From maintenance to recovery: Exploring the reorientation towards recovery in British drug policy during a time of reform and economic austerity

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Abstract

Over the past decade, a significant shift has taken place in British drug policy. The publication of the 2010 drug strategy shifted the primary focus of treatment away from attracting and retaining drug users in services, towards encouraging individuals to complete and exit treatment in ‘recovery’. The introduction of the recovery agenda emerged alongside widespread reform to the public health system and during a period of sustained economic downturn that has witnessed the introduction of pervasive austerity measures by successive UK governments. With the reorientation towards recovery in this climate, important questions have been raised over the shape of drug treatment provision on the ground. However, despite much speculation, there remains a lack of empirical research in this area.

This thesis presents a qualitative, exploratory study of the impact of the shift to recovery in two local authorities in the north of England. Through a total of 36 semi-structured interviews with drug treatment commissioners, staff and service users, this research provides an original contribution to the field by demonstrating the impact of the shift to recovery on local level policy and practice during a time of reform and economic austerity. It is argued that cuts to funding and changes to the commissioning of drug treatment services have created a highly competitive treatment system in which the success of providers is measured primarily through their ability to record successful completions of drug treatment. This has generated perverse incentives within the sector, giving rise to risky practices performed by treatment providers in the aim of demonstrating success. It is argued that these developments are best understood as the manifestation of neoliberal notions of competition, risk, choice and responsibility at the level of practice. This thesis concludes by offering important policy and practice recommendations.
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Chapter 1 | Introduction

1.1 Research overview

It is sometimes difficult to convey fully to those outside the field the enormity of the transformation that appears to have taken place in British drug policy in recent times. (Seddon et al., 2008:818)

The above statement, made in reference to the ‘criminal justice turn’ in British drug policy (see Duke, 2006; Seddon, 2006; Seddon et al., 2008), could quite as easily be used to express sentiments about the most recent shift in policy. In 2010, the Conservative-led coalition government published their drug strategy, titled: Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life (HM Government, 2010). The 2010 strategy was put forward as a ‘fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence’ (HM Government, 2010: 3). With the publication of the strategy, the primary focus of drug treatment shifted away from ‘reducing the harms caused by drug misuse’, towards offering ‘support for people to choose recovery as an achievable way out of dependency’ (HM Government, 2010:2–3, emphasis added).

The reorientation towards recovery occurred during a time of economic downturn, characterised by pervasive austerity measures implemented by successive UK governments. In addition, the past five years has witnessed widespread changes occurring throughout the public health system, most significant of which has been the Health and Social Care Act 2012 (HM Government, 2012), which fundamentally changed the commissioning and management of health care in England (Speed and Gabe, 2013).
With the shift to recovery against this backdrop, a number of drug policy commentators have speculated about the impact on drug service provision on the ground (e.g. Roberts, 2009, 2011; Stevens, 2011a; DrugScope, 2012, 2013; UKDPC, 2012b; Watson, 2012; Duke, 2013; McKeganey, 2014). However, despite this postulating, there remains a scarcity of empirical research examining the impact of the reorientation towards recovery in the current climate. Further, whilst the limited existing research has offered valuable insights (e.g. Roy and Buffin, 2011; UKDPC, 2012b; Measham et al., 2013; Neale et al., 2013; DrugScope, 2014, 2015b; Bjerge et al., 2015; Adfam, 2016; Roy and Buchanan, 2016), important questions remain. This thesis seeks to fill this void.

This research is a qualitative study exploring the impact of the reorientation towards recovery on drug service provision. Through semi-structured interviews (N=36) with drug service commissioners, staff and service users, and one national policy stakeholder¹, this research offers in-depth, empirical insights into the reorientation in policy as it is experienced by those at the level of practice. The argument developed through this thesis is that the shift to recovery during a time of economic austerity and widespread reform has generated a number of significant risks for treatment providers, service staff and service users. These risks are produced through an interplay of contributing factors, including: the extent and impact of cuts to services that support drug users; changes to the commissioning and tendering of services; a shift from process-driven to outcome-based targets; and an increased employment of recovering drug users within services. It is argued that the findings presented through this thesis can be understood through a consideration of neoliberal notions of

¹ See Chapter 3, section 3.4.
competition, risk, choice and responsibility. These concepts are explored in section 1.3.

This chapter functions to introduce the research, and is structured as follows. To begin, contextual information concerning the shift to recovery and the climate in which it has emerged is provided, before outlining the aims of the research. Following this, the political-economic system of ‘neoliberalism’ is examined, which is used to interpret the findings and construct the key arguments presented throughout this thesis. The chapter ends by providing an overview of the remaining chapters that make up this thesis.

1.1.1 From maintenance to recovery in British drug policy

As McKeganey (2014:957) has argued, in 2010, ‘a major paradigm shift occurred in UK drug policy’. The publication of the 2010 strategy signalled the formal shift in the primary focus of drug treatment away from attempting to attract and retain drug users in treatment for health improvement and crime reduction benefits (see Duke, 2006, 2013, Seddon et al., 2008, 2012, Seddon, 2010a, 2011; MacGregor et al., 2012), towards encouraging individuals to complete treatment and exit services. Whilst acknowledging the value of previous harm reduction policies and the progress made in terms of improving access, retention and stabilising drug use, the 2010 drug strategy placed greater emphasis on encouraging drug users to exit treatment in ‘recovery’, thus undergoing a ‘permanent change’ (HM Government, 2010:18).

The notion of recovery is highly contested. As will be examined in the following chapter, there is a lack of consensus within the field about what ‘recovery’ is and how it can be achieved (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007;
White, 2007; UKDPC, 2008). This lack of consensus is also reflected within government policy documents, which fail to provide an accurate definition, instead suggesting that it is ‘an individual, person-centred journey … that will mean different things to different people’ (HM Government, 2010:18).

Notwithstanding the lack of an agreed definition, the strategy contends that recovery is to be accomplished by supporting drug users to draw on their ‘recovery capital’ in order to improve their chances of achieving and sustaining recovery; by reorienting services to become more outcome-focused, and rewarding local authorities and providers for achieving outcomes; and by employing recovering drug users within local areas to motivate and inspire others to take steps towards recovery (HM Government, 2010:18–21; see Chapter 2).

1.1.2 Public health reforms and economic austerity

The reorientation towards recovery has occurred alongside widespread reform throughout the whole of public health. The government’s overall aims for the future of public health were first presented in the 2010 white paper Healthy lives, healthy people and later formalised in the Health and Social Care Act 2012 (Department of Health, 2010; HM Government, 2012; Royal College of Nursing, 2013). The 2012 Act is considered to be the most wide-ranging piece of legislation relating to public health since the establishment of the NHS, fundamentally changing the commissioning and management of healthcare in England (UKDPC, 2012b; Speed and Gabe, 2013).

The Department of Health explain that reforming the public health system was essential for three main reasons, specifically: rising demand and treatment costs; a
need for improvement; and the state of the public finances (Department of Health, 2012e). The Department of Health argue that there was a major requirement for improving health and wellbeing in England in areas such as mental illness, disability, and harm from alcohol, drugs and tobacco smoking (Department of Health, 2012b, 2012d, 2012e). However, the Department of Health claimed that the NHS was facing one of the tightest funding challenges to date, with large sums of money that could be better spent on patient care instead consumed by layers of unnecessary bureaucracy. As such, change was needed in order to achieve better value for money for NHS expenditure (Department of Health, 2012d).

To address these challenges, after almost 40 years, the 2012 Act returned a leading public health role to local government (Department of Health, 2012f, 2013; Phillips and Green, 2015). The shift to local commissioning through the Act aims to eliminate political interference and micromanagement when making decisions on patients’ care, and to place financial power in the hands of those considered best-placed to identify the needs of their populations (Department of Health, 2012a; Pownall, 2013:425; NHS England, 2014). The government maintain that, by removing unnecessary layers of bureaucracy, these changes will improve efficiency and effectiveness of health services, thus providing a higher level of care for patients (Department of Health, 2012a, 2012b, 2012d; Speed and Gabe, 2013).

The 2012 Act established a number of new national and local structures to support the commissioning and delivery of healthcare services. Importantly, Directors of Public Health were introduced into each local authority, who are ultimately responsible for the delivery of their authority’s duties (Department of Health, 2013). As part of their
role, Directors of Public Health are responsible for the commissioning and oversight of combined drug and alcohol services, and are expected to jointly commission these services with wider public services in the aim of delivering end-to-end support (HM Government, 2010; Public Health England, 2014).

The 2012 Act also called for Health and Wellbeing Boards (HWBs) to be established in each upper tier local authority in England, tasked with providing the strategic direction for improving health and wellbeing in the local area (DrugScope, 2013). HWBs are required to assess the current and near-future health and social care needs of their local areas through the production of Joint Strategic Needs Assessments (JSNAs). The needs identified through the JSNAs are to be met through the development of Joint Health and Wellbeing Strategies (JHWSs), which are documents outlining the integrated service approach to be taken by the local authority in order to meet these needs (DrugScope, 2013:2; Local Government Association, 2014; Alcohol Concern, 2015).

The introduction of clinically-led commissioning and the establishment of GP-led Clinical Commissioning Groups (CCGs) was a further development of the 2012 Act. Prior to the implementation of the 2012 Act, the planning and purchasing of health services for local authorities in England was the duty of regional Strategic Health Authorities (SHAs) and the 152 Primary Care Trusts (PCTs) (NHS England, 2014). The 2012 Act replaced the PCTs with 211 clinician-led, statutory CCGs, each serving a population size ranging from 61,000 to 860,000, thereby devolving responsibility to a narrower concentration of power (Department of Health, 2012a; Speed and Gabe, 2013:567; Local Government Association, 2014; NHS England, 2014). Whilst not
directly responsible for the drug and alcohol budget, CCGs now control the majority of the wider public health budget and are responsible for the purchasing of services to meet the needs of their local populations, many of which crossover with substance misuse services (Department of Health, 2012a; UKDPC, 2012b; NHS England, 2014).

As will be examined in greater depth in the following chapter, the most important development for drug treatment services was the introduction of Public Health England (PHE). PHE was established in 2013 as an operationally autonomous, executive agency of the Department of Health, tasked with protecting and improving the nation’s health and wellbeing (Department of Health, 2012b, 2012c). PHE was introduced to streamline the disjointed system of public health that existed prior to April 2013 by bringing together functions carried out by the NHS, Department of Health and various arm’s-length bodies, including the National Treatment Agency for Substance Misuse² (NTA) (Department of Health, 2012c; Royal College of Nursing, 2013). With the disbanding of the NTA in 2013, its key functions and pooled treatment budget (PTB) were absorbed into the wider budget for spending on public health (Roberts, 2011; UKDPC, 2012b; DrugScope, 2013, see Chapter 2).

The recovery agenda and the above reforms to the public health system were introduced during a period of sustained economic downturn; one that witnessed the implementation of a vast array of austerity measures by the coalition government. Indeed, since the election of the coalition government, austerity has become the

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² The NTA was established by New Labour in 2001 during the ‘criminal justice turn’ (Duke, 2006; Seddon, 2006; Seddon et al., 2012). The creation of the NTA sought to improve the access to and quality of treatment with the primary aim of reducing drug-related crime (Seddon et al., 2012:63–64). The NTA’s focus on reducing crime was highly influential in securing necessary funding for drug treatment (see Seddon et al., 2012:64), which was met with significant success (see NTA, 2010b).
‘justifying mantra’ for instigating cuts to budgets that have significantly reduced and adversely affected numerous public sector services, including criminal justice, health, welfare and social care (Levitas, 2012:322; Lowndes and Pratchett, 2012; Measham et al., 2013:6).

The scale of these austerity measures has been unprecedented. In their ‘emergency budget’ in June 2010, the coalition government proposed to cut spending on public services by £30bn over a four-year period, with the subsequent Spending Review increasing this figure to £81bn by 2015 (Lowndes and Pratchett, 2012:23). Local government budgets were worst affected, with 27 per cent cuts to the central support that finances the majority of local services (Lowndes and Pratchett, 2012:23; Taylor-Gooby, 2012:64). Further, the impact of austerity does not fall evenly, with the most disadvantaged groups in society being worst affected (Dolphin, 2009; Athwal et al., 2011; Taylor-Gooby and Stoker, 2011; Lowndes and Pratchett, 2012; Taylor-Gooby, 2012).

The aforementioned public health reforms and the climate of austerity in which they have been introduced has given rise to significant concern for the future provision of drug services, and for the individuals who access this support. The following section offers a brief overview of some of these concerns, before examining them in greater depth in the following chapter.

1.1.3 Delivering recovery at a time of reform and austerity

Against this backdrop of austerity and wide-ranging reform, key concerns have been raised over how the shift to recovery is unfolding at the local level (Roberts, 2009, 2011, DrugScope, 2012, 2013; UKDPC, 2012b; Watson, 2012; Duke, 2013;
Measham et al., 2013). Whilst some argue that the reorientation towards recovery has the potential to ‘transform’ the lives of drug users and bring benefits to individuals, their families and their wider communities (e.g. Best and Gilman, 2010; Best and Laudet, 2010; Best, Bamber, et al., 2010; Best, Rome, et al., 2010; Best, De Alwis, et al., 2017), others have raised significant concerns over the government’s vision of and approach to recovery.

In particular, concerns have been expressed over the extent to which the government have conflated recovery with abstinence within various policy documents (Monaghan and Wincup, 2013; McKeganey, 2014; Roy and Buchanan, 2016) and what this will mean for drug users who do not wish to pursue ‘recovery’ (Ross-Albers, 2013). With continuing cuts to support services, there are concerns over the extent to which drug users will be able to build on their recovery capital to accomplish and maintain recovery (DrugScope, 2012, 2015a; Whiteford et al., 2016; Wincup, 2016; Best, De Alwis, et al., 2017).

Issues are also raised with the shift from process-driven to outcome-based targets, with concerns that drug users are at risk of being pushed for abstinence before they are ready or when it is not in their best interests (Roy and Buffin, 2011; McKeganey, 2014; Roy and Buchanan, 2016; Best, De Alwis, et al., 2017). This issue is amplified where treatment providers receive proportions of their payment based on delivering outcomes (Maynard et al., 2011; Roberts, 2011; UKDPC, 2011; Duke, 2013; Best, De Alwis, et al., 2017). Moreover, with the emphasis on the employment of recovering drug users within the treatment sector, there are concerns over the speed at which
recruitment takes place and the responsibilities that are given to recovering drug users within their roles (White, 2009; Shapiro, 2012; Roy and Buchanan, 2016).

Numerous concerns are also raised over the absorption of the PTB into the wider budget for public health. Faced with reductions to local authority budgets, some have expressed concern that the drug and alcohol sector will experience disinvestment in some local areas as its importance is measured against other public health priorities (UKDPC, 2012b; DrugScope, 2013; Speed and Gabe, 2013). The above concerns are examined in greater depth in the following chapter along with a consideration of the scarce empirical research that has offered insights into these issues. The aims and objectives of this research are outlined below.

1.2 Research aims and objectives

The overarching aim of this research is to examine the impact of the shift towards recovery in British drug policy on local level policy and practice during a time of economic austerity and widespread public health reform. This broad aim can be broken down into the following overarching research questions:

1. How has the reorientation towards recovery in British drug policy influenced local level policy and practice?
2. To what extent have the recent public health reforms impacted on drug treatment services at the local level?
3. How have drug treatment services been affected by pervasive government austerity measures?

Alongside these questions, this thesis aims to contribute to understandings about the ideological mantra of neoliberalism and the existence of neoliberal notions of competition, risk, choice and responsibility within drug treatment services on the
ground. The following section examines the concept of neoliberalism and the way in which it is understood for the purposes of this research.

1.3 Neoliberalism

There is now an extensive body of literature examining the developments in political and economic systems that have unfolded across the world since the 1970s. These developments have been most commonly described as the emergence of neoliberalism (Harvey, 2005; Davies, 2014a, 2014b, 2016). Whilst there is a debate to be had around whether the term ‘neoliberalism’ is most accurate for conceptualising these changes (Monbiot, 2016), ‘few doubt that [it] has become an important part of our world’ (Levi-Faur, 2005:13). Indeed, as one of the most oft-cited commentators on this shift, David Harvey (2005:2–3), notes, ‘There has everywhere been an emphatic turn towards neoliberalism in political-economic practices and thinking since the 1970s’.

Until the 1990s, however, the term ‘neoliberalism’ was relatively unheard of, with little in the way of scholarly projects exploring its existence or historical development (Davies, 2014a:309). However, since this time, ‘neoliberalism’ is a label that has been almost indiscriminately used as a pejorative slogan to describe a variety of anti-democratic or pro-corporate powers (Davies, 2014a:310). This ubiquitous use has led some to argue that it is no longer conceptually and analytically valuable (Venugopal, 2015). To avoid falling into this trap, this section serves to outline only what are believed to be the most significant characteristics of this shift in liberal governance.

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3 Some commentators believe that these characteristics are best encapsulated in the term ‘regulatory capitalism’ (Levi-Faur, 2005; Braithwaite, 2008), as they would argue we are witnessing a change in regulatory practices as opposed to deregulation, as neoliberalism would have it. For Levi-Faur (2005:14), deregulation is an aspect of neoliberalism only in the ideological sense; at the practical level, neoliberalism is in fact conducive to increased regulation. Other terms used include ‘late modernity’ (Garland, 2001) and ‘advanced liberalism’ (Rose, 1999).
Key notions of competition, risk, choice and responsibility are specifically focused on, as these concepts are most significant for helping to make sense of the developments in drug policy and practice that are explored through this thesis. Prior to examining these concepts in greater depth, though, the section begins by offering a brief overview of the historical development of neoliberal governance.

1.3.1 The historical development of neoliberalism

Whilst the aim here is not to offer an all-encompassing genealogical account of neoliberalism\(^4\), it is important to preface the following discussion of neoliberalism with a brief insight into its development. Most accounts of neoliberalism’s genealogy (e.g. Davies, 2014a) begin in the years prior to the Great Depression of the 1930s and the writings of the early neoliberal pioneers of Ludwig von Mises and Freidrich von Hayek. As Davies (2014a:311) contends, the 1870s witnessed a decline of economic liberalism, which was characterised most famously by the Victorian laissez-faire economic system. This decline was accompanied by an increase in corporations, trade unions, regulation, and state socialism. However, with the Great Depression of the 1930s, and the birth of the ‘socialist calculation debate’, Mises and Hayek set about ‘re-imagining’ economic liberalism in ways that either accommodated these new developments or could effectively rebuff them.

In the years following the Second World War, Hayek established the Mont Perelin Society, which served as a think tank and network for liberal scholars across the globe (Davies, 2014a:311). Amongst others, the Society included both Hayek and Mises along with Milton Friedman (Harvey, 2005; Senker, 2015). As Harvey (2005:20) writes, the Society’s members labelled themselves as ‘liberals’ due to their

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\(^4\) Extensive accounts of neoliberalism’s historical development can be found elsewhere (e.g. Harvey, 2005; Foucault, 2008; Read, 2009; Davies, 2014a, 2016; Senker, 2015).
commitment to the ideals of personal freedom and their adherence to the free market principles of neoclassical economics, which sought to displace the early classical theories of the likes of Adam Smith. However, Harvey (2005:20) continues, the Society still ascribed to Smith’s championing of the ‘invisible hand’ of the market. In this way, early neoliberal principle was opposed to state interventionist theories such as Keynesianism, which was prominent in the years following the Great Depression (Harvey, 2005:20–21).

In the second half of the 20th century, the Mont Perelin Society gathered increasing political and financial support, most significantly in the US from a ‘powerful group of wealthy individuals and corporate leaders who were viscerally opposed to all forms of state intervention and regulation’ (Harvey, 2005:21–22). Despite this accumulation of support, however, it was not until the ‘troubled years’ of the 1970s when neoliberal thinking moved from the margins to centre-stage (Harvey, 2005:22). In the UK, neoliberal thinking was most evident under the rule of Margaret Thatcher, who was elected in 1979 with a strong mandate to reform the economy. It was at this point that neoliberalism became the ‘new economic orthodoxy’ (Harvey, 2005:22).

Whilst there is more to be said about the development of neoliberalism, in both a conceptual sense and its establishment in the advanced capitalist world, the following section examines the key tenets of neoliberalism in greater depth and demonstrates its impact in post-1970s Britain.
1.3.2 Unpacking ‘neoliberalism’: competition, risk, choice and responsibility

Broadly speaking, neoliberalism refers to a political-economic state characterised by practices of deregulation, privatisation and the promotion of free market economies (Harvey, 2005; Levi-Faur, 2005). To quote Harvey’s *A Brief History of Neoliberalism*, neoliberalism can be defined as:

…a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. (Harvey, 2005:2)

Some believe that this form of governance represents a revival of nineteenth-century laissez-faire capitalism and the separation of state and business; however, as alluded to above, this would be somewhat of an oversight (Harvey, 2005; Levi-Faur, 2005; Davies, 2014a). As Davies (2014a:310) pithily notes, ‘Neoliberalism is not a conservative or nostalgic project’. Indeed, whilst neoliberalism, like nineteenth-century liberal capitalism, views economic activity as fundamental in the function of a capitalist economy, nineteenth-century liberal capitalism focused on exchange within the economy whereas neoliberalism takes competition as its primary focus (Harvey, 2005; Foucault, 2008; Read, 2009; Davies, 2014a, 2014b). It is to the notion of competition that this section now turns.

**Competition**

As noted above, what is significant about neoliberalism is its emphasis on the importance of competition within the market. Whilst exchange was considered to occur naturally in free markets, competition is not. Thus, it is not enough for the state to simply withdraw all involvement from markets. Rather, for competition to exist within the economy, the state must engage in constant nurturing and fostering of markets (Harvey, 2005; Foucault, 2008; Read, 2009; Davies, 2014a, 2014b). As
highlighted by Rose (1999:141), the current form of governance is not characterised by the ““freeing” … of market relations from their social shackles, but of organizing all features of one’s national policy to enable a market to exist, and to provide what it needs to function’. As such, whilst taking inspiration from Victorian liberalism, neoliberalism aims to establish a new social and political model (Davies, 2014a:310).

The emphasis on fostering competition has been witnessed in numerous public sectors over the past four decades: from the early privatization of core public utilities such as British Gas, British Aerospace and British Telecom in the 1980s (Rhodes et al., 2014), to the more recent marketization of probation and criminal justice services (Maguire, 2012; Teague, 2014; Broad and Spencer, 2015); further and higher education (Newman and Jahdi, 2009; Molesworth et al., 2011; Brown and Carasso, 2013; Lynch, 2015); employment services (Carter and Whitworth, 2015); and the public health sector (Zolkiewski, 2004; Pollock and Price, 2011; Pownall, 2013; Speed and Gabe, 2013; Krachler and Greer, 2015). Marketization diverts responsibility for service provision away from the state by establishing markets for services, which are then tendered to a wide range of private and third sector providers in the ultimate aim of increasing competition (Clarke, 2004; Bach, 2016).

With regard to the public health reforms outlined above, whilst the government maintain that the shift to local commissioning through the Act will eliminate political interference and micromanagement when making decisions on patients’ care, critics have argued that the reforms represent a direct effort to introduce a neoliberal model of healthcare through the restriction of NHS funding and the expansion of marketization throughout the public health system (Pownall, 2013:424; Speed and Gabe, 2013; Krachler and Greer, 2015). Most significantly, with the establishment of
CCGs, the government have introduced mechanisms that allow for the commissioning of ‘any qualified provider’ (AQP). This has established a market structure within the NHS that encourages private and third sector providers to compete with NHS departments to become the dominant providers of public health services, thus freeing the state from its statutory obligations for the provision of services (Bach, 2012; Pownall, 2013; Speed and Gabe, 2013).

Alongside the above developments, a plethora of market values and mechanisms have been established within public sector services. This array of techniques are most often encapsulated by the term ‘new managerialism’⁵ (Clarke and Newman, 1997; Deem, 1998; Bach, 2016; Lynch, 2017). New managerialism is the dominant mode of governance aligned with neoliberalism (Lynch, 2015:193), and is based on the notion that, by subjecting public services to market forces and running them as businesses, competition will increase, thus resulting in improved standards, increased efficiency and decreased costs (Harlow, 2003; Diefenbach, 2009; Molesworth et al., 2011; Ward, 2011; Harlow et al., 2012; Rhodes et al., 2014; Lynch, 2017).

To this end, new managerialism is characterised by an increase in target setting and the monitoring of employee performance; an emphasis on outputs over inputs; the introduction and monitoring of league tables; and the establishment of punishment and rewards (Connell et al., 2009; Ward, 2011; Siltala, 2013:469; Juhila et al., 2017; Lynch, 2017:159–160; Räsänen and Saario, 2017). Notably, through the above techniques, the introduction of new managerialism has transformed the role of the

⁵ New managerialism is often used interchangeably with ‘new public management’ (NPM). Whilst there are some noteworthy differences (see Deem and Brehony, 2005), there is significant crossover between these terms. For ease of simplicity, ‘new managerialism’ is adopted within this thesis.
public sector workforce, with workers now responsible for producing measurable outcomes, and held accountable when such outcomes are not delivered (Banks, 2004; Connell et al., 2009; Le Bianic, 2011; Ward, 2011; Juhila et al., 2017; Räsänen and Saario, 2017). As Connell et al. (2009:334, emphasis in original) argue, ‘Both organisations and individuals are required to make themselves accountable in terms of competition’. Individual employees are expected to compete against their colleagues by adopting entrepreneurial attitudes in the aim of maximising profit for their organisation (Deem, 1998; Connell et al., 2009).

In line with its aim, there is evidence that features of new managerialism, such as competitive tendering, target setting and performance management, can lead to increased efficiency, greater quality and reduced costs (Smyth, 1997; Boyne, 1998; Deem, 1998; Krachler and Greer, 2015). Whilst it is beyond the scope of this chapter to provide an exhaustive examination of the impact of such practices within public sector services, it is worthwhile offering some examples here. One such example can be found within the NHS. In 2000, driven by a concern that too many patients were experiencing significant delays within accident and emergency departments (A&E), the Department of Health published its ‘NHS Plan’. This set a target for A&E departments to respond to, and subsequently admit or discharge, patients within a four-hour timeframe (Department of Health, 2000, 2001). After introducing this target, the percentage of patients waiting over four hours dropped from 23 per cent in 2002 to just 5.3 per cent in 2004 (Bevan and Hood, 2006a:420), thus demonstrating the efficiency gains that can be generated through the setting of measurable targets.
However, the introduction of outcome-based, quantifiable targets has also given rise to concerns of gaming by the public sector workforce, and has been found to have generated perverse incentives within numerous sectors (see, for example, Bevan and Hood, 2006b; Hood, 2006; Fox and Albertson, 2012; Eastwood et al., 2013; Rees et al., 2014; Ordóñez and Welsh, 2015; Egdell et al., 2016). For example, in relation to the four-hour A&E target cited above, whilst fewer patients were experiencing wait times of over four hours within A&E departments, evidence was found of patients being left in ambulances queued up outside A&E until staff were confident that they could be seen within the four-hour timeframe (Bevan and Hood, 2006a; Hood, 2006). Bevan and Hood (2006a:421) have described this as ‘hitting the target and missing the point’. In many ways, parallels can be drawn between this and Braithwaite’s (Braithwaite et al., 2007; Braithwaite, 2008) notion of ‘regulatory ritualism’, as will be discussed further in Chapter 5.

Significantly, issues of ‘gaming’ have also been identified within the various welfare-to-work programmes that have been introduced both in the UK and internationally (Struyven and Steurs, 2005; Finn, 2009, 2011; Carter and Whitworth, 2015). As many contend (e.g. Finn, 2011; Damm, 2012; Newton et al., 2012; Rees et al., 2014; Carter and Whitworth, 2015; Egdell et al., 2016), welfare-to-work programmes in the UK have experienced endemic issues of ‘creaming’ (cherry-picking) and ‘parking’ (neglecting) certain clients based on their suitability for work in order to meet certain targets. These issues are returned to at various points throughout this thesis.

Evidently, then, whilst the introduction of business-like mechanisms into public sector services can increase efficiency, caution must be exercised when considering
the means by which these targets are achieved, or if they are achieved at all. As mentioned above – and as examined in greater depth in the following chapter – alongside the shift to recovery in British drug policy, there has been a clear shift from process-driven to outcome-focused targets, the most significant of which being the number of drug users completing and exiting drug treatment services (HM Government, 2010; Home Office, 2012; Duke, 2013; Bjerge et al., 2015; Public Health England, 2016b). One of the key questions that this raises in light of the above evidence is whether outcome-focused target setting within drug treatment services is likely to give rise to practices of gaming or generate perverse incentives that have been found in other public sectors (see also Chapter 2).

The following section considers the remaining central features of neoliberal governance outlined within this chapter: the increasing emphasis placed on notions of ‘risk’, ‘choice’ and ‘responsibility’ in neoliberal societies.

**Risk, choice and responsibility**

For Giddens (2003:21), the concept of ‘risk’ ‘unlocks some of the most basic characteristics of the world in which we now live’. The word ‘risk’ has an interesting etymology. Believed to have emerged in the sixteenth and seventeenth centuries, it was first used to refer to the uncertainty sailors faced when embarking on voyages over unchartered waters (Garland, 2003). Following the development of the science of probability and statistics during the eighteenth and nineteenth centuries, statistical calculations of risk began to emerge (Lupton, 1999). Interestingly, throughout this early use, risk was only ever believed to be a natural phenomenon, ‘located exclusively in nature’ (Lupton, 1999:6); it was not until the nineteenth century that
the notion of risk began to be attached to humans and their behaviours (Lupton, 1999). Since the late nineteenth century, popular use of the term ‘risk’ has become somewhat synonymous with ‘danger’ and, as a concept, has become ‘inseparable from the ideas of probability and uncertainty’ (Douglas, 1994; Lupton, 1999; Giddens, 2003:22).

The ‘rise in risk’ (Garland, 2003:48) has also been accompanied by increases in insurance and management of risk (Garland, 2003; Giddens, 2003). As both Giddens (2003) and Garland (2003:61–2) note, the welfare state is, in essence, a risk management system:

> It insures its citizens, indemnifies them against losses, regulates economic risks and environmental dangers, protects individuals from social harm and economic disaster … Most of its specialist agencies – in social work, criminal justice, mental health, environmental health – have as their primacy function the management and reduction of particular kinds of risk. (Garland, 2003:61)

As Garland (2003:62) proposes, with the emergence of neoliberalism, governments have made efforts to withdraw from the model of the risk-managing welfare state as it promotes a ‘culture of dependency’ and ‘the erosion of individual responsibility’. As a result, with the shift in liberal governance, there has been a ‘privatisation of risk management’ (Miller and Rose, 2008:215); responsibility for risk management, insurance and blame has been devolved from the state onto individuals, families and communities (Rose, 1999; Garland, 2003; O’Malley, 2004). This process is referred to as ‘responsibilisation’. O’Malley (2009:276) offers a useful definition:

> ‘Responsibilization’ is a term developed in the governmentality literature to refer to the process whereby subjects are rendered individually responsible for a task which previously would have been the duty of another – usually a state agency – or would not have been recognized as a responsibility at all.

Tied into this concept of responsibilisation are notions of ‘choice’ and ‘blame’ (Rose, 1999; O’Malley, 2004). Individuals are viewed as choice-makers and are expected to
make decisions that maximise their health and wellbeing (Juhila et al., 2017). This process of ‘responsible... multiple public spheres – from crime control to health preservation (Rose, 1996, 1999; O’Malley, 2004; Crawshaw, 2014; Teague, 2014).

Within healthcare, for example, government campaigns aim to educate citizens in ways to reduce risks of ‘avoidable’ health complications: eating the right food and exercising for certain periods of time each day are classic examples of this (O’Malley, 2004). Inextricably bound up with such campaigns are sentiments of blame for those who seemingly choose to ignore these warnings: the overweight are held responsible for any health complications they encounter, from heart disease and stroke to diabetes (Rose, 1999; O’Malley, 2004:73). The same is true for criminal justice: individuals who offend are viewed as rational actors who have acted out of choice and are thus personally culpable for ‘choosing’ to offend (Feeley and Simon, 1992; Gray, 2005; Teague, 2014). However, this responsibilisation denies by implication the wider social and economic inequalities that often restrict the range of options or choices available to individuals (Feeley and Simon, 1992; Teague, 2014; Juhila et al., 2017).

Whilst discussion of the relationship between neoliberalism and drug policy is mostly reserved for the following chapter, it is worth noting here that Seddon and colleagues (Seddon, 2010a, 2011; Seddon et al., 2012) have demonstrated how the above notions of risk, choice and responsibility have also become increasingly evident in British drug policy over recent decades. Seddon (2011:416) contends that, by situating drug policy alongside the emergence of neoliberalism, it is possible to identify strong ‘family resemblances’ between seemingly distinct phases of policy, which are
‘suggestive of a strategic coherence that stretches back perhaps as far as the mid-1960s’ in line with reducing the risks posed by problem drug users.

Put briefly, since the mid-1960s, the drug problem has been framed as presenting a diverse range of risks: in the 1960s, the drug problem was viewed as a ‘socially infectious condition’ (Interdepartmental Committee on Drug Addiction, 1965: 8); in the 1980s, the problem was recast as a health risk in the form of HIV and other blood-borne viruses; and, in the 1990s, the primary concern was of criminal victimisation (Seddon et al., 2008, 2012, Seddon, 2010a, 2011:417). Throughout these policy phases, there exists the same problematisation of drug users: as presenting a range of threats to society; the same conception of drug users: as rational choice-makers who, presented with the right options, can make prudential decisions about their drug consumption; and the same strategic response: cajoling drug users to make the ‘responsible’ or ‘correct’ decisions (Seddon et al., 2012:34–5).

1.3.3 The good, the bad and the ugly

As argued, the neoliberal state subjects public services to market forces in an attempt to increase competition, generating greater efficiency at a lower cost to the state. Neoliberals would argue that practices of deregulation, privatisation and the promotion of free market economies result in diminishing financial requirements of the state, lowering taxation and increasing economic growth, which will trickle down from the wealthy to the poor, thus resulting in greater prosperity for all (Harvey, 2005; Spolander et al., 2014).

However, in line with the arguments made above, the neoliberal state can often do more harm than good. The past three decades have instead witnessed widening
inequality, as deregulation and privatisation have led to sharp reductions in workers’ wages while simultaneously decreasing their bargaining power within the labour market (Kotz, 2009; Davies, 2014b). Neoliberalism has also been viewed by many as the cause of, or at least a significant contributing factor to, the 2008 global financial crisis and the subsequent implementation of a raft of austerity measures by successive UK governments (Kotz, 2009; Whitfield, 2012; Davies, 2014b; De Vogli and Owusu, 2015; Bach, 2016). In line with the arguments made above, Bach (2016:13) notes that the Conservative-led coalition government of 2010-15 used the global financial crisis to ‘establish a pro-austerity frame’ that has been used to justify pervasive cuts to the public sector with the aim of enhancing privatisation and further limiting the role of government.

Davies (2014a:316, 2016) has argued that, since the global financial crisis in 2008, some have begun to question the nature and existence of neoliberalism, suggesting that we have witnessed its demise or that it now exists in a ‘zombie-like state’. For Davies (2016:123–4), however, whilst the neoliberal state that we are witnessing today is fundamentally dissimilar from the neoliberalism of the 1970s and ’80s, neoliberalism is still very much alive. Instead, Davies (2016:124–32) argues that we have observed the emergence of a new phase of neoliberalism, which is centred on an ethos of heavily moralised punishment. Davies adopts the term ‘punitive neoliberalism’ and states the following:

Under punitive neoliberalism, economic dependency and moral failure become entangled in the form of debt, producing a melancholic condition in which governments and societies unleash hatred and violence upon members of their own populations. When debt is combined with political weakness, it becomes a condition for further punishment. (Davies, 2016:130)
Others have also witnessed the increasingly punitive nature of neoliberal governance over recent years in line with reducing public sector spend (see, for example, Wacquant, 2009; Bell, 2011; Teague, 2014). Examples of this ‘punitive turn’ can be found in the proliferation of benefit sanctions (Taylor-Gooby and Stoker, 2011; Roberts and Bell, 2013; Rees et al., 2014; Davies, 2016) – most pertinently directed at drug users (Wincup, 2011, 2014; Duke, 2013; Monaghan and Wincup, 2013; Monaghan and Yeomans, 2016), growing prison populations despite stable or declining crime rates (Teague, 2014), and emerging ‘behavioural activation techniques’ within labour-market policies (Davies, 2016:123). As will be explored at numerous points throughout this thesis, the punitive flavour of neoliberalism offers a useful means through which to interpret the shift to recovery in drug policy and its impact on local level policy and practice. The following section outlines the structure and direction of this thesis.

