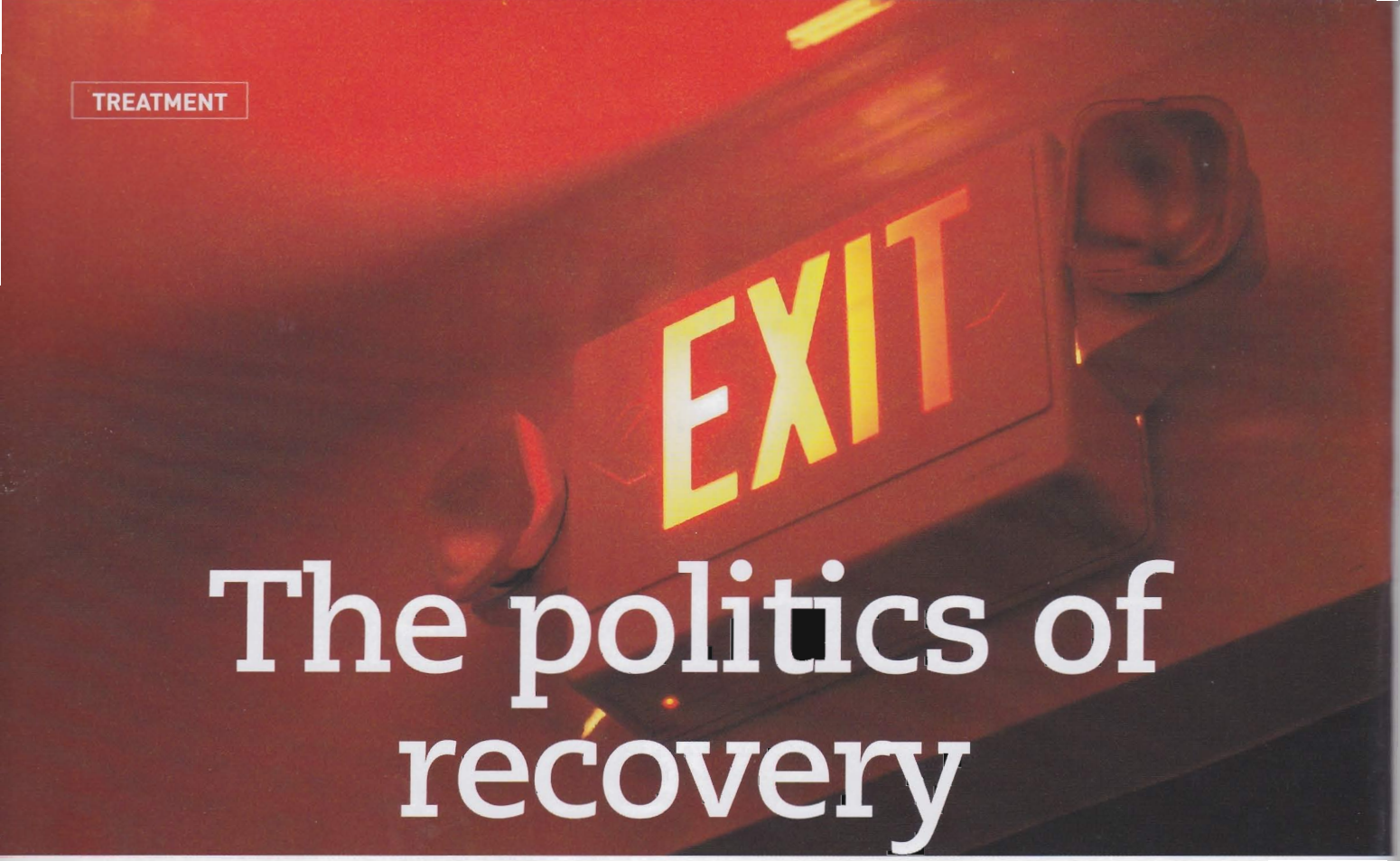

The politics of recovery

If problem drug users are to cut the virtual umbilical chord that often ties them into the drug treatment industry, it is time for a wholesale review of how the field sees its role in people's recovery. **David Best, Teodora Groshkova,** and **Paul McTague** say experts need to cede power to individuals and the community to ensure real progress.

For understandable reasons, many people who have beaten drug addiction want to move on with their lives and leave that episode behind. Unfortunately for those attempting to conduct research into how people successfully recover from drug problems, the evidence is elusive. Most of those who recover from drug problems drop off the researcher's radar. It is a major obstacle to understanding success stories and to help challenge stereotypes and tackle the stigmas that complicate recovery.

This gap within the evidence leads to what Professor Michael Gossop from Kings College London refers to as the 'clinical fallacy' – experts basing definitions of addiction on those who are in the middle of a crisis, rather than at the end of one. As a result we have ended up with a bleak and pessimistic perception of addiction, leading to the mantra that it is a chronic, relapsing condition. This helps to perpetuate a vicious circle, in which the perception that it is impossible to recover compromises people's chances of recovery from addiction.

While there is relatively little recorded longitudinal data on the outcome of recovery from substance dependence at a national level, work by addiction experts such as the US researcher and author William White has demonstrated that sustained recovery is achievable – not only through participation in rehabilitation programmes but also without engagement in formal treatment interventions. The latter – often referred to in the field as 'natural recovery', suggests that the factors that assist recovery are life events that are independent of treatment, such as positive work or relationship experiences and the building of personal resources and supportive networks. This model is built on the belief that recovery from addiction is not only possible, but that it is associated with personal growth and development, not the resolution of symptoms.

