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NAD

Nordic Studies on Alcohol and Drugs
2017, Vol. 34(2) 107–111
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DOI: 10.1177/1455072517691058
journals.sagepub.com/home/nad
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The recovery movement and its implications for policy, commissioning and practice

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Keywords
international comparisons, mental health, policy, recovery, strengths-based

While a recovery approach is widespread and relatively unquestioned in the USA, its implementation in the UK and to a lesser extent in Australia has provoked a number of questions about what this means in practice and what some of the implications are for treatment. This is particularly important as there is growing interest in recovery in Western Europe with policy recognition in Belgium and the Netherlands, and increased interest in research issues around recovery.

What this article sets out to do is to discuss the implications of a recovery model for commissioning and treatment systems, with a focus on where recovery approaches sit and what they can offer in terms of added value to treatment approaches.

The curse of definitions

As in the mental health recovery movement, attempts at operationalising recovery models in alcohol and drugs have been beset by challenges of definition. There have been two consensus group definitions (one in the USA and one in the UK) that have attempted to define recovery as something to do with sobriety (or controlled use), something to do with global health and something to do with active participation in the rights and responsibilities of

Submitted: 28 November 2016; accepted: 8 December 2016

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society/communities (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2008), broadly mirrored in the Substance Abuse and Mental Health Services Administration definition in the USA (Substance Abuse and Mental Health Services Administration, 2014). These definitions have been criticised primarily on three grounds that are related: first, that they are too broad to be meaningful; second, that they fail to account for the dynamic nature of change and so look like measures of a state rather than a process; and third, that they exclude the subjective and personal experiences of change that are seen as central to the lived experience of recovery (e.g., Best, 2014; Deegan, 1996).

However, this is a huge problem for policy makers who have to attempt to quantify and operationalise recovery as something more than a personalised and experiential process of growth. In England, in particular, this has led to an initial policy that set ambitious goals (UK Government, 2010) around allowing people to move on with their lives and exiting treatment but that, following a second policy document (Home Office, 2012) "Putting full recovery first", became far more focused on three core measurable components: exiting treatment and not returning; no arrests; and reductions in benefits associated with obtaining and maintaining employment, with the measurement window involving a one-year period of change in each of these component parts of recovery.

All three of these components can be linked to both the UK Drug Policy Commission (UKDPC) and the Betty Ford definitions – active citizenship as employment and avoidance of crime, sobriety as no need for treatment and improved global health. However, the danger has been that these goals are not equally accessible to all of those in treatment – particularly those with complex and severe problems associated not only with their substance use but also with mental health, family relationships, trauma and so on – and it has led to concerns that individuals not ready for recovery are being hastened to the exit door not because they are ready for stable recovery (Dennis, Scott, & Laudet, 2014 estimated that "self-sustaining recovery" takes around five years) but because specialist services do not get paid otherwise!

That the recovery agenda gained prominence in the UK around the time of the Global Financial Crisis has meant that the agenda for change and growth associated with the recovery movement has been linked to reducing treatment costs and expenditure with the workforce fearing that the push for self-reliance and mutual aid is simply an attack on professional services, and an attempt to reduce the cost burden associated with specialist addiction support.

In Scotland, there has been less of a concern with a "race to the bottom" in terms of the recovery agenda – specialist provision for addiction and recovery services remains firmly in the hands of NHS services – but rather there has been a sense of disappointment about how little has changed since the publication of "The road to recovery" strategy in 2008 (Scottish Government, 2008). While there is a different political climate since the advent of the devolved government, the derivation of Scottish recovery policy has remained closer to paralleling the mental health recovery model (an explicit aim in "The road to recovery") in a way that was not the case in the English policy which was predicated much more strongly on the reform and decentralisation of the treatment system. In effect, this has meant that the core components of drug and alcohol treatment delivery in Scotland have been changed much less radically than in England.

So what are the positive conclusions from the implementation of recovery models?