1.4 Outline of the thesis

Through a review of literature from diverse fields, Chapter 2 provides a critical account of the reorientation towards recovery in British drug policy at a time of economic austerity and widespread reform. The chapter begins with an account of the emergence of recovery, demonstrating that the change in policy can be understood as the outcome of the convergence of a complex range of contingent factors. The chapter then turns attention to the key themes of the recovery agenda, including: a critical account of the way in which ‘recovery’ is defined, justified and supported within the 2010 drug strategy and subsequent policy documents; the emphasis on recovery capital and peer support within the treatment system; and the shift from process-driven to outcome-based targets. In examining these key themes, the prevalence of neoliberal ideology within current drug policy is emphasised, which serves to
effectively set up the later analysis chapters. Building on this, the chapter ends with a critical discussion of the climate in which the recovery agenda emerged and the potential implications for local level policy and practice.

**Chapter 3** details the methodological approach adopted for this research. The chapter opens with a restatement of the aims of the research along with a discussion of how the research questions altered during the early phases of the research journey. Following this, consideration is given to the ontological and epistemological stance adopted and how this informed the data collection process. The sampling procedure is then outlined, and overviews of the research sites and participants are provided. The chapter then moves on to discuss the data collection and analysis techniques employed. The chapter ends with an in-depth discussion of the practical and ethical issues encountered throughout the course of the research. Reflexive evaluations of the research experience are interspersed throughout the chapter.

Chapters 4, 5 and 6 present the findings of the research. **Chapter 4** focuses on the changes to local policy in the research sites as a result of the reorientation towards recovery at a time of widespread reform and economic austerity. In doing so, many of the key themes that emerged from this research are explored in this chapter, including: the significance of the reorientation towards recovery on local level policy; the extent and impact of funding cuts to services; the effect of the wide-ranging public health reforms on treatment provision and joint working; and the impact of changes to the commissioning and tendering of treatment services. Through an examination of the above themes, the chapter demonstrates how the present issues arising from the shift to recovery in treatment services can be understood through a consideration of
neoliberal notions of competition, risk and responsibility, as outlined above. The chapter concludes by arguing that treatment providers are operating in a fiercely competitive environment in which demonstrating suitability and success to commissioners is crucial for securing contracts.

Building on the arguments presented in Chapter 4, chapters 5 and 6 examine more closely the ways in which neoliberalism manifests at the level of practice. This is achieved through a focus on two of the most significant themes to emerge from this research. **Chapter 5** provides a critical account of the successful completion of drug treatment target and its impact on day-to-day working practices. It is argued that the highly competitive environment in which treatment providers are operating and the drive to demonstrate success to commissioners through recording successful completions of treatment has given rise to a number of risky practices performed by drug treatment staff. To this end, the chapter offers valuable insights into the effects of competition, target setting and performance management on day-to-day treatment practices.

**Chapter 6** is the final findings chapter. The chapter examines the changing composition of the drug treatment workforce following the shift from maintenance to recovery, focusing on the increase of peer support workers within the research sites. It is argued that, whilst the employment of recovering drug users into treatment services holds benefits for the individuals and their clients, the speed at which peer support workers are recruited and the responsibilities bestowed upon them present a number of significant challenges. The chapter argues that the employment of peer support workers within treatment not only serves as a useful illustration of the effects of
competition, but also highlights the increasing responsibilisation of drug users and the risk that this presents.

Chapter 7 concludes this thesis. The chapter draws together the key findings of the research and details the contributions to knowledge. The arguments presented throughout the three analysis chapters are examined together to provide answers to the research questions and to demonstrate how the shift to recovery is best understood through a consideration of neoliberal governance. In doing so, contributions to theory are also presented. Practical recommendations for policy are then offered before identifying key areas for further research.
Chapter 2 | From maintenance to recovery in British drug policy

2.1 Introduction

This chapter draws together literature from diverse fields to provide a critical account of the shift towards recovery in British drug policy. In 2010, the Conservative-led coalition government of the time published its drug strategy, calling for greater emphasis on drug users achieving ‘full recovery’ from dependency. In doing so, the strategy shifted the primary focus of treatment away from attracting and retaining drug users in services, towards encouraging individuals to complete and exit treatment. This shift in policy can be viewed as the outcome of a complex interplay of contingent factors that converged at a particular point in time, propelling the ill-defined concept of recovery to the heart of drug treatment policy and practice.

This chapter begins by providing a contextual account of the diverse factors that influenced the shift to recovery, focusing on the complex interplay of the political, social and economic issues of the time. Following this, a critical discussion of the key features of the recovery agenda is offered, with specific focus on the main themes contained within the 2010 drug strategy and subsequent policy documents. In doing so, key arguments concerning the shift to recovery in a context of wide-ranging public service reform and economic austerity are considered. Consideration is also given to the existing, albeit scant, empirical research that has examined the impact of the shift to recovery on local level policy and practice. To conclude, gaps in current knowledge are highlighted and key research questions are raised.
2.2 The reorientation toward recovery: converging factors

Since the late 1980s, the drug treatment system in Britain can be characterised as one based primarily on the reduction of harm from problematic drug use. Harm reduction has been defined as ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption’ (Harm Reduction International, n.d.). With deep roots in humanitarianism and libertarianism, the harm reduction approach recognises that the cessation of drug use may not be achievable – or even necessarily desired – by all drug users, and that the minimisation of harm associated with problematic drug use should be the primary treatment response (Newcombe, 1992; Riley and O’Hare, 1999; Measham et al., 2013).

The harm reduction approach in Britain emerged initially in response to widespread concern over the transmission of HIV and other blood-borne viruses (BBVs) by injecting drug users (Stimson, 1990; Mold, 2008; Keene, 2010; Mold and Berridge, 2010; Seddon, 2010a). A significant development occurred in 1988 when the Advisory Council for the Misuse of Drugs (ACMD) asserted in their AIDS and Drug Misuse report that ‘We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse’ (ACMD, 1988:17). In response to the perceived threat of HIV, the ACMD put forward ‘a hierarchy of goals’ for drug treatment, which included the reduction of shared use of injecting equipment; the transitioning from injectable to oral drug use; a reduction in overall drug use (both illicit and prescribed); and, ultimately, abstinence (ACMD, 1988; Newcombe, 1992:1–2; McKeganey, 2011b).

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6 For a detailed account of the discovery of HIV and its impact on drug treatment, see Mold (2008:128–142).
The Conservative government at the time, under the leadership of Margaret Thatcher, accepted the recommendations of the ACMD and authorised the embedding of harm reduction practices within drug treatment (Measham et al., 2013). As McKeganey (2012:277) notes, this very quickly changed the direction of drug treatment:

In the wake of the AIDS and Drugs Misuse Report, the priority of many of those working in the world of drug treatment shifted virtually overnight from a focus on treating individuals for their drug dependency to adopting a public health, population focused, approach aimed at reducing drug users HIV-related risk behaviour.

The most tangible manifestation of this shift was the widespread development of needle and syringe exchange services alongside the increase of methadone prescribing on a maintenance basis, which aimed to entice drug users into treatment in order to reduce the risk of HIV transmission (Strang, 1990; Berridge, 1991, 2012; Stimson, 1995; Spear, 2002; Mold, 2008; Mold and Berridge, 2010:109; McKeganey, 2012).

Since the late 1980s, needle exchange and opioid substitution therapy (OST) have remained constant elements of drug treatment, even in the face of changing policy priorities (McKeganey, 2012). Indeed, throughout the 1990s – a period that has been described as the ‘criminalisation’ of drug policy, characterised by the introduction of a range of criminal justice-focused interventions that served to channel drug users into treatment in the aim of reducing drug-related offending (see Duke, 2006; Seddon, 2006; Stevens, 2007; Seddon et al., 2008, 2012) – the principles of harm reduction remained. Whilst the harm reduction approach adopted is said to have shifted from one based on voluntarism to one underpinned by coercion (Hunt and Stevens, 2004; Seddon, 2010a), the use of harm reduction practices nevertheless remained compatible within the new paradigm, suggesting that crime was viewed as another type of harm to be reduced (see Seddon, 2011; Seddon et al., 2012).
In 2001, New Labour established the National Treatment Agency for Substance Misuse (NTA). The NTA was tasked with improving the availability, capacity and effectiveness of drug treatment (NTA, 2009a). By 2008/09, the number of people in treatment had increased from 100,000 to 207,580 (NTA, 2009b), with approximately 70 per cent of drug users on methadone programmes (NTA 2008 cited in McKeganey, 2011a:22). For many years, the use of methadone maintenance prescribing\(^7\) was perceived as a great success; research has demonstrated its value in terms of attracting and retaining drug users in treatment; reducing the spread of HIV and other BBVs; reducing the extent of drug-related crime; reducing the use of heroin; and reducing the risk of overdose among opiate users (Buning, 1990; Stimson, 1996; Strang, 1998; Gossop et al., 2000; McIntosh and McKeganey, 2002; Mold, 2008; Robson, 2009). However, the use of methadone in treatment also has its critics. For example, from its early use on a maintenance-prescribing basis in the 1980s and 1990s, some have viewed the prescribing of substitute drugs to dependent opiate users as akin to giving money to compulsive gamblers or drink to dependent drinkers (Robson, 2009).

Yet, it was not until the early years of the new millennium when the criticisms directed at the use of methadone maintenance began to find a wider audience from both within and outside of the field\(^8\). The main criticism at this time centred on the notion that drug users were being ‘parked’ on methadone within treatment, with very few drug users ever ‘recovering’ from their dependent drug use (Duke, 2013; Duke et al., 2013). The remainder of this section traces the events from 2004 up to the election

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\(^7\) The prescribing of opiates to dependent users on a long-term basis is a practice that extends much further than this account addresses, to a period now often referred to as the ‘British System’. Accounts of opiate prescribing at this time can be found elsewhere (e.g. Berridge, 1999; Spear, 2002).

\(^8\) An early influential factor not detailed in this account was Wired In (originally called WIRED), which is a grassroots movement that established itself with a key aim of championing and facilitating the emergence of the recovery agenda in national policy (Recovery Stories, n.d.).
of the 2010 Conservative-Liberal coalition government and provides an account of how the practice of methadone maintenance quickly fell out of favour to be ultimately replaced by the recovery agenda.

2.2.1 Service users want abstinence

Whilst it is difficult to find a true starting point of this decline, a number of drug policy commentators cite research conducted in Scotland, which aimed to assess what drug users are looking for when they access treatment, as one of the key early influential factors of change (McKeganey, 2011a; Neale et al., 2011; Wardle, 2012; Duke, 2013; Duke et al., 2013). In 2004, McKeganey and colleagues published a research paper as part of the Drug Outcome Research in Scotland (DORIS) study (McKeganey et al., 2004). The research found that the goal of the majority (56.6 per cent) of service users was to achieve abstinence, with only 7.4 per cent and 7.1 per cent of service users citing goals of stabilisation or reduced drug use, respectively (McKeganey et al., 2004:426).

Following the DORIS report, the NTA also began conducting annual service user satisfaction surveys in England (NTA, 2007a, 2007b, 2008). As was the case in the DORIS study, in each of the three NTA reports, the majority of respondents consistently cited the cessation of drug use as their main goal of treatment. In an era of maintenance prescribing, the overwhelming evidence that service users’ primary aspirations of treatment were to become abstinent carried a great deal of weight (McKeganey, 2011a; Wardle, 2012; Duke, 2013).
2.2.2 New Labour drug policy: ‘wasteful, unwise and misdirected’

In addition to the findings that drug users want abstinence, highly influential criticisms were also being aimed at the Labour government from the Centre for Social Justice (CSJ), the right-wing think tank led by Iain Duncan Smith (Wardle, 2012; Watson, 2012; Duke, 2013; Roberts and Bell, 2013; McKeeganey, 2014; Bjarne et al., 2015; Lancaster et al., 2015). In 2006 and 2007, the CSJ published two reports: *Addicted Britain* in 2006 and *Addictions: Towards Recovery* in 2007 (Centre for Social Justice, 2006, 2007).

 Whilst the 2006 report drew attention to the ‘failure of this [New Labour] Government’s drug strategy’ (Centre for Social Justice, 2006:14), it was the 2007 report that presented the most critical evaluation. The 2007 report directed a number of extensive criticisms at New Labour’s drug strategy, claiming that the government had ‘failed to address drug and alcohol problems’ (Centre for Social Justice, 2007:8). The report argued that spending by the New Labour government on drug treatment was ‘wasteful, unwise and misdirected’ (Centre for Social Justice, 2007:8), with the philosophy of treatment dominated by methadone maintenance perpetuating and entrenching addiction, which had ‘seriously undermined’ the chances of recovery (Centre for Social Justice, 2007:12). In proposing a number of policy reforms, the CSJ report argued that abstinence was the most appropriate option in the treatment of addiction. Given the political affiliations of the CSJ, their reports ‘found a ready audience amongst senior figures within the [Conservative] party helping to frame their ideas for the sorts of changes that needed to be implemented once in government’ (McKeeganey, 2014:960).
2.2.3 Media influence

Alongside the CSJ reports, the media also became concerned with the perceived lack of success of drug treatment under New Labour and the NTA (Duke et al., 2013; Measham et al., 2013; Lancaster et al., 2015). In 2007, the media began to report on the growing unrest within the drug sector and apparent failings of the NTA’s extensive use of methadone maintenance within treatment. In a series of BBC interviews with Paul Hayes (chief executive of the now-dismantled NTA), the BBC’s Home Affairs correspondent, Mark Easton, criticised the NTA on a number of fronts. The most significant criticism concerned the low numbers of drug users who were exiting treatment drug-free at the time. In October 2007, Easton reported that, despite an additional investment of £130 million in drug treatment between 2004 and 2007, the total number of people leaving treatment free from dependency had only increased by 70 over that same period (BBC News, 2007).

Between 2007 and 2008, the media played an important role in stirring the abstinence versus harm reduction debate, bringing the debate more into the public domain, and bringing Labour’s drug policy under more intense scrutiny (Duke et al., 2013:970; Measham et al., 2013; Lancaster et al., 2015). The recurring sound bite from some treatment providers, politicians and the media at this time was that drug users were being ‘parked’ on methadone. As Duke (2013) argues, ‘The drugs “problem” was increasingly redefined and framed as a harm reduction and methadone problem with too many users stuck in the “methadone parking lot.”’
2.2.4 The ‘collective property of government’: Entering the political domain

With the growing opposition towards methadone maintenance, recovery soon became
the ‘collective property of government’ and the shift towards a recovery-oriented
framework was beginning to take hold (Wardle, 2012; Duke, 2013). By this time,
Labour had caught up with the Conservative opposition’s ambitions for reorienting
policy towards recovery and this was evident in their 2008 drug strategy:

> While we have been successful at fast-tracking people into treatment, we need
to focus more upon treatment outcomes, with a greater proportion free from
their dependence and being re-integrated into society … Our aim is that fewer
and fewer people start using drugs; that those who do use drugs not only enter
treatment, but complete it and re-establish their lives. (HM Government,
2008:4)

The 2008 strategy maintains that the focus for drug treatment should be for drug users
to achieve abstinence from their drug(s) of dependency and reintegrate into society.
With the publication of this strategy, it was clear that significant political shifts were
starting to take place within drug treatment.

The 2010 general election brought an end to Labour’s 13 years in government with
the formation of a Conservative-Liberal coalition government. The change in
government opened up a ‘natural’ policy window⁹ (Duke et al., 2013), providing an
opportunity to shift the focus of treatment away from the methadone-focused
approach of the previous Labour government, towards a recovery-oriented approach
that had been receiving increasing support. As Duke et al. (2013:973) argue, with the
election of the Conservative-led coalition government, there was a clear expectation

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⁹ In their work, Duke et al. (2013) draw on the work of Kingdon (1995) and his ‘agenda-setting
process’ to examine the shift to recovery in British drug policy.
to ‘do something different in line with the conventional Conservative ideology and the overall need to reduce public expenditure’.

The government published their drug strategy in December 2010. Whilst Labour’s 2008 strategy displayed clear ambition for shifting the focus of treatment, the term ‘recovery’ in reference to overcoming addiction was not used within the strategy (Ashton, 2016). Indeed, it was not until the 2010 strategy that the concept of recovery occupied a leading role within policy. Prior to engaging in a critical discussion of the key themes laid out in the 2010 strategy, it is important to note that some policy commentators have also drawn attention to the economic climate as a key contributing factor influencing the shift to recovery. This will be returned to in section 2.3.3.

What this section has demonstrated is that shifts in the direction of drug policy do not occur in isolation, and are often greatly influenced by the political, economic, social and cultural context of the time (Duke, 2013; Measham et al., 2013). This is an important observation and helps to make sense of the many policy developments that have occurred since the mid-2000s. Indeed, as Wardle (2012) suggests, between 2004 and 2010, a series of influential factors paved the way for the recovery movement to emerge and quickly dominate social, media and political debate around the future of drug treatment. In this short period of time, recovery ‘established an irresistible momentum that first brought it to national political prominence and then made it the cornerstone of the incoming coalition’s 2010 drug strategy’ (Wardle, 2012:294). The following section examines the 2010 drug strategy in greater depth, offering critical
comment on some of the key themes and raising a number of important areas for investigation.

2.3 Building recovery in communities: supporting people to live a drug free life

The publication of the 2010 drug strategy, *Reducing demand, restricting supply, building recovery*, signalled the formal shift in the direction of treatment away from primarily ‘reducing the harms caused by drug misuse’ to ‘offering support for people to choose recovery as an achievable way out of dependency’ (HM Government, 2010:2–3). The strategy points to recovery as bringing increased wellbeing, citizenship and freedom from dependence (HM Government, 2010:18). As addressed earlier, one of the key criticisms directed at New Labour’s drug policy was the belief that too many drug users were being ‘parked’ on methadone with little opportunity to move on with their lives (Duke, 2013). In response to this, notions of being ‘freed’ from dependence are central to the government’s recovery agenda (Lancaster et al., 2015).

Outlining their approach, the government contend that recovery is: ‘an individual, person-centred journey’; ‘built on the recovery capital available to individuals’; ‘in a system that is locally led and locally owned’; ‘where all services are outcome focused’; ‘delivered using a ‘whole systems’ approach’; ‘by an inspirational recovery oriented workforce’; and ‘supported by recovery networks’ (HM Government, 2010:18–21). As the remainder of this chapter will highlight, whilst some have welcomed the shift to recovery and the new opportunities it presents, the government’s vision for their recovery-oriented treatment system has attracted a number of significant criticisms from within and beyond the field. The following
sections examine the opportunities and risks presented by the reorientation towards recovery, beginning first with the emphasis on recovery in general, before paying attention to the key themes of the recovery agenda as outlined above.

2.3.1 The emphasis on recovery

As some have argued (see, for example, Best, 2010; Best and Gilman, 2010; Best, Bamber, et al., 2010; Best, Rome, et al., 2010; Best and Ball, 2011; Wardle, 2012; Timpson et al., 2016; Best, De Alwis, et al., 2017), the reorientation towards a recovery-focused drug treatment system brings with it a number of potential benefits for drug users, their families and the wider community. Recovery is viewed as ‘a powerful force … [that can transform] the lives of individuals blighted by addiction’, bringing with it ‘improved life quality and a sense of empowerment’ (Best and Laudet, 2010:2). As Best et al. (2017:109) have argued, the recovery approach promotes greater inclusivity, a less ‘clinical’ approach to treatment, and a greater awareness of the positive influences of families, communities and other support systems.

Advocates of the shift to recovery have also drawn attention to the small body of empirical work referenced earlier (see McKeganey et al., 2004; NTA, 2007a, 2007b, 2008), which suggests that the primary goal of the majority of service users is to become abstinent and move on from services. As Best et al. (2010:267) argue, treatment services were failing to support drug users to initiate a recovery journey and move on from treatment. From this point of view, the formal shift to recovery within treatment can also be viewed as better meeting the needs of service users.
However, many have criticised the government’s approach to their recovery-oriented treatment system, particularly as it is implemented in the current climate (see Chapter 1). Key concerns have been raised over the way in which the government have defined recovery in various policy documents (e.g. Monaghan and Wincup, 2013; McKeganey, 2014; Roy and Buchanan, 2016). Others have raised concerns over the reduction of funding for residential rehabilitation and the overt drive to deliver recovery in the community (Stevens, 2011a). In addition, some have argued that recovery has been ‘hijacked’ by government and subsumed into a broader policy of responsibilisation, accountability and risk management (Wincup, 2011, 2014; Monaghan, 2012; Monaghan and Wincup, 2013; Monaghan and Yeomans, 2016; Roy and Buchanan, 2016). The following section considers the definitions of recovery that have been offered since the mid-2000s, before examining the government’s definition of recovery (or lack thereof) and the potential implications it has for those in treatment.

2.3.2 Defining recovery

Although the term recovery is now common currency in drug treatment in both the UK and US, there remains no consensus as to how to define it (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; White, 2007; UKDPC, 2008; Measham et al., 2013; Senker and Green, 2016). Since its re-emergence in debates on how best to treat problem drug use, a number of researchers, addiction specialists and consensus groups have put forward somewhat conflicting views on what recovery entails (see, for example, The Betty Ford Institute Consensus Panel, 2007; White, 2007; UKDPC, 2008). Key discrepancies in definitions of recovery centre on whether

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10 Whilst the 2010 strategy represents the first time that recovery has occupied a leading role within drug policy, the notion of recovery is by no means a novel development. As such, some have argued that we are instead witnessing the reemergence or revival of recovery in drug treatment (see Mold and Berridge, 2010; Yates and Malloch, 2010; Berridge, 2012).
recovery involves total abstinence from all substances or whether it can be achieved with the aid of prescribed substitute medication; whether it is an on-going process or an end state; and whether recovery extends beyond the cessation of substance use (Substance Abuse and Mental Health Services Administration, 2005; Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; White, 2007; UKDPC, 2008).

Existing research exploring drug users’ views on recovery has found that whilst definitions of recovery often differ (predominantly concerning the place of substitute opiate drugs in recovery), recovery is widely understood as a voluntary, on-going process, lacking any definitive end-point; it is often transient, fragile and unpredictable; and it almost certainly comprises more than abstinence or control of substances, instead encompassing positive life changes, such as improvements in health and wellbeing, and integration back into society (Laudet, 2007; UKDPC, 2008; Measham et al., 2013; Neale et al., 2014; Senker and Green, 2016:16; Timpson et al., 2016).

With the conflicting definitions offered by those within the field, one of the key questions in the build-up to the 2010 strategy was how the government would define recovery. As noted in Chapter 1, the government fail to offer any explicit definition of the term. Instead, the 2010 strategy merely suggests that recovery is ‘an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people’ (HM Government, 2010:18). In so doing, the government appear to provide support for both medically assisted recovery and abstinence-based recovery. However, as some have highlighted, whilst stating that recovery ‘will mean different things to different people’, the strategy contradicts this view by conflating
recovery with abstinence (Monaghan and Wincup, 2013; Roy and Buchanan, 2016; Wincup, 2016). Phrases such as ‘[G]etting [people] into full recovery and off drugs and alcohol for good’, and ‘Supporting people to live a drug-free life is at the heart of our recovery ambition’ clearly indicate this conflated stance (HM Government, 2010:18, emphasis added).

The government’s support for an abstinence-only approach was also reinforced in their 2012 publication, Putting Full Recovery First, which served as a follow-up to the 2010 strategy (Home Office, 2012). Within the 2012 document, associations were again made between recovery and abstinence, noting that the government ‘will re-orient local treatment provision towards full recovery by offering people more abstinence-based support’ (Home Office, 2012:4). As McKeganey (2014:958) notes, from these policy documents, it is evident that a clear link was drawn by government between drug user recovery and drug user abstinence.

2.3.3 Implications of the government’s vision of recovery

One of the key issues with the government’s apparent vision of recovery is that, for service users who do not wish to seek abstinence, there is a risk that treatment providers will no longer afford them adequate support. Ross-Albers (2013) addresses this issue directly:

Those of us who want and need nothing more from our drug services than respect, dignity and a maintenance script are being told very clearly by this government that our lives are less valid, that our choices are less legitimate, and that unless we knuckle under the cosh of a state-imposed notion of sobriety, abstinence and temperance, that we will have our benefits taken away, our children removed, our housing and employment threatened.

Ross-Albers continues to argue that, for individuals who are living stable, fulfilling lives on a substitute prescription, the government’s definition of what constitutes
recovery ‘silences, stigmatises and further marginalises those of us who are either active drug users or are stable on maintenance scripts’ (Ross-Albers, 2013). Moreover, there are concerns that abstinence-focused treatment practices may lead to service users being encouraged to exit when it is not in their best interests (Roberts, 2009; Roy and Buffin, 2011; Roy and Buchanan, 2016; Best, De Alwis, et al., 2017), placing service users at greater increased risk of overdose following detoxification (Roberts, 2009). Whilst Roberts (2009:39–40) maintains that drug treatment services should not refrain from detoxing clients when they are ready, he argues that services need to respond to the increased risk that abstinence-focused treatment brings, such as premature detoxification from opiates (see Strang et al., 2003; Hunter, 2011; Neale et al., 2013). These issues are returned to throughout this chapter.

A further issue with the government’s apparent approach to recovery concerns the climate in which the recovery agenda emerged. As explored at the start of this chapter, the shift to recovery can be understood as the outcome of a complex interplay of contingent factors that converged at a specific point in time. As some have suggested, in addition to the factors outlined earlier, a further key factor influencing the shift to recovery was the economic climate. As noted in Chapter 1, the recovery agenda was introduced during a period of sustained economic downturn, which the coalition government used to establish a pro-austerity frame that has been characterised by sustained cuts to local authority budgets and increasing marketization of public services (Bach, 2012, 2016; Levitas, 2012; Lowndes and Pratchett, 2012). Cuts to budgets have resulted in the shrinking of numerous public sector services, including criminal justice, health, welfare and social care (Levitas, 2012; Lowndes and Pratchett, 2012; Measham et al., 2013:6). As some drug policy
Commentators have argued (Ashton, 2008, 2016; Wardle, 2012; Duke, 2013; Measham et al., 2013; Roy and Buchanan, 2016), it is through this pro-austerity frame that the reorientation of drug policy towards recovery took hold.

Certainly, since the end of the last decade, drugs policy has become increasingly embroiled in debates concerning the need to reduce welfare dependency in line with the broader ambition of austerity, with abstinence-based recovery viewed as an effective method to encourage problem drug users into employment (Wincup, 2011; Monaghan and Wincup, 2013; Monaghan and Yeomans, 2016:124; Wincup and Monaghan, 2016). In the build-up to the 2010 strategy, growing focus was placed on the cost of the drugs problem – not only the cost of maintaining people on methadone prescriptions but also the cost of supporting a population of drug users who are predominantly unemployed, claiming benefits and not contributing to the economy through employment (Ashton, 2008, 2016; Duke, 2013). As Duke et al. (2013:972) note, the financial cost of supporting such a large population of drug users within a drug treatment sector that had burgeoned under the NTA was considered unsustainable in a climate of austerity and public service cuts.

Clear indications of the economic cost of the drugs problem as a driver for reorienting policy can be found in a number of policy documents leading up to the 2010 strategy. For instance, in Labour’s 2008 drug strategy, proposals were made to tighten the conditions on drug users receiving benefits ‘who have a responsibility to move successfully through treatment and into employment’ (HM Government, 2008:32). Similar proposals were also incorporated into the Welfare Reform Bill 2009 with a view to issuing drug users with a ‘treatment allowance’ – a form of social security
benefit – in return for agreeing to a set of conditions, including the engagement in treatment programmes (Wincup and Monaghan, 2016:264–5). However, the most punitive proposals were included in the 2010 drug strategy consultation paper, which sought to introduce benefit sanctions for drug-using welfare claimants who fail to engage with treatment (Home Office, 2010:14).

The hard-line proposal in the 2010 consultation paper attracted a number of negative responses from within and beyond the drug treatment sector (see DrugScope, 2010; Release, 2010; UKDPC, 2010; UKHRA, 2010). Fortunately, the 2010 drug strategy did not include the controversial benefit sanctions for drug users. Duke (2013:7) explains this less radical approach by maintaining that the formation of the coalition government and the drug strategy consultation process had resulted in the ‘tempering of the more hard-line Conservative ideals with the values of the Liberal Democratic Party’. The outcome of this, Duke notes, was a compromise in many areas of public policy, including the drug sector. However, whilst the 2010 drug strategy stopped short of the highly criticised benefit sanctions, there remained clear emphasis on the cost of the drugs problem and the need to get drug users out of treatment and into work:

Approximately 400,000 benefit claimants in England are dependent on drugs or alcohol and generate benefit expenditure costs of approximately £1.6 billion per year. If these individuals are supported to recover and contribute to society, the change could be huge. (HM Government, 2010: 4, emphasis added).

As Ashton (2016) has argued, it is evident that the 2010 strategy is still very clearly focused on turning a population of dependent drug users from economic drains into economic gains by encouraging drug users out of treatment, off benefits and into employment. With regard to the earlier proposals to introduce benefit sanctions,
Ashton (2016) argues that, rather than being abandoned, the use of benefit sanctions to encourage drug users to become abstinent and gain employment had merely ‘morphed into the more appealing label’ of recovery by the time of the publication of the 2010 strategy.

As Wincup (2011:22–3) has argued, the focus on encouraging drug users to exit treatment, come off benefits and get back to employment should be viewed as part of a broader ‘culture of responsibility’ that aims to address the ““sin” of worklessness’. Indeed, as alluded to above, numerous attempts have been made by successive governments to reform the welfare system, which have been constructed as both an economic and moral necessity in a period of sustained economic recession (Wincup and Monaghan, 2016:266). With a view to drug use, Wincup and Monaghan (2016:261) note how drug users have been actively constructed as ‘undeserving’ welfare claimants in light of their ‘choice’ to continue to use drugs, which forms part of a ‘new welfare commonsense’. The authors argue that neoliberal welfare regimes ushered in throughout the developed world have held drug users as a primary target, who have been cast in a growing category of ‘scroungers’ by both media and political discourse (Wincup and Monaghan, 2016:261–2).

These ideas fit well with the recovery agenda, with its undercurrents of responsibilisation and reducing welfare dependency (Monaghan, 2012:30). As Duke (2013:50) has argued, the recovery agenda ‘ratchets up neoliberal subjectivity further and places more responsibility on individuals to gain control over their drug use, seek help for their drug problems, draw on their own “recovery capital” to become drug free and cease offending’. Thus, the reorientation towards recovery illustrates once
again the ‘strategic coherence’ that Seddon et al. (Seddon et al., 2008, 2012, Seddon, 2010a, 2011) have highlighted within drug policy over the past half-century (see Chapter 1).

In accordance with the above arguments, in the concluding chapter of their 2012 publication, Seddon et al. (2012:167) briefly apply their framework for making sense of the shift towards recovery, arguing that the way in which the drugs problem has been viewed and responded to over the last half-century is again evident. Once again, we can see the same problematisation of drug users: as presenting a risk to society (albeit this time, the most significant risk is an economic one); the same conception of drug users: as rational choice-makers; and the same strategic response: cajoling drug users to make correct decisions (i.e. stop using drugs, come off benefits and get back to work).

As this section has examined, whilst some have expressed support for the shift to recovery in drug policy (e.g. Best and Gilman, 2010; Best, Bamber, et al., 2010; Best et al., 2016), a number of drug policy commentators have expressed concern over the government’s approach to recovery and the underlying motivations for reorienting policy at a time of economic austerity. From the above discussions, clear questions are raised, not only about the extent to which the rhetoric surrounding recovery is playing out at the level of practice (Monaghan, 2012; Duke, 2013; Lancaster et al., 2015), but also about how those working in services view the shift in policy, along with the way in which it is being defined within treatment and the implications this has for service users.
The following sections of this chapter continue this critical account of the recovery agenda by examining in greater depth the key themes of the government’s recovery-focused approach and its potential impact on the ground. In doing so, arguments concerning the evidence of neoliberal ideology within drug policy are examined further.

2.4 Recovery capital

The strategy cites the importance of ‘recovery capital’ in achieving and maintaining recovery (HM Government, 2010). The notion of recovery capital, as it applies to recovery from drug dependency, was first conceptualised by Granfield and Cloud (1999), with its theoretical foundations in the concept of social capital (Bourdieu, 1986; Bourdieu and Wacquant, 1992). This section begins with an introduction to the concept of social capital, before considering in greater depth the notion of recovery capital. In doing so, its significance in the recovery process will be addressed, drawing on textual and empirical literature that has examined this concept. To end, the notion of recovery capital is briefly examined through a neoliberal lens, and key research questions are raised.

Whilst there have been a number of writings on social capital, including Coleman (1988) and Putnam (1995), Bourdieu (1986; Bourdieu and Wacquant, 1992) is cited as the first to analyse this concept and its application to social life. Focusing on social class and the wider social structure, Bourdieu (1986:248) defined social capital as:

[T]he aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition … which provides each of its members with the backing of the collectively-owned capital’.

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11 The term ‘recovery capital’ has also been used in the mental health field (e.g. Tew, 2013).
Bourdieu (1986:248) continues by explaining that the amount of an individual’s social capital is dependent on the ‘network of connections’ that can be mobilised and on the ‘volume of the capital (economic, cultural or symbolic) possessed in his [sic] own right by each of those to whom he [sic] is connected’. Thus, for Bourdieu (1986), vital aspects of social capital are the access to and quality of the resources available to an individual. These ideas fit well with the concept of recovery capital, as will now be addressed.

Within the addictions field, recovery capital was first defined by Granfield and Cloud (1999:179) as:

[T]he sum of one's total resources that can be brought to bear in an effort to overcome alcohol and drug dependency. It is embodied in a number of tangible and intangible resources and relationships, including those that existed prior to a person's drug involvement, during the period of drug use, and conditions likely to prevail in the future. It encompasses attitudes and beliefs that one has toward the past, present, and the future. It also includes one's mental status and other personal characteristics that can be drawn upon to resolve a dependency problem.

As the authors explain, ‘Much of a person’s ability to extract himself/herself from substance misuse is related to the environmental context in which that person is situated, the personal characteristics s/he possesses, and a range of perceptible and imperceptible resources available to that individual’ (Cloud and Granfield, 2008:1972). Put simply, those with greater levels of recovery capital are more likely to achieve and sustain recovery compared to those with lower levels of capital (see Cloud and Granfield, 2008; Laudet and White, 2008; White and Cloud, 2008).

Granfield and Cloud outline four dimensions of capital: social capital, human capital, physical capital, and cultural capital (Granfield and Cloud, 1999; Cloud and Granfield, 2008). Social capital, as in the definition set out by Bourdieu (1986) above,
essentially refers to an individual’s social networks and relationships (Cloud and Granfield, 2008). As Cloud and Granfield (2008:1973) explain, ‘membership in a social group confers resources, reciprocal obligations, and benefits on individuals who may use this “stock” to improve their lives … The possession of social capital helps facilitate particular ends, whether it is in acquiring employment or whether it is overcoming a major life obstacle’. With regard to recovery, the emotional support of others, along with the opportunities that they can provide, can significantly increase the chance of sustained recovery (Cloud and Granfield, 2008).

Physical capital is concerned with an individual’s income and tangible financial assets that can be used to support the process of recovery. Cloud and Granfield (2008:1973–4) explain that those with higher levels of physical capital (i.e. those who are financially stable), have access to benefits such as health insurance, which can be used to acquire medical treatments such as detoxification and impatient or outpatient care. Whilst the availability of public health-funded treatment services in the UK means that this is perhaps less important than in the US, the greater a person’s physical capital, the more options that will be available to support their recovery (for example, moving out of the geographical area and away from any negative influencing factors associated with dependent use; Cloud and Granfield, 2008).

Human capital refers to the qualifications, skills and knowledge possessed by an individual, along with the state of their physical and mental health, which are important factors in the recovery process (Cloud and Granfield, 2008:1974). Whilst Cloud and Granfield (2008:1974) recognise that the list of factors that human capital incorporates is extensive, the three most significant attributes that determine a
person’s chances of recovery are: heredity, mental health and employability. Importantly, the complex, bidirectional relationship between mental health and problematic drug use has been researched widely (e.g. Gossop et al., 1998; Neale, 2002; Roberts and Bell, 2013), with the increased difficulties achieving recovery in this group raised as a key cause for concern (Cloud and Granfield, 2008; UKDPC, 2012b; Roberts and Bell, 2013). Likewise, Cloud and Granfield (2008) note that, without employment and a legitimate source of steady income, recovery from drug use is much more difficult, particularly as many users will resort to the illegitimate lifestyles that serve to sustain their use.

