorly, with workers forced to rely upon the treatment provider for information and discretion in treatment likely to reduce. This is particularly troubling given the theme of 'personalisation of treatment' that has arisen in this research and within the treatment literature. If treatment is to be personalised, then a reduction in worker autonomy may have a negative effect on the ability of that worker to truly personalise the treatment being offered.

Whilst it is disappointing to see a lack of coherence in the responses in regards to the 'speaker' in drug treatment, this actually serves to show that workers are not a mono-culture as has previously been the perception, but a series of interconnected individuals with their own influences and beliefs. Similarly, this may not be an indication of 'the speaker' being different, but that as 'listeners' workers draw on information from a number of sources and use that to determine their view of addiction. Certainly, this chapter demonstrates that there is no dominant discourse surrounding treatment for the workers. There is clearly an open discourse within the culture and as such it would be difficult to see how recovery could not be successfully implemented with existing staff.

Summary

This chapter sought to understand the relationship between workers and the discourse surrounding drug treatment, particularly the discourse originating from government. It was found that the workers themselves relied upon a varied group of narratives, with only the 'therapeutic relationship' identified as a dominant idea. This was identified as being potentially an artefact of the sampling, with a high number of respondents having a historical

relationship with the therapeutic relationship. The relationship between government commentary on drug addiction/treatment and workers was however shown to be weak, with workers more likely to be influenced by traditional knowledge bases and 'popular' programming than government documents and commentary. It was also noted that there had been a movement away from self-education in the sample, with workers less likely to research their subject area than before the change in treatment models. This chapter demonstrated that workers were not part of a closed discourse, but were actively absorbing material from the wider drug treatment world. This links back to the previous two chapters, where workers were shown to be part of a wider occupational and organisational discourse as well as strongly linked to the recovery discourse. This chapter furthers the concept that workers are part of their own discourses and sought to identify areas of influence for them. By looking at the areas of influence, it is possible to see the links between their relationship with recovery and treatment outcomes, with workers' shown to favour rigorous measures and evidence when looking for influences. In Chapter five the workers showed that their acceptance of PbR was related to the robust measurement of outcomes and the evidence that what they were doing influenced the addiction of the client. This is echoed in their sources of influence, with academia, psychotherapy and medicine seen as strong, trustworthy sources of knowledge.

Chapter 8: Conclusion

8.1 Workers and recovery

This research sought to examine the relationship between drug treatment workers and the changes to treatment under the 2010 National Drug Strategy (NDS). It has done this by examining the relationships the worker has with the discourse surrounding drug use and treatment, through examining worker beliefs and understanding of treatment and addiction. The inspiration for much of this research is the notion that workers are reluctant to change from the harm reduction methods of treatment utilised in the early 2000s (and earlier), and that workers themselves are insulated from the appeals of the incoming recovery model of treatment. As shown in section 4.6, this was defined as a 'closed discourse' with workers existing within their own bubbles of influence, unaware of the benefits of recovery as their trusted speakers on the subject would be critical or not address it. They are also prevented from accepting any benefits from recovery because of the cognitive dissonance that recovery causes, as it fundamentally challenges worker understandings of treatment and appropriate treatment methods. The quote that inspired much of this work argues that without a purge of harm reduction workers from the workforce, the cause of recovery will be a failure as it will not be implemented correctly. This research sought to examine this relationship between the worker and recovery as a concept and as a discourse around addiction. By looking at worker engagement with recovery ideals, it was hoped that an examination of workers' acceptance of new ideas could also be undertaken.