As the drugs field increasingly examines what constitutes recovery, so some of the pessimistic assumptions about the likelihood of recovery have been challenged. For us, it seems a good time to analyse the assumptions and implications of this change in focus.

In our view, recovery is about empowerment of users and

right conditions that enable these groups to regain power over their lives and progress out of addiction. Recovery is owned by the person in recovery – it is their story and their journey.

The other side of this is that the recovery agenda should be much more egalitarian and should challenge the status of the experts. Professionals should be much more modest and honest about the limited role they can play in the recovery journey, and we should recognise the paucity of the 'science' of recovery.

As a consequence, workers and services must challenge what role they play and where their activities may act as barriers to the recovery process. This will inevitably involve a 'de-professionalisation' of major aspects of client recovery. We are not experts and it is debatable whether we should want there to be experts, certainly not in such a central role.

Long-term addiction recovery is not simply about the relationship between the individual and the treatment programme. It involves access to a range of personal and social opportunities – such as a meaningful job and healthy social ties – that occur independently of the actions of professionals and beyond treatment. Access to these opportunities, and the extent to which they are utilised, can be influenced by a treatment programme – as long as the programme is committed to recovery. But these chances are predominantly a function of the communities and their ongoing support. This is an agenda about, and for, communities.

The long-term aim of this recovery agenda is to address stigma and the social exclusion of users. If part of the recovery process involves increased commitment to the local community, then it also involves challenging drug users themselves to tackle stigma and become a visible force for changing perceptions and values of addiction.

And by merging the recovery agenda with its equivalents in the mental health fields, we can move away from the ubiquity of the diagnosis and the prescribing pad. We should recognise that an individual's recovery journey is about developing community pride and a key aspect of community growth.

This should not diminish the importance of medical treatment in many recovery journeys, but it recognises that this is not sufficient in isolation. The medical model will not be adequate to deal with the problems that will need to be addressed in the later stages of recovery journeys. This is a challenge for the science of recovery as well as for the practice of drug treatment.

All of the above may sound like a fanciful exercise in wish fulfilment, but the fact the recovery agenda is very much part of the English and Scottish drugs strategies, means that recovery should be the expectation of services users and carers. Treatment programmes must embrace this concept. Whether this involves those whose addiction is maintained on opiate substitutes or those on the road to abstinence, the client is entitled to expect more than a bucket and straw, and a chat with a harassed drug worker.

THE REAL RECOVERY JOURNEY IS ABOUT PERSONAL GROWTH EMBEDDED IN FAMILIES AND COMMUNITIES

This has implications for commissioners and the cutting of the pie. Assuming that we will not have lots of extra money, there needs to be a new model for service provision that cannot end when a client comes, blinking in the sunshine, out of detoxification or rehabilitation. Drug and alcohol commissioners must learn from the mental health recovery networks how to engage in real community care and support. They need to work towards building communities of recovery, where the champions and advocates are part of the community and part of local recovery. This is not treatment as we know it: that model should only be applied to the symptom management at the start of the journey and for those who slip on the way.

The real recovery journey is about personal growth embedded in families and communities, something that our dominant treatment models are far too peripheral and parochial to deal with. It also has implications for policy: this is nothing to do with the National Treatment Agency (the clue is in the name) or the Royal College of Psychiatrists – this is a de-medicalising, de-professionalising and de-stigmatising that has to be locally owned and embedded.

This is intrinsically political in two senses. The first is that the dichotomy of patient and professional is not only the wrong language for recovery, but the wrong relationship. In recovery there is no expert who parachutes in with answers. Instead the roles, such as coaches, advocates and activists, are inter-changeable. This has implications for what we need to do as addiction specialists: to learn new skills and roles, strengthen the leadership positions of service users and families and engage them as individual stakeholders and also as community representatives. This agenda is not about de-professionalisation per se, but about the recognition that our way of working must become more community-focused and, crucially, community-owned.

The second political agenda is to challenge the stigmatising of recovering drug users by shifting the emphasis to one where recovery is embedded in notions of citizenship, social capital, and community growth. This will move towards giving recovering users a viable place in the growth of their own communities.

Our field is at a crossroads. The recovery agenda is a real opportunity for creating real hope and belief within communities and families and in users and workers. Also with the policy makers and governments who had lost faith in our increasingly unconvincing pronouncements of positive outcomes and widespread engagement.

Nobody will be beyond long-term recovery. The price we pay is to recognise where we have failed, particularly with our focus on symptoms and causes, our limited professional successes and our myopic science of addictions. We must accept that if we are to have a field that is based on recovery, our role as professionals must shrink significantly in favour of users, families and community-building which is free of professional traps, labels and stigmas.

So what would that mean in practice? First we need to recognise that our field is too small and too insular. We need to recruit those who have recovered as active community advocates, who can train professionals and challenge their assumptions and take the message to the local communities. Linked to this, all workers must be those who make treatment more community-based and who recognise that all treatment is a partnership, whose successes will be judged by the users, their families, and the recovery communities.

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