Lastly, cultural capital refers to the cultural norms and belief systems held by an individual. Cloud and Granfield (2008:1974) suggest that dependent users who accept conventional societal norms have a greater chance of recovery than those who have been socialised to reject them. In the process of recovery, the authors argue, individuals begin to adjust their views in line with the socially and culturally accommodated value systems (Granfield and Cloud, 1999; Cloud and Granfield, 2008). Without these value systems, individuals lack the ability to function effectively in conventional society (Cloud and Granfield, 2008).

Taken together, it is argued that people with access to the necessary resources and support systems that constitute the above forms of capital have a much greater chance at recovery than those who lack access to this capital (Cloud and Granfield, 2008). In their 2008 publication, Cloud and Granfield also introduce the notion of ‘negative recovery capital’. The authors maintain that, rather than measuring the amount of recovery capital possessed by an individual as ranging from none to significant
amounts, recovery capital should be measured on a ‘positive and negative continuum’, in which individuals can fall on the negative scale for some aspects of capital (Cloud and Granfield, 2008:1977). In other words, individuals may not only lack access to the necessary resources to help initiate and sustain recovery, but they might also be subject to factors that actively impede the opportunity to recover (Cloud and Granfield, 2008:1977).

Factors such as age, gender, mental and physical health, and time spent in prison can all serve as negative recovery capital. Significantly, as noted earlier, mental health issues can present a key barrier to recovery given that, for many people, substances have been used to self-medicate against traumatic experiences and enduring mental health issues such as anxiety, depression and schizophrenia, to name but a few (UKDPC, 2012a; Du Rose, 2015). For Cloud and Granfield (2008:1979), those who suffer from severe mental health issues face ‘immense challenges’ in their attempts at recovery. With regard to imprisonment, the authors recognise the deleterious effects that prison can have on an individual’s chance of recovery due to the attitudes and belief systems that are often reinforced through imprisonment (Cloud and Granfield, 2008:1979–80).

The importance of recovery capital has been supported empirically (e.g. Granfield and Cloud, 1999; Laudet et al., 2006; Laudet and White, 2008; Best et al., 2012, 2016; Duffy and Baldwin, 2013; Boeri et al., 2016; Penn et al., 2016; Weston et al., 2017). In what is now one of the most widely cited empirical studies from the US, Granfield and Cloud recruited a total of 46 former drug users who they described as ‘natural recoverers’ due to the lack of formal treatment interventions in their recovery
(Granfield and Cloud, 1999; Cloud and Granfield, 2008). Each of the ‘natural recoverers’ in Granfield and Cloud’s sample were from middle-class backgrounds, the vast majority had completed high school, and many had higher education degrees (Cloud and Granfield, 2008). The authors argued that central to the recovery of these individuals was their access to financial and other resources that they could draw upon in their recovery journeys (Cloud and Granfield, 1994; Granfield and Cloud, 1999).

Widespread evidence has also been provided in a UK context (e.g. Best et al., 2012, 2016; Melick et al., 2013; Best, McKitterick, et al., 2015; Timpson et al., 2016; Whiteford et al., 2016; Weston et al., 2017). For example, Best et al. (2012) conducted research with 205 former alcohol and/or heroin users and demonstrated that improvements in quality of life for the individuals in their sample were achieved through support from peer networks and the introduction of more meaningful activities in their day-to-day lives, which each serve to increase and strengthen recovery capital. More recently, Best et al. (2016) have also examined the initiative, ‘Jobs, Friends and Houses’ (JFH), to illustrate the significance of recovery capital. JFH is a social enterprise that provides employment, education and accommodation opportunities to recovering drug users predominantly through the construction of housing for themselves and others in recovery (Best, 2016; Best et al., 2016). Through interviews and observations with those involved in the scheme, Best et al. (2016) demonstrate that JFH not only supports individuals to build on their personal recovery capital, but also helps to increase community recovery capital, which is concerned with the spread of attitudes and behaviours by people in communities (see Best and Laudet, 2010; see section 2.6).
With the centrality of, and evidence for, recovery capital established, Cloud and Granfield (2008) cite the importance of treatment services working to support drug users to increase their recovery capital in order to initiate and sustain recovery. Notably, they argue that traditional treatment activities tend to focus on addressing the physiological side of drug use whilst largely ignoring the less-perceptible aspects of individuals’ lives that can determine their ability to achieve recovery (Cloud and Granfield, 2008). With the emphasis on recovery in British drug policy, the 2010 drug strategy and the subsequent ‘recovery roadmap’ point to the importance of local services focusing on interventions that can help to build an individual’s recovery capital, and, in so doing, meet their other needs aside from physical dependence (HM Government, 2010; Home Office, 2012). In addition, as is explored in section 2.6, the introduction of recovery champions holds the benefit of increasing community recovery capital and the ‘social contagion’ of recovery (Best and Laudet, 2010; Best et al., 2016; see section 2.6).

As such, the government appear to be taking note of the evidence for the importance of building recovery capital. However, in the current economic climate, in which many treatment services have experienced decreases in funding (see section 2.7), questions are raised over the extent to which services are able to support clients in addressing their wider needs – such as housing, employment and mental health support; challenging stigma and discrimination; and (re)building relationships with loved ones – in order to accrue the capital necessary for recovery (DrugScope, 2012, 2015a; Best, Bird, et al., 2015; Best et al., 2016; Whiteford et al., 2016). As Wincup (2016) has demonstrated, these issues are perhaps even greater for women than they are for men.
Alongside the above issues, it is also important to highlight that, in line with the arguments made in the previous section, the emphasis on recovery capital has been viewed by some as further evidence of neoliberal governance (e.g. Duke, 2013; Roy and Buchanan, 2016). Indeed, the emphasis on recovery capital can be viewed as part of a broader strategy of responsibilisation in which drug users are encouraged to take necessary steps to improve their chance of successful recovery (Duke, 2013; Wincup, 2016). Rose (1996, 1999) argues that the ideology of neoliberalism – or advanced liberalism, as Rose prefers – casts individuals as ‘enterprising selves’ who are expected to work on themselves in order to make improvements to their lives. As such, engagement in a range of social activities, including health, welfare and education, are reconceptualised as part of the development of human capital (Rose, 1999:142). For Rose (1999:142), ‘The powers of the state thus had to be directed to empowering the entrepreneurial subjects of choice in their quest for self-realization’.

As this section has examined, the recovery agenda places great emphasis on service users taking an active role in their attempts to recover by engaging in behaviours that serve to increase their recovery capital. Whilst there is a largely uncontested evidence base that those with greater amounts of capital face the fewest barriers in their attempts to recover (e.g. Cloud and Granfield, 2008; Best and Laudet, 2010; Best et al., 2012), there are concerns over the extent to which treatment services are able to appropriately support their clients in building this capital (DrugScope, 2012, 2015a; Whiteford et al., 2016; Wincup, 2016), particularly given the challenges faced by drug users to find stable accommodation and employment (see Spencer et al., 2008). Moreover, with the apparent conflation of recovery with abstinence and treatment completion, questions are also raised over the extent to which services will support
drug users whose intentions are not to become abstinent (Ross-Albers, 2013) or the extent to which they will encourage service users to detox prematurely (Roberts, 2009; Hunter, 2011; Roy and Buffin, 2011). The following section picks up on some of these issues by examining another key theme of the recovery agenda: the shift to outcome-based targets within drug treatment.

2.5 From process-driven to outcome-based targets

The reorientation towards recovery has been accompanied by a shift from process-driven to outcome-based targets (HM Government, 2010; Duke, 2013; Duke et al., 2013). Whilst the 2010 strategy contends that the treatment system will continue to work towards meeting process-driven targets (such as improving access to treatment), treatment providers will now be commissioned primarily with a range of outcomes in mind (HM Government, 2010). The strategy offers a list of eight outcomes, including: the prevention of drug-related deaths and blood-borne viruses; sustained employment, the ability to access and sustain suitable accommodation; and improvement in mental and physical health and wellbeing (HM Government, 2010:20). In doing so, this appears to support the government’s ambition to ensure that service users have access to the resources required to build the necessary recovery capital to initiate and sustain recovery.

However, whilst listing these eight outcomes, it is clear from the strategy and subsequent policy documents that the primary target for treatment providers is to ensure that service users are completing and exiting treatment ‘drug free’. Indeed, the Public Health Outcomes Framework (PHOF) cites the successful completion of drug treatment as the key proxy measure of recovery (Public Health England, 2016a, 2016b). Successful completion of drug treatment is defined within the PHOF as:
Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment. (Public Health England, 2016a)\(^{12}\)

PHE (2016a) highlight that the above measure includes a non-representation element, meaning that if an individual exits treatment but then returns within a six-month window, they will not be recorded as having successfully completed.

With the successful completion of drug treatment now the key target within the treatment sector, providers are faced with the challenge of determining how quickly service users should be supported into completing treatment. Guidelines published by PHE suggest that whilst clients’ progress reviews should be personalised and deliberative, reviews should normally be carried out at six-monthly intervals (Public Health England, 2013:9). As discussed in the preceding section, although clients with high levels of recovery capital will be able to move fairly quickly along their recovery journeys, clients with more complex needs, and those who are more entrenched in their level of use, will require a greater level of support, and will likely progress much more slowly. Given this, it is important that services cater to individuals’ needs, taking account of their personal circumstances (McKeganey, 2014). However, as will be discussed below, a number of concerns have been raised over the extent to which this will happen in practice, particularly concerning the introduction of Payment-by-Results (PbR) within the sector.

In 2012, in line with the shift to outcome-based commissioning, the Department of Health introduced a pilot PbR programme in eight geographical areas (HM

\(^{12}\) At the time of writing, this is the most up-to-date indicator definition contained in the PHOF.)
Government, 2010; Hill et al., 2012; Mason et al., 2015). In addition to these pilot sites, local authorities were also free to commission services through a PbR scheme. The conventional understanding of PbR is an approach to the funding or purchasing of services, which pays providers based on their activity level (Hill et al., 2012:29). As Hill et al. (2012:29) explain, however, in 2010, the coalition government unveiled their new vision for PbR in which providers are paid for the outcomes they deliver rather than their level of activity.

The introduction of PbR into the treatment sector is designed to incentivise providers to support people into recovery as well as simultaneously offering better value for money (Hill et al., 2012:30; Mason et al., 2015). Providers involved in the pilot scheme were paid a percentage of their funding based on the outcomes they provide. In some areas, this was as little as 10 per cent; however, in one of the pilot areas, 100 per cent of the contract value was paid on delivery of outcomes (Hill et al., 2012:31). Again, although the stated outcomes that providers worked towards included freedom from dependence, reducing crime and improving health and wellbeing, the key outcome measure by which providers’ success was judged – and by which payment was made – was the number of service users successfully completing treatment (Mason et al., 2015).

The shift to outcome-based commissioning, and particularly where providers are rewarded for producing outcomes, is indicative of the growth of new managerialism within the treatment sector. As examined in Chapter 1, new managerialism has been described as the organisational arm of neoliberalism, and is characterised, among other things, by an increase in target setting, an emphasis on outputs over inputs, and
the establishment of punishments and rewards (Siltala, 2013; Juhila et al., 2017; Lynch, 2017; see Chapter 1). Each of these features can be found within the government’s recovery agenda. Indeed, the introduction of target setting and PbR in the treatment sector – as has been the case within other public sector services, including healthcare (see Appleby and Jobanputra, 2004; Maybin, 2007; Allen, 2009), criminal justice (see Collins, 2011; Fox and Albertson, 2011, 2012; Maguire, 2012), and welfare and employment sectors (see Rees et al., 2014; Carter and Whitworth, 2015; Egdell et al., 2016) – can be viewed as part of a broader effort to further expose the public sector to competition by incentivising a broader range of private and third sector providers to bid for contracts in the aim of increasing efficiency, improving standards and driving down costs (Clarke, 2004; Diefenbach, 2009; Ward, 2011; Harlow et al., 2012; Bach, 2016; Lynch, 2017).

As noted above, a number of issues have been raised concerning the shift to outcome-based commissioning and the introduction of PbR within the drug treatment sector. One of the most significant issues is that, with proportions (or even 100 per cent) of providers’ payments based on achieving successful treatment completions (UKDPC, 2011; Hill et al., 2012; Mason et al., 2015), there is a risk of treatment providers ‘gaming’ clients by ‘creaming’ (cherry-picking) those most likely to succeed and ‘parking’ (neglecting) those with more complex needs and thus more barriers to recovery (Maynard et al., 2011; Roberts, 2011; UKDPC, 2011; DrugScope, 2012; Duke, 2013). As examined in Chapter 1, this is a practice that has been witnessed in other public sectors. Most significantly, endemic issues of creaming and parking have been found in welfare-to-work programmes, including the most recent Department of
In addition, within the treatment sector, some have expressed concern that the shift to outcome-based commissioning and the introduction of PbR will give rise to other perverse incentives, such as encouraging drug users to exit treatment prematurely in order to reach targets and/or receive payment (UKDPC, 2011; Best, De Alwis, et al., 2017). Roy and Buchanan (2016:400) argue that narrowly defining recovery as the successful completion of drug treatment in a climate in which the success of providers is measured by their ability to deliver outcomes runs the risk of service providers making unrealistic demands of detoxification and abstinence from service users (Roy and Buchanan, 2016).

One of the significant risks of encouraging service users to enter recovery too soon is the risk of the client relapsing, coupled with the increased chance of overdose following any period of reduction or abstinence (Strang et al., 2003; Stimson, 2010; Neale et al., 2013; Boyt, 2014). Whilst the above risks have been raised over the introduction of PbR within the sector, irrespective of whether providers are commissioned through a PbR model, the successful completion of drug treatment remains as the primary outcome measure by which a provider’s worth is determined and thus has the potential to give rise to these issues.

Despite the above concerns, empirical research examining the impact of these developments at the level of practice has been significantly lacking. A review of the PbR pilots conducted by Mason et al. (2015) has, however, offered some insight into
their impact on the ground. Interestingly, the authors found that the PbR pilot areas had fewer treatment completions over the period studied when compared to areas not commissioned through a PbR model (Mason et al., 2015). Addressing this finding, Mason et al. (2015:110) maintain that, as a proportion of funding for providers under a PbR model is dependent on service users not re-presenting to treatment within a 12-month period\textsuperscript{13}, providers are more risk averse in discharging clients for fear of relapse and non-payment. However, given that Mason et al.’s (2015) study was purely quantitative, it remains to be known whether their hypothesis is accurate.

Indeed, other empirical research suggests that there is cause for concern. Early research conducted by Roy and Buffin (2011) found that treatment staff in their sample reported concerns over the speed at which service users were being moved through the system, and the extent to which OST was becoming increasingly time-limited. However, as the researchers utilised a structured questionnaire in their study, they fail to provide in-depth insights into these issues. Nevertheless, more recent research conducted by DrugScope (2014, 2015a) has also suggested that these issues are occurring in practice. DrugScope report that the shift to outcome-based commissioning has resulted in cases of creaming and parking clients based on their level of need (see DrugScope, 2014:20) along with feelings of anxiety among service users who feel pressure to reduce their prescribed substitute medication (see DrugScope, 2015a:8).

Furthermore, in another study, Neale et al. (2013:168) found that whilst this did not appear to be occurring among their sample of service users – with some service users

\textsuperscript{13}Although the PHOF states the non-representation period is six months, services commissioned under the PbR pilots had a non-representation element of 12 months.
instead becoming impatient with the speed at which they were being reduced off their OST – the authors argued that there is the potential for this to happen ‘inadvertently’, with service users willingly subjecting themselves to rapid detox. Given this, the authors recognise that there is a requirement to remain vigilant and a need for further research (Neale et al., 2013). Indeed, whilst the above studies have offered valuable insights, empirical research has thus far failed to provide conclusive evidence. As such, there is a need for further research to examine this complex issue (Measham et al., 2013; Neale et al., 2013; Roy and Buchanan, 2016; Best, De Alwis, et al., 2017).

As this section has addressed, the shift from process-driven targets to outcome-based targets forms a fundamental aspect of the government’s recovery agenda. In support of the arguments made in the preceding sections of this chapter, the introduction of outcome-based commissioning, and particularly PbR, provides evidence of new managerialism within the sector and an effort to increase competition, drive up efficiency and drive down cost. With the successful completion of drug treatment now the primary measure by which providers’ success is judged – and by which those commissioned through PbR are paid – there are significant concerns over the risks that this might bring to the treatment sector. Given the lack of in-depth, empirical research exploring these issues, important questions remain, which this research seeks to answer. The following section turns attention to the next key theme of the recovery agenda: the employment of individuals with lived experience of treatment and recovery within drug services.
2.6 Mutual aid, peer support and the changing face of the treatment workforce

The 2010 strategy explains that ‘recovery can be contagious’ and that people are ‘most motivated to start on their individual recovery journey by seeing the progress made by their peers’ (HM Government, 2010:21). The value of peer support for recovery from substance use is not a novel development, and instead has a long history, predating any form of structured treatment. Indeed, White (2004:532) points out that the history of peer support can be traced back as far as the eighteenth century, with Native American recovery ‘circles’ forming some of the earliest abstinence-based mutual aid (MA) groups. From this point, various mutual aid societies have been established, such as the early temperance societies in the nineteenth century, through to Alcoholics Anonymous (AA)\(^\text{14}\) and Narcotics Anonymous (NA) groups that have existed since the 1930s and 1950s, respectively (White, 2004:533–4)\(^\text{15}\).

Since the establishment of AA, MA groups have been predominantly based on the 12-step philosophy and comprise of informal, bi-directional relationships of mutual support (see White, 2004; Bassuk et al., 2016:2).

Historically, MA groups have tended to run independently and in parallel to structured treatment (Measham et al., 2013). However, with the shift to recovery in national policy, the government have emphasised the importance of promoting the use of local MA networks such as AA and NA to support people in their recovery (HM Government, 2010). As Measham et al. (2013) have found, this has taken hold at the local level in Lancashire, with providers directing service users into community-based

\(^{14}\) Along with the Oxford Group from which the co-founders of AA, Bill Wilson and Bob Smith, first began to assist fellow alcoholics into recovery (see White, 1998; Atkins, 2014).

\(^{15}\) See White (2009) for a detailed history of mutual aid groups.
MA societies, which, whilst bringing benefits for service users, has also altered the demographic of those attending these groups, causing friction with those already in attendance (see Measham et al., 2013:50–1).

In addition to the promotion of MA, the 2010 drug strategy also stresses the need for treatment providers to recognise the benefits that those with lived experience of recovery can bring to the treatment workforce (HM Government, 2010; Home Office, 2012; Public Health England, 2015). The clearest indication of this has been the formal introduction of networks of recovery champions (HM Government, 2010). The 2010 strategy called for the employment of recovery champions at three levels: strategic, therapeutic and community (HM Government, 2010:21). Strategic recovery champions are described as leaders, such as service commissioners and Directors of Public Health (see Chapter 1), who are tasked with promoting the recovery-oriented system. Therapeutic recovery champions are established as those delivering services who have adopted the recovery approach (HM Government, 2010:21). Of most interest here, though, are the community-level recovery champions.

At the community level, recovery champions are specifically tasked with spreading the contagion of recovery by encouraging and supporting existing service users along their own journeys of recovery (Best and Laudet, 2010; HM Government, 2010; Best, Loudon, et al., 2013; Measham et al., 2013; Best et al., 2016). In addition to motivating those currently in treatment, the government contend that having visible examples of recovery can also spread into the wider community and attract others into services (Best and Laudet, 2010; Public Health England, 2015:7). This forms part of
what Best and Laudet (2010) have called ‘community recovery capital’ or ‘collective recovery capital’ (Best and Gilman, 2010).

As a result of the increased emphasis on the benefits that those with lived experience can bring to the treatment sector, there has been a considerable increase in the recruitment of ex-service users into an assortment of paid and voluntary peer support worker (PSW) roles over recent years, which has significantly altered the composition of the treatment workforce (NTA, 2010a; Measham et al., 2013; Wardle, 2013; DrugScope, 2014, 2015b; Adfam, 2016; Roy and Buchanan, 2016). Adfam (2016:33–4) report that at least 86 per cent of the treatment providers they surveyed employ people with lived experience of treatment and recovery into paid and voluntary recovery champion and other PSW roles within their service; 68 per cent recruit former service users into paid roles, whilst 94 per cent recruit ex-clients into various voluntary positions, from administration to recovery champion.

Whilst the employment of those with personal experience of substance use within treatment services has a history beyond the recent revival of recovery (Mold, 2008; Mold and Berridge, 2010; Wardle, 2013), Wardle (2013:16) contends that, in recent years, ‘we have, quite suddenly, “discovered” the energies and inspiration that non-paid peer mentors, recovery champions and group work specialists can bring’. This ‘discovery’ was made some years prior within the mental health field (Davidson et al., 1999, 2012; Repper and Carter, 2011) and, as this section will later address, can be viewed as part of a much broader process of increasing service user involvement (SUI) that has occurred throughout the public sector (Martin, 2011; Bach, 2012; Foot et al., 2014).
Within the drugs sector, Wardle (2013:4–10) contends that, since 2001, the drug treatment workforce has developed through three primary stages. Of interest here is the third stage, which Wardle notes began in 2007. Since 2007, a significant shift in the balance of those considered to be the ‘experts’ in the field has occurred. This began with condemnation of the methadone maintenance approach as explored at the start of this chapter, which also brought with it heavy criticism of the population of treatment staff at the time. Wardle (2013:8) argues that, around this time, ‘most professionals working in community settings were regarded as unreliable at best, and downright problematic at worst’.

With the renewed emphasis on recovery, former drug users who were already in recovery became the specialists, viewed as ‘one of the most authoritative sources of expertise’ (Wardle, 2013:7). As Wardle (2013) notes, those who provide the most inspiration to change are now those typically classed as ‘unskilled’.

In one way, the increasing employment of ex-service users can be understood as part of a broader trend of increasing SUI within public services over the past two decades (Martin, 2011; Bach, 2012; Foot et al., 2014). SUI refers to the process of ensuring that those with experience of using a particular service are directly involved in the planning, development and delivery of that service (NHS England, 2015:1; Public Health England, 2015). The rationale behind this is that, with their first-hand experiences of using the service, service users will have greater insight into what works and what can be done to enhance the service for its users (NHS England, 2015). To this end, service users are viewed as having an important role to play in the

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16 This was partly a result of the NTA recruiting inexperienced or untrained workers to account for the expansion of the treatment population between 2001 and 2009 (NTA, 2009b; Wardle, 2013).
modernisation and refashioning of service provision in the aim of making it more user-centred (Cowden and Singh, 2007; Martin, 2011:909).

The increased emphasis on SUI has been witnessed in a variety of public sector services over recent decades, including mental health, education, criminal justice and social work (Thornicroft and Tansella, 2005; Cowden and Singh, 2007; Heffernan, 2009; Clinks, 2011; NHS England, 2015), and was further promoted by the recent public health reforms outlined in Chapter 1 (HM Government, 2012; Local Government Association, 2012). Within the drugs sector, the 2015 Public Health England service user involvement guide discusses four levels at which involvement of service users can take place: involvement in their own care or treatment plan; involvement in strategic development and commissioning; involvement in developing and delivering peer support services; and involvement in developing and delivering user-led, recovery-focused enterprises (Public Health England, 2015:7). As such, the increase in the involvement of service users in developing and delivering peer support within structured treatment services can be viewed as illustrative of this broader shift in the provision of care.

However, the increased recruitment of recovering drug users into PSW roles has occurred simultaneously with significant reductions in ‘professional’, frontline and back office staff at a time when caseloads for services are also increasing (UKDPC, 2012b; DrugScope, 2014, 2015b; Public Health England, 2014; Adfam, 2016). DrugScope (2015b:7) report that 53 per cent of respondents surveyed had experienced reductions in front line staff, with 40 per cent reporting reductions in back office staff and management. With the reduction of frontline staff, DrugScope (2014, 2015b:38)
have also found evidence of volunteer and paid recovery champions taking on responsibilities traditionally assigned to ‘professional’ staff, such as conducting one-to-one client assessments.

Whilst it has been argued that there is simply now less need for ‘traditional’, ‘skilled’ treatment staff, with those considered to be ‘expert-by-experience’ often more effective at promoting recovery than their ‘professional’ counterparts (Best, Rome, et al., 2010; Wardle, 2013), the deprofessionalisation of roles and the increasing reliance on voluntarism has been witnessed across many public sector services, and can be understood as central to neoliberal welfare reform, deficit reduction and the dismantling of the state (May et al., 2005; Bach, 2012; Rowson et al., 2012; Duke, 2013; Measham et al., 2013; Roy and Buchanan, 2016).

Bach (2012:400) has highlighted that the Conservative government’s vision of the Big Society has led to significant reductions in staffing levels and a reliance on volunteers and low-paid workers to plug the gaps, while being touted as a more user-centred and cost-effective means of delivering public services. Indeed, as Duke (2013:49) contends, the fostering of mutual aid and peer support within recovery communities fits neatly within the Big Society agenda and the responsibilisation of individuals, families and communities. As was argued in section 2.4, the stress on building recovery capital demonstrates that drug users have become actively involved in their own recovery; with the emphasis on recruiting recovery champions, it can be argued that drug users are being made responsible not only their recovery but also for the recovery of their peers.
Notwithstanding the above debate, it is important to consider the potential benefits and challenges that the increased employment of PSWs can bring to the drug treatment sector. As established above, the primary benefit of employing people with lived experience is to offer hope and inspiration to existing service users to follow their path to recovery, along with spreading into the wider community and attracting others into treatment (Best and Gilman, 2010; Best and Laudet, 2010; Best, Rome, et al., 2010; HM Government, 2010; NTA, 2012b; Best, Loudon, et al., 2013; Measham et al., 2013; Public Health England, 2015). Whilst existing empirical research on the benefits of PSWs for service users in structured treatment is still in its infancy\(^\text{17}\), research conducted in the mental health sector, where the employment of PSWs in treatment has a longer history, has offered useful insights (Davidson et al., 1999, 2012; Repper and Carter, 2011).

Indeed, research into the employment of PSWs in mental health services has demonstrated a range of benefits. Along with offering hope and inspiration to achieve recovery (Davidson et al., 1999, 2012; Repper and Carter, 2011), the employment of PSWs can also reduce the negative stigma and negative perceptions of self experienced by service users in treatment by demonstrating the potential for personal growth (Davidson et al., 1999; Ochocka et al., 2006). Moreover, PSWs are often able to deliver better outcomes for their clients, as they can offer more authentic empathy and validation to clients having shared similar experiences (Mead and MacNeil, 2006; Repper and Carter, 2011; Davidson et al., 2012; Noorani, 2013).

\(^{17}\) This is not to overlook the large body of research that has demonstrated the benefits of peer support for recovery from drug use more broadly (see White, 2009), but rather that there has been significantly less research examining the benefits of peer support within mainstream treatment services (notable exceptions include Best, Loudon, et al., 2013; Measham et al., 2013; DrugScope, 2015a).
In addition to providing benefits to service users, the opportunity of employment into peer support roles within treatment services can also strengthen an individual’s own recovery. As identified by Cloud and Granfield (2008) and built on by Best et al. (2016), one of the key barriers to recovery is ‘negative recovery capital’ in terms of barriers to housing and paid employment (see section 2.4). The increased emphasis placed on ensuring that services make recovery ‘visible’ through the employment of PSWs has provided greater opportunities for recovering drug users to gain employment – whether paid or voluntary – and build on their recovery capital (Best and Laudet, 2010; Measham et al., 2013; Wardle, 2013; Best et al., 2016; Penn et al., 2016; Roy and Buchanan, 2016). In addition, the development of a positive social identity through employment can challenge the internalised stigma and external exclusion felt by many problem drug users (Measham et al., 2013; Best, 2016).

However, the employment of ex-service users into treatment also comes with its own set of specific risks. Most significantly, it has been argued that ex-service users who are recruited into positions of responsibility within treatment are at increased risk of relapse due to the nature of their role, particularly if they are recruited too soon after exiting treatment or have been given too much responsibility (White, 2009; Shapiro, 2012; DrugScope, 2015b; Roy and Buchanan, 2016). Within the mental health sector, evidence has been presented of PSWs experiencing readmissions to hospital after experiencing difficulties with their own recovery within their peer support roles (McLean et al., 2009). Whilst not only undermining their recovery, PSWs who relapse can also negatively impact the aspirations of recovery for the clients with whom they were working (Chinman et al., 2006; Repper and Carter, 2011). As Shapiro (2012) notes, the task for service providers in the drugs field is to ensure that
service users are given enough time after entering into their own recovery journey before being recruited into services, along with being offered adequate support throughout their roles.

A further risk for PSWs in treatment is that, by recruiting PSWs and giving them a title (such as recovery champion) this has the potential to create unequal power relations between the PSW and their clients, thus undermining the reciprocal nature of mutual support (Davidson et al., 1999; Mead et al., 2001; White, 2004; Repper and Carter, 2011; Bassuk et al., 2016). Interestingly, as Mowbray et al. (1998) have found, whilst given a role and a title within services, PSWs can also experience feelings of low status compared to other, ‘professional’ staff, who perhaps do not view them as equals. Shapiro (2012:9) has accurately hypothesised about this occurrence within the drug treatment sector:

> There is a real danger that recovery champions can get caught between a rock and hard place. They have been promoted out of their peer group, but at the same time, they are not part of the professional suits sitting around the meeting table. This has always been a potential problem for service user representatives, but the issue can be more acute for people tagged with the label ‘champion’.

Given the above risks, it is important to ensure that recovering drug users who are employed within treatment services are given the support and guidance necessary to perform their duties whilst simultaneously continuing to safeguard their own recovery (Shapiro, 2012; Public Health England, 2015; Roy and Buchanan, 2016). Research has found that whilst service providers are increasingly recruiting ex-service users via structured development programmes, considerable numbers still actively recruit without a structured programme in place (DrugScope, 2015b; Adfam, 2016).
As this section has demonstrated, the reorientation towards recovery has brought with it a significant change in the composition of the drug treatment workforce. This has occurred as a result of a desire to harness the recovery benefits that ‘experts-by-experience’ can bring to drug treatment services. The employment of service users can be understood as part of a broader drive to promote SUI within public sector services. However, the increased employment of PSWs has occurred alongside substantial reductions to both frontline and back office staff, raising questions over the extent to which this merely reflects broader processes of neoliberal welfare reform. At the level of practice, the presence of ‘experts-by-experience’ within community drug services generates both benefits and risks.

Whilst research from within and beyond the drugs field has provided useful insights, questions for further research remain. Much hinges on the means by which recovering drug users are employed by services, including the speed at which they are recruited after completing treatment, the responsibilities placed on them within their roles, and the support and training available to them throughout their employment. This thesis aims to add to the debates introduced here and to provide answers to the questions raised. The following section departs from the direct examination of the government’s recovery agenda by considering more broadly the potential impact of the recent public health reforms on drug service provision at a time of economic austerity.
2.7 Delivering recovery at a time of widespread reform and economic austerity

The emergence of the recovery agenda has occurred alongside wide-ranging reform of the public health system. The Health and Social Care Act 2012 fundamentally changed the commissioning and management of healthcare in England by returning a leading public health role to local authorities (HM Government, 2012). These reforms have been implemented during a time of economic austerity, which has witnessed unprecedented cuts to local authority budgets (Levitas, 2012; Lowndes and Pratchett, 2012). The reforms to the public health system within this austere economic climate present a further challenge to fulfilling the ambitions of the recovery agenda. This section begins by exploring the impact of the public health reforms on the drug treatment sector before examining the existing, albeit scant, empirical evidence that has offered some useful insights into the picture on the ground.

Within the new public health system, strategic responsibility for drug treatment falls within PHE’s Health Improvement and Population Health Directorate, but, as noted in Chapter 1, the planning and commissioning of drug and alcohol services is ultimately the responsibility of Directors of Public Health (Roberts, 2011; DrugScope, 2013). Set within the context of these changes, the 2010 strategy emphasises the need for Directors of Public Health to ensure that drug and alcohol services are competitively tendered and rewarded (HM Government, 2010:19). A clear example of this has been the introduction of PbR as examined in section 2.5. The emphasis on ensuring that services are competitively tendered demonstrates the broader trend of marketization and a need to drive up efficiency and drive down costs (Measham et al., 2013:51).
As noted in Chapter 1, in April 2013, the NTA was abolished and its key functions transferred into PHE. With this change, the PTB and all other spend on drug treatment was absorbed into the wider public health budget. At the time, this accounted for approximately one quarter of the total health budget, and one third of the public health budget allocated to local authorities (Roberts, 2011; UKDPC, 2012b; DrugScope, 2013). Whilst the total budget for public health is ring-fenced within PHE, there is no longer a ring-fence specifically around spending on drug services (Roberts, 2011; Royal College of Nursing, 2013; Roy and Buchanan, 2016).

Through drawing budgets for drug services into the wider remit of public health, and placing responsibility for the commissioning and delivery of services in the hands of Directors of Public Health, existing research has highlighted opportunities for diversifying the services offered in a locality and for developing innovative, joined-up approaches, linking drug services with wider responsibilities such as housing, employment and education (UKDPC, 2012b; DrugScope, 2013, 2015a; Public Health England, 2014; Roy and Buchanan, 2016). As Roberts (2011) notes, this is has been made easier by linking services within the NHS and local authorities through the establishment of HWBs. Assessing local need and developing strategies to address identified needs is also more structured through the introduction of JSNAs and JHWSs (UKDPC, 2012b; see Chapter 1). Roberts (2011:126) contends that this new approach will hopefully bring a greater emphasis on early intervention and a greater integration of drug and alcohol services.

However, with reductions to local authority budgets (see Lowndes and Pratchett, 2012; Taylor-Gooby, 2012) and competing demands on available funding, many have
expressed concern that drug treatment services may experience disinvestment within some local authorities as their relative importance is weighed against other public health concerns (e.g. UKDPC, 2012b; DrugScope, 2013; Speed and Gabe, 2013; Roy and Buchanan, 2016). Whilst, theoretically, most services are at increased risk of disinvestment within the new system, due to their stigmatisation as an ‘undeserving’ group and their ‘self-inflicted’ condition, this risk is amplified for problematic drug users (DrugScope, 2012; UKDPC, 2012b; Lloyd, 2013).

Further, as HWBs are not statutorily required to provide a seat for specialist representatives of the drug and alcohol sector, or from the voluntary and community sector more broadly, there is a challenge for drug and alcohol service providers to highlight the benefits that their services can offer in terms of improving the wider public health needs of local communities (DrugScope, 2013). Commenting on the potential impact of these reforms, Roberts (2011:128) notes:

> These proposals will have dramatic implications for drug and alcohol treatment, and the individuals, families and communities who are reliant upon it. They could provide a platform for improving outcomes for service users, but at the same time there is genuine risk that over the next few years we could witness deprioritisation and substantial disinvestment in services that could set the sector back years.

Whilst empirical research examining the impact of the shift to recovery in this climate remains scarce, key pieces of research have offered valuable snapshots into the current picture on the ground. The data presented in the following section is drawn predominantly from a UKDPC study, which was conducted immediately prior to the introduction of the public health reforms (UKDPC, 2012b), and annual *State of the Sector* reports published since 2014 (DrugScope, 2014, 2015b; Adfam, 2016).
2.7.1 The ‘State of the Sector’

In the continuing climate of austerity, existing research has highlighted an increasing need among local authorities to continually reassess and retender services to ensure efficiency and value for money (DrugScope, 2014, 2015b; Public Health England, 2014). With the reorientation towards recovery and the shift to outcome-based commissioning, research has found that significant numbers of services have been through contract renegotiation or retendering, or are expected to go through it in the near future (UKDPC, 2012b, 2012c, DrugScope, 2014, 2015b; Adfam, 2016). For example, in the most recent State of the Sector survey, 44 per cent of services had been through retendering or contract renegotiation in the previous year, with 49 per cent expected to go through one of these processes in the following year (Adfam, 2016:6).