8.2 Payment by Results and organisational change

In this research it was found that workers in a payment by results (PbR) area are more accepting of the organisational definition of recovery than those outside of the scheme. Whilst it has been highlighted within this thesis that there are a number of definitions of recovery and that these definitions vary in significant ways, the organisational definition is by far the most important to the workers themselves, as this is the definition that would determine day-to-day practice. It is the belief of this paper that the increased acceptance of the organisational definition is in part caused by the method by which organisational

definitions change. The PbR system arguably changed the definition of successful treatment through its measurement of outcomes rather than being a fundamental change to treatment itself. Those within the PbR model were more readily willing to accept the organisational definition of recovery (15/16 interviews) than those in the non-PbR models (0/6 and 1/2 interviews). This indicated that perhaps the PbR model served to 'soften' the change from harm reduction to recovery, with workers seeing it as part of PbR (a change in the measure of outcomes and funding) rather than a fundamental change to the ideology behind treatment. This reduces the cognitive dissonance as it is no longer an attack on their ideas and beliefs (they are not 'wrong' in this instance) but a change to the measures they record. This represents a contribution to theoretical knowledge surrounding the formation of organisational norms and definitions within drug treatment.

When this is taken into consideration with the workers' views of treatment outcomes, it is possible to see the mechanism through which this has taken place. Workers highlighted that in the non-recovery models of treatment, the Treatment Outcomes Profiles (TOPs) were not seen as being an accurate reflection of the work done and therefore the outcomes measured by those forms were not valid measures of effectiveness of treatment. However, under PbR the TOPs were now seen as a robust measure of treatment outcomes, mainly because of the new forms of checks and balances that went with them. The non-PbR model subverted their trust in the measures by allowing falsification of results. By being robust in its checks, PbR allows the worker greater faith in the results the organisation is using to demonstrate effectiveness. In this way, PbR serves to reinforce the organisational definition of recovery, helps the worker to see the results of treatment and to have faith in those results. This is a new method of looking at PbR, with existing research looking at the effect of PbR on recovery rates or looking at the outputs themselves (see Mason et al 2015 & Jones et al 2017). This research proposes that there is another way to look at PbR, as a facilitator of organisational change.

This is a new contribution to our theoretical knowledge surrounding PbR and has consequences for future evaluation of PbR projects, as it introduces a new strand to our understanding of organisational culture both within drug treatment, but also in other state-based agencies. Given the stark difference in the acceptance of organisational definitions between the PbR recovery area, the non-recovery area and the non-PbR recovery area, it is possible to posit that PbR has served an additional function and directly impacts upon the practice of workers. Here it has allowed workers to buy into the definitions offered, as there are clear measurements, but also rigorous protections in place to minimise 'gaming' these measures. It could therefore be argued that it is not PbR per se, but rather the robust evaluation of outputs that increased the worker buy-in to organisational change. This was seen by the workers as an improvement in accountability rather than a different system to abuse. Those workers within the non-PbR recovery area cited that they still had no faith in the measures and as such resorted to their own existing beliefs rather than the organisational definitions. By having a system of measurement that has historically been open to abuse, continuing to use this as a measurement for a new treatment model means that workers will be more likely to return to their historic views on treatment, thereby producing a closed discourse within treatment. This is a new relationship between workers and PbR, and will need to be researched further in the future.

The factors identified in this research can also influence policy through the deployment of PbR when organisational and personal definitions are challenged by new policy. When viewing this through the lens of managerialism and the 'new penology', we can see an additional effect of the measurement of outputs within state agencies: the ability for the state to use these measures to influence workers' beliefs and practice. In changing the outputs, but ensuring the evaluation is robust, workers in this study were more likely to change their fundamental beliefs to align with those of the organisation. This has ramifications for policy, as it indicates a method through which policy changes can influence worker practices and

beliefs. Further study is needed as this is a limited sample in a specific field and time, but this research does indicate that workers can be influenced by policy, but that it is not the ideology or practice of the policy that influences worker engagement, but the quality control of the evaluation. If the workers believe that they are being assessed fairly, then they are more willing to change their practices than when the system is open to abuse.