There are four areas in which the recovery movement can be seen as having brought clear benefits that are in keeping with US ideals of a recovery-oriented system of care (Sheedy & Whitter, 2009):

- It has led to a re-balancing of the treatment system and a reminder of the importance of aftercare (e.g., McKay, 2016) in ensuring that the acute needs of clients are supplemented by ongoing needs around such things as recovery housing (e.g., Jason, Olson, & Foli, 2006), employment and education and wider issues of quality of life and wellbeing.
- As a consequence the focus has shifted to some degree from the clinic to the community and increased attention on families and environments that are supportive of positive change, and it has led to an increasingly inclusive model of change that has brought increased focus on resources in the community (Asset Based Community Development; ABCD; Best, McKitterick, Beswick, & Savic, 2015) and to the idea that there is a community response that requires a collective and participative approach. This also involves the transition from the status of the client and expert dyad to much more of a partnership approach (Sheedy & Whitter, 2009).
- A transition from a deficit to a strengths-based model that has created an agenda in keeping with other strengths-based models such as positive psychology and criminology, restorative justice and therapeutic jurisprudence. This has been based on an emerging evidence base – around mental health and addiction recovery – that has at its core a belief the core values of CHIME: connectedness, hope, identity, meaning and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). This strengths-based approach has afforded greater hope to family members and communities, but especially to people with addiction problems, that a long-term solution is possible.
- An inclusive approach that involves staff as well as clients of specialist services. One of the main consequences of the recovery approach is that it is inclusive and so has led to the idea of recovery systems (e.g., Kelly & White, 2011) with increased attention on the wellbeing of the workers as part of a recovery model based on the assumption that there can be no "us and them" and that wellbeing is a shared objective and shared pursuit.

The switch to a recovery approach has also been associated with a significant increase in research activity around improving the evidence base on recovery housing (e.g., Jason, Olson, Ferrari, & Lo Sasso, 2006; Mericle, Karrikar-Jaffe, Gupta, Sheridan, & Polcin, 2016), on the mechanisms of action of mutual aid groups (Kelly, 2016) and overall models of what is known to be supportive of long-term recovery pathways – recovery housing, peer-delivered interventions and mutual aid (Humphreys & Lembke, 2013).

What is the downside of the recovery movement?

From the UK experience in both Scotland and England, there is the risk of a coalescing of recovery enthusiasm with a self-help mantra that encourages reduced central spending and so cutbacks in specialist treatment services and expert jobs. This is also linked to two further risks that are real although sometimes overstated: the fear that recovery is simply a new term for the 12-step/Minnesota Model approach, and that this is part of a larger moral crusade around temperance. While there is no standard sign-up for recovery advocates (and the authors are reluctant to speak for others who represent a diverse array of positions on all of the above), the fear of political manipulation for economic purposes appears to be the biggest risk. The dominance of the 12-step model and the advent of a "new abstentionism" (Ashton, 2007) not only appear to be scare-mongering, they also do a considerable disservice to the advocates of Therapeutic Community, natural recovery, SMART, medication-assisted and specialist-treatment-based pathways to

recovery. The false war between recovery and harm reduction is another example of a battle for control of limited budgets (and perhaps more importantly ideological hegemonies) that is at odds with the estimation by Dennis and Scott (2007) that the average duration of an addiction career is around 27 years – a window which not only affords opportunities for multiple interventions but also necessitates continuity of life as a means of enabling recovery.

Where does this leave us?

The recovery movement is not a homogenous phenomenon, with differing philosophies and approaches informing its evolution, and it can be seen as an uneasy alliance of abstinence and medication-based models, specific philosophies and theories (12-step and Therapeutic Communities) and between a diverse range of proponents including family members, people in recovery (or recovered), practitioners, policy makers and a diverse range of other stakeholders. In spite of attempts at creating a consensual definition (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2008), the results tend to be vague and imprecise and it may be more useful to think of recovery approaches as a kind of pre-figurative political movement (Beckwith, Bliuc, & Best, 2016) that challenges orthodoxy and has led to the assembly of a new set of evidence approaches (Humphreys & Lembke, 2013). The risk of such an uneasy alliance and flexible definition is that it leaves "recovery" at the mercy of multiple interpretation, including those with a particular political agenda, including challenges to professional services and the overall alcohol and drug field. There is much to commend a recovery movement – but its utilisation as a Trojan horse to breach the walls of specialist addiction provision is a lesson that must be learned and an area where advocates of recovery and of harm reduction must come together to resist.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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