Of services that had been re-commissioned, in almost all cases, the contracts were for a single or lead provider model (UKDPC, 2012b). As the UKDPC (2012b, 2012c:7) note, in the current era of austerity, there is a need to realise savings by establishing economies of scale, with larger providers also more able to bid for contracts in the current climate. In addition, in a further effort to ensure continued efficiency, contract lengths have also shortened, with the vast majority of service providers now working to contracts of three years’ duration or less (DrugScope, 2014, 2015b; Public Health England, 2014; Adfam, 2016). In each of the State of the Sector surveys, there is consensus amongst respondents that shorter contract lengths and thus the frequent retendering and commissioning of services is having a ‘harmful and disruptive effect on service provision’ (DrugScope, 2015b:8), and had generated anxieties among staff over job security (DrugScope, 2014, 2015b; Adfam, 2016).
Moreover, with the strain on local authority budgets, Adfam (2016:27) report an increased weighting on price within tenders, with a suggestion that commissioners are awarding contracts to organisations who offer cheaper options, giving little consideration to the quality and sustainability of the service provided. In addition, tenders are increasingly requiring providers to deliver on social and public health outcomes that extend beyond drug and alcohol services directly (such as obesity and smoking cessation; DrugScope, 2015a:14). The increased focus on cost has also led to a movement away from contracting large NHS providers towards an increase in voluntary sector provision (UKDPC, 2012b). In the current climate, research has found that NHS providers are increasingly unable to compete on price with voluntary organisations, which are able to respond to the highly competitive environment by finding significant cost savings (DrugScope, 2012; UKDPC, 2012b).

In respect of funding for drug and alcohol services, research has found that significant numbers of services have experienced decreases in funding, compared with relatively few services reporting an increase. In the most recent State of the Sector report (Adfam, 2016:17), it was found that 38 per cent of respondents had experienced a decrease in funding over the previous 12 months, compared to just 11 per cent reporting an increase. Residential rehabilitation services are being affected more than community services, with over half (58 per cent) of residential services reporting a decrease in funding compared to 10 per cent reporting an increase (Adfam, 2016:18).

As already highlighted in section 2.6, with the emphasis on building recovery in communities, there has been a call for increased SUI within treatment services, with research reporting significant increases in the employment of ex-service users into
both paid and voluntary positions in services at a time of reductions to professional frontline and back office staff (DrugScope, 2014, 2015b; Adfam, 2016). With regard to the decrease in frontline staff, a quarter of all respondents in the 2015 *State of the Sector* survey expressed concern over their ability to continue to provide services at a time when increasing numbers of clients were accessing their services (Adfam, 2016:6).

A consistent theme expressed by respondents over the three years of the *State of the Sector* surveys related to issues with joint working. Despite the reforms to the public health system bringing increased opportunities for developing innovative, joined-up approaches between service providers in local authorities (Roberts, 2011), each year, *State of the Sector* reports have shown that historic issues remain. Particular areas of concern were links with housing support, joint working with mental health services, and support for clients with dual diagnosis and complex needs (DrugScope, 2014, 2015b; Adfam, 2016). Whilst more services than not have experienced improved access to employment services and physical health services, respondents felt that access to mental health services and housing support had worsened over the reporting periods (DrugScope, 2015b; Adfam, 2016). These findings raise further concerns over the extent to which treatment services are able to adequately support service users to expand and build on their recovery capital.

Whilst the above findings have offered useful insights, key questions remain about how the public health reforms and the drive to deliver the ambitions of the recovery agenda are playing out in different local authorities. As the UKDPC (2012b) note, local areas each have different structural arrangements, some are affected more by the
worsening economic situation, and some areas are adapting to the changes much faster than others. Above all, concerns have been expressed over the ability of providers to maintain their current levels of funding in order to continue to work towards achieving the ambitions of the drug strategy in the face of increased caseloads and reductions in frontline staff, in addition to continuing reductions to local authority budgets (DrugScope, 2014).

2.8 Conclusion

This chapter has drawn together a range of empirical and theoretical literature in order to examine the shift towards recovery in British drug policy during a time of economic austerity and wide-ranging reform. As explored through this literature review, whilst existing empirical research has provided valuable insights into some of the most significant aspects of the recovery agenda, research has thus far failed to examine how the pieces of this puzzle combine and manifest in local policy and practice. Moreover, the few notable exceptions to this (e.g. Roy and Buffin, 2011; Measham et al., 2013) have also failed to consider the impact of the wider context in which the recovery agenda has been introduced, including the impact of austerity and the wide-ranging public health reforms. In addition, the existing literature has largely failed to offer any theoretical explanations for the changes that are occurring and the impact on the ground. Lastly, whilst the UKDPC and State of the Sector studies detailed in the previous section have offered useful snapshots into the impact of some of these developments, these reports are significantly limited by their lack of depth, with data having been primarily collected through online surveys.

Through reviewing this literature, gaps in knowledge have been identified and key questions for further research have been raised. In particular, with concerns over the
government’s approach to recovery and the apparent conflation of recovery with abstinence, questions have been asked over the way in which recovery is being defined in treatment services on the ground and the implications this has for practice (Duke, 2013; McKeganey, 2014; Roy and Buchanan, 2016). With existing research having documented some of the key issues that this lack of consensus definition can create, it is important to add to this knowledge through further empirical study.

In addition, important questions remain over the impact of the shift to outcome-based commissioning and the successful completion of drug treatment target (Public Health England, 2016a). As existing research has demonstrated (Hunter, 2011; Roy and Buffin, 2011; Measham et al., 2013; Neale et al., 2013; DrugScope, 2015a; Best, De Alwis, et al., 2017), there is a risk that the focus on producing outcomes will give rise to perverse incentives and will result in providers encouraging service users out of treatment prematurely in order to hit targets. In addition, there are concerns over the extent to which practices of ‘gaming’ will enter the sector, particularly where providers are commissioned through a PbR model (Maynard et al., 2011; Roberts, 2011; Roy and Buffin, 2011; UKDPC, 2011, 2012b, DrugScope, 2012, 2015a; Duke, 2013; Roy and Buchanan, 2016).

The increased emphasis on employing people with lived experience within treatment services has also raised questions for further research. Whilst existing research has demonstrated the benefits of employing recovering drug users in services (Best and Gilman, 2010; NTA, 2012a; Best, Loudon, et al., 2013; Measham et al., 2013; DrugScope, 2014, 2015b; Adfam, 2016; Best, 2016), there are clear concerns over the means by which individuals are being recruited into these roles and the
responsibilities bestowed upon them. It has been argued that ex-service users who are recruited into positions of responsibility within treatment are at increased risk of relapse due to the nature of their role, particularly if they are recruited too soon after exiting treatment or have been given too much responsibility (White, 2009; Shapiro, 2012; DrugScope, 2015b; Roy and Buchanan, 2016).

Lastly, there are significant concerns over the climate in which the recovery agenda has emerged. There is a great deal of uncertainty over the impact of the public health reforms on service provision in the austere economic climate, with fears over the future investment in treatment services and the impact of cuts to wider support services for drug users (UKDPC, 2012b; Speed and Gabe, 2013; DrugScope, 2014; Roy and Buchanan, 2016). In this climate, key questions are raised over the extent to which service users will be adequately supported to accrue the capital necessary to initiate and sustain recovery (DrugScope, 2012, 2015a; Best, Bird, et al., 2015; Whiteford et al., 2016).

To echo the sentiments of others, the shift to recovery in the current climate represents a ‘large social experiment’ (UKDPC, 2012b), which is ‘not based on evidence, but on guesswork’ (Stevens, 2011a:20). Whilst there are some pieces of empirical research that have examined the shift to recovery, in-depth, empirical research into the impact of this shift on local policy and practice remains scarce. In particular, as Measham et al. (2013:78) note, little is known about how the shift to recovery has altered local policy and practice from the perspectives of commissioners, providers and service users. The following chapter outlines the methodological approach adopted in this research to bridge this gap in knowledge.
Chapter 3 | Methodology

3.1 Introduction

As argued in the previous chapter, whilst many have hypothesised about the impact of the shift to recovery on local level policy and practice (e.g. Roberts, 2011; DrugScope, 2012, 2013, McKeeganey, 2012, 2014; UKDPC, 2012b; Watson, 2012), very few have researched it empirically. Moreover, whilst existing empirical research has offered valuable insights (e.g. Roy and Buffin, 2011; Duke et al., 2013; Measham et al., 2013; Neale et al., 2013; DrugScope, 2014, 2015b; Bjerge et al., 2015; Adfam, 2016; Roy and Buchanan, 2016), important questions remain concerning the impact of this shift, particularly as it is experienced by commissioners, providers and service users alike. This research aims to fill this gap in knowledge.

This chapter describes, and offers justification for, the methodological approach adopted for this research. To begin, the aims and objectives are revisited, before detailing the epistemological stance and how this informed the data collection process. Following this, the sampling procedure is outlined and a description of the sample is provided. Attention then turns to the methods of data collection employed before discussing the data analysis procedure. Finally, consideration is given to the practical and ethical issues that arose throughout the course of this research.

Reflexive evaluations of the research are interspersed throughout this chapter. It is important to recognise that qualitative researchers are not detached, neutral and unbiased research instruments, and instead influence and shape the research process (Willig, 2013:25). This is the result of both who we are, such as our social identities,
values and personal beliefs (personal reflexivity), and also as a theorist, such as how the design of the study and the analysis of the data constructs the research findings (epistemological reflexivity; Willig, 2013:10).

3.2 Revisiting the research aims

As detailed in Chapter 1, the overarching aim of this research is to examine the impact of the shift towards recovery in British drug policy on local level policy and practice during a time of economic austerity and widespread public health reform. This broad aim can be broken down into the following overarching research questions:

1. How has the reorientation towards recovery in British drug policy influenced local level policy and practice?
2. To what extent have the recent public health reforms impacted on drug treatment services at the local level?
3. How have drug treatment services been affected by pervasive government austerity measures?

The review of existing literature carried out in the previous chapter demonstrated the current gap in knowledge in relation to these overarching questions. As noted in Chapter 1, alongside these questions, this thesis also aims to contribute to understandings of neoliberalism through an exploration of its existence and impact within treatment services at the level of practice.

Following a review of the existing literature, Chapter 2 concluded by setting up the following subsidiary research questions:

i. How is recovery defined at the level of practice? How do those working within the drug treatment sector interpret the shift to recovery?
ii. What impact has the shift to outcome-based commissioning had on local level policy and practice?

iii. Has there been an increase in the employment of recovering drug users in PSW roles within treatment? What responsibilities are PSWs given? What opportunities and risks are presented by their employment?

iv. Are service users adequately supported to accrue the recovery capital necessary to initiate and sustain recovery?

v. What opportunities and challenges do the reforms to the public health system present to treatment services?

vi. Have drug services experienced cuts to funding? What challenges does this present for continued provision of support?

vii. Has the tendering and commissioning of drug services changed in the current climate? What impact is this having for treatment services?

viii. How can the changes witnessed within the treatment sector be conceptualised through neoliberal notions of competition, risk, choice and responsibility?

It is worth noting here that the research aim and the questions to be answered through the research altered slightly during the early stages of data collection. Prior to entering the field, a key focus of the research was to explore the impact of the recession on service users’ drug use and drug-using practices. However, during initial interviews, whilst both treatment staff and service users discussed changing patterns of drug use\(^{18}\), few participants suggested that the recession had altered service users’ drug use in any noticeable way. Instead, it became clear that the broader issue to be addressed

\(^{18}\) For example, both service staff and service users provided anecdotal evidence in support of the growing use of synthetic cannabinoids, particularly by service users being released from prison. This finding offers support for emerging research into the use of synthetic cannabinoids in prison (for a comprehensive example, see Ralphs et al. (2017)).
was how the shift to recovery had impacted service provision within the research sites. As such, the research aims and questions were adapted to reflect this.

### 3.3 Epistemological considerations

A relativist ontology and constructionist epistemology informs this thesis. Opposed to the views of positivism, it is taken to believe that knowledge of the world and the meaning ascribed is not unambiguous, objective and waiting to be discovered. Rather, meaning is taken to be socially and historically constructed by individuals, both individually and collectively, through their subjective experiences and understandings of the world they are interpreting (Schwandt, 1994; Crotty, 1998; Hacking, 1999; Mason, 2002; Creswell, 2007). As Crotty (1998:42) explains:

> [A]ll knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.

It follows, ontologically, that data should be generated through conversations and interactions with social actors. The term ‘constructionism’ is utilised rather than ‘constructivism’, as it is held that meaning and knowledge, whilst individually constructed, is also historically and socially generated and transmitted through shared social constructions of phenomena (Schwandt, 1994; Hacking, 1999). This is not intended to deny the singular, independent meaning-making of the individual, as it is shown through this research that individuals construct meaning in quite distinct ways. Rather, the term was favoured due to the added dimension of the collective creation and transmission of socially and historically-situated meaning, which is found within this research to be largely evident when examining participants’ understandings and experiences of the shift to recovery.
Here, it is also important to bring in Giddens’ (1993:79) concept of the ‘double hermeneutic’. In contrasting the natural and social world, Giddens (1993) notes that the natural world does not self-constitute meaning, as meaning only comes into existence when individuals attempt to interpret and make sense of it. However, as Giddens (1993:79, emphasis in original) notes, ‘Social life … is produced by its component actors precisely in terms of their active constitution and reconstitution of frames of meaning’. What this presents to those who study the social world, then, is a second layer of interpretation being imposed on the phenomena we study, as Giddens continues to discuss:

The conceptual schemes of the social sciences therefore express a double hermeneutic, relating both to entering and grasping the frames of meaning involved in the production of social life by lay actors, and reconstituting these within the new frames of meaning involved in technical conceptual schemes. (Giddens, 1993:79, emphasis in original)

This view of the social world is acutely pertinent throughout this research, particularly when addressing individual and shared notions of recovery, as addressed in Chapter 4.

3.4 Sampling

This research is a comparative case study of two drug treatment services operating in two local authorities in the north of England. A total of 36 participants were recruited, which included drug service commissioners, service staff and service users, and one national policy stakeholder. This section provides an overview of the sampling procedure adopted, along with a breakdown of participants recruited and a description of the drug treatment services. Practical issues encountered when recruiting participants are also discussed.
3.4.1 Sampling procedure

A purposive sampling strategy was adopted (Bryman, 2016). The strategy intended to identify two local authorities characterised by contrasting levels of deprivation to serve as a comparative case study. As noted in section 3.2, in the early stages of this research, one of the key research questions concerned the impact of the recession on drug use and drug-using practices. Informed by research conducted in the 1980s and 1990s that documented escalating heroin use in many deprived areas at a time of rising unemployment (Parker et al., 1987, 1988; Pearson, 1987; Seddon, 2006), it was hypothesised that drug use and drug-using practices might have been impacted in similar ways since the 2008 economic recession (Bretteville-Jensen, 2011; Lakhdar and Bastianic, 2011). As the recession disproportionately impacted the most deprived communities (Dolphin, 2009; Athwal et al., 2011), it was also hypothesised that drug use would have worsened disproportionately in these areas.

Utilising the English indices of deprivation\(^\text{19}\), two local authorities – Metropolis and Southside – were identified based on various contrasting factors commonly accepted as indicators of deprivation. Factors included: the rate of unemployment, the proportion of residents claiming Jobseeker’s Allowance (JSA), life expectancy, and housing tenure. In each of these factors, Metropolis scored significantly higher in terms of its level of deprivation in comparison to Southside.

Once the two local authorities had been identified, internet searches for drug services within the two local authorities were conducted. The two drug services approached for participation were selected due to the nature of the services they provide, and

\(^{19}\) The English indices of deprivation measure deprivation at lower-layer super output areas – small geographical areas covering a minimum of 1,000 and a maximum of 3,000 residents.
whether it was believed that they could provide access to a diverse range of service users. The two services identified were Total Care in Metropolis and Resicare in Southside. At the time of the research, Total Care was commissioned as the clinical prescribing service in Metropolis, whilst Resicare was operating a residential rehabilitation service in Southside.  

When approaching the services for participation, I contacted individuals who could operate as potential gatekeepers and thus facilitate access to the research sites (Crano et al., 2014; Flick, 2014; Bryman, 2016). In recruiting Total Care, I contacted Steve, a particularly well-known figure within the drug treatment sector, and an individual whom my supervisors had previously introduced to me. Steve introduced me to the service manager in Total Care via email and, by doing so, acted as a source of endorsement for my research. The process of requesting participation from Resicare was somewhat similar. At a conference in 2014, I met the ex-Managing Director of Resicare, Chris. After discussing my research with Chris, he sought approval for my research from the current Managing Director of Resicare. Being introduced to the drug service managers by individuals who hold a degree of importance and influence significantly eased the process of gaining access.

Once I gained access to the two services, participation was agreed with the service managers from each site. In recruiting service staff from Resicare, the majority of individuals were identified and introduced to me by Alan, the service manager. Again, this no doubt helped to endorse my research, leading to greater levels of staff

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20 A more detailed overview of the research sites is provided in the following section.
21 As addressed in section 3.7.5, in the interest of confidentiality, participants’ names and the names and locations of service centres have been replaced with pseudonyms.
participation. Within Total Care, contact with staff members was initially made through the manager, Sarah.

As will be addressed in section 3.7.1, the NHS Research Ethics Committee made it clear that, to avoid any possible coercion, service users should not be approached directly for participation, and should only be recruited via introduction by service staff. Initially, I was of the impression that this would create additional barriers to participation; however, in practice, having service staff identify participants who were interested in taking part made the recruitment process much easier. For instance, when it came to interviewing service users from Resicare, Alan had arranged for eight participants that had shown interest to be available over a two-day period. Similarly, in Total Care, I spent a total of four days across two sites and was able to interview service users as and when they were available, which was most often immediately after one-to-one or group sessions with their key workers.

Whilst having service staff identify willing participants made the recruitment process easier, there are a few issues that should be identified here. Firstly, as service users were recruited as and when they were present in the service centres, there was limited scope to recruit participants based on certain characteristics or demographics. Nevertheless, to achieve a sample with variety, at times, I asked service staff if any service users were available below the age of 30, for instance, or if any individuals were available who were in touch with services for the first time. Whilst this was met with some degree of success, it was nevertheless limited by the availability of service users over the days I was attending the centres. Secondly, as staff members were aware that part of the research involved asking service users about their experience of
services, there are concerns around the extent to which service users were selected by staff based on whether they would speak favourably about their service. However, given that service users provided both positive and critical views of service provision during interviews, this concern does not appear to have materialised.

The final sample size for this research amounted to 36 participants. A breakdown of participants is provided in Table 1. Given that Total Care is a much larger organisation in comparison to Resicare, a greater number of participants were available during fieldwork days and thus more participants were recruited from Total Care than Resicare. Nevertheless, a sufficient sample size was achieved from both organisations.

Table 1: Breakdown of participants

<table>
<thead>
<tr>
<th>Participant Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service staff (Total Care)</td>
<td>8</td>
</tr>
<tr>
<td>Service users (Total Care)</td>
<td>12</td>
</tr>
<tr>
<td>Service staff (Resicare)</td>
<td>5</td>
</tr>
<tr>
<td>Service users (Resicare)</td>
<td>8</td>
</tr>
<tr>
<td>Service commissioners (Southside)</td>
<td>2</td>
</tr>
<tr>
<td>National policy stakeholder^22</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

3.4.2 Research sites

As noted earlier, at the time of the research, Total Care was providing a clinical treatment interventions service in Metropolis. The drug service in Metropolis was commissioned in three parts, with Total Care operating alongside two other prime providers: SubstanceAid and Regain. SubstanceAid was commissioned to provide the intake service while Regain was commissioned as the recovery service.

^22 The description of this participant is intentionally vague. The individual in question is Steve, who, as noted earlier, is a well-known figure within the field and has occupied a very specific position within the treatment sector. Given this, due to concerns of anonymity, the stated description was chosen.
Whilst Total Care was solely commissioned to deliver clinical interventions in Metropolis, with the majority of their work focused on substitute opiate prescribing, they were also providing recovery-focused support groups and additional wrap-around, holistic services. In addition, during the data collection period, Total Care had employed a small number of paid recovery champions and unpaid service users representatives. The provision of recovery-focused interventions by Total Care when not commissioned to do so is of significance when considering the extent and impact of competition within the drug treatment sector, as demonstrated throughout this thesis.

Resicare are an abstinence-focused drug and alcohol service provider. Within Southside, Resicare run a tier 4 residential rehabilitation programme. In addition, at the time of the research, Resicare was providing a range of community-based services in various local authorities, including both Southside and Metropolis. Research with Resicare staff and service users took place at their residential rehabilitation site in Southside.

3.4.3 Problems faced recruiting participants

One of the key challenges encountered during this research was the challenge of securing participation from drug service commissioners. Early on in the research process, prior to securing participation from Total Care and Resicare, I attempted to recruit two drug services based in two different local authorities in the county. The recruitment process was slightly different in that I first approached the commissioners for participation rather than the drug services themselves. After attending a meeting with the service commissioners for one of the local authorities, my research proposal was passed through the research governance team within the council. However, I was
later informed that, due to the already-stretched resources, the two local authorities approached would not be willing to participate\textsuperscript{23}.

Another issue when recruiting service commissioners was experienced in the latter stages of the research when requesting participation from Chantelle, the drug and alcohol service commissioner for Metropolis. When Chantelle and I met to discuss the research and agree participation, Chantelle became considerably anxious and concerned by a number of aspects of the study – most notably the recording of the interview and the use of direct quotations. In an attempt to allay her concerns, I advised Chantelle that I was happy to send her the interview transcript so that she could approve the use of quotations\textsuperscript{24}, and advised that she could take a week to consider whether she wished to engage. Chantelle later agreed to participate and we arranged an interview at her place of work.

During the interview, we discussed a number of topics concerned with the commissioning and delivery of drug services, and how this had changed due to the shift towards recovery and the recent public health reforms. However, shortly after the interview, Chantelle emailed me stating that she was feeling anxious about the interview and concerned about the depth and detail of questions asked. After a brief email discussion, Chantelle withdrew from the research and asked for her interview data to be withdrawn. Upon reflection, it is possible that Chantelle’s anxiety over the research illustrates the highly politicised nature of drug treatment at this time, as documented throughout this thesis.

\textsuperscript{23} Whilst initially disappointing, this served as an early indication of the financial issues currently faced by treatment providers.

\textsuperscript{24} This is often referred to as ‘member checks’, which, according to Thomas (2017) can be used for participant approval.
3.5 Research methods

3.5.1 Interviews

In order to address the research questions, it was essential to understand the lived experiences of participants within the research. As such, qualitative, semi-structured interviews were utilised with all participants. The majority of the interviews were conducted between late-September 2015 and early-January 2016, with a final interview conducted in June 2016. A total of 36 interviews were conducted, with some interviews taking place over a two-day period due to time constraints during the first meeting. The length of the interviews differed markedly: the longest interview lasted two hours and 48 minutes and the shortest lasted 11 minutes. On average, interviews with service staff lasted between one and two hours. Service user interviews mostly lasted between 30 minutes and one hour; however, some interviews with Resicare service users lasted upwards of an hour and 30 minutes.

During interviews, it was important to give interviewees the freedom to construct meaning. For each interview, I attempted to keep the questions asked of participants – and especially service users – as broad and open-ended as possible (Gilbert, 1993; Seale, 2004; Creswell, 2007). For instance, the opening question during interviews with service users was often a version of:

Can you tell me a bit about your background, your upbringing, relationships and that kind of thing?

The original intention of opening the interview in this way was to elicit a greater level of depth, as respondents were able to discuss a range of often-disparate personal

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25 All but one of the interviews conducted for this research were on a one-to-one basis. The anomaly was the interview with the commissioners in Southside in which two commissioning personnel were interviewed together. This allowed for an insight into the different roles and experiences of each commissioner.

26 See Appendix A for interview guides.
experiences that they considered relevant for understanding their histories of drug use. In addition, this would allow service users to start their narrative where they wanted and to discuss anything they felt was relevant to the research (Flick, 2014; Bryman, 2016). This approach proved successful. In a practical sense, whilst some interviewees required clarification or explanation about what I was asking them (one participant, for instance, asked what I expected him to tell me in relation to his background), participants were able to discuss their personal histories and life events leading into, and at times out of, drug use. For many of the interviews with service users, it often felt like I had to ask very few opening questions before the figurative ball began to roll, and only slowing when I drew the interview to a close. As suggested by Bryman (2016), interviewees were only interrupted when clarification was required on certain points or when the interviews were going too far off track.

Whilst the interviews with service commissioners and service staff were slightly more structured in nature, it was important to also let new avenues of discussion arise. For example, when interviewing service staff, questioning would usually begin with:

So I'd first like to start by asking you what your role is within [treatment service].

Again, by opening interviews with this broad question, respondents were able to explain, in their own ways, the focus, targets and responsibilities of their roles. In hindsight, had it not been for this approach to questioning, the significance of the shift to recovery on treatment policy and practice might not have been realised.

Alongside the one-to-one interviews, consideration was given to the use of group interviews with both service staff and service users. The use of group interviews would have allowed for an exploration of consensus and conflicting views of
participants on the topics covered (Flick, 2014; Bryman, 2016). However, during the one-to-one interviews, staff sometimes expressed strong, often negative, views on the impact of the shift towards recovery on the provision of support. Whilst it might have been useful to explore these opinions further within a group setting, I felt that asking participants to express their opinions in front of their colleagues could potentially disrupt their future working relationships and also potentially produce altered or mediated opinions.

With consent, all interviews were audio recorded. In addition to recording the interviews, field notes were made during the interviews. I would often note down any potential questions that arose from participants’ accounts, or simply any thoughts or feelings I had about the interviewee or the interview in general (see section 3.6). The recording of these notes often proved useful to supplement the interview transcripts during the data analysis.

3.5.2 Reflexive account of interviews

A range of literature concerning qualitative data collection within social research suggests that the researcher should remain neutral and should keep their involvement in the interview to a minimum (Deutscher et al., 1993; Gilbert, 1993; Holstein and Gubrium, 2004). As Deutscher et al. (1993:92) advise: ‘The interviewer must be an inert agent who exerts no influence on response by tone, expression, stance or statement’. However, it is now widely recognised that this situation is largely unattainable, and rather unreasonable to strive for (Holstein and Gubrium, 2004; Seale, 2004). Instead, the view of qualitative interviews as ‘interactional, interpretive activity’ (Holstein and Gubrium, 2004:140), in which interviewers function as co-creators of knowledge (Finlay, 2002), is preferred.
Reflecting on the interviews conducted for this research, it felt most appropriate to not view them as serving as a ‘pipeline for transporting knowledge’, but rather ‘as a social encounter in which knowledge is actively constructed … a site of, and occasion for, producing reportable knowledge’ (Holstein and Gubrium, 2004:141). Indeed, in keeping with the overall research strategy, the aim of the interview was to feel like an everyday conversation, forming a reciprocal relationship with participants (Oakley, 1981).

Whilst the image of the inert agent is viewed as both unattainable and unreasonable, it is important to give consideration to the ways in which my characteristics as a researcher might have influenced the data collection process. It is widely accepted that a researcher’s age, gender, ethnicity, social class, and a myriad of other features can all influence the data generated (Seale, 2004; Manderson et al., 2006; Belur, 2013; Bryman, 2016). Whilst there are many examples that could be offered in relation to this, the most salient factors appeared to be my gender and the vocabulary I used during interviews. This section deals with these factors in turn.

The influence of gender on the research process is well documented (Padfield and Procter, 1996; Seale, 2004; Manderson et al., 2006; Miller, 2010). During some interviews, it became apparent that my status as a male researcher potentially influenced the information provided by participants. This was apparent when interviewing both female and male participants. For instance, when interviewing Brandon, a 43-year-old service user, he often made remarks about women that made me feel uncomfortable. An example is when he was telling me about a service user partnering system they have in place in Resicare:
I tell you another thing about here, going back to the buddying up, boy and girl. Confidential this, but they fucking put … a Scouse lad, they put a ten year releasee – been in ten years, one sentence – in a house with a 23-year-old minx of a girl. What the fuck do they think’s going to happen? Fucking hell he’s human, isn’t he? Imagine what his [sex] drive was like? She’s a little minx, you know what I mean?

Brandon, Resicare service user

When hearing Brandon talk about the female service user in this derogatory manner, not only did it make me feel uncomfortable, it also made me question whether he would have expressed this in this manner if I were a female researcher. Brandon perhaps felt that he could be more candid during the interview with a male researcher.

The reverse relationship was also observed during an interview with Amanda, a 32-year-old service user. Amanda informed me that she had traumatic childhood experiences that she believed had led to her drug use, followed by a series of relationships in which she experienced domestic violence. Although I was interested to learn more about her experiences and how they had influenced her drug use, Amanda stated that she did not wish to discuss them with me. Although largely unknowable, it is likely that Amanda might have been more open to talking about these issues with a female researcher (Sorenson et al., 1987; Fraga, 2016). Overall, it is most likely that my gender will have affected the data collected; in some circumstances, some interviewees will have been more open during interviews, and others less so.

Regarding the vocabulary used during interviews, whilst this was not evident very often, it was raised during my interview with Jason, a service user in Resicare:

*If you’ve got someone who learnt at university talking about ‘crack cocaine’ and ‘heroin’ use, well, I haven’t done that; I fucking smoked ‘rock’ and smoked ‘gear’, you know what I mean? Talking to me about heroin and crack cocaine – you’re not using the same language as me.*

Jason, Resicare service user
Whilst Jason was making a distinction between treatment workers with first-hand experience of addiction and those who had only learned about it at ‘university’ (see Chapter 6), hearing this made me reflect on my own vocabulary used during the interview:

Talking to me about heroin and crack cocaine – you’re not using the same language as me.
I’m guilty of that as well.
Yeah, well that’s because you don’t know different; it’s just the way it is.

Jason, Resicare service user

Although my use of formal terms for drugs not once elicited a response in the manner that Jason speaks about above, had I used terms such as ‘rock’ instead of crack cocaine and ‘gear’ (or ‘brown’) instead of heroin, participants might have perceived me differently and thus potentially framed their accounts differently during interviews. This feeds into a broader point related to being an outsider to the group being researched. Put briefly, it is important to consider that, as a researcher with no experience of drug addiction or drug treatment, it is likely that I elicited qualitatively different responses to those that a researcher with first-hand experience might have generated (Dwyer and Buckle, 2009; Hayfield and Huxley, 2015).

Notwithstanding this, to echo the sentiments of Dwyer, it is not believed that being an insider to a group makes for a better or worse researcher; it just makes for a different type of researcher (Dwyer and Buckle, 2009:56). Moreover, when considering the above scenarios – amongst many others that occurred during interviews – I return to the idea of the interview being both a ‘topic’ and a ‘resource’ (Seale, 2004). Indeed, the data generated during interviews served as both resource: what the interviewees said about their experiences; and as topic: how this information was conveyed including the extent to which participants divulged information (Seale, 2004:183).
3.5.3 Practical issues encountered during interviews

A practical issue that can be encountered when interviewing drug users, particularly when dealing with heroin and crack-cocaine users, is that respondents can sometimes find it difficult to concentrate for the length of the interview (Wright et al., 1998). In one particular interview with a service user from Total Care, it was clear from the outset that the respondent was not in the ideal frame of mind to take part in the interview. The participant was jittery during the interview and spent most of the time rolling across the room on an office chair. It was difficult to get the participant to first understand what I was asking, and then to answer the questions asked. In this respect, the interview became very structured in nature, with the participant typically providing very short responses.

In the course of my questioning, I asked the participant when the last time he had used illicit substances, and also the last time he had taken methadone for which he was being prescribed. It transpired that whilst the respondent had not taken heroin or crack-cocaine on the day of the interview, he had also not yet picked up his methadone prescription from the chemist, which could potentially explain his behaviour. As a result of the participant’s behaviour, I felt that it was inappropriate to prolong the interview in an attempt to draw out the answers to my questions and thus decided to draw the interview to a close prior to its natural conclusion.

Another practical issue faced during interviews was a language barrier issue during my interviews with two service users, Danica and Joseph, whose first language was not English. In each of these interviews, it was apparent at times that the participants were struggling to understand the questions I was asking and thus the flow of the
The interview was stifled, with each interview lasting only 11 minutes and 13 minutes, respectively. The following example is taken from Danica’s interview:

**OK, so are you able to tell me a little bit about your background and your upbringing?**
*Erm... [long pause]*
**So where you grew up, or things like that...**
*I not understand*
**Where were you... What’s your upbringing been like here?**
*Here I come from to stop the drugs and picking up prescription and everything to changing, changing my life*
**OK, so how long have you been using drugs for?**

Danica, Total Care service user

The above excerpt highlights the issues that can arise as a result of language barriers during interviews. I opened the interview with Danica in the same manner that I opened interviews with the majority of other service users. However, it was evident from the initial question that Danica did not understand what I was asking her. After attempting to rephrase the question, it was apparent that Danica had misunderstood my questioning and instead told me why she was attending Total Care. As such, I decided to discuss Danica’s drug-using history first before returning to the question of her upbringing. Later in the interview, I asked Danica where she was born, which allowed for the discussion of her background to unfold.

Given this issue, it would have been beneficial to use an interpreter during the interviews with Danica and Joseph; however, the cost of hiring an interpreter was considered prohibitively expensive in the context of this research (see Hendrickson et al., 2013). Moreover, research has found that the use of interpreters can raise issues of validity, as the translator may interpret participants’ accounts in ways the participant did not intend (Björk Brämberg and Dahlberg, 2013). Rather, I should have instead...
included as one of the selection criteria that the interviewee should have reasonable English language skills\(^{27}\).

### 3.6 Analysis

Interview data were analysed thematically with the aid of QSR NVivo. Thematic analysis offers a flexible analytic method for ‘identifying, analysing and reporting patterns (themes) within data’, and is compatible within a constructionist framework (Braun and Clarke, 2006:79; Willig, 2013). As the identification of themes is a fundamental component of most qualitative data analysis methods, Boyatzis (1998:4) has argued that thematic analysis should be viewed as a process of analysis rather than a standalone method. However, its use as a distinct method of analysis has grown significantly over the last decade (Braun and Clarke, 2014) and, in light of this, it was considered appropriate to adopt thematic analysis as a method in its own right (Braun and Clarke, 2006; Willig, 2013).

The key stages of the analysis process are as follows. To begin, all interviews were transcribed and imported into NVivo. Each interview transcript was then read in full in order to familiarise myself with the data. Following this, initial notes were made about the data and its relevance to the research questions. As Willig (2013:61) notes, making note of the initial thoughts about the data can influence the choice of codes throughout the more ‘systematic process of coding’. At this point, the field notes made during interviews were referred to, and comments were made on each transcript to inform the later data analysis stages. Examples of notes made include how the participants were acting during the interview (such as the participant wheeling across

\(^{27}\) Again, however, this would likely have been at the discretion of treatment staff and thus would not have been an objective measure.
the room on the office chair), and the manner in which participants discussed certain issues (such as Total Care staff members being overtly critical of their own practices). The use of field notes allowed for an additional layer of analysis that has, at times, proved important for the research findings.

During the coding of the data, both manifest and latent codes were identified (Boyatzis, 1998:16; Braun and Clarke, 2006; Joffe, 2011). Manifest codes are drawn from the surface level of the data, such as what a participant has explicitly stated (e.g. ‘cuts’ and ‘challenge’; Boyatzis, 1998:16; Braun and Clarke, 2006; Joffe, 2011). On the other hand, latent codes are those that go beyond the surface-level semantic content and instead identify underlying meanings within the data (e.g. ‘competition’ and ‘responsibility’; Boyatzis, 1998:16; Braun and Clarke, 2006; Joffe, 2011).

Following the systematic coding process, themes were identified within the data. As Braun and Clarke (2006:82, emphasis in original) note, ‘A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set’. Themes identified were almost entirely data-driven (Boyatzis, 1998). However, as detailed in Chapter 2, many drug policy commentators have offered their hypotheses on the impact of the shift to recovery on local level police and practice. For instance, some have hypothesised that, as a result of the public health reforms and the new commissioning landscape, the drug treatment sector is at risk of disinvestment (Roberts, 2011; UKDPC, 2012b; DrugScope, 2013; Speed and Gabe, 2013; Roy and Buchanan, 2016). As such, whilst the themes identified within the data were drawn out from the ground up, the data was
also at times subjected to the range of hypotheses offered (Boyatzis, 1998; Braun and Clarke, 2006; Willig, 2013).

After themes had been identified, they were reviewed in relation to the research questions, the broader research context and how they work with each other in ‘tell[ing] a story about what is going on in the data’ (Willig, 2013:62). For instance, when thinking about how some of the service workers in Total Care viewed the risks associated with the drive to achieve successful completions of drug treatment (see Chapter 5), I considered this alongside the theme concerning the rise of the ‘unskilled’ workforce (see Chapter 6). In doing so, a more detailed picture of the data was able to emerge, suggesting that traditional prescribing workers have concerns over job security with the shift to recovery and the increasing employment of recovery champions and other PSWs in place of ‘professional’ staff.

During this review stage of the analysis process, some less significant themes were integrated into more significant themes or were excluded altogether. For example, whilst a number of participants raised issues surrounding the increased use of synthetic cannabinoids and prescription medication, this was not considered significant enough as a stand-alone theme in the wider context of the research and so was integrated into a broader theme concerning the challenges faced by services in an age of austerity.