It is also possible to look at the relationship between outputs and worker engagement from another perspective: that worker engagement with a treatment model is negatively impacted by poor output measures. The impact of this discussion is mainly on the practice of the workers themselves, with workers in the two areas without PbR being more negative about the value of treatment and the purpose of their work. In terms of policy design, this means that any policy implementation must be accompanied by robust evaluative processes in order for workers to engage with it. This has implications for the policy being implemented too, with workers in areas without PbR being clear that recovery is a suitable goal for drug users, but being more negative about the quality and effectiveness of the treatment being offered in their service. Workers in Midshire cited the value of the 'old' treatment model in comparison to their current model. Yet workers in Westshire, who were using this 'old' model stated that their model was also not fit for purpose. In the recovery-led PbR area of Eastshire, workers were more likely to say that this was the best model of treatment they had used and worker support for treatment was the highest of all sample areas. It would be premature to attribute this to PbR as a whole, but the results certainly show that the more robust system of measurement allowed the workers more faith that what they were doing was working.

In their evaluation of the 2010 NDS HM Government (2017a) utilise treatment closure data to demonstrate an increase in the number of positive treatment outcomes under the recovery

model. What this research demonstrates is that this is not an effective measure of the impact of treatment on clients, as workers demonstrated that the Treatment Outcome Profiles (TOPs) do not accurately estimate the success of treatment. Within the review of the 2010 NDS (HM Government 2017a), it is commented that existing reviews of PbR have shown that non-PbR treatment out performs PbR in terms of those leaving treatment successfully. There is an implication that this means that PbR treatment is less effective than non-PbR treatment. This research supports the claims by Mason et al (2015) that this difference in outcomes could be down to the more rigorous scrutiny that PbR outcomes are subject to. This thesis also goes further and shows that workers within a PbR area agreed that they were not asked to fraudulently complete TOPs forms under this model. As such, if this is true across other treatment areas, PbR areas could represent a more truthful representation of treatment success and failure than non-PbR areas. It is the position of this paper that PbR completions may represent a more truthful picture of drug treatment than non-PbR and that benchmarking PbR areas against non-PbR areas (and their lower performance against such areas) may represent not a failure of PbR but the level of fraud present in traditionally measured areas. This has implications for the policy of PbR in general, serving to redefine the 'failure' of PbR as possibly being an unfair comparison with existing measures of success. Linking back to the main aim of this research, these findings serve to vindicate the worker-centred approach taken by this research, with the qualitative approach being key to uncovering this knowledge. Whilst Mason et al (2015) argue that the discrepancy between PbR and non-PbR is caused by increased scrutiny on the outcomes of services, this research goes further, arguing that this discrepancy is a result of occupational pressure to provide the best possible results. This could only have been discovered through interviewing workers and highlights the value of including workers within evaluations of treatment in future research, with valuable insights into how treatment functions as well as its effectiveness being discovered through this method. As such, this research represents a contribution to future research methods, with worker interviewing shown to be both effective

and to yield insight that could not have been gained through the methods commonly used to assess drug policy.

8.3 Workers and acceptance of recovery

From the beginning, this research sought to challenge the narrative that drug workers were a homogenous group that largely favoured harm reduction as a treatment model (Buchanan 2010 cited in Weston 2016 & Best et al 2010). This resistance to change was the perceived norm surrounding drug workers and was cited as a potential impediment to effective implementation of recovery as a model of treatment. Whilst there have been studies into the organisational beliefs of drug workers (Seddon et al 2012 & Weston 2012), they have not addressed the relationship between workers and recovery. In this way, this research represents a contribution to the theoretical knowledge surrounding the relationship between workers and occupational culture.

As highlighted throughout this thesis, there exists an understanding that workers are tied to harm reduction ideologies and could not engage with recovery as this is counter to their previously held beliefs. This is represented within this research as a closed discourse, with workers immune from the allure of recovery as they are not exposed to it within their day-to-day lives. However, this research found that workers were not closed off from recovery, with all workers expressing support for the broad definitions of recovery. This has significance for our theoretical understanding of drug workers as an occupational group, as well as drug treatment in general. In her original research on drug workers and criminal justice values, Weston (2016) found that workers were accepting of the need to reduce crime through drug treatment and as such reducing crime was an important measure of the success of drug treatment. This study similarly found that workers had embraced the key components of recovery, often integrating it with the key components of harm reduction. This research serves to support Weston's (2016) argument that workers are not resistant to change and

will adjust their beliefs and working practices to reflect the work they are undertaking and the model of treatment they are using.

The high levels of support for many of the key features of recovery certainly show that workers are far from being an impediment to recovery being implemented, as was suggested in existing research. In the case of the workers in Westshire, they were eager for the recovery model to be implemented within their area, and an end to harm reduction as a goal for treatment. These findings were not in line with existing theories on drug workers and their beliefs and represent a new avenue of research into treatment. Certainly, the general support for abstinence as a goal was unexpected and not in line with the research in the area that suggested that drug workers were predominantly harm reduction focussed (Best et al 2010). Instead, what could be seen was a melding of the harm reduction and recovery models, with recovery used as an end point, but harm reduction being seen as a vital step on that road. Workers were evenly split on whether abstinence was needed to achieve recovery, but this represented the same split that was present in the literature around recovery. Instead of finding that workers are a closed discourse, it could be argued that they represent the discourse well, with the same discussions present in both the literature and the interviews. This is important not just for future research, but also policy and practice, with workers demonstrating that they are an active participant in treatment discussions and are aware of the major discussions within the discourse. This research is evidence that workers should be involved in future policy discussion, rather than merely the recipients of policy, with their voice as important to successful treatment as treatment providers and drug users themselves.

This research also argues that representing workers as a closed discourse and incapable of change serves to push the agenda that workers are not professionals. This is a position

which served those within the recovery agenda, as it allows the equalisation of staff and peer support workers, a core principle of the recovery movement. It also allowed the disqualification of drug workers from the discourse around recovery as they were seen as being entrenched in their support for harm reduction, meaning concerns and criticisms from practitioners were silenced. Within central government, this narrative allows for cost-cutting through wage devaluation, as non-professional workers can be employed at a lower wage. Yet this research shows that the workers within this sample have an organisational culture and occupational beliefs that inform practice, both traits of a profession. Also, they are not entrenched in the harm reduction approach to treatment and were supportive of the recovery method of treatment, meaning that the recovery movement discounted an ally. As such, this research demonstrates that when seeking to influence drug treatment, pressure groups and academics should not discount workers as allies and their own influence on the practice of the workers. This research demonstrates that workers are much more in tune with the discourse surrounding treatment than was previously anticipated, however it also highlights a threat to that engagement.

Within this research, the workers interviewed all highlighted that they were less involved with the discourse than they were previously. Cuts in funding have led to workers being more stressed (due to larger workloads) and having less time to research their field than they did previously. The removal of field specific trade magazines has also led to a disengagement with the wider drug treatment world, whilst in-work stress has meant workers are less inclined to research outside of their work hours. This research argues that whilst workers are not a closed discourse currently, there is the danger of this happening if funding for research time or in-work research is not restored, therefore negatively impacting upon the practice of workers. Similarly, workers highlighted the importance of the DANOS accreditation in the formation of their knowledge and that without the stimulus of education they were less inclined to research current developments in drug treatment. This research argues that drug

workers are more engaged with the discourse surrounding drug treatment than previously believed, but this engagement is dependent upon access to that discourse and that is being eroded. The engagement of workers with the discourse surrounding drug treatment is vital, it offers academia and government a route to impact practice and change occupational behaviours. Much as with the PbR discussion above, the impact of engagement with discourse goes beyond personal development and impacts professional practice across the sector and has wider implications for future policy changes. This research represents the start of further research into how workers form the theoretical backdrop to their work and as such deserves further exploration.