The management and modification of themes was made easier with the use of NVivo. Whilst computer-aided qualitative data analysis software (CAQDAS) has been subject to some criticism, with fears that its use can distort the research process (see Flick,
2014), it is important to remember that CAQDAS does not do the analysis for the researcher. Indeed, the use of NVivo simply assisted in the coding, storage and management of the data during analysis.

3.7 Ethical considerations

Ethical approval to conduct this research was granted by an NHS Research Ethics Committee (REC) in September 2015 (REC reference 15/NW/0599). However, the process of gaining ethical approval was a drawn-out, arduous experience. This section begins by discussing the practical issues of gaining approval before outlining the ethical considerations encountered during the course of this research.

3.7.1 Gaining ethical approval

When approaching Total Care to participate, I was informed that, as funding for drug treatment is now part of the wider public health budget, NHS ethical approval was required. Gaining approval from the NHS REC to conduct the research was a lengthy, onerous task, and one of the most significant challenges encountered during this research.

An application was submitted through the Integrated Research Application System in February 2015 and a REC meeting was arranged for the following month. During the meeting, the Committee expressed a number of concerns regarding the research design. Prior to the REC meeting, the original research design included both quantitative methods (structured questionnaires) and qualitative methods (interviews and participant observation). The intention was to distribute questionnaires to service users across the two sites along with an invitation to engage in a follow-up interview upon completion of the questionnaires. However, the Committee expressed concern
that this method of recruiting service users would compromise anonymity. More significantly, though, the Committee questioned the value of recruiting service users for the research and maintained that inadequate consideration had been given to the way in which service users would be approached for participation. Based on these concerns, the research received an unfavourable opinion.

Following this decision, the research design was simplified considerably in order to allay the concerns of the REC. Whilst a stronger case for using the intended research design could have been made, I was becoming increasingly conscious of the time it was taking to receive ethical approval and the implications this might have had on the agreed participation of the two services. In order to simplify the design, the decision was made to employ qualitative methods of data collection only and to abandon the use of questionnaires. In doing so, the recruitment process for engaging service users was altered so that they were now to be recruited via introduction from service staff only. Abandoning the questionnaires in light of the Committee’s concerns is not considered to adversely impact the research, as the intention of using questionnaires was merely to identify participants for interview and to supplement the data generated throughout interviews. Further, due to the overall aim of the research – and particularly as it later developed (see section 3.2) – abandoning the questionnaire element had little impact on the research questions and the overall data generated.

A second application was submitted to the REC in July 2015. In addressing the suggestion that service users would not be included in the research, it was stressed in the application that the direct participation of service users was essential for gaining in-depth, first-hand accounts of their drug-taking behaviours and their experiences of
treatment services. At the second REC meeting, whilst the Committee was content with the changes that had been made in terms of the research design and recruitment process, and were convinced of the value of engaging directly with service users, the use of participant observation within the research was again questioned. Moreover, although the intention of participant observation was to observe the day-to-day activities of service workers and not service users per se, concerns were raised about how service users could opt-out of being observed if they so wished. From a practical perspective, it was considered unrealistic to gain consent from every single individual who entered the field of vision (Haggerty, 2004). However, to allay the concerns of the Committee, the decision was made to simplify the research design further and to abandon the use of participant observation. Again, whilst the use of observation would have generated additional data, this data would have merely been used to supplement the data generated through the interviews and thus was not considered crucial to the research.

In September 2015, the Committee offered a favourable opinion and the research was approved. Thanks to the cooperation of both Total Care and Resicare, the data collection began almost immediately. Nevertheless, the experience of gaining ethical approval from the NHS REC was an extremely lengthy process (spanning eight months from first applying to gaining approval) and there were a number of unexpected compromises and sacrifices in terms of the research design. It seemed that the REC were attempting to steer the research towards a research design deemed to be ‘less risky’, particularly when it came to the suggestion of not engaging with service users directly.
It is apparent that gaining ethical approval for qualitative, empirical research is becoming increasingly more challenging. Kevin Haggerty has documented this phenomenon with his notion of ‘ethics creep’ (2004:394). In addition, a number of academics have since commented on the bureaucratisation of the ethical review process, questioning whether RECs actually consider the rudimentary ethical issues posed by research or whether they merely produce a rigid structure denoting the ‘allowed from the disallowed’ (Winlow and Hall, 2012:410). The following sections detail the specific ethical considerations encountered throughout the course of this research.

3.7.2 The risk of harm to participants

One of the main ethical issues encountered during this research was the risk of causing emotional harm to service users when interviewing them about their personal histories of drug use and their experience of services. Previous research into sensitive topics has highlighted the demand for special consideration when engaging with participants who experienced trauma (see Dyregrov, 2004). Given the nature of this research, and the highly personal and interpersonal nature of in-depth interviewing, asking service users to reflect on their past, including their upbringing, relationships, employment, and, ultimately, times of drug use, could lead to service users recounting traumatic experiences and being emotionally harmed during interviews (Lee, 1993; Dyregrov, 2004).

To mitigate this risk, participants were informed that they did not have to speak about anything that they felt might be distressing. In addition, if at any point participants felt distressed, they were free to take a break from the interview, or withdraw altogether. After each interview, interviewees were given a participant debrief sheet, which
provided advice about who to contact if they were left feeling distressed as a result of the interview.

During the fieldwork, a small number of interviewees became upset when discussing certain experiences. For example, when interviewing Brandon and Michael, two Resicare service users, both became visibly upset when discussing their childhoods. In both instances, the participants were asked if they wanted to take a break or leave the interview; however, both said they wished to continue, and in fact welcomed the continued questioning:

**Are you okay to continue?**
*Of course, yeah.*
**Okay. So we don’t have to dwell on that.**
*You ask me what you want, mate.*

Brandon, Resicare service user

Additionally, participants who appeared distressed during interviews would often tell me that they found the research to be an overall positive or cathartic experience, as they could ‘get things off [their] chest’ or simply ‘have a rant’²⁸. Michael even stated that the interview would help him in his recovery:

*You see, but you see this, what I’ve just done with you, this is gonna help me, this’ll help me, this. You see this crying and this, it’ll help me. And I mean that, you know, sometimes you need to speak to somebody you don’t know.*

Michael, Resicare service user

Michael felt that being able to openly discuss his personal trauma in a confidential interview would eventually support him in his recovery journey. In light of this, when considering the risks of researching sensitive topics, it is important to not lose sight of the positive benefits that participants experience throughout the interview process.

²⁸ Whilst participants’ ‘rants’ were not always relevant to the research aims, it was important to allow participants space to discuss issues that they felt were relevant.
3.7.3 The risk of harm to the researcher

As the previous section demonstrated, the issue of harm to wellbeing is often cited in relation to participants of research, yet much less attention is paid to the risk of emotional harm to the wellbeing of researchers (Dickson-Swift et al., 2007). As it transpired, this was an important factor during this research. Whilst being well informed of the difficulties reported by other field researchers when hearing participants speak of traumatic life events (Dickson-Swift et al., 2006, 2007), it was at times particularly challenging to listen to service users’ experiences. However, it was not so much hearing of histories of domestic violence or childhood abuse, for instance, that caused distress; rather, it was the most unexpected issues participants raised that were most problematic, and it was often difficult to pinpoint exactly what had affected me during the interview.

I often came out of interviews feeling exhausted, not just because they had lasted a particularly long time, or because I had to listen intently to what the participants were saying through muffled tears, for instance, but I also found it much more exhausting to interview a participant whose histories elicited some negative reaction from me. Although I felt I was not visibly emotional, participants sensed that what they were recounting was causing some distress and would comment on this, as indicated by Michael:

‘I can see you was getting emotional when I was speaking to ya because, you know ... you’ve probably had a totally different life ... [but] I’ve probably touched on things that have happened in your life.’

Michael, Resicare service user

Most of the time, though, participants would wait until the dictaphone had been switched off to comment on this – perhaps because they didn’t want to interrupt the flow of the interview, or because they felt awkward to do so – and this would often
lead to more in-depth discussions about particular life events that I was not able to capture on tape. As an aside, reflecting on these instances made me once again consider my characteristics as a researcher. Schwalbe and Wokomir (2001:91) note that the ‘interview situation is both an opportunity for signifying masculinity and a peculiar type of encounter in which masculinity is threatened’. Whilst a detailed discussion of masculinities and the influence on research is not of value here, it is worth considering that, by showing emotion in the way that I did during interviews – and, indeed, the way in which participants perceived me during interviews – no doubt influenced the extent to which participants ‘opened up’.

3.7.4 The ethics of paying drug users for participation

The ethical quandary of paying drug users for participation within research has been well documented (Sieber and Sorensen, 1992; Grady, 2001; Ritter et al., 2003; Seddon, 2005; Fry et al., 2006; Neale et al., 2017). With reference to some of the arguments presented in the above accounts, this section outlines the dilemmas faced when deciding whether or not to pay drug users for participation within this research.

The primary issue that had to be addressed when considering whether or not to offer payment for participation concerned the issue of remuneration acting as an ‘undue inducement’, coercing drug users to participate and thereby undermining the notion of voluntary consent (Sieber and Sorensen, 1992; Grady, 2001; Ritter et al., 2003; Seddon, 2005; Fry et al., 2006; Neale et al., 2017). As noted earlier, due to the nature of this research and the methods adopted, there was a risk that service users may suffer some degree of emotional harm when reflecting on experiences of drug taking. Whilst this was an ethical consideration in its own right, as the majority of the service users who participated in this research can be described as economically
marginalised, offering financial remuneration for the completion of an interview could potentially put the individual in a situation where they feel that it would be foolish to not participate, even if it may mean risking the emotional harm of recounting traumatic experiences. Thus, offering monetary incentives for participation can be viewed as exploiting an individual’s economic marginalisation and impairing voluntary consent.

As Ritter et al. (2003:2) note, when navigating the issue of financial incentives impairing voluntary consent, it is difficult to determine the value of payment likely to cross the unknowable line of being rightful remuneration and an undue incentive impairing consent. As the authors suggest, this is especially difficult when it comes to problematic drug users, as they are most often drawn from the most deprived communities. One of the ways in which Seddon (2005) suggests we can determine this is to examine the refusal rate. Whilst it was not possible to easily establish the refusal rate – as service users were recruited via drug service staff – on a number of occasions when in the presence of service staff requesting participation from service users, some immediately refused to participate, even with knowledge of the incentive. This suggests that remuneration does not always act as an undue incentive. In addition, a number of participants informed me that they would have taken part in the research even if the gift voucher were not offered.

A further consideration when paying drug users to participate in research is whether to make payment in cash or in gift vouchers. Existing literature has highlighted the ethical issue of paying drug users in cash, as the money might be used to purchase drugs (Ritter et al., 2003; Seddon, 2005). Whilst this was not an immediate concern, it
was anticipated that the REC would flag the use of cash as a potential risk. As such, the decision was made to offer Love2shop vouchers to the value of £10 for service users participating in the research. As it transpired, the REC did indeed question the payment method in place. However, the decision to offer gift vouchers in place of cash was made almost exclusively with the concerns of the REC in mind, rather than whether it presented a real risk to mitigate. This again feeds back to the argument presented earlier regarding ethics committees denoting the ‘allowed from the disallowed’ (Winlow and Hall, 2012:410).

Yet, the offer of gift vouchers rather than cash can also be seen as problematic. Ritter et al. (2003) pertinently note that offering non-cash payments to drug users who participate in research dictates the way in which this payment can be spent, thereby implying that drug users are irresponsible and incapable of making sound judgements. Similarly, Neale et al. (2017) suggest that offering vouchers instead of cash can convey a feeling of distrust in the participant and an immediate assumption that the money would be used to buy drugs. Further, the use of gift vouchers might also be viewed as economically flawed. Indeed, gift vouchers are not difficult to exchange for cash, but when this exchange occurs, participants are ‘short-changed’ as it is likely that they will only receive half of the value of the voucher (Seddon, 2005; Neale et al., 2017).

Setting aside the above debate, the view most strongly supported in this study is that payment should be viewed as simply reimbursing the participant for their time and experiences shared, and is a means of ensuring that they are not left ‘out of pocket’ (Ritter et al., 2003:1–2). For one participant in particular, viewing payment as a form
of rightful recompense certainly felt apt. The participant in question, David, had completed treatment with Total Care and was due to begin training to become a peer mentor in order to ‘give something back’. On my first day in this particular Total Care service centre, I was introduced to David by his keyworker and was informed that he would be interested in participating. However, I was unable to interview David on the day we had met and instead had to interview him the following day. During David’s interview, he informed me that he had travelled in on both days just to participate. In instances such as this, offering a £10 gift voucher to a participant who had given up their time to participate in this research cannot be viewed as an undue incentive, but might be more appropriately viewed, at least as was my feeling in this particular instance, as a ‘tokenistic gesture that devalues the importance of the participant’s involvement’ (Ritter et al., 2003:2).

3.7.5 Informed consent, confidentiality and anonymity

The final issues to be addressed here concerned the importance of informed consent, confidentiality and anonymity throughout the research process. It was only through careful consideration and adherence to these three fundamental principles that the ethical challenges detailed so far within this section could be addressed and mitigated as far as possible.

Informed consent

Prior to taking part in this research, all prospective participants were issued with a participant information sheet (PIS), which detailed the aim of the research, why the participant had been chosen and what was expected of them by taking part. In addition, the PIS issued to service users included information pertaining to the potential risk of harm through the interview process along with the financial remuneration offered for taking part. It was only through including this information
that participants could be considered well informed about the research. At the end of each PIS was a consent form for participants to sign and date, confirming that their participation was wholly voluntary and that they understood that they could withdraw at any point.

Participant information sheets and consent forms were issued in person prior to the interview so that the participants had a chance to ask any questions regarding the study. However, one of the issues encountered when issuing the PIS to service users was that they would often just sign the consent form without reading the PIS. This not only raises a concern that the participants might not be fully informed about the research and their role in it, but it also raises a thorny issue of whose interests are served by the PIS. For example, whilst the use of the PIS is designed to ensure participants provide informed consent (Flick, 2014; Bryman, 2016), instances such as this would suggest that they serve more as a ‘tick-box exercise’.

In these circumstances, I verbally summarised the information contained within the PIS before each interview and asking participants if they had any questions or concerns. Verbalising this information to participants was also important to ensure that they fully understood the aims of the research and the focus of the interview. This was particularly important for the participants whose first language was not English and for the participant who was considered as not being in the right frame of mind during the interview. Throughout this process, all participants stated that they understood the aims of the research and their role within it.

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29 It should be noted that this was not the case for all participants, with some spending a much greater amount of time reading through the PIS (such as the commissioner for Metropolis, Chantelle, who withdrew her consent). Nevertheless, this was the case for the vast majority of participants.
Confidentiality and anonymity

Assurances of confidentiality and anonymity were made to all participants through the PIS and also verbally at the start of each interview. However, as noted by Baez (2002), whilst statements of confidentiality and anonymity can be made to participants, full assurance of these factors is ultimately based on participants’ trust of the researcher. This was particularly apparent within this research, as will now be addressed.

During fieldwork, it was clear that participants differed in the extent to which they were assured that the study was confidential and anonymous. This is perhaps best illustrated with two key examples. The first example is the interview with Michael. During Michael’s interview, he, very openly, discussed traumatic experiences throughout his life that had impacted his drug use. At one point during the interview, Michael informed me that he had once ‘sold [his] body’ in order to get money to pay for drugs:

_I don’t even know why, you know what, I don’t even tell people this in [therapy], d’you know what I mean, I sold my body one night. Not, not, not, I didn’t have sex with anyone, it was to get the guy away from [the area], so I could rob him, d’you know what I mean?_  

Michael, Resicare service user

Michael explained that this experience had troubled him for many years. It is interesting to note that Michael had not discussed this experience in the group therapy sessions within Resicare. Whilst this might indicate a lack of trust within the group sessions – as a number of other participants alluded to – it nevertheless demonstrates his trust in the research. After telling me this, I felt it was appropriate to reassure Michael that everything he said was confidential; however, this was met with the following response:
And it is all confidential as well…
I know that, you know, I can tell just by, I know ya, I trust ya, I’m astute like that.

Michael, Resicare service user

Whilst I had only met Michael immediately prior to conducting the interview, it is clear that Michael trusted me enough to openly discuss sensitive, personal experiences. However, this was not the experience shared with all participants. Whilst participants at times stated that they did not wish to disclose certain information\(^{30}\), the experience with the drug and alcohol commissioner in Metropolis (detailed in section 3.4.3) is perhaps most illustrative of the lack of trust that can be encountered.

Regardless of the extent to which participants held complete trust in the confidentiality and anonymity assured to them, it was of vital importance to take adequate measures to ensure that these assurances were met. All written materials, such as participant consent forms and annotated interview guides, were stored in a locked drawer. These materials will be disposed of after the thesis has been completed. All digital media, such as the interview recordings and the transcripts of interviews, were stored on a password-protected computer at the University of Manchester.

3.8 Conclusion

This chapter has outlined and offered justification for the methodological approach adopted for this research. Informed by a social constructionist epistemology, a qualitative research design was employed, which involved semi-structured interviewing as the data collection method. The use of semi-structured interviews

\(^{30}\) Examples of participants not wishing to disclose information included service workers who did not want to identify an organisation they were being critical of during interviews and service users who did not wish to disclose information pertaining to traumatic childhood experiences (see section 3.5.2).
elicited rich, in-depth insights into participants’ experiences, allowing them to construct accounts in ways they deemed most significant. The flexibility of thematic analysis allowed for the identification of both manifest and latent themes from within the data, along with consideration of how these themes fit together to tell a story of the data. A breakdown of the 36 participants recruited for the research was also provided, along with a description of the two research sites. Some of the practical issues experienced when recruiting participants were also outlined.

The discussion ended with a consideration of the ethical challenges faced during this research, including the challenge of gaining ethical approval and the ethical dilemmas experienced in the field. It is important to recognise that, despite these challenges, each has provided an opportunity for learning and development. For instance, although the process of gaining ethical approval to conduct the research was arduous, and resulted in a number of sacrifices being made, the experience will prove to be beneficial for future research projects. Moreover, although again inconvenient, the issue of participant withdrawal in this research served to further highlight the highly politicised nature of the drug treatment sector at this time – an issue that is highlighted throughout the following chapters.
Chapter 4 | Examining the shift to recovery in local level policy at a time of austerity and widespread reform

4.1 Introduction

This chapter focuses on the changes to local policy within Southside and Metropolis as a result of the reorientation towards recovery at a time of economic austerity and widespread reform. In doing so, the chapter examines how changes to the national picture, as outlined in chapters 1 and 2, are impacting on Resicare and Total Care. As examined in Chapter 2, one of the key questions posed in the literature is how the shift to recovery at national policy level has altered local strategy on the ground (Roberts, 2009; Stevens, 2011a; DrugScope, 2012; UKDPC, 2012b; Watson, 2012; Duke, 2013; McKeganey, 2014). Whilst some useful insights have been offered (e.g. Roy and Buffin, 2011; UKDPC, 2012b; Measham et al., 2013; Neale et al., 2013; DrugScope, 2014, 2015b; Bjerge et al., 2015; Adfam, 2016), the existing literature is principally a collection of hypotheses, with empirical, qualitative data largely absent. This chapter seeks to go some way in filling this gap in knowledge.

In doing so, the chapter seeks to provide answers to the following research questions:

i. How is recovery defined at the level of practice? How do those working within the drug treatment sector interpret the shift to recovery?

ii. Have drug services experienced cuts to funding? What challenges does this present for continued provision of support?

iii. What opportunities and challenges do the reforms to the public health system present to treatment services?

iv. Are service users adequately supported to accrue the recovery capital necessary to initiate and sustain recovery?
v. Has the tendering and commissioning of treatment services changed in the current climate? What impact is this having for treatment services?

vi. How can the changes witnessed within the treatment sector be conceptualised through neoliberal notions of competition, risk, choice and responsibility?

The chapter is structured as follows. To begin, an account of the shift towards recovery within Metropolis and Southside is provided. In doing so, the extent to which the recovery agenda has influenced local policy is examined, including the way in which participants define recovery and the explanations they offer for the shift. Following this, the climate in which the reorientation towards recovery has taken place at the local level is considered. Here, findings related to reductions in funding and the risks generated for service provision are presented. Alongside this, cuts to wider support services and the implications for partnership working are addressed. Subsequently, the impact of changes to the tendering and commissioning of services is considered. The chapter then examines the extent and impact of competition within the sector, before ending with a consideration of how neoliberal notions of competition, risk, choice and responsibility can help to make sense of the findings presented.

The argument advanced through this chapter is that the reorientation towards recovery at the local level has occurred alongside reductions to funding that are having a noticeable impact on the ability of providers to deliver support to service users. Simultaneously, changes to the tendering and commissioning of services have created a highly competitive environment in which treatment providers are fiercely competing against one another in order to survive.
4.2 The shift to recovery in Metropolis and Southside

As Duke (2013) contends, one of the key questions with regard to the shift to recovery is the extent to which this change in national policy has altered policies and practices on the ground. The research found that a clear shift to recovery had taken place at the local level in Metropolis and Southside. In Southside, the commissioners explained that the treatment system was re-commissioned in 2012 with a clear focus on improving ‘exit pathways’ for clients:

...we put in place a system that gives people who need it harm reduction and safety and all those things, but for those who actually feel like ‘it’s time for me to move on’, there’s some kind of exit pathway for you. ‘Cause I think there was a feeling that, in the past, maybe people did have those moments of saying, ‘do you know what, I want to get away from this, I want to do other things’, and there was no clear exit, nowhere to head towards, and that’s what we wanted.

Byron, Southside commissioner

As Byron explains, the aim within Southside was to make exit pathways more visible and accessible in order to increase the opportunities for service users to move on from treatment. Whilst it was not possible to incorporate the views of the commissioner in Metropolis (see Chapter 3), it was evident from interviews with staff in Total Care that the shift to recovery had also firmly taken hold within Metropolis, as Becky and Harold explain:

There’s been a big push the last few years about getting people into recovery, getting people out of services, back living meaningful lives, and ... we’ve been really good at capturing that and tailoring our services around that.

Becky, Total Care manager

I mean, years ago, it used to be maintaining people on their methadone scripts. ... Then all of a sudden the ‘recovery’ word appeared, and that was getting banded around a lot and it was all about recovery ... the whole ethos changed, the commissioners, and everything. It was about, ‘yeah, we’ve done a good job getting people on methadone, and keeping them on methadone, but now it’s time to get them off it.’

Harold, Total Care service worker
From interviews with Total Care staff, it was clear that there had been an overt shift within Metropolis towards establishing a recovery-focused treatment system. As will be examined in the following chapters, this had an observable impact on the day-to-day working practices of Total Care, with a direct focus on encouraging drug users to complete treatment and exit services. Conversely, for Resicare, the reorientation towards recovery in local policy in Southside had had little impact on the nature of their work or their philosophy as an organisation:

...it’s always been about recovery. It’s not been about harm reduction and maintenance and stuff like that for Resicare. Ever. … we’ve got this vision that from a platform of entire abstinence, that’s a great place to then rebuild your life.

Alan, Resicare service manager

Alan maintained that, as Resicare’s philosophy had ‘always been about recovery’, the shift in national policy had merely aligned their goals with national and local priorities. Interestingly, in the quote above, Alan offers Resicare’s vision of recovery, suggesting that it involves ‘entire abstinence’ from substances. As explored in Chapter 2, with the reorientation towards recovery, one of the key questions posed within the literature was how recovery would be defined on the ground level within treatment services (see, for instance, Laudet, 2007; White, 2007; Measham et al., 2013). With existing literature highlighting the lack of an agreed definition within the sector (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; White, 2007; UKDPC, 2008; Measham et al., 2013; Senker and Green, 2016), one of the aims of this research was to understand how recovery was defined at the local level in Southside and Metropolis. The following section addresses this.
4.2.1 Defining recovery

As discussed in Chapter 2, the concept of recovery as it applies to substance misuse lacks any consensus definition. Rather than offer an explicit definition of recovery, the 2010 drug strategy suggests that recovery is ‘an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people’ (HM Government, 2010:18). However, whilst appearing to offer support for medically-assisted recovery, the government’s vision of a recovery-oriented treatment system appears increasingly to conflate recovery with abstinence (HM Government, 2010; Home Office, 2012; Monaghan, 2012; Monaghan and Wincup, 2013; Roy and Buchanan, 2016). Given the lack of consensus within the field, and the apparent contradictions within the 2010 strategy, it was important to understand how recovery was defined within Total Care and Resicare.

Reflecting the picture within the existing literature, this research found a lack of consensus among participants as to how recovery should be defined. Definitions of recovery differed between both organisations and between the staff and service users within them. One of the key inconsistencies in existing definitions concerned the use of substances in recovery. As indicated in the earlier passage from Alan, the view adopted by Resicare was that recovery involves total abstinence from all substances. On the other hand, Total Care defined recovery as abstinence from drugs of dependence (typically heroin and crack-cocaine) and from use of substitute medication, yet noted that occasional use of ‘recreational’ drugs such as cannabis was acceptable. As will be explored later in this chapter, and in greater depth in Chapter 5, it became apparent that recovery had been conflated with drug treatment completion in Total Care.
Whilst it was seemingly clear how recovery was defined at the organisational level, it became apparent that individuals’ personal views on recovery often differed, and were sometimes in conflict with the views of their organisation. For instance, whilst the majority of interviewees cited recovery as involving, at the very least, abstinence from drugs of dependence and substitute medication, others argued that recovery could be achieved with the aid of a substitute prescription. For instance, Janet offered the following definition:

*I think, if someone hasn’t used drugs for 20 years, any drugs, they’re working full time, they’re not committing crime, they might be a parent, a grandparent, [have] a mortgage … If they’re on daily methadone, for me, I would say they’re recovered because the problem was heroin injecting, they no longer heroin inject – they are recovered.*

Janet, Total Care service worker

The view offered by Janet is very much aligned with the ‘vision’ of recovery offered by the UKDPC (2008). They suggest that recovery involves ‘control over substance use’, which, they note, accommodates both abstinence and maintenance approaches (UKDPC, 2008:6). In line with this view, Janet suggests that if an individual has made positive improvements in their lives – such as working full time – they should be considered as being in recovery regardless of their use of substitute medication. Expanding on her view, Janet argued that recovery has been redefined within drug treatment:

*They’ve changed what recovery means … In the drugs field at the moment, recovery seems to mean a 12-step form of abstinence. So, the word recovery has been quite co-opted in. Because a few years ago, recovery meant that as soon as somebody asked for help and maybe told their family they were using or stopped injecting, that was recovery. They don’t even need to see drug services, they could still be using, but as soon as they thought ‘I’m in charge of my own health’, that was [recovery]. That was where it came from – the mental health patients in the States … whereas recovery [in drug treatment] now seems to mean abstinence and no medication. And also, abstinence and no medication have been conflated. Abstinence used to mean no illegal drugs, now abstinence seems to mean no medication as well…*

Janet, Total Care service worker
Here, Janet broadens her definition of recovery further, to accommodate those who are perhaps continuing to use opiates but had began to take some control over their own use. As Janet alludes to, the definition of recovery as involving individuals taking back control over their lives was very much the definition of recovery that emerged from the mental health field (Jacobson and Greenley, 2001; Repper and Perkins, 2003; Stickley and Bonney, 2008).

Interestingly, Janet opens her passage above with the statement that ‘They’ve changed what recovery means’. This is suggestive of Janet’s broader narrative of the emergence of recovery and the political justifications she feels are responsible for the shift, as will be discussed below. Whilst Janet was not opposed to the idea of drug users ceasing to use drugs and ‘moving on’ with their lives, she had many objections to the way in which recovery was being defined and delivered at the ground level, and the implications this had for service users’ wellbeing. As evident in the following chapter, this was a view also shared to varying extents by her colleagues.

In support of the concerns of others in the field (e.g. Monaghan, 2012; Monaghan and Wincup, 2013; Roy and Buchanan, 2016; Wincup, 2016), Janet ends the above discussion by arguing that recovery has been conflated with abstinence. As noted in Chapter 2, one of the potential problems with this is that it denies the successes of drug users who are living stable, fulfilling lives on substitute opiates (Ross-Albers, 2013). Indeed, Janet noted that, regardless of an individual’s personal achievements – such as being in stable accommodation or reconnecting with lost family – if a person is using methadone, these successes are largely incompatible with the current definition of recovery.
Despite being one of Resicare’s service managers, Damien also recognised that some people might consider themselves as in recovery while using methadone:

_I suppose recovery's about helping someone to rebuild their life and trying to move away from being dependent on services. So, right, there is a percentage of the population who can do that while on methadone, who can stop using illicitly, get a job, be able to hold down a family, meet all life's responsibilities. So I suppose for them, that is recovery. But they are only the minority._

Damien, Resicare service manager

Here, whilst noting that they are ‘the minority’, Damien recognises that the important aspect of recovery is not necessarily the level of substance use but rather the extent to which individuals can make positive improvements to their life. Whilst participants offered conflicting views on the place of substances within recovery, in line with definitions offered elsewhere (Laudet, 2007; UKDPC, 2008), most viewed recovery as involving much more than just abstinence or control over substance use.

As demonstrated so far in this section, representative of the lack of definition in national policy, this research found no agreed definition of recovery at the local level, both between organisations and the individuals working within them. Whilst the lack of consensus over the definition of recovery has been found to hold benefits for service design elsewhere (see Measham et al., 2013), some interviewees drew attention to the problems that can arise through this lack of agreement. One of the key problems cited by Resicare staff was that, with the emergence of the recovery agenda, some organisations had ‘rebranded’ as recovery agencies without altering their approach, as Damien and Alan explain:

_The word recovery, it doesn't really mean anything now. It's more like a buzzword, so everyone uses it. So you'd have drug services in the past that used to do care plans with people – now they do the exact same work, but rather than call it a care plan, they call it a recovery plan. So they haven't actually changed what they're doing, they've just changed the wording of it. Some services can claim maintaining people on methadone is recovery._
Damien, Resicare service manager

Some other organisations really do believe that they can do it all, and they’ve renamed and rebranded themselves as recovery agencies. I don’t see them as true recovery agencies. There’s some of them that are harm reduction agencies and that’s still what their driver is, it’s harm reduction, retaining people in treatment.

Alan, Resicare manager

As Damien notes, this lack of meaning within the sector has enabled organisations to freely apply the label of recovery to their work (see also Measham et al., 2013). Alan maintained that providers had done this in order to continue to compete for service contracts. As will be discussed in section 4.5, this is by no means surprising in a competitive environment in which third sector organisations are expected to operate in a more business-like fashion in the contract culture (Clarke, 2004:32). Nevertheless, picking up on some of the arguments made in this section, the chapter now turns attention to the ways in which participants interpreted and made sense of the shift to recovery.

4.2.2 Participants’ interpretations of the shift to recovery

As explored in Chapter 2, existing literature has drawn attention to a range of political, social and economic factors that were considered to have influenced the reorientation towards recovery in national policy (e.g. Wardle, 2012; Duke, 2013; Duke et al., 2013; Measham et al., 2013; McKeganey, 2014; Bjerge et al., 2015; Lancaster et al., 2015). When discussing the shift to recovery, participants’ interpretations of the shift largely echoed these factors. For some participants, the emphasis on recovery within treatment was viewed as a positive development. Alan argued that, from a moral standpoint, it was inappropriate to retain drug users in treatment:
...there’s still thousands and thousands of people in treatment, you know, four years plus, six years plus, ten years plus, I don’t think … that’s morally right for people to be retained in treatment that long on medication...

Alan, Resiccare manager

In support of this view, Gwyneth explained that treatment services were obstructing service users’ aspirations by not optimising their opportunities for recovery:

...it’s good practice really, from a personal point of view. You don’t meet any opiate users who want to be on methadone for the rest of their life, and when they first started treatment and people asked what they wanted, it was, ‘well, I want to be drug free’. So we were letting them down, I think, with the traditional drug system.

Gwyneth, Southside commissioner

Justifying the restructuring of the treatment system in Southside, Gwyneth maintains that service users’ primary goal of drug treatment is to become drug free. Indeed, when interviewing service users from both Total Care and Resiccare, the majority of interviewees stated that their ultimate ambition of treatment was to stop using illicit drugs and substitute opiate medication. Danica provides an example:

I want stop when I feel I’m going to be good and don’t need it then I’m gonna stop. I don’t want to [be] using nothing. I want to be like clean.

Danica, Total Care service user

The finding that the majority of service users aim to become abstinent supports the early research conducted in Scotland (McKeganey et al., 2004), which was viewed as influential in the refocusing of policy (Neale et al., 2011; Wardle, 2012; Duke, 2013; McKeganey, 2014). However, one of the criticisms of McKeganey et al.’s research was that it failed to recognise that, whilst most service users’ cited abstinence as a goal of treatment, this was often a long-term rather than short-term goal (Neale et al., 2011). In support of this, service users explained that abstinence was something that they needed time to achieve, and something that they would achieve when they were ‘ready’, as Jasper notes:

What the hell is abstinence-led recovery? Nobody wants to remain on methadone and go to the chemist every day or even every week … it’s not like
people want to be on these drugs, you know? So, people would have been abstinent when they were ready to become abstinent.

Jasper, Total Care service user

This issue will be returned to in the following chapter when focusing on the successful completion of drug treatment target and its impact on the day-to-day working practices of Total Care staff.

In addition to the need to believe that a recovery-oriented treatment system would better meet the needs of service users, participants also made reference to the benefits to society that recovery can bring. For instance, Tony suggested the value that those in recovery can add to their communities:

...they can go on and be productive members of society ... and you know what, actually, your community’s going to be better off ... you’ve got assets in this community that currently are draining it. But if we can get people into recovery, then they become an asset to your community...

Tony, Total Care Recovery Champion

Tony’s view supports the key arguments drawn on in Chapter 2 regarding the economic justification for the shift to recovery. As Seddon et al. (2012) suggest, the emphasis on recovery can be viewed as part of a strategic coherence in drug policy concerned with cajoling drug users to make responsible choices in order to reduce the risks they pose to society. The notion of turning economic drains into economic gains (see Ashton, 2016) within Tony’s quote fits neatly into these ideas. Further supporting this argument, Tony also made reference to the economic cost of maintaining people on methadone:

I think, again, I’m just of a really cynical nature, cost. Do you know what I mean? Money. It’s got to be a massive drain, that kind of maintenance scripting ... then you’ve got criminal justice, so it costs a lot of money to put people in prison and keep them there. Health, hospitals – that’s massive. We’re talking billions and billions of pounds every year ... I’m not in the minds of policy makers, but I would imagine for them, bottom dollar, bottom line is money.

Tony, Total Care Recovery Champion
Other participants also cited the economic cost of the drugs problem, particularly in relation to the lack of employment among methadone maintenance clients. However, it was apparent that participants often conflated methadone with unemployment, suggesting that it was not possible to work while being prescribed substitute opiate medication. When discussing the benefits of recovery, Sarah appears to do this:

...we’ve got somebody who’s left drug free this week who’s been in drug treatment for 30 years, and it’s tragic. When you think about it you think you’ve got staff who’ve not been alive that long. In 30 years, I was doing my nurse training and I’ve had a career and so many house moves, and that person’s been on a methadone prescription and not had a job.

Sarah, Total Care manager

The view that methadone acts a barrier to employment has been discussed elsewhere (Spencer et al., 2008; Richardson et al., 2012). Both Peter and Janet picked up on this focus on welfare dependency among methadone maintenance clients. As evident throughout the remainder of this thesis, the frontline workers in Total Care – and Peter and Janet in particular – were critical of the emergence of recovery, both in terms of the justifications for the shift and in the way in which recovery was being delivered in Total Care. Regarding their views on the reasons for the shift in policy, Peter and Janet offered the following sentiments:

I think it’s about an agenda perhaps, from people like the Daily Mail, or right wing Tory MPs, that you’ve got this welfare culture, where people just stay dependent on things, dependent on services, dependent on this, that and the other. And one of those things that fits in with that is methadone.

Peter, Total Care service worker

...voters like the sound of it - it sounds good when you say, ‘look at all these people, they’re doing NA.’ … I think voters see that it’s the magic fix. I think if you explain harm reduction to the general public, they don’t get it, they think well they’re still taking drugs … they use words again and again like ‘parked on methadone’, ‘stuck in treatment’ where they would never say that about somebody on insulin or never would, never say that about somebody on statins for blood pressure. They wouldn’t say ‘parked on statins’. So drugs are a very different part of health. There’s a lot more moral judgment.