8.4 Further research

This research has shown that workers are able to offer valuable knowledge to discussions of drug treatment and the effectiveness of such treatment. As such, they should no longer be excluded or minimised in evaluations or discussions of treatment. The results of this research demonstrate that excluding/minimising the voices of drug workers serves to obscure the true picture of effective drug treatment. If research is to be representative of the realities of drug treatment, further research into drug workers is needed as well as research of drug treatment involving inputs from drug workers. Of particular interest is the discussion of worker wellbeing, particularly workers that are former drug users, as the stress of the work was seen to be a risk to the recovery of the worker. This has implications for the policy of employing in-recovery workers and for the working practices of drug workers themselves, as it leads us to question whether practices that are harmful to recovery should be part of drug treatment practice. Further research is vital in this area, as for recovery to be effective it requires people to be living examples that recovery is achievable.

This research has also shown the value that PbR has in the acceptance of organisational change within a group. This needs further research, not just within drug treatment but within other sectors

to further examine if this is a feature of PbR as a whole or merely a factor in this sample, or if there is another factor causing the effect. This research has served to show that drug workers are a vital and underutilised resource within drug policy research. There are a number of new areas of research and new ways of understanding drug treatment that have resulted from this research and as such it is the hope of the author that this research can be used as a launch pad for further research into drug workers and their relationship with drug policy.

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Appendix 1: Ethics form, example consent form and ethical approval



| |
|----------------|
| For Office Use |
| Checklist No: |
| Date Received: |

ETHICS REVIEW CHECKLIST

Sections A and B of this checklist must be completed for every research or knowledge transfer project that involves human participants. These sections serve as a toolkit that will identify whether a full application for ethics approval needs to be submitted.

If the toolkit shows that there is **no need for a full ethical review**, Sections D, E and F should be completed and the checklist forwarded to the Research Governance Manager as described in Section C.

If the toolkit shows that **a full application is required**, this checklist should be set aside and an **Application for Faculty Research Ethics Committee Approval Form** - or an appropriate external application form - should be completed and submitted. **There is no need to complete both documents.**

Before completing this checklist, please refer to [Ethics Policy for Research Involving Human Participants](#) in the University Research Governance Handbook.

The principal researcher/project leader (or, where the principal researcher/project leader is a student, their supervisor) is responsible for exercising appropriate professional judgement in this review.

This checklist must be completed – and any resulting follow-up action taken - before potential participants are approached to take part in any study.

| | | | |
|---|-------------------------------------|--|---------------------------|
| Type of Project - please mark (x) as appropriate | | | |
| Research | <input checked="" type="checkbox"/> | | Knowledge Transfer |
| | | | <input type="checkbox"/> |

Section A: Applicant Details

| | |
|--------------------------------|----------------------|
| A1. Name of applicant: | Barry Blackburn |
| A2. Status (please underline): | Postgraduate Student |
| A3. Email address: | |

| | |
|----------------------|--|
| | |
| A5. Telephone number | |

Section B: Ethics Checklist

Please answer each question by marking (X) in the appropriate box:

| | | Yes | No |
|-----|--|--------------------------|-------------------------------------|
| 1. | Does the study involve participants who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning disabilities, your own students)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. | Will the study require the co-operation of a gatekeeper for initial access to the vulnerable groups or individuals to be recruited (e.g. students at school, members of self-help group, residents of nursing home)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. | Will it be necessary for participants to take part in the study without their knowledge and consent at the time (e.g. covert observation of people in non-public places)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. | Will the study involve discussion of sensitive topics (e.g. sexual activity, drug use)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. | Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. | Does the study involve invasive or intrusive procedures such as blood taking or muscle biopsy from participants? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. | Is physiological stress, pain, or more than mild discomfort likely to result from the study? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. | Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. | Will the study involve prolonged or repetitive testing? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| | | | |
|-----|--|--------------------------|-------------------------------------|
| | Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Will the study involve recruitment of participants (including staff) from specific Faculties (rather than University-wide) other than your own at Canterbury Christ Church University? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. | Will the study involve recruitment of participants (including staff) through the Department of Social Services of a Local Authority (e.g. Kent County Council)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. | Will the study involve recruitment of patients or staff through the NHS? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Now please assess outcomes and actions by referring to Section C 

Section C: How to Proceed

C1. If you have answered '**NO**' to **all** the questions in Section B, you should complete Sections D–F as appropriate and send the completed and signed Checklist to the Research Governance Manager in the Graduate School and Research Office for the record. **That is all you need to do. You will receive a letter confirming compliance with University Research Governance procedures.**

[Undergraduate and Master's students should retain copies of the form and letter and submit these with their research report or dissertation (bound in at the beginning). Work that is submitted without these documents will be returned un-assessed.]