Janet, Total Care service worker
Here, both Peter and Janet view the shift to recovery as a political drive to reduce welfare dependency and to gain votes from the public (Wincup, 2011; Monaghan and Wincup, 2013; Monaghan and Yeomans, 2016; Wincup and Monaghan, 2016). Janet makes a very interesting comparison between drug users being treated with substitute opiate drugs and diabetics being treated with replacement insulin. She argues that drug use is not viewed as a medical issue in the same way that other health problems are, alluding to the debates that have existed in the field over how we should view addiction (White, 2000; Heyman, 2009, 2013; Schaler, 2010; Branch, 2011; Russell et al., 2011) and the way in which the concept of ‘drug’ has a moralising component (see Seddon, 2010b, 2016). For Janet, the difference in the ways in which the general public view these two populations was a key factor influencing the shift from maintenance to recovery.

Through discussions regarding the key driving forces behind the shift to recovery, it became evident that participants’ views on the recovery agenda differed markedly. Whilst no participants suggested that stopping use of methadone and leaving services was inherently problematic, for some participants, the way in which recovery was playing out at the local level in the current climate generated significant cause for concern. In exploring this climate, the following section considers the impact of economic austerity and the public health reforms on local level policy in Metropolis and Southside.

4.3 Recovery in an age of austerity and widespread reform

As has been established, the reorientation towards recovery has occurred alongside wide-ranging public health reforms. To briefly reiterate, the Health and Social Care Act 2012 altered the commissioning and management of healthcare in England by
returning a leading public health role to local authorities under the leadership of Directors of Public Health (HM Government, 2012; UKDPC, 2012b). As part of the reforms, the NTA was abolished and its key functions and PTB absorbed into the newly established PHE (Department of Health, 2012b, 2012c). Within the new public health structure, Directors of Public Health are responsible for commissioning combined drug and alcohol services alongside wider public health services in order to better address the needs of their local populations (HM Government, 2010).

However, the introduction of the health reforms has occurred during a period of sustained economic downturn that has been characterised by the implementation of enduring cuts to public services in the aim of reducing the public deficit (Lowndes and Pratchett, 2012; Taylor-Gooby, 2012; Bach, 2016; Smith et al., 2016; The King’s Fund, 2017a, 2017b). In 2016, the Institute for Fiscal Studies demonstrated that, on average, councils in England have experienced real-term cuts of almost 26% since 2009-10 (Smith et al., 2016:1). More recently, The King’s Fund (2017a, 2017b) has reported that planned public health spend has fallen by more than five per cent since the introduction of the public health reforms, with a further projected real-term reduction of £600m by 2020/21.

One of the key risks presented by the changing commissioning landscape in the austere financial climate is the risk of disinvestment in drug and alcohol services (Roberts, 2011; Watson, 2012; DrugScope, 2013; Stevens, 2015; Roy and Buchanan, 2016). With the introduction of Public Health England, funding for drug treatment has been absorbed into the wider public health budget and is no longer ring-fenced (Roberts, 2011; Royal College of Nursing, 2013; Roy and Buchanan, 2016). Further,
with decisions over the commissioning of public health services now devolved to local authorities, there is a risk that drug services may experience disinvestment within some areas as their relative importance is weighed against other public health concerns during a time of competing demands on available funding (DrugScope, 2013; Speed and Gabe, 2013; Roy and Buchanan, 2016).

Whilst existing research has provided some useful insights into the experiences of drug treatment services within the current climate (DrugScope, 2014, 2015b; Adfam, 2016), in-depth empirical research of this nature remains scarce. One of the key aims of this research, therefore, was to examine the impact of the above changes on drug services on the ground. The following sections demonstrate the effects of austerity and public health reforms in Metropolis and Southside along with examining the means through which Resicare and Total Care were responding to these changes. It should be noted here that, not surprisingly, only the commissioners in Southside and the service manager of Total Care attributed changes they had experienced to the public health reforms. However, many of the issues raised by participants through this research can be understood as at least partly a consequence of the reforms.

4.3.1 Cuts and cost saving in Metropolis and Southside

Both Total Care and Resicare had either experienced or were anticipating funding reductions. For Resicare, Alan claimed that the budget in Southside had been reduced by 40 per cent in the past year:

\[
\text{I had to reduce my budget by 20 per cent for the last six months of it there. Then it’s just recently gone out to tender - there was a further 20 per cent of cuts. So, in real terms, Southside has been cut by 40 per cent.}
\]

Alan, Resicare manager
Alan maintains that Southside had experienced a 40 per cent reduction in funding. However, when discussing the budget reductions with the commissioners in Southside, Gwyneth offered a slightly different account:

_Well, for us, it was 20 per cent; 20 per cent from our drugs and alcohol budget overall ... That came into play from April 2015 ... so what we did, because we knew we had to make the cuts from the first of April, we renegotiated contracts with our current providers on the basis of a lower level of funding, and then throughout that six-month period, then we went through a retender exercise._

Gwyneth, Southside commissioner

From Gwyneth’s explanation, it appears that, rather than the budget being reduced by 40 per cent as Alan suggested, there had actually been a single reduction in the six months leading up to the contract retendering, with the budget remaining the same within the new contract. Despite this inconsistency, as will be addressed below, the reduction to funding experienced by Resicare had raised a number of significant concerns for future service provision.

Unlike Resicare, Total Care had not experienced any reductions to funding since taking over the contract in 2012; however, Sarah explained that they were anticipating a reduction in the new contract that was out to tender at the time:

...
_within the new model, the new integrated service, there is a reduction in funding available. So when we were putting the tender together we’ve had to think quite creatively about how to get the best use out of that._

_Are you able to give me an idea of how much less is being offered?_  
_I think it’s probably about 15 per cent._

Sarah, Total Care manager

In an attempt to confirm participants’ accounts of the reductions to funding, freedom of information (FOI) requests were submitted to both local authorities querying the total expenditure on drug and alcohol services. The data obtained from the FOI request (see Table 2) showed that the expenditure on drug and alcohol treatment in Southside had decreased by approximately 19 per cent when the service was re-
commissioned in 2015. In Metropolis, the data show that the expenditure on drug and alcohol treatment reduced by approximately 26 per cent when the service was re-commissioned in 2016. Whilst this is significantly more than the figure quoted by Sarah, it is important to consider that the data available from the FOI requests accounts for all spending on drug and alcohol treatment in the local authorities.

Table 2: Spend on drug and alcohol treatment in Southside and Metropolis (£)

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southside</td>
<td>-</td>
<td>2,939,376</td>
<td>2,642,873</td>
<td>2,265,542</td>
</tr>
<tr>
<td>Metropolis</td>
<td>12,143,587</td>
<td>12,296,191</td>
<td>11,976,122</td>
<td>8,854,317</td>
</tr>
</tbody>
</table>

Perhaps unsurprisingly, due to the size and nature of their service in comparison to Total Care and other large providers, Resicare cited significantly greater challenges as a result of the cuts to budgets than Total Care. One of the key issues raised concerned the extent to which Resicare could compete for contracts against other providers. Alan illustrates this with reference to the contract being out to tender in Metropolis at the time:

I can give you an example, Metropolis has just been out to re-tender, so the information gets, specification all gets published on the big portal and providers are able to express their interest and bid for it. But ... some of the questions and the criteria for being able to qualify to deliver the service absolutely rules small services out of it because they don’t have the financial muscle, the set of accounts, the range of services, that wouldn’t allow them, you know, there’s just, there’s lots of criteria that rules people out, just, right at the start.

Alan, Resicare manager

The issue of smaller providers being increasingly marginalised within the drug treatment sector as large providers such as Total Care begin to dominate the market has been speculated about elsewhere (Blenheim, 2015). Again, as will be addressed in

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31 The calculation for Southside was based on the average spend on drug and alcohol treatment during the final two years of the previous contract compared to the first year of the new contract. Data for the first year of the previous contract was not available. The calculation for Metropolis was based on the average spend in the three years of the previous contract compared to the first year of the new contract.
greater depth in section 4.5, this is not surprising in a competitive market in which those with greater economies of scale are more likely to succeed due to their ability to operate at lower levels of cost (Ogus, 1994; Bach, 2012; Damm, 2012). However, this also questions the extent to which Resicare continue to view themselves as suitable competitors within the drug treatment sector (Davies, 2014b).

Nevertheless, in a climate of reducing budgets for delivering drug treatment, Sarah explained that even Total Care had been unable to bid for contracts in some local authorities due to a lack of adequate funding:

...there has been contracts come up when Total Care hasn’t been the provider and when we’ve looked at it we’ve actually decided not to go for those contracts … Because financially you can’t make it work. Or we’ve not felt that we’ve been able to deliver a service that would be safe and give good quality on the budget that has been available in some areas. So we’ve actually not gone forward with the process.

Sarah, Total Care manager

From Sarah’s statement above, it appears that, even for an organisation the size of Total Care, it is becoming increasingly difficult to deliver drug services in this economic climate. Whilst this was clearly a problem that Total Care had to deal with, this also indirectly affected Resicare. Along with contract tenders specifying criteria that automatically ruled out Resicare being a suitable lead provider, Alan and Damien explained that the decreasing budgets had also resulted in lead providers being unable to afford to subcontract Resicare to deliver their specialist abstinence-based recovery programmes:

...less people are wanting to partner with Resicare as a result of the cuts … People still value what we do in terms of the big lead providers that mainly do the clinical services. But … the challenges they’re facing mean that it’s difficult for them to subcontract Resicare because they’ve not got the resources. So they’re trying to do it themselves.

Alan, Resicare service manager
The risk for Resicare is the same as any sort of small provider, is that you just get marginalised out, people don't want to look at you because of all the cuts, the big services need to keep all the money to themselves. Or they want to keep it all to themselves.

Damien, Resicare manager

Most interestingly, Damien explained that this had happened during the previous retendering in Metropolis in 2012:

So last time we went in on a contract, we went in with another provider ... who said, right, we want Resicare to do this, this and this. Because, apparently, they were going to be delivering our rehab programmes in a community setting, providing housing. [Resicare programme] would have changed the face of Metropolis. And then, when they actually won the contract, they actually turned around and said, well, actually there's not enough money in the envelope for this. Which I don't get, me, because basically they tell you how much money's in the contract before you actually submit for it ... So how this agency wrote the bid and then turned around to us and said there's not enough money, that's just...you knew how much money there was, do you know what I mean. So I don't get that.

Damien, Resicare manager

Damien explained that Regain\textsuperscript{32} had originally included Resicare as a subcontractor in their bid, yet when they won the contract to provide the recovery service, they argued that they could no longer afford to subcontract them. As Alan suggested at the end of his earlier quote, in instances such as this, lead providers often attempt to deliver Resicare’s services themselves. However, Patrick maintained that this would ultimately be unsuccessful due to providers’ lack of specialist expertise in recovery services:

...rather than use subcontractors, they do it in-house ... they’ve got no specialist staff, they just take the stuff, do it in-house, and it will fail.

Patrick, Resicare manager

There is a clear picture emerging regarding the security of smaller providers in the current treatment landscape. With the increasing dominance of larger, prime providers such as Total Care, there is a risk that one or two large providers will increasingly

\textsuperscript{32} Although Damien did not want to confirm on record that he was referring to Regain, it was evident from his account that it was Regain he was describing.
dominate the sector. Yet, the question remains as to how long the sector can support these large providers, with concerns arising as to whether they will become too big to be allowed to fail (Blenheim, 2015).

A final issue expressed by Resicare directly concerned their tier 4 residential rehabilitation services. Alan explained that, due to the funding for tier 4 services being significantly reduced – as has been documented elsewhere (DrugScope, 2015b; Adfam, 2016) – only individuals with the most complex needs are being approved for residential care:

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*Another challenge that we face is that the people that are presenting at tier 4 have got far higher complex needs, dual diagnosis, physical health problems. So there’s less money but the tier 4 budgets have been cut and the only people that are getting an opportunity to go into rehab are people with extreme needs.*

Alan, Resicare manager

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Alan explained that this had created an issue in which tier 4 services were finding it increasingly difficult to address the needs of service users when faced with the cuts to funding. This issue was exacerbated by the lack of joint working with mental health teams:

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*...the rehabs are only getting people who have got high needs, but there’s less money, so, you know ... now you’ve got people with more complex needs ... they might need a longer period in treatment but then local authorities, the maximum they’ll pay is 20 weeks. But all the research suggests that, if someone has dual diagnosis, the treatment should take longer and ... you should work in collaboration with mental health services. But mental health services are being cut, so you can’t get any joint working done while they’re in the rehab because those people don’t exist any more within mental health teams.*

Alan, Resicare service manager

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The issue of joint working with mental health teams was a dominant theme to emerge from this research and is examined in depth in the following section.
Whilst Alan explained that Resicare faced significant issues as a result of the constrained financial climate and the changing drug treatment landscape, Sarah maintained that Total Care would be largely unaffected by the cuts they were expecting. In explaining this, Sarah noted that Total Care had been able to make significant cost savings both throughout their current three-year contract and through the re-commissioning process. As noted in Chapter 3, at the time of the research, three prime providers delivered the drug service in Metropolis, with a fourth delivering the alcohol service. However, the contract out to tender at the time of the research was for an integrated drug and alcohol service that would be delivered by a single provider. As Sarah explains, the integration of the four services would allow for significant back-office cost savings to be made:

*I think the first thing we’ve done is we’ve looked at back-office savings. So with the integrated model, lots of different agencies they all have their own buildings, they all have their own management teams, they all have their own service managers, their own admin. So by integrating your service delivery you can make quite significant savings without affecting frontline delivery.*

Sarah, Total Care manager

In addition to the savings made through the service redesign, Sarah also stated that, with the emphasis on recovery, significant numbers of service users had completed and exited treatment, resulting in smaller caseloads for service workers. This had allowed for changes to the staffing makeup of the service and thus further cost savings:

*Since 2012, I think because we’ve focused more on the recovery agenda and supporting service users to move out of treatment, keyworker caseloads are lower now than they were at the start of the contract in 2012 … when staff have left and moved on, it’s enabled us to look at what we actually need to actually deliver the service, so we haven’t necessarily replaced like with like. So, for example, if a keyworker’s left because caseloads are lower, we haven’t replaced with another keyworker, so we’ve recruited a qualified social worker to work with families. Or we’ve not replaced a keyworker but we’ve recruited recovery champions.*

Sarah, Total Care service worker
Whilst Sarah maintained that reductions to staff was a pragmatic response to a changing level of need within the service, as will be examined in Chapter 6, many participants viewed the replacement of keyworkers with recovery champions as a concerted cost saving measure, with significant implications for the health and wellbeing of recovery champions and service users alike. Whilst Sarah maintained that caseloads were lower at the end of the contract than they were at the beginning, Peter explained that this was inaccurate:

*Generally, within Total Care, our caseloads have increased. With me, it’s a bit more complicated, but for various reasons. But I think, as a general thing... our workloads have increased.*

**What do you put that down to?**

*Not having as many people. I mean we were before, under the NHS, we were the prescribing service. And the vast majority of us were doing a prescribing role. There was a recovery service, but it was smaller, much smaller. So... there were just a hell of a lot more drugs caseworkers. Caseloads were lower. I think that’s probably better, because those people were complex. We had the resources to see them every two weeks. We had the doctor availability to see people more regularly. Now, we’re stretched all the time.*

Peter, Total Care service worker

Earlier in his interview, Peter also made the following remark:

*So for example, we’re under pressure not to see people every two weeks, where possible, to try and see people every four weeks. Because we’ve had so many cuts to staff, it’s about what you emphasise as a drugs service, what priority you give to things. You can’t give everybody all of your time.*

Peter, Total Care service worker

It is clear that Peter paints a very different picture regarding the workload of keyworkers within Total Care and the impact it was having on service provision. From Sarah’s account, it could be argued that Total Care were merely ensuring that caseloads of workers were kept at a level that allowed for efficiency to remain high. However, as Peter notes, this had negatively impacted workers’ performance and the quality of the service received by clients. Participants also claimed that this was an issue with Regain in Metropolis, with high numbers of staff having been made redundant in order to reduce costs, which in turn had negatively affected the quality of
service provision. As Bach (2016) has demonstrated, this is an issue that has been identified elsewhere, with reductions to the public sector workforce raising concerns over increasing workloads and safe staffing levels across many sectors.

Service users appeared to support Peter’s claims and often made remarks concerning the lack of available staff. For instance, Paul made reference to workers’ increased caseloads and explained how this had impacted the service he received:

_I think they’ve got more workloads, I mean, I’ve had where, say, a worker, you could be at home and they’ll bring the script down to ya, d’you know, if you’re not able to get up here._

Paul, Total Care service user

Paul explained that increased staff workloads had resulted in workers no longer making home visits to clients. Whilst Paul did not feel that this had impacted him in any significant way, existing research has demonstrated the numerous benefits that home visits and other outreach work can bring (see Roy et al. 2013 cited in Roy and Buchanan, 2016). In addition, Jenny made a comparison between the service as it existed under the NHS and the service under Total Care:

...

...if you’re more than ten minutes late, you don’t get seen, and I’m not used to that. I was used to [previous service] - if you were ten minutes late, ‘oh it doesn’t matter, sit down and have a coffee’ and like, here, it’s all so strict and like ‘cause they’re rushed off their feet ... if you’re running late, you don’t get to see nobody, it’s not, the meetings [are] very strict and very cold, you could say. Very business-vibe.

Jenny, Total Care service user

Jenny’s reference to workers being ‘rushed off their feet’ and the ‘very strict and very cold’ business vibe in Total Care supports the earlier claims made by Peter and accords with arguments over the introduction of new managerialism within public sector services (Clarke and Newman, 1997; Deem, 1998; Clarke, 2004; Diefenbach, 2009; Ward, 2011; Bach, 2016; Lynch, 2017). When discussing the above issue, Jenny explained that Total Care had also introduced a ‘late pod’:
If you’re more than ten minutes late, you go into the late pod. You either don’t get seen at all and then the late pod opened then you get put in the late pod at 3pm.

Jenny, Total Care service user

A number of service users made reference to the introduction of the late pod in Total Care, which service users were required to attend if late for their appointments and provide reasons for their tardiness. However, should service users also fail to attend the late pod, they would be restricted from seeing their keyworker that day and thus not be able to collect their OST prescription, as Jenny explained:

And I’ve got the kids – they finish school at ten past [three], you know, I couldn’t really do the late pod, so I’d have to like, you know, I wouldn’t get no script for that day and I’d have to turn up the day after in the morning and hopefully get seen, and that weren’t the case because it’s different, you know? You can’t mess them about so to speak. Not that I intended to, but.

Jenny, Total Care service user

The discovery of the late pod in Total Care raises some important points for consideration. Firstly, as Jenny alluded to above, the introduction of the late pod offers further evidence of the business-like fashion in which third sector providers are beginning to operate (Clarke, 2004), and is a clear attempt at keeping efficiency high, particularly considering the reduction in keyworkers in Total Care. However, the late pod also has the function of cajoling ‘irresponsible’ drug users to make prudential choices about their behaviour (Seddon et al., 2012). Indeed, this demonstrates the conception of drug users as rational choice makers who, if given a range of (albeit constrained) options, can make ‘correct’ decisions (Seddon et al., 2012). This fits neatly into the notion of responsibilisation as detailed in Chapter 1, and will be discussed in greater depth in section 4.5.

Despite the differing accounts offered by Sarah and Alan regarding the impact of the cuts to their services, both raised concern over the security of future investment in
drug treatment. In addition, concern was also expressed over cuts to peripheral support services and the impact of these cuts on service users’ chances of recovery. This issue is addressed below.

4.3.2 Opportunities and challenges to partnership working

With the shift to recovery, emphasis has been placed on the importance of supporting drug users to draw on available recovery capital in order to better equip them for recovery (Cloud and Granfield, 2008; Best and Laudet, 2010; HM Government, 2010). Whilst questions have been raised over the extent to which the emphasis on recovery capital further intensifies the responsibilisation of drug users (Duke, 2013), research has nevertheless demonstrated the importance of capital in the recovery process (e.g. Granfield and Cloud, 1999; Laudet et al., 2006; Cloud and Granfield, 2008; Laudet and White, 2008; Best et al., 2012, 2016; Duffy and Baldwin, 2013; Melick et al., 2013; Timpson et al., 2016; Boeri et al., 2016; Penn et al., 2016; Weston et al., 2017).

With the significance of recovery capital established, the 2010 drug strategy emphasises the necessity for joint working with wider support systems in order to ‘address the needs of the whole person’ (HM Government, 2010:20). The strategy contends that collaborative working with areas such as education, training and employment, through to prison, probation and youth justice services are all important in the aim of delivering “end to end” support’ (HM Government, 2010:20). This is made easier through the shift to local commissioning, which provides greater opportunity for diversifying the services provided in local authorities and developing innovative, joined-up approaches that are needed to fulfil the ambitions of the recovery agenda.
With this in mind, participants were questioned about the extent to which drug services were linking with wider support services in order to establish the extent to which service users had access to the support required to accrue recovery capital. With regard to employment, many service users expressed the importance of having a job once they had exited treatment. This was not only for financial reasons, but also so that they had something to occupy their time, as Chris explains:

*If I was off drugs and that, I need something to occupy my mind, you know, cos you’re sat in the house all day watching tele and you get your money, your benefit and you’re sat there and you’re not touching drugs, you’ve got hundred quid in your pocket and you’re like, it’s tempting [to use]. So I’d need a job.*

Chris, Total Care service user

Chris makes reference to the importance of occupying time with meaningful activities while attempting to abstain from drug use (see Best et al., 2012; Best, Savic, et al., 2013; Duffy and Baldwin, 2013; Best, McKitterick, et al., 2015). For many people, this meaningful activity will come in the form of employment (Best et al., 2012, 2016; Duffy and Baldwin, 2013). Issues concerning access to employment support were not substantial. Many participants explained that whilst the usual challenges of drug users finding employment remain (see Spencer et al., 2008), actual availability of jobs had not worsened over recent years. However, Damien explained that it is important for people in recovery to do something they are passionate about:

*Jobs is a funny one ... Not everyone comes out of rehab and they're ready to go straight into work. The hard thing is trying to find that thing for that individual that they're passionate about, because that's what's going to make a difference. There are jobs out there, that's the reality. People are saying there's not but there is. It depends what you want to do though, doesn't it? I mean, I'm not saying there's anything wrong with stacking shelves in a supermarket, but for some of our clients, at the moment of them leaving rehab, that might not be the right thing for them. They need something that fires them up, that gives them that reason to get out of bed in the morning.*

Damien, Resicare manager
Damien maintained that service users are often passionate about helping others to achieve recovery once they had become abstinent, with volunteering positions often being a means to do this. This ties in well with the government’s calls for increased peer support within drug treatment and is discussed in depth in Chapter 6.

Unanimously, participants explained that the key issues in relation to wider support for drug users concerned access to housing and joint working with mental health services. With regard to housing, participants frequently cited the reductions to the Supporting People budget – a housing support service for vulnerable people (see National Audit Office, 2014) – and the impact this had on service users’ access to accommodation. For Resicare, this had presented an issue for their tier 4 services and the access to secondary housing for clients, as Alan notes:

For housing, we’ve got a model where we draw down housing benefit ... Supporting People. So, I’ll give you an example. In Southside, we have a property ... and we get £150,000 a year Supporting People funding for that project. We did get that ... And with not a lot of consultation, and not much notice, not just us, but everybody got told, SP funding has stopped. So in a matter of say an 8-week period, 8 weeks’ notice, we found that £150,000 was gone.

Alan, Resicare manager

In addition to cuts to Supporting People funding, participants from Total Care noted that many homeless services in Metropolis had been decommissioned recently, which had a direct impact on service users’ access to support. Discussing the impact of cuts to wider support services for drug users, Becky made reference to a particular organisation in Metropolis that had recently stopped operating:

So it’s trying to build up relationships with different agencies, and one of the things that I think has happened with the commissioning cuts is sometimes you’ll have a really good relationship with an agency and then a week later you find out that that agency no longer exists ... So thinking specifically, [service] ... used to pick up all the rough sleepers in town ... They did a lot of outreach work with the rough sleepers, but they’re no longer with us, and they’ve been in Metropolis for years and we worked really closely alongside
them. So some of that’s difficult because you might find an agency that can do really good work with clients and you build that relationship up and then all of a sudden they’re no longer there … The funding got completely cut.

Becky, Total Care manager

During his interview, Peter also made reference to the same organisation and explained that, as a result of their closure, some of the homeless clients that Total Care engage with are not presenting to treatment as often:

... they would go around and they’d find some of our client groups, some of our more socially excluded client group that are out there every night. They’re into petty crime; they’re a high overdose risk because of their lifestyles. The whole thing’s been decommissioned, just because there’s no budget left for that ... So that client group ... don’t show up the same way ... They’re just off the map, if you like.

Peter, Total Care service worker

The impact of cuts to wider support services on drug treatment providers’ ability to provide support to certain client groups is evident here. As both Becky and Peter note, the closure of the homeless outreach service had a clear impact on the extent to which Total Care could engage with more hard-to-reach clients. The closure of the homeless service and the removal of Supporting People funding has implications for the ability of drug users to address their wider housing and accommodation needs, restricting opportunities for accruing the capital necessary for recovery and thus further marginalising drug users (Cloud and Granfield, 2008; Best, 2016).

Whilst clear issues were raised regarding service users’ access to stable accommodation, participants explained that the greatest challenge facing drug treatment was the lack of partnership working with mental health services. Issues of joint working between drug treatment and mental health teams are by no means novel (Gossop et al., 1998; Neale, 2002; UKDPC, 2012a; Roberts and Bell, 2013; Du Rose, 2015). However, over recent years, it appears that partnership working with mental health has worsened in the drug treatment sector (DrugScope, 2015b; Adfam, 2016).
This view was supported in this research. Both Resicare and Total Care offered similar insights into the challenges faced when attempting to work in partnership with mental health services:

*I would say that our links with mental health services are probably the same as most other providers that are trying to help people recover or treat people with addiction problems: a real challenge and not very good.*

Alan, Resicare manager

*I think mental health services in Metropolis are beyond atrocious. I hope with all my heart that none of my family ever need mental health services. To get anyone admitted onto a ward is near on impossible. They just don’t exist … And this is historic – certainly all the time I’ve worked in Metropolis. But it’s getting worse and worse.*

Becky, Total Care manager

Becky explained that the mental health provider in Metropolis had recently closed five of its wards due to reductions to funding. One of the consequences arising from this was that people with mental health needs in the community were no longer receiving support and were ‘getting lost’ within the system. During Harold’s interview, he explained that, at the same time that mental health services are being cut, more people are presenting to services with mental health problems:

*Mental health services are a mess, aren’t they? I mean, they're getting hit with funding. It's ridiculous what's happening there because I think you're seeing more and more people with mental health out there. You think, they should be in treatment, or they should be somewhere … but because of the funding cuts they're just… they're getting left, they're getting missed, you know what I mean?*

Harold, Total Care service worker

The decrease in available mental health support alongside increasing numbers of drug users presenting with complex mental health needs has exacerbated an already-problematic partnership between drug treatment and mental health. Alan explained that not having access to adequate mental health support had significantly impacted clients’ progress in residential rehabilitation, demonstrating further how mental health can serve as a key barrier to recovery (Gossop et al., 1998; Neale, 2002; Cloud and
Granfield, 2008; UKDPC, 2012a; Roberts and Bell, 2013; Du Rose, 2015). In response to this issue, Resicare had recently employed a clinical psychologist to work with clients:

That’s why we’ve had to try and find some funding, we’ve taken on a clinical psychologist … We’ve got some three years funding through a benefactor that doesn’t cover all the costs of a clinical psychologist. All we can afford is a day a week of a proper, from a fully qualified clinical psychologist. A day a week. That’s what we can afford.

Alan, Resicare manager

Whilst having already experienced a reduction in funding, Resicare also had to plug gaps in mental health support as a result of the cuts to mental health services in the local authority. Whilst Alan explains that Resicare was able to secure funding for the clinical psychologist from a sponsor, this nevertheless created increased strain on the service. This is a clear illustration of the impact of funding reductions to peripheral support services and the resulting challenges faced by drug treatment providers. The following section expands on the challenges faced by treatment providers by examining the changes to the commissioning and tendering of services.

4.3.3 Changes to commissioning and tendering

Alongside the issues discussed so far within this chapter, participants also raised concern over the changing tendering and commissioning strategies within and beyond their respective authorities. Specifically, participants made reference to the merging of drug and alcohol budgets; the emphasis on prevention and early intervention; changes to contract lengths and commissioning cycles; and an increased focus on cost within contract tender specifications. This section explores each of these four matters in turn.
Integration of drug and alcohol services

One of the key changes cited by participants from both Resicare and Total Care was the move towards the greater integration of drug and alcohol services. Within Southside, the drug treatment service had recently been re-commissioned as a joint drug and alcohol service, with the service in Metropolis currently out to tender for a combined service. Gwyneth describes this development in Southside:

*It really is since the Health and Social Care Act came into play. So when public health moved across into the local authority, that's when we really kind of merged what we were doing. Because, previously, when we had the National Treatment Agency, and drug funding was ring-fenced by the pooled treatment budget ... and the PCT used to commission all the alcohol side of things. So we used to work closely, you know, we used to have joint commissioning groups who used to sit down and decide together how we're going to spend the money, but it was two different organisations, so it's like duplication, really - two contracts. So when public health came across to the local authority ... we commission now jointly drugs and alcohol.*

Gwyneth, Commissioner Southside

As Gwyneth alludes to, the merging of the drug treatment budget with wider public health spend had allowed for the joint commissioning of drug and alcohol services. For the majority of interviewees, commissioning a combined drug and alcohol service was viewed as a necessary and positive development due to the extent to which service users were co-dependent on both heroin and alcohol. There was a great deal of consensus that alcohol use among ‘traditional’ heroin users had increased, with alcohol in some instances replacing heroin as the ‘drug of choice’. A number of explanations were offered for this, including the declining availability and purity of heroin over recent years, as cited elsewhere (see ACMD, 2016; Ahmad and Richardson, 2016). Damien made reference to this development:

*Drinking's just exploded where it didn't use to. When I first started working, a lot of drinkers and addicts were almost separate; you did one or the other. It wasn't until I went working in [local authority] that was one of the first areas I know where people are doing both to excess. And now that's everywhere, that is. Because the gear's gone so shit, a lot of people are*
drinking … because it's socially acceptable, it's cheap, you don't have to steal for it.

Damien, Resicare manager

Due to the increase in alcohol use and the merging of two previously separate populations of substance users, Total Care had experienced an increase in heroin users who were presenting for clinical intervention with alcohol dependency issues. However, as Total Care was commissioned solely as a prescribing service, service users who used both heroin and alcohol were often not receiving the support they needed, as Becky contends:

We see a lot of alcohol users, but it is people that have got a drug problem, so people that are generally in prescribing … started drinking alcohol in a problematic way and then they don’t necessarily get picked up by the [alcohol service] team. I’ve worked in Metropolis for seven years and service users that use drugs and drink alcohol always fall between the two services. We change the goalposts all the time for who’s paying for the detox, who’s responsible for the detox, who’s referring for the detox, where they go, it changes on a very regular basis, and service users fall down because of that.

Becky, Total Care manager

As Becky explains here, due to the way that the services were commissioned in Metropolis, drug users presenting to Total Care who also had alcohol issues often do not receive the support they require due to confusion or disagreement over which service is responsible for their treatment. By commissioning a combined drug and alcohol service, Becky argued that this would allow service users’ needs to be better addressed.

In relation to this, Gwyneth noted that the absorption of the PTB into the wider public health budget had allowed more funding to be allocated to treating alcohol users. A review of drug and alcohol commissioning in 2014 found that local authorities were beginning to invest more into alcohol treatment, which was viewed as a greater need
in comparison to drug treatment (Public Health England, 2014). Gwyneth notes that this was the case in Southside:

*It [removal of the ring fence] was being able to kind of spend the money more. I suppose, look at what the needs are and spend the money according to the needs because previously we were awash with money for drug treatment and had very, very little for alcohol, which was probably fine going back to late ’80s, you know, early ’90s when that was where the pressures were. But then we’ve seen, gradually, the number of traditional drug users decreasing, the number of alcohol users increasing, and we’ve got a big conflict really - we’ve got money to spend on needs of drug users where we’re meeting those … and then we’ve got an alcohol using population who to be honest is not getting the support and treatment that they needed at the time.*

Gwyneth, Southside commissioner

The above passage is particularly noteworthy. On face value, this appears to support fears over disinvestment in drug treatment as its importance is weighed against other local health priorities (Roberts, 2011; DrugScope, 2013; Roy and Buchanan, 2016). Indeed, Gwyneth explicitly notes that the removal of the ring fence had allowed for money previously spent on drug treatment to be diverted into alcohol treatment. In addition to this, Gwyneth also explained that, in Southside, drug use was not considered to be one of the six key health priorities, appearing to support the notion that treatment for dependent drug users would be considered insignificant in comparison to other health priorities (DrugScope, 2012, 2013; UKDPC, 2012b; Lloyd, 2013; Speed and Gabe, 2013; Roy and Buchanan, 2016). However, the reality was more nuanced than this. Gwyneth and Byron explained that, whilst drug use was not a priority within Southside, the increase in poly-substance users and the integration of drug and alcohol services had served to offer protection over the continued investment in drug treatment:

*...we have six key public health priorities and alcohol is one of the six … Drug use isn’t, but I suppose we tend to look at it as substance misuse because you very rarely find, well particularly for, you know, I suppose, illicit drugs, very rarely used in isolation, obviously alcohol is used as well.*

Gwyneth, Southside commissioner
...from our specialist point of view ... substance misuse gets on that list of priorities, even if there are other things ... that are driving it.

Byron, Southside commissioner

Whilst it is possible to assume that, had the two systems not been integrated, service providers in Southside could have perhaps witnessed more substantial reductions in funding for drug treatment, it was apparent the integration of drug and alcohol services provided some level of protection for drug treatment funding.

However, whilst many viewed the integration of drugs and alcohol as a positive development, some participants expressed concern over the extent to which existing staff would be required to take on the roles and responsibilities of an alcohol worker when the systems were integrated in Metropolis. This was an issue raised by Harold:

...years ago, it used to be you had a drug service, you had an alcohol service. And then all of a sudden, you had drug and alcohol service. It was like that at [drug service], there were a lot of workers there who really weren't trained to be alcohol workers but yet they also ... had loads of clients who had alcohol [problems]. So it was getting them trained. So I don’t think that was fair for the people who you were working with.

Harold, Total Care service worker

Sarah supported Harold’s view and explained that, should Total Care win the contract for providing the integrated service, one of the potential issues they could face would be allowing staff to take time to train in responding to alcohol and other substance use, and maintaining the appropriate level of service provision during their absences.

Focus on prevention and early intervention

Along with the commissioning of combined drug and alcohol services, participants in both Resicare and Total Care explained that they had witnessed an increased emphasis on prevention and early intervention in order to reduce dependency and strain on acute care services. Discussing this development in Southside, Byron offers the following view:
...the idea is just to try and get in there sooner ... seeing people who are presenting with reasonable level of substance misuse, but, probably they are less complex in other areas, so somebody might be using whatever their substance of choice is at a reasonable level, but if they’ve still got a stable home, they might still be in employment, they might still have quite a lot of capital, recovery capital - if we’re going to use the terminology - around them and we feel like, if they want to address that substance misuse there and then, we can probably work with them quite quickly ... And if it stops them turning up at hospital and all the other key expensive points that people turn up at, it’s all the better.

Byron, Southside commissioner

Byron cites the importance of early intervention for addressing individuals’ substance use before it becomes more problematic and whilst they still have reasonable levels of recovery capital, as well as for reducing the cost of wider acute care services. This development shows clearly how the emphasis on recovery and the importance of capital has filtered down and influenced commissioning decisions in local authorities, along with the innovative means through which commissioners are responding to constrained financial conditions. In relation to this, respondents from both services explained that there had also been increased attention paid to addressing wider health needs, such as obesity and smoking cessation, in order to alleviate the strain on acute services, as Sarah explains:

*I think we’ve seen a greater emphasis on prevention and public health. So some of the things that we’ve done in response to that is we’ve brought in a new nursing model. So we’ve employed nurses specifically to work with our clients but to do holistic health assessments, also to tap into things like smoking cessation, diabetes checks, obesity, the things that are impacting on the city. So that’s something that has come in more since the shift over to public health.*

Sarah, Total Care manager

Sarah, Alan and Gwyneth explained that providers were being asked to expand service provision in line with wider public health needs such as obesity and smoking cessation. Whilst the increased emphasis on prevention and early intervention is what some had hoped for with the introduction of the public health reforms (e.g. Roberts, 2011), it also demonstrates a broader drive to increase pressure on providers to
demonstrate social value in times of austerity (see Roy and Buchanan, 2016). In addition, these developments can be understood as a means of responsibilising public services and communities to identify and manage ‘risky’ or ‘at risk’ individuals (Rose, 1999; Teghtsoonian, 2009; Juhila et al., 2017; see section 4.5). In support of this argument, Sarah outlined one of Total Care’s intentions for their treatment system in Metropolis if they won the contract:

> And some of the things we’ve done in other areas that we would want to bring into Metropolis if we were successful is training up people in communities to deliver individual brief interventions, and that could be community champions, it could be pharmacists, but it could equally be barbers and hairdressers: places where people go.