C2. If you have answered '**YES**' to **any** of the questions in Section B, you will need to describe more fully how you plan to deal with the ethical issues raised by your project. This does not mean that you cannot do the study, only that your proposal will need to be approved by a Research Ethics Committee. **Depending upon which questions you answered 'YES' to, you should proceed as follows**

(a) If you answered '**YES**' to any of **questions 1 – 10 ONLY** (i.e. not questions 11, 12 or 13), you will have to submit an application to your Faculty Research Ethics Committee (FREC) using your Faculty's version of the **Application for Faculty Research Ethics Committee Approval Form**. This should be submitted as directed on the form. The *Application for Faculty Research Ethics Committee Approval Form* can be obtained from the Faculty Research web site, or via the Research Ethics page of StaffNet.

(b) If you answered '**YES**' to **question 11** you have two options:

(i) If you answered '**YES**' to **question 11 ONLY** you must send copies of this checklist to the Dean and to the Chair of the Research Ethics Committee in the Faculty concerned. Subject to their approval you may then proceed as at C1 above. This may not be necessary if the proposed study is University-wide and involves all Faculties – the Research Governance Manager in the Graduate School and Research Office can advise.

(ii) If you answered '**YES**' to **question 11 PLUS any other of questions 1 – 10**, you must submit an application to your Faculty Research Ethics Committee (FREC) as at C2(a) and also send copies of your completed *Application Form* to the Dean and to the Chair of the Research Ethics Committee in the Faculty concerned.

(c) If you answered '**YES**' to **questions 12 or 13** you do not need to submit an application to your Faculty Research Ethics Committee. **INSTEAD**, you must submit an application to the appropriate external NHS Research Ethics Committee (REC) or Local Authority REC, *after* your proposal has received a satisfactory Peer Review. Applications to an NHS REC or a Local Authority REC **must** be signed by the appropriate Faculty Director of Research before they are submitted.

IMPORTANT

Please note that it is your responsibility in the conduct of your study to follow the policies and procedures set out in the University's Research Governance Handbook, and any relevant academic or professional guidelines. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct over the course of the study should be notified to the **Faculty and/or other Research Ethics Committee** that received your original proposal. Depending on the nature of the changes, a new application for ethics approval may be required.

Section D: Project Details

| | |
|------------------------------------|---|
| D1. Project title: | Rehabilitation to Recovery: A study into the effects of changes in policy to the structure, function and philosophy of Drug treatment. |
| D2. Start date | Jan 2012 |
| D3. End date | Jan 2015 |
| D4. Lay summary (max 200 words) | A qualitative study into how changes in governmental policy affect organisational structure, and service delivery in the drug treatment sector. Specifically looking at whether changes in policy truly represent a change in philosophy and whether changes in policy really change the ways staff deliver treatment or if personal beliefs play a greater role in the ways staff treat addiction. I will be looking at staffing attitudes and procedures as a whole and not at specific cases of drug treatment. This study will also be focused on the staff and the impact of changes in policy on their culture and work and not at the perceptions of drug users themselves. The study will also look into the formation of Governmental policy, what influences the choices that are made and how rigid the policy is to implement for local government. It will track the changes in drug treatment in Kent from the advisors of Government policy through to the frontline workers that are implementing the treatment through the use of 1:1 interviews and ethnographic research undertaken with drug treatment practitioners. This will not be conducted covertly or without consent. |

Section E1: For Students Only

| | |
|--|--|
| E1. Module name and number or MA/MPhil course and department: | Mphil Criminology |
| E2. Name of Supervisor or module leader | |
| E3. Email address of Supervisor or Module leader | |
| E4. Contact address: | Canterbury Christ Church University North Holmes Road Canterbury |