Sarah, Total Care manager

The above quote offers a clear illustration of the neoliberal responsibilisation of individuals and communities to engage in tasks that would once have been considered the sole responsibility of state agencies (O’Malley, 2009), and thus demonstrates the privatisation of risk management (Miller and Rose, 2008:215) within the treatment sector. These arguments are expanded in section 4.5.

**Changes to commissioning cycles**

In addition to the emphasis on prevention and early intervention, participants also cited a number of issues resulting from changes to commissioning cycles and the frequency of retendering. As discussed earlier, at the time of the research, the drug service in Metropolis was out to tender, and the service in Southside had just been re-commissioned. In addition to this, participants explained that the services within surrounding areas had also been recently re-commissioned. For instance, Becky noted that the local authorities surrounding Metropolis had been re-commissioned within the past two years:
[Local authority] was re-commissioned a couple of years ago, maybe 12 months ago actually; our neighbouring boroughs have been re-commissioned in the last couple of years...

Becky, Total Care service manager

Moreover, participants raised concerns over shorter contract lengths, with the ‘standard’ contract length decreasing from 10 years to three years, as Harold explains:

*I mean, years ago, like I said, you got 10 years. I think they got 10 years at [previous Metropolis provider] but now... There are still some people who do get at least 10 years, but I think it’s just the way the funding and the commissioners have gone. It’s every three years now.*

Harold, Total Care service worker

The ‘constant cycle and churn’ of tendering and commissioning (DrugScope, 2015b:6), coupled with shorter contract lengths, is an issue that has been reported elsewhere (DrugScope, 2014, 2015b; ACMD, 2015; Adfam, 2016). As discussed in Chapter 2, *State of the Sector* surveys reported that 54 per cent of community services had experienced either contract retendering or renegotiation within the 12 months prior to the survey, with 49 per cent expecting to go through one of these procedures in the following 12 months (DrugScope, 2015b:7). Additionally, 78 per cent of all providers reported to be working to contracts of three years’ duration or less, with some providers working to either a two-year or one-year ‘rolling’ contract (Adfam, 2016:29).

Whilst it has been reported elsewhere that service re-commissioning can result in improved service delivery (see Adfam, 2016:24), frequent retendering within the drug and alcohol sector has shown to have a number of adverse effects (DrugScope, 2014, 2015b; ACMD, 2015; Adfam, 2016). A key issue articulated by participants regarding frequent contract retendering was that it often results in service disruption, and generates anxiety among staff and service users. Harold offers his perspective of the previous commissioning cycle in Metropolis:
It was a bit comical because the needle exchange on Top Street, it was going up and down like a yoyo – up and down the street being moved about … it was disruption for the clients as well with needle exchanges getting moved about, and things like that, and, ‘right, who do I go to for recovery now?’; ‘who do I go to for harm reduction?’ There was a big upset at the time; it was really confusing and that’s happened every three years. It’s just happened in [local authority] now. All the services have been moved about and changed, and people who have been in the services for years, it’s confusing for them because they don’t know where to go, who to turn to or what to do. It seems to be happening so much now you don’t get that long 10-year period of stability.

Harold, Total Care service worker

Harold explained that prior to the re-commissioning in Metropolis, Regain was contracted to provide the needle exchange service while SubstanceAid was commissioned as the recovery service. However, during the re-commissioning, the contracts for providing the needle exchange and the recovery service were effectively swapped between Regain and SubstanceAid (see Chapter 3). This, Harold explained, resulted in a great deal of confusion for both service users and staff:

*I mean because I was with Regain at the time and it was a bit confused because you were a harm reduction worker on a Friday, you woke up Monday morning, you were a recovery worker and it was, ‘hang on, how does that work? ... I mean our job titles – they change every time we win a contract or every time you win a tender. Like you're a keyworker, you're a drugs worker, you're a substance misuse practitioner or you're a recovery link worker ... and it’s confusing for us; how do you think it’s like for the people who use the services?*

Harold, Total Care service worker

In line with Harold’s view, there was a general feeling of confusion among service users when discussing the closure or relocating of services. For instance, in reference to 2012 re-commissioning in Metropolis, Jenny describes her experience:

*They shut down [service] ... there was no like, there was just shutters up, no like information like where to go ... I didn’t know nothing or about they’d all like gone into Total Care, that everywhere had shut down. Everywhere that I knew ... everywhere was getting shut down ... God, they all like shut down and one big place opened in town, but I didn’t even know that it was, you know, about a month. And when I did find out, you know, when I came to finding the place, they’d moved buildings and they’d just moved in here. They shut down that one when I got there and moved here, so I didn’t know where this was place until about a year, just over a year ago.*

Jenny, Total Care service user
With the contract in Metropolis out to tender for a single provider contract at the time of the research, this had generated significant concern among staff as to whether they would retain their jobs within the new system, particularly if Total Care failed to win the contract. When discussing the re-commissioning, Sarah raised this concern:

*We went through it just over three years ago. We’ve been through it all before ... It creates a lot of anxiety for staff ... I think for staff and TUPE*, yeah, because I think there will be some redundancies. Hopefully there won’t be a lot and they will all be voluntary, which is what happened last time, certainly with Total Care, but people are anxious about ‘will I have a job?’ ... *So, yeah, there are anxieties across the staff team.*

Sarah, Total Care service manager

The issue of redundancy following re-commissioning was discussed earlier and will be returned to later in this section. Frontline workers also commented on the anxiety for staff over job security through provider takeover and TUPE:

*Workers get stressed about it, workers worry about it - it’s your mortgage, your bills, that kind of stuff. And some of that stress might go on to clients as well...*

Richard, Total Care service worker

Again, the issue of staff anxiety through the TUPE process has been highlighted in existing literature (ACMD, 2015; DrugScope, 2015b; Adfam, 2016). As DrugScope (2015b:16) demonstrate, re-commissioning and frequent provider change can negatively impact team stability and result in low staff morale (see also ACMD, 2015). Commenting on the previous re-commissioning in Metropolis, Charlie explained that staff in Total Care who had been TUPE transferred from the previous NHS provider were ‘very unhappy’:

*Staff morale is very, very low – lots of sickness. In Total Care I’m talking about ... They came over from the NHS trust, which, you know, is completely different. But, yeah, complete change of culture and people are very ... I haven’t been in there since April but very unhappy, very unhappy.*

Charlie, Resicare service user
The problems with regard to the ‘culture change’ and staff morale that Charlie makes reference to are picked up again and discussed in greater depth in the following chapter.

A further issue cited with the increase of shorter contract durations is that it negatively impacts service providers’ abilities to establish themselves in an area and provide an adequate service before having to prepare for a further round of tendering. A number of participants raised this concern during interviews, noting that it often takes a year to 18 months for a provider to ‘find their feet’, leaving a period of only six to 12 months until preparations for retendering had to begin. This is an issue that has been expressed by other service providers (see DrugScope, 2014; Adfam, 2016).

In respect of this, it was interesting to find that the service in Southside had recently been commissioned for a five-year contract. Whilst this was considered unusual, Gwyneth explained that the commissioners were aware of the disruption caused by frequent retendering:

...the standard is three years, but we felt as though by the time you’ve got something embedded, you know, it takes 18 months to firmly get something properly established and you’re doing things right and then six months later you’re going to have to start the whole procurement process again and it is very destabilising.

Gwyneth, Southside commissioner

As will be examined below, it was apparent that the commissioners in Southside were attuned to the issues faced by providers in the current climate and were keen to commission services in such a way as to avoid negatively impacting the quality of service provision.
Focus on cost in contract tender specifications

Along with problems associated with frequent commissioning cycles, a further key issue raised by participants concerned the increasing weighting on cost within contract tender specifications. In support of arguments made elsewhere (see Jolly, 2013; DrugScope, 2015b), managers from both Total Care and Resicare suggested that commissioners were placing increasing focus on the cost of service delivery within tenders, with decreasing importance placed on the quality of service provision. This, Alan argues, has forced providers into further reducing the cost of their service delivery in order to be awarded the contract:

The overall budget’s been cut, yet … there’s a weighting in the tender that you can gain, let’s just say it’s 10 per cent, 10 per cent of the overall mark is based on cost. So, say there was 5.9 million, you’re working with that tender and you think that there’s the percentage there, that if we go under, we’re going to score that extra 10 per cent … So you’ll get organisations, because they might win loads and loads of contracts … they’re able to undercut… So, it’s forcing providers into making a cut. So the budget might be £5.9 million, but basically what they’re saying there, the commissioners, is that’s not what you’re getting, we want you to come in under that.

Alan, Resicare manager

Whilst Alan uses an example of a 10 per cent weighting on cost within tenders, the commissioners in Southside explained that, in the recent procurement process, 20 per cent of the tender was based on price:

Twenty per cent was based on price … we were under some pressure to be honest with you to make that a little bit higher, you know, so whether it should be 60 based on quality and 40 based on price. But we really have hung on in there saying, actually, you know, the financial envelope has significantly reduced anyway, it’s not… providing we can get decent quality providers who can deliver these services, that is more important than them coming in, you know, an extra £50,000 cheaper because, ultimately, we want them to be successful.

Gwyneth, Commissioner Southside

Gwyneth explicitly supports the assertion that commissioning decisions are moving away from a focus on quality towards increasing focus on cost of service delivery.
However, Gwyneth’s claim that she and her colleagues had prevented the additional 20 per cent weighting on cost further supports the argument made above that the commissioners in Southside, whilst under pressure to respond to a constrained financial climate, were ultimately able to mediate issues in an attempt to safeguard the quality of service provision.

The increasing focus on cost within tenders is not surprising in a context of budget reductions, as addressed earlier. Moreover, as will be argued below, the competitive tendering of services functions as an effective means of increasing competition between providers, thus driving down cost and providing best value for money for commissioners (Smyth, 1997; Boyne, 1998; Deem, 1998; Hansen, 2010; Krachler and Greer, 2015). Notwithstanding this, participants expressed concern that the increasing weighting on cost within contracts coupled with reducing budgets had resulted in some providers gaming the system by submitting unrealistic bids and undercutting competitors in order to win contracts and then failing to deliver an adequate service.

With regard to this issue, Alan noted that one of the ways in which providers often reduce service costs in order to avoid delivering at a loss is by making staff redundant after taking over a contract, thereby lowering the wage bill:

*So, I can imagine that an organisation that can say they’ll do this, that and the other, and then can come in and … are very, very ruthless in what they do, in terms of when they take over a contract about making people redundant. I saw it in Metropolis, I saw an organisation come in, make lots of people redundant, so that they could save costs and there was lots of sort of problems with that. Nobody replaced those staff, and the consequence is that they haven’t delivered … you’ll get these providers that will undercut, undercut, undercut, not deliver, not deliver – reduces the budget. So, I wonder if that’s what happened in Metropolis…*

Alan, Resicare manager

Whilst TUPE is designed to protect workers’ terms of employment following provider takeover, a worker can be made redundant if their role is no longer available due to
economic, organisational or technical reasons involving changes to the workforce (GOV.UK, n.d.). Again, although Alan did not explicitly name Regain as the organisation in question, Damien also suggested that this was a process that Regain engaged in. When discussing this, both Alan and Damien believed that ‘strategic tendering and commissioning’ was occurring. This, Damien suggests, begins with the way in which providers approach the tender writing:

...commissioning's a flawed process ... So the tender goes out, so you write a bid. They say, ‘right, this is how much money we're going to give you, this is the sort of idea of what we want – you tell us what you're going to do with that money.’ So I don't know, say Regain, for example, have a team bid – has all come out of university who approach it like it's a dissertation. They're going for top marks in everything. So they'll write it – they haven't got a clue about actual drug services or about the delivery of drug services on the ground floor, they haven't got a clue of the client group that they're actually working with – they're just approaching this like some theoretical exercise: ‘how can we make this what we need to write fit in with what they're looking for?’ And what happens ... you get a panel of experts from around the country who will come and look at it and go ‘that's wonderful, that. Give them the job, because look what they say they can do on a bit of paper’.

Damien, Resicare manager

It is evident here that Damien views the hiring of bid writers within Regain as an underhand tactic, providing an unfair advantage by gaming the system. Whilst the hiring of bid writers is not prohibited within the sector, it demonstrates the tactics that organisations can employ in order to be successful, and the way in which competitors view these tactics (Clarke, 2004; Davies, 2014b). In addition to this, both Damien and Alan believed that commissioners were aware that Regain would make people redundant after winning a contract and thus lower the overall cost of the service in time for it being put back out to tender, as Damien explains:

I wonder whether the likes of Regain are winning a lot of contracts now. Because they have quite a bit of money put to one side ... when they win a contract, they can go in and just make everyone redundant if they want to, and start again. I wonder whether commissioners are strategically sort of ‘Well, we'll give this contract to Regain – they'll come in and make everyone redundant, they'll really lower the cost of our services.’ And then ... because Regain have took the bill down from sort of five million to two-and-a-half
Damien, Resicare manager

Damien’s supports Alan’s earlier argument concerning Regain, and suggests that commissioners are aware of their practices and thus strategically award contracts to them in order to reduce the cost of the contract through staff losses. This view is interesting from a neoliberal perspective. As noted above, for competition to exist within a market, potential competitors must sense a degree of equality and fairness within the market conditions (Davies, 2014b). Thus, Davies (2014b:57) argues, competition must be viewed as ‘real’ and not ‘rigged’, with each competitor ‘playing by the same rules’ in order for a market to function effectively. From Damien and Alan’s view, there is a clear perceived lack of fairness among providers and an absence of ‘rules’ among competitors.

As this section has demonstrated, there had been a series of noteworthy changes to the tendering and commissioning of services within Metropolis and Southside. Alongside the issues that have been cited throughout this section, it was also discovered that the introduction of these changes at a time of shrinking budgets for drug treatment had generated significant competition between providers. The following section examines the extent of competition within the sector, focusing specifically on the experiences of Total Care during a period of service re-commissioning.

4.4 Intensified competition

Existing research has highlighted the extent to which competition within the sector has become increasingly intensified (see DrugScope, 2014). As mentioned at numerous points throughout this chapter, one of the key themes to emerge from this research was the degree to which providers are now competing against one another to
win contracts. This section examines the extent of this competition within the drug treatment sector. In doing so, it serves to effectively set up the following two chapters, which examine in greater depth the working practices employed by treatment providers in this climate.

During interviews, participants drew attention to the increased competition that has been generated between service providers. Whilst it was viewed as an expected feature of the treatment sector, references were often made to the risks that competition can produce, particularly concerning the provision of adequate support for service users. For instance, Harold argued that competition between providers can create barriers to joint working on clients’ cases. Here, he provides an example from when he worked for Regain in another local authority:

*I've seen it at [local authority], when Total Care was going in for the tender. I wanted to contact somebody who worked with Total Care to work on something but I was advised not to because they're going for the tender … There's bound to be competition because they are competing against each other, you know what I mean? So is that healthy for us, is that healthy for the service users? Who knows.*

Harold, Total Care service worker

Harold’s claim that he was advised not to contact Total Care to work jointly on a case because they were in competition with Regain for a contract is striking. However, participants explained that this was not unusual within the current climate. Indeed, the reluctance of providers to work in unison with their competitors has been highlighted elsewhere (UKDPC, 2012b:53; DrugScope, 2014).

The situation within Metropolis at the time of the research serves as perhaps the most useful illustration of the competition that can exist between providers and the (un)intended consequences. As noted earlier, at the time of the research, three
providers delivered the drug treatment service in Metropolis. As a result of the recent tendering for a single provider model, significant competition had been generated between the three providers. From the perspective of Total Care, this had resulted in concerted attempts to demonstrate success to the commissioners in a bid to position themselves well against the other providers during the re-commissioning process. This was particularly noticeable for the frontline workers interviewed within Total Care. Peter summarises this situation:

*Recovery’s a big thing. Commissioners, as I say, are setting out a specification of what targets they want, and then the treatment provider, Total Care, has been commissioned with two other services and so we want to look good as against them, and we want to win this next bid that’s coming up, which will be decided upon on [date]. So, that’s what it’s all about. That’s the game. That’s the game.*

Peter, Total Care service worker

Peter explained that Total Care had ‘been aware for some time’ that the service in Metropolis was going to be re-commissioned and were ‘desperate to position themselves well’ in order to look favourable to commissioners with the ultimate aim of winning the contract. As will be discussed in greater depth in the following chapter, along with the changes to tendering and commissioning cited above, the reorientation towards recovery in local policy had been accompanied by a shift from process-driven to outcome-based targets. At the time of the research, in line with the PHOF (2016b), the key target for Total Care was to achieve successful completions of treatment. Janet explains the shift in targets:

*We have to prove our worth and we have to hit targets otherwise we don’t get the contract again … we have targets we have to meet, and the targets aren’t getting people into treatment, stopping them using…*  

**What are your targets?**  
*There are a certain amount of people out of treatment every month.*  

Janet, Total Care service worker

Here, Janet makes reference to the move from process-driven to outcome-based targets within Total Care. Whilst the following chapter examines the successful
completion of drug treatment target and its impact in greater depth, it is worth reiterating here that the focus on outcome-based, measurable targets is symptomatic of the expansion of new managerialism within the public sector, and serves as a direct means of increasing competition among providers (Connell et al., 2009; Ward, 2011; Siltala, 2013; Fuertes et al., 2014; Juhila et al., 2017; Lynch, 2017; Räsänen and Saario, 2017).

Alongside the emphasis on displaying success through treatment completion rates, a further means through which Total Care sought to demonstrate their value to commissioners was through the recruitment of recovery champions and other PSWs within their service. Again, whilst a discussion of the employment of PSWs is reserved for Chapter 6, it is worth noting here that, as Total Care was not directly commissioned to employ recovery champions at the time of the research, their employment was viewed as a further effort to demonstrate success to commissioners. The following section seeks to make theoretical sense of the key findings presented in this chapter by examining the key notions of neoliberal governance outlined in Chapter 1.

4.5 Making sense of recovery in an age of austerity

As alluded to in numerous discussions throughout this chapter, many of the developments that have occurred in Metropolis and Southside, and their impact on Resicare and Total Care, can be understood through consideration of key notions of neoliberalism. This section synthesises some of the key findings presented in this chapter and examines them in reference to competition, risk, choice and responsibility.
The first point to note is that, as Clarke (2004:32) contends, with the emergence of neoliberalism and the introduction of new managerialism within the public sector, voluntary sector organisations are ‘expected to behave in a more “business-like” fashion in the contract culture’. This explanation offers a useful means for making sense of many of the findings presented in this chapter. For example, it was apparent that business-like behaviours were evident in the ‘strategic commissioning’ procedures engaged in by some providers within the sector. It was clear from Damien’s account of Regain’s tender-writing practices that voluntary sector providers are embracing techniques from the corporate sector in order to succeed in a competitive marketplace.

Total Care’s response to reductions in funding, such as through the recruitment of social workers and recovery champions in place of keyworkers, can also be understood as acting in a more business-like fashion, with a clear drive to ensure they are performing efficiently. Moreover, direct references by service users to the ‘business vibe’ in Total Care also support this claim; Total Care seek to operate as efficiently as possible by cajoling service users to turn up to appointments on time with the threat of consequences if failing to do so. The introduction of the ‘late pod’ exemplifies this approach. As such, the introduction of the ‘late pod’ in Total Care also offers support for the argument that drug users are conceived of as rational choice makers who can be cajoled into behaving responsibly (see Seddon, 2010a; Seddon et al., 2012).

Notions of risk and responsibilisation can also help to make sense of the increased focus on prevention and early intervention within the two local authorities. Early
intervention provides an efficient method of identifying and managing ‘risky’ populations and benefits the economy by reducing the strain on acute services. Total Care’s proposal for barbers and hairdressers to deliver brief interventions in communities is a discernible illustration of this process of responsibilisation (Rose, 1999; O’Malley, 2009; Teghtsoonian, 2009; Juhila et al., 2017). In relation to this, requiring treatment providers to do ‘more for less’ by addressing wider health needs of their clients, such as obesity and smoking cessation, serve to reduce the cost to the state and can be understood as central to neoliberal strategy (Ward, 2011:207).

With regard to the cuts experienced or anticipated by Resicare and Total Care, as Bach (2016:16–17) argues, deficit reduction in the UK has been skewed heavily towards reductions to state expenditure in the vision of the Big Society, and has been used as a means of fostering innovation of public sector providers. In relation to this, Bach (2012:402) explains that the most immediate impact of cuts to funding are felt by the public sector workforce, with cuts to staff – and particularly ‘back office’ and managerial positions – the desired outcome in the aim of achieving the Big Society. The argument presented by Sarah that the commissioning of an integrated system in Metropolis has allowed for significant reductions to staff and thus substantial cost savings exemplifies this notion.

Lastly, as noted in Chapter 2, the 2010 drug strategy emphasises that treatment services should be competitively tendered within local authorities (HM Government, 2010). Competitive tendering of services is central to new managerialism, and functions to increase efficiency, improve standards and drive down cost (Smyth, 1997; Boyne, 1998; Deem, 1998; Hansen, 2010; Krachler and Greer, 2015). The
findings presented in this chapter suggest that this outcome is being met within the treatment sector: by competitively commissioning services, and by placing a greater focus on the cost of delivery, treatment providers are being forced to cut costs and increase efficiency in order to continue to compete in the market. Whilst it appears that Total Care has managed to respond effectively to this challenge, smaller providers like Resicare lack the capacity to compete and are thus becoming marginalised within the sector. This, though, is an expected response to competition, with only those most shrewd and with the greatest economies of scale likely to survive (Ogus, 1994; Bach, 2012; Damm, 2012). This raises important questions over the extent to which smaller providers continue to view themselves as viable competitors in this race to the bottom (Davies, 2014b).

4.6 Chapter summary and conclusion

This chapter has examined the impact of the reorientation towards recovery on local level policy within Metropolis and Southside during a time of economic austerity and widespread reform. It has presented the experiences of Total Care and Resicare along with findings that apply to drug treatment more broadly within the current climate. The findings presented in this chapter demonstrate that the economic climate in which the shift to recovery has occurred within the local authorities has significantly impeded the extent to which Resicare, and, to a lesser extent, Total Care are able to continue to support service users.

Returning to the research questions, this chapter has demonstrated that, whilst there was some degree of contention between participants as to how recovery should be defined, unanimously, participants agreed that recovery comprises more than control of drug use, instead encompassing positive life changes, such as finding stable
accommodation and employment, connecting with family, and meeting ‘life’s responsibilities’. Despite this view, however, it was evident that both Resicare and Total Care narrowly defined recovery as denoting abstinence from some or all substances.

Importantly, this chapter has examined the extent and impact of cuts to funding to Resicare and Total Care. The findings demonstrate that, whilst both providers had or were anticipating reductions to their budgets, as the much smaller provider, Resicare had been more adversely affected by these cuts. In addition to direct cuts to their funding, it was also discovered that cuts to wider support services, and particularly housing and mental health support, were having a profound impact on Resicare and Total Care. In relation to this finding, it was established that, whilst the shift to local commissioning through the public health reforms promised greater opportunities for joint working within local authorities, reductions to funding have severely constrained the extent to which partnership working is possible. One of the key implications of this is that service users will find it more difficult to accrue the capital necessary to initiate and sustain recovery attempts.

This chapter has also examined the changing nature of tendering and commissioning within Metropolis and Southside. It has been established that, as a result of the public health reforms, the budget for spending on drug treatment had been absorbed into the wider budget for spending on public health within the local authorities, enabling the joint commissioning of drug and alcohol services. Whilst participants viewed this as a positive development, the diversion of drug treatment funding to alcohol provision suggests that fears of disinvestment within the sector might still be realised. In
addition to this change, the findings presented in this chapter suggest that treatment providers are now being commissioned for shorter periods, and are being required to deliver a broader range of services for a reduced budget. Combined with an increased focus on cost within contract tenders, and a shift from process-driven to outcome-based targets, this chapter has established that treatment providers are now operating in a highly competitive environment.

Examining these key findings in light of neoliberal theorising, this chapter has demonstrated how key notions of competition, risk, choice and responsibility manifest at the local level. Importantly, it is argued that both the climate in which providers are operating, and the way in which providers are responding to the challenges they face, can be understood through reference to new managerialism and the introduction of business-like mechanisms into the public sector. This is particularly useful for considering the extent and impact of competition, which emerged as a significant theme throughout this research. The following chapter examines in greater depth the drive to achieve successful completions of drug treatment and, in doing so, demonstrates the impact of the highly competitive environment on Total Care’s treatment practices.
Chapter 5 | The drive to demonstrate success: The successful completion of drug treatment target

5.1 Introduction

This chapter provides an in-depth, critical account of the successful completion of drug treatment target and its impact on the day-to-day working practices within Total Care. As examined in Chapter 2, the shift to recovery in national policy was accompanied by a shift from process-driven to outcome-based targets (HM Government, 2010; Home Office, 2012; Duke, 2013), with the successful completion of drug treatment established as the key proxy measure of recovery (HM Government, 2010; Public Health England, 2016a, 2016b). Given the apparent conflation of recovery and abstinence in national policy (Monaghan, 2012; Monaghan and Wincup, 2013; Roy and Buchanan, 2016; Wincup, 2016) the shift to outcome-based commissioning and the emphasis on successful completion of treatment has raised concerns that abstinence and treatment completion will become an overly simplistic measure of ‘success’ on the ground (e.g. Roy and Buffin, 2011; Measham et al., 2013; Neale et al., 2013; DrugScope, 2015a; Roy and Buchanan, 2016).

There are concerns that the emphasis on outcomes will generate perverse incentives and give rise to risky practices, including encouraging service users to detox and exit treatment prematurely, and ‘gaming’ the system by ‘creaming’ (cherry-picking) clients with the fewest barriers to recovery and ‘parking’ (neglecting) those with more complex needs and thus more significant barriers to recovery (Maynard et al., 2011; Roberts, 2011; UKDPC, 2011, 2012b, DrugScope, 2012, 2015a; Duke, 2013). As demonstrated in Chapter 1, such practices have been identified in other public sectors, most notably the various welfare-to-work programmes introduced in the UK over
recent years (Newton et al., 2012; Rees et al., 2014; Carter and Whitworth, 2015; Egdell et al., 2016). However, whilst existing empirical research in the drugs field has offered some useful insights (e.g. Roy and Buffin, 2011; Measham et al., 2013; Neale et al., 2013; DrugScope, 2014, 2015b; Adfam, 2016), research has thus far failed to provide in-depth evidence to substantiate these concerns.

Picking up where Chapter 4 left off, this chapter presents a case study of Total Care and demonstrates how the emphasis on drug users completing and exiting treatment had altered the day-to-day working practices of frontline staff. It is argued that the highly competitive environment in which Total Care was operating and the drive to demonstrate success to commissioners through recording successful completions of treatment had given rise to a number of risky practices performed by Total Care staff. The findings presented in this chapter substantiate concerns that service users are being encouraged to detox and exit treatment prematurely, placing them at significant risk of relapse and overdose. In addition, building on the arguments presented in Chapter 4, this chapter serves to further situate the research findings within a broader framework of neo-liberalism, looking specifically at the nature of competition and its impact on the ground level.

5.2 The drive to demonstrate success: the successful completion of drug treatment

5.2.1 The successful completion of drug treatment target

As examined in Chapter 2, the successful completion of drug treatment is defined within the PHOF as:

Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6
months as a percentage of the total number of opiate users in treatment. (Public Health England, 2016a, 2016b)

As an organisation, Total Care’s success in respect of successful treatment completion was measured using the above indicator definition. However, when interviewing frontline workers, it became apparent that their definition of a successful completion deviated somewhat from this definition. From the perspectives of frontline workers, a successful completion is achieved when a service user completes a detox from their substitute opiate medication and is not using their drug(s) of dependence:

To become a successful completion, you have to have come off a methadone or Subutex prescription. If at that point you can say that you have not used, that you are currently not using at the point that you come off your script then you are a successful completion.

Peter, Total Care service worker

Importantly, whilst broadly similar to the definition set out in the PHOF, frontline workers made very few references to the stipulation that service users had to remain out of treatment for a minimum of six months in order to be classed as having successfully completed treatment. Upon further consideration of this finding, it emerged that Total Care was narrowly defining successful completion of drug treatment, in an operational sense, as service users detoxing and exiting treatment34:

All it means to the organisation is that they [service users] get from, I don’t know, 30 or 40 mils [millilitres] of methadone, to eventually being on nothing. And once they’re on nothing, they’ve taken their last dose of methadone, I ring them and say, ‘Are you doing okay?’ And they say, ‘Yeah.’ I say, ‘Are you using?’ They say, ‘No.’ And I say, ‘Right, I’m closing your case.’ And obviously, there will have been preparation. I’ll have said to them, go to Regain, get your support from MA or whatever. But I close the case and then that is a successful completion.

Peter, Total Care service worker

Once they’re actually off a prescription, then they’re classed as off our books kind of thing ... a successful completion.

Richard, Total Care service worker

34 Given this finding, unless otherwise stated, references to successful completions within this chapter refer to this operational definition rather than the definition used in the PHOF.
Peter’s quote above acutely captures the process of recording a successful completion in Total Care. It is evident from the above descriptions that Total Care’s aim was simply to get service users into detox and treatment exit, with seemingly little consideration for their aftercare aside from advising clients to attend Regain’s recovery service or attend mutual aid. This transpired to be an important issue, and is returned to later in this chapter.

Whilst some service workers explained that achieving successful completions was not the only target they had – with other targets including hepatitis vaccinations and testing – almost unanimously, interviewees explained that Total Care’s key performance indicator was heavily linked to the number of successful completions they could achieve:

*Total Care wants to get as many people as possible off methadone and buprenorphine scripts and then be able to record it as somebody who’s successfully completed treatment … our performance is very closely linked to that.*

Peter, Total Care service worker

As discussed in the preceding chapter, whilst Total Care was not commissioned through a PbR model, it was evident from interviews with frontline staff that they were under significant pressure to demonstrate success to commissioners in order to be best placed to win the contract that was out to tender in Metropolis at the time. When discussing the target of successful completions, a number of participants raised concerns over the impact that this pressure was having on their day-to-day working practices. The following section addresses these issues.
5.2.2 The pressure to produce: achieving successful completions

One of the key challenges articulated by participants concerned the ‘constant’ emphasis on having to encourage clients to complete treatment and exit services. The drive to achieve successful completions had resulted in service workers being instructed by their manager to review clients for completion as frequently as possible:

...there’s a lot of emphasis on constantly reviewing who might be suitable for successful completion; it’s regularly discussed by managers … if somebody’s even half suitable for a detox, we have been told we should encourage that process.

Peter, Total Care service worker

We’re actually told: if anybody mentions the word detox, push them for it. That’s what we’re told.

Richard, Total Care service worker

The finding that service workers are being instructed to encourage or push clients to enter detox was also supported by the personal experiences of some service users. As discussed in the previous chapter, the majority of service users interviewed explained that their primary goal of treatment was to become abstinent. However, whilst this was a short-term goal for some, others suggested that they were not yet ready to become abstinent, instead needing a prolonged period of OST. When discussing the increased emphasis on recovery within Total Care, some service users explained that their keyworkers respected their desire to remain on substitute medication, at least until they were ready for abstinence. For instance, Helen explained that after a previous unsuccessful reduction attempt, she was now more cautious of reducing too quickly, which her keyworker respected:

I’ve got the same keyworker that I had last time [prior to relapsing], so he knows pretty much everything about me anyway … he knows I want to reduce off it, but he knows I don’t want to do it straight away ’cause I need to get settled on it first.

Helen, Total Care service user
Notwithstanding this, other service users were more critical of the emphasis on abstinence-based recovery within Total Care and supported Richard’s assertion that service users were being ‘pushed’ to detox:

My own personal belief as to how people achieve abstinence is that when they’re ready for it, and you can’t push somebody into being ready; it’s just something that happens for people … they’re going to be throwing people off the books who are completely not ready for it and their lives are going to suffer as a result. They’re going to get paid because, as far as the systems concerned, they’re off the books: it must be a success.

Jasper, Total Care service user

Jasper supports the view that abstinence is a voluntary endeavour that cannot be forced (Laudet, 2007; UKDPC, 2008). He also argues that the drive to achieve successful completions and to get people ‘off the books’ was leading to service users being ‘thrown’ out of treatment before they were ready. Jasper’s personal experience of treatment in respect of this was particularly interesting and will be addressed later in this chapter.

The finding that service users are being encouraged or pushed to enter detox provides clear indication of the potential impact of the successful completions target on service workers’ day-to-day practices. When probed further on this issue, whilst participants referred to a series of ‘checks and balances’ that are in place to prevent service users entering detox before they were ready35, Richard explained that the criteria for entering service users into detox had also become less strict, thus easing the process of achieving a successful completion:

They’re putting everybody through … it used to be quite strict to get in but it’s got less strict for the detox part of it and that’s just down to trying to get people through and then it looks good if they come out the other end. And it looks good to Total Care that we’ve got people clean ‘cause they’re in detox.

35 Examples of the ‘checks and balances’ included service users being stable on their substitute opiate prescription (i.e. taking it as prescribed and not ‘topping up’ with heroin); engaging with programmes offered by Regain; and being approved for detox by an assessment panel consisting of a manager from Total Care, representatives from SubstanceAid and Regain, and the client’s care manager.
Richard, Total Care service worker

Richard’s claim that the criteria for entering service users into detox becoming less strict in order to ‘get people through’ and demonstrate Total Care’s success is a clear example of the nature and effects of competition on treatment practices.

As Peter noted earlier, at the end of a client’s detox, the task for a worker to secure a successful completion is to contact the client and ensure that they are no longer using substances. When discussing this with Peter, it was evident that there was a great deal of pressure placed on workers to close clients’ cases on the same day as the client completing their detox, as Peter explains:

...if you can contact them on the day and they’re not using, you can close it. And, and, this is quite an important point because I do want to make this point: we were actually under instruction to close it the same day … everything else took a back seat. If you have a successful completion, you know, you were under pressure to follow it up that day … and if you’re off, and you’re sick or something or you don’t work that day, the manager will follow it up that day and try and get that successful.

Peter, Total Care service worker

When queried on this issue, Peter explained that he was of the impression that workers are encouraged to close service users’ cases as soon as possible for fear that they would relapse and would not be recorded as having successfully completed treatment. As will be discussed later in this chapter, whilst service users who re-presented to treatment within six months of exiting would understandably not have been recorded as a successful completion on the NDTMS database, this was not of paramount importance for Total Care. Rather, it was important that Total Care managers targeted staff to accelerate as many service users as possible into detox and treatment exit in the aim that at least a proportion would remain out of treatment for the required six month period. Nevertheless, Peter’s reporting of the urgency to close clients’ cases due to the apprehension of clients relapsing is indicative of a much
broader issue of relapse following completion that emerged through this research. This issue will be returned to later in this chapter.