Section E2: For Supervisors

Please tick the appropriate boxes. The study should not begin until all boxes are ticked:

| | |
|--|-----|
| The student has read the relevant sections of the University's Research Governance Handbook, available on University Research web pages at: http://www.canterbury.ac.uk/research/governance/index.asp | √ |
| The topic merits further investigation | √ |
| The student has the skills to carry out the study | √ |
| The participant information sheet or leaflet is appropriate | √ |
| The procedures for recruitment and obtaining informed consent are appropriate | √ |
| If a CRB/VBS check is required, this has been carried out | n/a |


Comments from supervisor:

This is a wholly appropriate proposed piece of research. The student has had all relevant training in research methods and is a practitioner within the professional arena that he is investigating. I can see no ethical issue that may arise from this methodology.

Section F: Signatures

- I certify that the information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I certify that a risk assessment for this study has been carried out in compliance with the University's Health and Safety policy.
- I certify that any required CRB/VBS check has been carried out.
- I undertake to carry out this project under the terms specified in the Canterbury Christ Church University Research Governance Handbook.
- I undertake to inform the relevant Faculty Research Ethics Committee of any significant change in the question, design or conduct of the study over the course of the study. I understand that such changes may require a new application for ethics approval.
- I undertake to inform the Research Governance Manager in the Graduate School and Research Office when the proposed study has been completed.

- I am aware of my responsibility to comply with the requirements of the law and appropriate University guidelines relating to the security and confidentiality of participant or other personal data.
- I understand that project records/data may be subject to inspection for audit purposes if required in future and that project records should be kept securely for five years or other specified period.
- I understand that the personal data about me contained in this application will be held by the Research Office and that this will be managed according to the principles established in the Data Protection Act.

| Principal Investigator | Supervisor or module leader (as appropriate) |
|--|--|
| Name: Barry Blackburn Signed: Date: 9/1/13 | Name: Dr Tom Cockcroft Signed:  Date: 12/09/13 |

Section G: Submission

This form should be returned, as an attachment to a covering email, to the Research Governance Manager at roger.bone@canterbury.ac.uk

N.B. Remember to include copies of the Participant Information Sheet and Consent Form that you will be using in your study. (Model versions on which to base these are appended to this checklist for your convenience)

Providing the covering email is from a verifiable address, there is no longer a need to submit a signed hard copy version.

[MODEL] CONSENT FORM

Title of Project: **Rehabilitation to Recovery: a study into the effects of changes in policy to the philosophy, culture and strategy of drug treatment**

Name of Researcher: Barry Blackburn

Contact details:

Address:

| |
|---|
| Crime and Policing Department Canterbury Christ Church University North Holmes Road Canterbury |
|---|

Tel:

| |
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| |
|--|

Email:

| |
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|--|

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential
4. I agree to take part in the above study.

| |
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Name of Participant Date Signature

Name of Person taking consent Date Signature
(if different from researcher)

Barry Blackburn
Researcher Date Signature

Copies: 1 for participant
 1 for researcher

Rehabilitation to Recovery: a study into the effects of changes in policy to the philosophy, culture and strategy of drug treatment

PARTICIPANT INFORMATION SHEET

A research study is being conducted at Canterbury Christ Church University (CCCU) by Barry Blackburn.

Background

This study is looking at how changes to drug policy affect the work and culture of drug treatment. It is using the capacity for changing culture and organisation as an indication of how successful the policy has been at changing the methodology of drug treatment and therefore how likely the policy is to affect drug use and drug user's lives.

What will you be required to do?

Participants in this study will be required to complete a survey or a short interview with the researcher discussing their role in the formation and implementation of the local drug treatment service.

To participate in this research you must:

- Work or have worked for a drug treatment service or local government agency involved in drug treatment.
- Not be actively engaged in drug treatment as a service user.

Procedures

You will be asked to either fill in a survey or participate in a face to face interview. Some participants will be invited to return for a group interview at a later date.

Feedback

Full transcripts of interviews can be returned if requested, as can an electronic copy of the finished study.

Confidentiality

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by Barry Blackburn. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

Dissemination of results

Currently there are no plans to publish the results of the study, but this may be subject to change.

Deciding whether to participate

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason.

Any questions?

Please contact Barry Blackburn

Appendix 2: Example coding table

| Main theme | Sub-theme(s) | Description | Keywords |
|--|--|--|--|
| Influence of previous careers/discipline | Holistic treatment | Treatment is seen as being about a number of disciplines | <i>Onion (layers of), process, learning, answers, black and white, environment</i> |
| | Therapeutic relationship | Relationship being developed between worker and client is seen as crucial to effective treatment | <i>Personalisation, holistic, relationship, therapeutic, experience, information</i> |
| | Background as only part of the process of learning | The acknowledgement that their background is not the only approach to treatment | <i>Learning, experience, other, counselling, psychosocial, medical, new</i> |
| | Background at the forefront | Some workers used their background as the primary driver of their treatment | <i>Useful (treatment), behaviour (client)</i> |
| Rational discussion about drugs | Government involvement in the discussion | Some workers see the government as a good example of a rational discussion and others do not. | <i>Rational, irrational, government, policy, ground level</i> |
| | Irrational discussion | Worker sees irrational discussion as being superior to an inconsistent one | <i>Irrational, conversation, Portugal, Holland, good</i> |
| Good influences on treatment | Celebrities | The influence that celebrities (particularly celebrities with addiction problems) have on the drug debate | <i>Therapeutic, experience, TV, documentary, recovery, Brand</i> |
| | NA/AA (abstinence/recovery figures) | Acceptance of abstinence/recovery narratives as a good source of treatment information. | <i>Recovery, NA, AA, CA, anonymous, 12-step</i> |
| | Academia | Academic material and academic institutions as a good source of information. Link between academic research and workers. | <i>Books, journals, magazines, Nutt, Stevens, research</i> |
| | Government | The government as a good source of information or a good influence on narratives surrounding drug treatment | <i>NTA, PHE, Government, MPs, ministers, papers, statistics</i> |

| Main theme | Sub-theme(s) | Description | Keywords |
|----------------------------------|--|--|--|
| Research outside of work | Importance of research | The workers beliefs as to the importance of keeping up with current developments | <i>Current, research, CPD, development, treatment.</i> |
| | Personal preservation as a reason not to update. | Not researching as a form of self-preservation. Either recovery or non-recovery oriented. | <i>Recovery, preservation, mental health, family, research</i> |
| | Not researching | Reasons for not researching outside of those given already | <i>Research, DDN, lazy, de-motivated, austerity, funding, busy</i> |
| | Government material | The perceived usefulness of government material for developing the skills of the worker. | <i>PHE, NTA, Government, statistics</i> |
| | Education as a trigger to research | The use of education to spur on further study of their subject and to expand on their foundational knowledge | <i>Motivation, diploma, further education, research, CPD</i> |
| Separation between work and home | Separation as part of protecting the worker/family | Separation of work/home as part of protecting the worker from the harms caused by the job | <i>Family, home, harm, stress, austerity</i> |
| | Separation because of stress/boredom | Separation caused by boredom with the role or stress caused by the role. | <i>Motivation, boredom, stress, work as stress, austerity</i> |

Appendix 3: Semi-structured interview questions

- How did you get into drug treatment, what motivated you?
- How do you keep up with changes in treatment?
- How do you plan the treatment of a client?
- Does personal information about the client help with your treatment plan?
- Do you consider factors outside of the addiction itself when designing a treatment plan?
- How much influence does the company have on your treatment plan?
- How much does your personal opinion of the causes of drug addiction affect your treatment plan?
- Who do you consider to be good influences on the direction of drug treatment?
- Do you read/watch media stories about drug addiction?