The pressure placed on service workers to achieve successful completions was intensified by the introduction of a ‘tracking system’, which recorded the number of successful completions achieved by each worker, with any instances of underperformance being raised during supervision meetings:

*There was like a tracking system on each individual worker and how many successful completions they’d had … I was quite low on it for quite a while even though I can honestly say I work hard and I do what I can, you know? … But there was a tracking system and we were actually told that it would be raised in supervision with people who were sort of not getting very many successful completions having a discussion with the manager about why that might be and whether they’re discussing recovery often enough. And, you know, people were starting to get a bit worried about it and it’s discussed at team meetings regularly whether we’re having enough successful completions … I have felt under pressure … I’ve certainly lived with the feeling that all my other work seemed to be like far less important than the fact that I didn’t have that many successful completions. Which is bizarre.*

Peter, Total Care service worker

This is perhaps one of the most overt and tangible manifestations of the pressure placed on service workers to encourage clients to enter detox in order for Total Care to achieve successful completions. As will be discussed in section 5.3, from a neoliberal perspective, it can be argued that the tracking of workers’ performance ultimately serves to increase the efficiency of Total Care, thus increasing its chances of success within the retendering process (Ogus, 1994; Connell et al., 2009; Le Bianic, 2011; Davies, 2014b; Juhila et al., 2017; Räsänen and Saario, 2017). This is an important finding that has significant implications for the wellbeing of both staff and service users. As the following section demonstrates, the pressure placed on service workers to achieve successful completions has generated significant risks for service users.
5.2.3 Risks presented by the focus on successful completions

As examined in Chapter 1, existing research from within and beyond the drugs field has demonstrated the risks that can arise from the introduction of outcome-based quantifiable target setting, including the production of perverse incentives and practices of ‘gaming’ that have been found in numerous sectors (e.g. Bevan and Hood, 2006b; Hood, 2006; Finn, 2011; Fox and Albertson, 2012; Newton et al., 2012; Eastwood et al., 2013; Rees et al., 2014; Carter and Whitworth, 2015; Ordóñez and Welsh, 2015; Egdell et al., 2016). With the shift to outcome-based target setting in line with the recovery agenda, concerns have been raised over the extent to which similar issues will be found in the treatment sector (e.g. Maynard et al., 2011; Roberts, 2011; UKDPC, 2011, 2012b, DrugScope, 2012, 2015a; Duke, 2013; Neale et al., 2013; Roy and Buchanan, 2016; Best, De Alwis, et al., 2017).

With regard to the impact of target setting, Janet explained that Total Care’s emphasis on achieving successful completions and the pressures placed on service workers to perform well had sometimes led to keyworkers speeding up or slowing down their clients’ detoxes in order to meet monthly targets:

*I’m not saying our figures are massaged, but say someone is going to do well on the 30th, I might not make the phone call ‘til the beginning of the next month because it’s monthly, it’s monthly targets. People get their detoxes speeded up and slowed down to fit in monthly targets and it doesn’t matter, it’s almost irrelevant if we think it’s going to be successful or not.*

Janet, Total Care service worker

Very clearly, Janet explains here that in order to meet monthly targets, service workers will either speed up or slow down clients’ detoxes depending on whether successful completion figures are low or high for that present month. More striking, though, is the final statement Janet makes that it is almost irrelevant if the detox will
be successful\textsuperscript{36}, thus clearly implying that the primary aim for Total Care is accelerate
as many service users as possible into detox and treatment exit in the hope that a
proportion will not re-present within six months and thus be recorded as a
successful completion on the NDTMS database.

In addition to the above issue, evidence of ‘gaming’ was also found within Total Care. There was a concern amongst some frontline workers that clients with complex
needs – who require more intensive support – were no longer receiving the attention
they require and instead being ‘left behind’:

...we have a lot of complex clients and I have a concern – I’ve had this for some time – that the agenda is being driven by [a] national obsession with getting people out of treatment. There’s a hell of a lot of people who have mental health issues, quite complex mental health issues, who have a whole load of physical health problems, who’ve been in this lifestyle for long periods of time, in and out of prison. So they’ve got a wide range of complex problems and sometimes those people are not getting the attention that they would have had … the really complex people do need plenty of time, do need resources and they are getting a little bit left behind, I think.

Peter, Total Care service worker

As Peter alludes to here, with the focus on getting service users out of treatment,
service users who suffer more entrenched, complex issues are being neglected in
favour of clients who are easier to detox. Harold also raised this issue concerning
complex clients:

So, say somebody’s on 70/80mil of methadone, or they’ve been on it for 10/15 years, it’s going to be harder to get them to do a reduction and to get them to come off it. Where somebody who’s done a year, who’s only on 20mil, but we’ve sort of got to treat them both the same. We get a bit of flexibility but a few years ago you could take longer working with the person who’s been on it 15 years because you knew it was going to be a hard battle.

Harold, Total Care service worker

\textsuperscript{36}It should be noted that none of the participants interviewed for this research appeared to internalise the view expressed by Janet, and it was very clear that staff cared about the welfare of their clients, but this is a powerful statement nonetheless.
This offers evidence for the concerns expressed regarding the issues of ‘creaming’ and ‘parking’ service users depending on their ability to complete treatment (Maynard et al., 2011; UKDPC, 2011, 2012b, DrugScope, 2012, 2015a; Duke, 2013). In addition, whilst concerns over gaming practices have predominantly been raised in relation to PbR commissioning, these findings demonstrate that the highly competitive environment in which Total Care was operating and the desire to demonstrate success to commissioners was enough to give rise to these issues. This finding might also help to explain Mason et al.’s (2015) data, which demonstrates that providers that are commissioned through a PbR model are more risk-averse at discharging clients for fear of relapse and non payment. With Total Care’s funding not directly dependent on drug users remaining drug free after treatment completion, they are perhaps more willing to take risks. From the arguments presented so far within this chapter, this certainly appears to be the case.

To further his argument, Peter later explained that the lack of attention paid to supporting complex clients was also being reflected in performance-related emails from managers:

...we get emails every so often, we’re doing well as against the...I don’t know, we’re the top in [the borough], we’re the third in the country, in terms of successful recovery. You don’t get any emails ever saying we’re doing really well with our complex clients. That’s great stuff. That’s the sort of thing that nobody’s kind of really emphasising.

Peter, Total Care service worker

The chief focus on successful completions is once again apparent here. The data demonstrate that the dominant focus on achieving successful completions has clear implications for service users with complex needs. Given the greater challenges associated with supporting complex clients to enter detox and successfully complete treatment, along with the pressures placed on service workers to hit monthly targets, it
is easy to see how elements of gaming can enter into the day-to-day working practices of Total Care staff. As noted, when discussing the emphasis on encouraging service users to exit treatment in recovery, participants had significant concerns over the extent to which clients were relapsing once they had left treatment. The following section considers this issue.

5.2.4 Successful(?) completions: risk of relapse following treatment exit

It is important to begin this section by stressing that the focus on successful completion of drug treatment is not inherently problematic. In fact, as discussed in Chapter 4, assisting people to exit treatment in recovery is almost universally viewed in a positive light. Harold exemplified this view:

_We're doing a good job, I think, personally. We help people. We are getting successful outcomes - we are getting people off treatment._

Harold, Total Care service worker

Here, Harold clearly portrays the focus on encouraging completion as something to be celebrated. However, in much the same way as the successful completions target, Harold frames ‘successful outcomes’ as ‘getting people off treatment’. By limiting successful outcomes to merely getting people out of treatment, this obscures the bigger picture, which is concerned with not only getting people into sustainable recovery, but also bringing improvements in health and wellbeing, as well as active citizenship (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; UKDPC, 2008; HM Government, 2010; Home Office, 2012; Neale et al., 2014; Senker and Green, 2016; Best, Andersson, et al., 2017).

When discussing the target of successful completions with participants, it was evident that many had concerns over the extent to which clients were able to maintain their recovery once they had left treatment. During interviews with Janet, Peter and
Richard, the issue of clients relapsing after successfully completing treatment with Total Care was frequently raised. During Richard’s interview, he, rather candidly, explained that not one of his clients who had completed a detox and exited treatment was able to maintain their recovery:

*People staying clean is the bigger question … I haven’t seen any clients go through a detox and stay off, and I’ve been here a year.*

Not one client?
No, not one client.

Richard, Total Care service worker

As reported by Richard earlier, given the extent to which service users were entering detox, the claim that not one of his clients had managed to sustain their recovery is particularly striking. Interestingly, on the day of interviewing Peter, he noted that, during his lunch break that day, he had seen one of his old clients who had successfully completed treatment but had relapsed and was re-presenting to treatment:

*And what I’ve already seen, there was one this afternoon, 1.30 today, I was walking out from lunch, saw a woman and I recognised her. Oh yeah, it was one of my clients in June. She successfully completed. She’s back again. After two months, she started using again. Somebody who’s quite complex, by the way, with mental health issues … but the fact is, it goes down as a successful completion.*

Peter, Total Care service worker

Peter explained that, whilst his client had completed treatment in June, she had relapsed two months after exiting treatment, and had continued to use drugs until re-presenting at the time of our interview in November. Whilst Peter notes that ‘it goes down as a successful completion’, again, this was defined through the narrow operational definition within Total Care and not the PHOF definition.

Nevertheless, the point made by Peter that his client had relapsed after two months of being out of treatment posed another question as to how long clients are usually able to maintain their recovery. When discussing this issue with participants, the general
response was that periods of maintaining recovery ranged from a matter of days or weeks, to a few months. For instance, Richard noted that it is very rare for a client to maintain their recovery for any substantial period of time after leaving treatment:

> Many clients have went through, done a detox, came out. Most people in the first week or two, in the first week or two, they're using. I mean, some people it's two days, three days. It's not long, it's not like they're clean for four or five months, very seldom that happens.

Richard, Total Care service worker

The finding that most clients relapse within the first few days or weeks supports Peter’s earlier assumption that service workers are encouraged to close clients’ cases on the same day of completing a detox through fear that they might relapse before they can be recorded as having completed and exited treatment. Given the above findings, it was important to understand participants’ explanations for the perceived high rate of relapse following treatment completion. The following section explores this issue.

### 5.2.5 Reasons for relapse: contributing factors

As highlighted earlier, it was clear that both service workers and service users had significant concerns over the extent to which service users were being encouraged to detox and exit treatment in the aim of meeting targets. For Richard, the high rate of relapse was directly caused by the drive to achieve successful completions:

> ...because of the way we’re working now - we push people through, get them through - that looks good, but then they’re coming out and they’re using straight away.

Richard, Total Care service worker

It was noted at the start of this chapter that the case of Jasper was particularly interesting in respect of this finding. Jasper’s story was unique to the rest of the service users interviewed for this research in that he was, until recently, one of very few people in the country being prescribed diamorphine in the treatment of his
dependence (see Metrebian et al., 2006; Strang et al., 2010; British Medical Association, 2013). However, Jasper explained that his diamorphine prescription had been stopped, which had a detrimental impact on his wellbeing:

*I was on [diamorphine] ampules for about 10 years and then Dr Price came in … she saw me for the very first time and she announced to me, ‘you’re coming off the ampules at a rate of one per month and I’m replacing them with 120mg slow-release morphine sulphate’ - oral tablets. And I said, ‘this isn’t going to work, I don’t think it’s a good idea, my life is still not in order; I know it’s been a long time, but I’m not using, my life is stable, I have a partner and somewhere to live and a plan’ … Ever since Price did that, everything just fell apart for me … I’ve lost my partner, I’ve lost my home, I’m not working, I’m committing crime - cyber crime - to pay for whatever needs paying for.*

Jasper, Total Care service user

Along with having his diamorphine prescription replaced with a prescription for oral morphine tablets, Jasper explained that his dosage was also involuntarily reduced:

*I wasn’t only changed over to morphine sulphate; the actual amount of equivalent drugs that I’ve been given is like maybe 20 per cent of what I was on. So, I was not only forced to swap from an IV to an oral - from diamorphine to morphine, I was also reduced by 75, 85 per cent involuntarily. I said, ‘I don’t like this, I’m not happy, it’s not a good idea’, ‘yes your concerns have been noted. It’s happening.’ And that was how the change was presented to me.*

Jasper, Total Care service user

Whilst Jasper’s case study is rare in that he was being prescribed diamorphine, it nonetheless offers a pertinent example of the implications that arbitrary and involuntary changes to prescribing can have on service users’ wellbeing.

It is important to note that, whilst interviewees made direct links between the successful completion target and the perceived high rate of relapse, there was also a number of other contributing factors cited. Firstly, references were made to the chronic, relapsing nature of addiction (O’Brien and McLellan, 1996; McLellan et al., 2000; McKeeganey et al., 2006; McKeeganey, 2014; Lancaster et al., 2015; Bassuk et al., 2016). As Peter explains:
...the nature of drug dependency is there can be a condition where you get relapses, so no matter what system you put in place, you could have people coming through, properly prepared and still relapsing. So you get that anyway; no matter how many resources you put in to it you could get that.

Peter, Total Care service worker

Whilst citing the relapsing nature of addiction as an important factor to consider, by suggesting that people might relapse even if they were ‘properly prepared’, Peter appears to imply that this might not always be the case, thus supporting the arguments made above. Nevertheless, in addition to the chronic relapsing nature of addiction, Peter was keen to highlight another key contributing factor that he believed was responsible for clients’ relapse, which was the poor working relationship between Total Care and Regain, the recovery provider in Metropolis.

As discussed in Chapter 4, the commissioning structure in Metropolis at the time of the research was perceived to be a significant issue by participants from both Total Care and Resicare. When discussing the issue of relapse following successful completion, Peter explained that the recovery service in Metropolis was not working as effectively as it should have been:

*I mean, the links with Regain have been atrocious, which is partly about them having poor management, very rapid staff turnover, lack of direction, needing time to find their feet. … Regain, I think, floundered for a while. But yeah, communication’s poor.*

Peter, Total Care service worker

From a consideration of the arguments presented in the previous chapter, Peter’s analysis of Regain’s apparent failings can be understood as the outcome of the changing tendering and commissioning practices in Metropolis. When discussing the lack of joint working, Peter explained that Regain had occupancy of two office spaces within the same building as Total Care yet did not use them:

*Regain, you see, we’ve got two empty rooms here. They never even come here. There’s like, one room at Regain that is never used. They used to come, but*
the woman that came didn’t do very much, being honest. I mean, we didn’t see her most days and when we did see her, there was very little co-working. I think once, in several months, she sat in with one of my clients. And I forced her to do that.

Peter, Total Care service worker

Peter maintained that one of the factors contributing to the high rate of relapse of Total Care clients was the lack of joint working and follow up from Regain. As will be explored in greater depth in section 5.3, this can be understood as a means through which Total Care staff can devoid themselves of blame by projecting it onto their competitors. Moreover, it should be noted that, as Total Care and Regain were both competing for the contract in Metropolis, it is perhaps no surprise that they were not working in partnership. Indeed, this has been argued elsewhere in relation to treatment providers being expected to simultaneously work in partnership and compete against one another (UKDPC, 2012b:53; DrugScope, 2014).

Whilst other participants supported Peter’s assertions regarding the lack of joint working from Regain, a number of other reasons for lack of client engagement with the recovery service in Metropolis were offered. For instance, Janet suggested that the lack of client engagement is also partly a result of service users believing that they are ‘cured’ once they have completed a detox:

*But people don’t go to those things afterwards [aftercare services] cause they actually, it’s like they’ve been almost told ‘you’ve done it, you’ve had the cure, you’re not on methadone, everything’s fine’.*

Janet, Total Care service worker

This argument from Janet relates to the broader issue surrounding the conflation of recovery and abstinence within policy documents (Monaghan and Wincup, 2013; McKeganey, 2014; Roy and Buchanan, 2016). Janet explained that once service users have completed their detox and had their cases closed by Total Care, they often think they have reached the end of their recovery journey and no longer require support
from treatment services. This can again be traced back to the commissioning structure and the lack of partnership working in Metropolis at the time.

In addition, both staff and service users made reference to the lack of appropriate or effective support groups that Regain was providing. For example, when interviewing Helen, she explained that she had completed a detox with Total Care in 2015 but relapsed shortly after and re-presented to treatment after five months of continued use. When discussing this, she noted that her relapse was due to having nothing to occupy herself with each day. Helen continued to suggest that this was not necessarily a case of there being an absence of available groups at Regain, but that the groups available were not suited to her needs:

*There is things there … doing like creative writing groups and stuff like that – but it’s not really the sort of thing I want to do … a lot of the things they do … are very basic groups, like basic English, basic maths and it’s no use for me, d’you know what I mean, I can do all that. … So I said to them, and they were like, well it’s, there’s nothing… we can only do what work they give to us to do, which is no use to me d’you know what I mean, it was no use so I ended up with too much time on my hands.*

Helen, Total Care service worker

As addressed in the preceding chapter, participants stressed the importance of recovering drug users gaining employment. This was viewed as important not only for financial reasons, but also to ensure that they could occupy their time with ‘meaningful activities’ (see also Best et al., 2012; Best, Savic, et al., 2013; Best, McKitterick, et al., 2015). As Helen suggests, the lack of available ‘meaningful’ activities following her detox resulted in her having ‘too much time on [her] hands’.

In support of Chris’s quote in the preceding chapter, Helen notes the following:

*You’ve got to make sure there’s something else in place once you’ve come towards the end of your … reduction – you need something in place for you to do. If you’ve got, cos otherwise, you’re just back into the other circle, having nothing to do and you need something in place.*

Helen, Total Care service user
As this section has addressed, whilst it is clear from the data presented that interviewees viewed the practices employed by Total Care in the drive to achieve successful completions as a key factor responsible for the high rate of relapse, consideration must also be given to the other factors involved. Regardless of the factors responsible, however, participants were concerned that the high rate of relapse following treatment completion was putting service users at greater risk of overdose and potential death.

5.2.6 Risk of relapse: overdose and death

With the perceived high rate of relapse so soon after exiting treatment, participants expressed concern that clients were at greater risk of overdose. A key risk faced by drug users who relapse following a detox and period of abstinence is the risk of overdose due to reduced tolerance to opiates (Strang et al., 2003; Stimson, 2010; Neale et al., 2013; Boyt, 2014). Along with the issue of lower tolerance levels following detox and periods of abstinence, Peter also suggested that service users are more chaotic when not in treatment, which further increases the risk of overdose:

...in that period of time [after leaving treatment], they are at much higher risk of overdose for two reasons. One is because of the difference in tolerance … the other reason is if you’re not in services, you’re more chaotic.

Peter, Total Care service worker

With the high risk of overdose following treatment completion, some participants also suspected that the drive to achieve successful completions within treatment had contributed to the increases in DRDs that were being witnessed at the time of the research (see ONS, 2017):

So I think, this is my, it sounds like a conspiracy theory … that is partially why drug-related deaths are going up.

Janet, Total Care service worker

...that’s happened because of the way we’re working now - we push people through, get them through - that looks good, but then they’re coming out and
they’re using straight away. And I think, for instance, that’s why we’re now giving naloxone 37; we’ve been told, ‘push for naloxone – get it out to everybody.’ That just happened in the last month or two and that was coming from commissioners and coming from ‘shit, more people have died recently, we need to do stuff’. 

Richard, Total Care service worker

Whilst both Janet and Richard suggested that the current treatment practices employed by Total Care had contributed to the increase in DRDs, Sarah offered a different explanation:

So a lot of service users, especially as they get older, will develop liver disease, COPD, heart disease. So it’s all those kind of things that affect health but seem to affect our service users more. So we see very few drug-related deaths in the purest sense in terms of overdose or whatever.

Sarah, Total Care manager

As will be discussed in Chapter 7, following the increases in DRDs, research conducted by both PHE (2016d) and the ACMD (2016) concluded that the increase in deaths were primarily due to increases in the availability and purity of heroin following somewhat of a ‘drought’, as well as the ageing population of heroin users, which accords with Sarah’s view above. However, citing this research, the ACMD (2016) have acknowledged that current treatment practices may also be contributing to these deaths. This is returned to in Chapter 7.

More interestingly, when discussing the risk of overdose and DRDs with Janet, she explained that the death of service users following a detox does not have any implications for Total Care’s performance measures:

To be brutal, I don’t think it bothers our targets, our results, if they die. As long as they’re not on our books, it doesn’t affect us. … if they die after a detox, they’re still a success … We had one recently, a case we closed, a person had one of the worst breakdowns the staff had ever seen and we got a success for it.

Janet, Total Care service worker

37 Naloxone is an opioid antagonist that can be used to reverse the effects of an opioid overdose (Public Health England, 2016d:21).
From the perspective of both Total Care’s narrow, operational definition of a successful completion and the broader PHOF definition, this statement holds true. As discussed earlier, within the PHOF, a successful completion of drug treatment is defined as a service user exiting treatment and not returning within six months (Public Health England, 2016a, 2016b). If a service user suffers a fatal overdose following a detox, they quite simply cannot return to treatment.

In line with this finding, at various points during interviews with Total Care workers, references were made to how well Total Care was performing and how they were best placed to win the contract that was out to tender at the time, as Peter explains:

> And we’ve done well on that, not just this office, but Total Care’s done well on it, so we’re probably quite well placed to win this contract that’s about to be announced today.

Peter, Total Care service worker

When examining the available NDTMS data, it was evident that the number of successful completions in Metropolis had been consistently increasing over the three-year period in which Total Care had been commissioned, taking the total number of successful completions within Metropolis to above the national average by the time of this research. On first glance, the continual increase in the percentage of opiate users successfully completing treatment in Metropolis appears to run counter to the views of the participants presented in this chapter. Indeed, as demonstrated above, it was evident from interviews with staff that they had witnessed several clients relapse after completing and exiting treatment, with ‘not one’ of Harold’s clients sustaining their recovery. If this were the case, then why do the NDTMS data suggest otherwise?

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38 In the interests of anonymity, the NDTMS data is not included in this chapter.
As noted at the start of this chapter, this can be explained by Total Care’s predominant focus on accelerating service users into detox and out of treatment in the hope that a proportion would not re-present to treatment within the six-month window. In support of this, participants suggested that whilst many clients relapse a matter of days or weeks following treatment exit, they will often continue to use for months before returning to treatment, as Peter explains:

*I’ve got a few people on my caseload now, I’ve got a guy I saw a couple of days ago, he was a successful completion in December, and he’s back in treatment in August and he went for about four or five months using.*

Peter, Total Care service worker

Peter claimed that, when service users relapse following treatment exit, as they are no longer in contact with their keyworkers, they often ‘let things build up’ before presenting at services again. This was also supported in interviews with service users when discussing their personal experiences of relapse. Some even suggested that their relapses could last for a number of years, as Brandon explains:

*But this is it, some people [are] bang at it [getting clean] all the time, getting off every couple of months. My relapses have been years, three or four years. When I go in again, it’s like a merry go round every three or four years.*

Brandon, Resicare service user

A possible explanation for this was offered by Richard, who explained the negative impact that relapses can have on levels of self-esteem:

*The other [risk of relapse] is the mental side of it, is it reinforces that thing in their head – ‘I can’t do this, this detox it’s too much for me, I can’t do it.’ So they give themselves that message again. It might take a long time for them to get there again ... ‘I’m a failure and I’ve just failed at this again’ so it’s self fulfilling prophesy kind of thing.*

Richard, Total Care service worker

Richard suggested that clients who relapse after detoxing often consider themselves as having failed treatment, rather than treatment failing them (see McLellan et al., 2000; Laudet and White, 2008). Again, service users supported this, noting the mental pain experienced after relapsing:
There was pressure from myself to keep doing it [detoxing] and every time I failed, it hurt.

David, Total Care service user

Given this, the high rate of relapse reported by participants that runs counter to the NDTMS data for Metropolis is more than likely a result of clients re-presenting to treatment after the six-month window has passed. The findings presented here suggest that there are noteworthy pitfalls with the arbitrary six-month marker that is used to determine recovery (see Release, 2015; Roy and Buchanan, 2016), and raise questions over the extent to which this measure should be extended or abandoned in favour of more tangible outcomes, as the government endorse in their 2010 strategy (HM Government, 2010). This is returned to in Chapter 7.

It should be noted, however, that the pressure placed on service workers to close clients’ cases is a pragmatic managerial response in a highly competitive environment. Indeed, this is the only thing that managers could control. If managers assessed workers’ performance on the number of clients who stayed out of treatment for longer than six months, then workers would be more cautious about discharging clients. Whilst this may result in fewer clients relapsing, this would ultimately serve to undermine Total Care’s success by way of the NDTMS data.

The findings presented in this section are greatly significant and acutely highlight the risks that can arise as a result of Total Care’s dominant focus on recording numbers of treatment exits. As this section has demonstrated, there is substantial concern amongst Total Care’s frontline workers that significant numbers of service users are being pushed for abstinence and treatment exit only to relapse within a matter of weeks or months. The highly competitive environment in which Total Care was operating and
the focus on successful completions had generated perverse incentives and had given rise to a series of risky practices to achieve these goals. Building on the arguments presented above, the following section makes theoretical sense of these findings in order to offer a more considered account of the successful completion of drug treatment target.

5.3 Making sense of successful completions

As indicated at various points, the findings presented in this chapter are perhaps not surprising. Existing research from within and beyond the drugs field suggests that the existence of perverse incentives and ‘gaming’ practices should be expected when outcome-based, quantifiable target setting is introduced into competitive sectors (e.g. Bevan and Hood, 2006b; Hood, 2006; Finn, 2011; Fox and Albertson, 2012; Newton et al., 2012; Eastwood et al., 2013; Rees et al., 2014; Carter and Whitworth, 2015; Ordóñez and Welsh, 2015; Egdell et al., 2016). However, whilst this body of existing research has focused primarily on the issues arising from PbR commissioning, the findings in this chapter have demonstrated that, even with an absence of direct payment for outcomes, the desire to demonstrate successes in order win contracts in a highly competitive environment serves as an indirect financial incentive to do what it takes to succeed (Davies, 2014b).

Whilst the findings are perhaps not surprising, it is important to make theoretical sense of the individual behaviours of the Total Care staff. As this section will demonstrate, service workers’ practices can be interpreted in a number of ways. Firstly, drawing on the work of Braithwaite (Braithwaite et al., 2007; Braithwaite, 2008), it will be argued that the excessive focus on, and pressure to achieve, successful completions had led to service workers losing sight of the broader aim of
successful completion of treatment – i.e. sustainable recovery from drug dependency. Secondly, it will be argued that the actions of individual staff members can be understood as a consequence of new managerialism and the extent to which they are held accountable for delivering outcomes. Finally, with reference to the work of Sykes and Matza (1957), and Bauman’s (1989) writings on the role of bureaucracy, it will be argued that the commissioning structure in Metropolis at the time of the research enabled service workers to devoid themselves of responsibility for any negative outcomes by detaching themselves from the ‘final destination’.

One way that this situation can be understood is to consider what Braithwaite and colleagues have described as regulatory ritualism (Braithwaite et al., 2007; Braithwaite, 2008). In their study of nursing home regulation in the US, England and Australia, Braithwaite et al. (2007:6–7) modify Robert Merton’s (1968) typology of adaptation to normative order to examine the acceptance and rejection of regulatory goals and the means of achieving those goals. While addressing each of the five modes of adaptation originally identified by Merton, the authors are primarily interested in the mode of adaptation known as ‘ritualism’.

Ritualism, the authors posit, is ‘the most daunting challenge of regulatory capitalism’\(^{39}\) and is concerned with the ‘acceptance of institutionalized means for securing regulatory goals while losing all focus on achieving the goals or outcomes themselves’ (Braithwaite et al., 2007:7). The authors argue that the excessive focus on directives and procedures within the workplace serve to restrict and sometimes even undermine the accomplishment of the outcomes that the procedures are designed to

\(^{39}\) As noted in Chapter 1, regulatory capitalism is a concept developed by Levi-Faur (2005). Rather than viewing the political and economic state of the late twentieth century as the ‘freeing’ of markets through a reduction in regulatory practices, instead, regulation is argued to have increased over this period.
achieve. From the data presented here, it is particularly evident that the excessive pressure and obstinate focus on detoxing clients in order to record them as a successful completion resulted in the loss of focus on the broader goal that the detoxing and successful completion of treatment is intended to achieve: sustainable recovery from dependent drug use. Supporting the notion of regulatory ritualism, it became clear that the success of Total Care is measured primarily through outputs rather than outcomes:

The pressure is to produce...is to get people into treatment and then get them out. And it isn’t always about good practice…

Peter, Total Care service worker

The declaration by Peter that ‘it isn’t always about good practice’ would seem to support the link between Total Care’s practices and the high rate of relapse of clients classed as successful completions. In Peter’s quote above, he supports this view of outputs rather than outcomes, yet he also highlights a slightly more complex issue.

As addressed in depth above, during periods of fieldwork with Total Care, it was evident that a number of staff members were acutely aware that the focus on achieving successful completions often lost sight of, and actively undermined, recovery as the goal of drug treatment. Examples of this are when Richard asserts that the ‘bigger question’ is whether people actually sustain their recovery after exiting treatment and when he, along with Janet and Peter, explain that Total Care are often reassessing clients who had exited treatment only to relapse after a matter of days or weeks. The clearest indication of this, though, is when Janet asserts that it does not matter if service users die following a detox because Total Care can still record this as a successful completion as they will not re-present to treatment.
Given the views of some frontline workers that the drive to achieve successful completions can often work against the intended outcome of supporting service users into achieving and sustaining recovery, one question that remains to be answered is why those workers continued to routinely follow the prescribed protocols even where they felt this was not the best thing for the client. The following quote from Janet illustrates this:

There’s a little part of me that thinks to people ‘don’t detox yet, don’t detox yet’. I know you can’t wait until your life is perfect before you detox, but I think, if you ask a load of our clients ‘do you want to detox?’ they’ll go ‘yeah, that sounds good, it’s the cure, it’s the magic cure I’ve been told about’.

Janet, Total Care service worker

Similarly, in reference to clients with complex needs, Harold explains that whilst he knows they have little chance of achieving recovery, he has to ‘keep pushing’:

...we've got to keep pushing recovery and keep mentioning like, do you want to reduce … However, you just know you're banging your head against a brick wall if somebody’s been on it 15 years and somebody’s been on it a year but you’ve got to keep pushing. It’s our job, you know what I mean?

Harold, Total Care service worker

The above quotes are particularly noteworthy. Firstly, the quote from Janet appears to offer further support for Neale et al.’s (2013) findings that service users are often willing to subject themselves to rapid detoxification in order to be ‘cured’. However, when considered alongside Harold’s quote, it also demonstrates that service workers are aware that encouraging clients to reduce their OST or enter detox might not be in the best interests of their clients. As such, this presents a conflict between service workers’ beliefs on what is best for their clients and their objective responsibilities and targets as Total Care employees. So why does this conflict appear to be continually resolved in favour of Total Care’s targets? Perhaps the answer is as simple as Harold states: the job of Total Care frontline workers is to encourage people into detox and successful completion of treatment.
As addressed in Chapter 1, new managerialism has transformed the role of the public sector workforce, with workers now held responsible for producing quantifiable outcomes and accountable when failing to do so (Smyth, 1997; Boyne, 1998; Deem, 1998; Banks, 2004; Connell et al., 2009; Le Bianic, 2011; Ward, 2011; Juhila et al., 2017; Räsänen and Saario, 2017). In this climate, workers are expected to perform duties in ways that serve to maximise profit for their organisations (Deem, 1998; Connell et al., 2009). This is based on the conception of individuals as ‘enterprising selves’: rational actors who engage in behaviours to maximise their utility in order to further their own interests (Ogus, 1994; Rose, 1999; Harvey, 2005; Davies, 2014b).

In other words, for Total Care staff, faced with the prospect of reprimand by their managers – along with increasing job insecurity (see Chapter 6) – it is in their best interests that they operate in ways that will best allow them to meet their targets. As Davies (2014b) notes, this is evident in a number of organisations that operate in highly competitive environments. Indeed, Stevens (2011b:244) makes a similar point in his ethnographic study of civil servants. In this work, he argues that civil servants who ‘make themselves useful to the task of creating and carrying out policy … are more likely to achieve their own goals of professional advancement’.

The above arguments help to make sense of service workers’ actions, and indeed provide further evidence of regulatory ritualism in practice (Braithwaite et al., 2007; Braithwaite, 2008). However, the picture is still somewhat more complex than this. During the analysis of the data collected from Total Care frontline staff, it emerged that staff members at times attempted to justify the encouragement of service users into detox and treatment completion by maintaining that it was their job to do this,
and that anything after this was not their responsibility. This is reminiscent of the work of Sykes and Matza in their 1957 publication, *Techniques of Neutralisation* (Sykes and Matza, 1957). In this work, Sykes and Matza propose that people make statements that neutralise or justify behaviour that might be viewed as ‘wrong’, criminal or deviant. When discussing the potential consequences of the successful completions target, Harold explains that as an employee of Total Care, he will do whatever they want:

> ...at the end of the day, I'm a drug worker based at Total Care so whatever Total Care want, they're the ones that employ me, I'll go with whatever Total Care wants.

Harold, Total Care service worker

In addition to statements such as this, as discussed briefly above, staff also appeared to shift responsibility away from Total Care onto Regain, further neutralising their behaviour. The following statements from Peter and Harold illustrate this:

> Total Care, quite reasonably, is being measured by one criteria in particular, which is successful completions: it wants to get on and do that. And that's, in itself, is fine. But it has to work with another organisation, namely Regain, and once we close the case, it's over to Regain and if Regain don't follow these things up, that's not our problem.

Peter, Total Care service worker

> ...it looks good to Total Care that we've got people clean cos they're in detox and then it's nothing to do with us, to a certain extent, kind of thing, you know, I do, I do believe that that's like, we've done our bit, we've got our figures, so we're OK, it's down to you who's doing the aftercare.

Harold, Total Care service worker

Very clearly here, Harold and Peter both present the view that, once a service user has completed a detox and exited treatment, they are no longer the responsibility of Total Care. This points to a broader issue regarding bureaucracy, which has at times throughout history been viewed as influential in the commission of perceived wrongdoing. The most widely cited example of this is perhaps Zygmunt Bauman’s analysis of the role of bureaucracy in the Holocaust (Bauman, 1989).
In this analysis, Bauman maintains that ‘the choice of physical extermination as the right means to the task of Entfernung was a product of routine bureaucratic procedures’ (Bauman, 1989:17). One of the insightful arguments that Bauman offers in explaining how people were able to operate during the Holocaust was due to the functional division of labour within the bureaucratic structure. Put simply, workers operate at different levels, perform qualitatively different tasks, and require different knowledge and expertise than other workers within the same bureaucratic structure. What this allows for, Bauman explains, is to separate oneself from the responsibility of the final destination of a procedure, whatever that might look like. One of the arguments that Bauman makes to illustrate this point is that workers within a chemical plant producing napalm would not, should they so choose, even consider the potential use of the napalm; they are solely responsible for its production, not its final use.

By citing Bauman here, the intention is not to declare any comparison between the Holocaust and the current situation within drug treatment, but to show how the theoretical foundations of Bauman’s analysis offer useful insights for thinking about the limits of responsibilities of Total Care workers. Through his analysis of the role of bureaucracy within the Holocaust, Bauman (1989:106) offers similar arguments to those made by Braithwaite in that, within bureaucratic structures, there is a tendency for workers to ‘lose sight of the original goal and to concentrate on the means instead – the means which turn into the ends’. As argued already, we can conceive of this occurrence within Total Care. What Bauman’s analysis adds, though, is a further theoretical explanation for how Total Care staff members were able to encourage successful completions even in instances where they thought this was not in the best interests of their clients. As staff were employed to encourage service users into detox
and close their cases once they had successfully detoxed and were no longer using
drugs, they would not conceive of themselves as responsible for any negative
eventuality following exit from their service.

As this section has demonstrated, the behaviours of Total Care staff as identified
through this research can be understood as the result of an excessive focus on goals
and the means of achieving the goals, and as a result of the nature of bureaucratic
structures that allow for individuals to distance themselves from the final outcome of
their actions. Drawing on the theoretical assumptions above help to further situate the
findings of this research within a broader context of neoliberalism.

5.4 Chapter summary and conclusion
This chapter has offered a critical account of the successful completion of drug
treatment target within Total Care. Building on the findings presented in Chapter 4, it
has examined how the shift to recovery and the focus on encouraging drug users to
complete treatment and exit services has altered the day-to-day working practices of
Total Care staff. The tenacious focus on achieving successful completions and the
highly competitive environment in which Total Care was operating had generated
significant pressure on frontline workers to hit targets in order to demonstrate success
to commissioners during a period of retendering. The overbearing focus on outcomes
had led to service workers speeding up or slowing down clients’ detoxes in order to fit
with their monthly targets. In addition to this, evidence of ‘creaming’ and ‘parking’
was found, with service workers neglecting clients with the most complex needs and
instead directing resources to those with fewest barriers to recovery (Maynard et al.,
The findings presented in this chapter suggest that the risks surrounding service users being encouraged out of treatment or having their OST involuntarily reduced have been somewhat realised (Hunter, 2011; Boyt, 2014; Roy and Buchanan, 2016). There was significant concern that the focus on achieving successful completions had resulted in service users being pushed prematurely out of services, with high proportions being unable to sustain their recovery once they had exited treatment. Participants suspected that the high rate of relapse of clients following treatment exit was contributing the current increase in DRDs.

In making theoretical sense of these findings, it has been argued that the behaviour of Total Care and its staff should not be viewed as idiosyncratic, and is instead to be expected in such a highly competitive environment. Indeed, Davies (2014b:69) argues the following:

A strategic competitor thus pushes as hard as possible against the rules, seeking to define the competition and interpret its rules in ways that make victory most likely … using extraneous tactics, gaming and subtle forms of cheating, none of which are (or can be) codified in the rules.

This fits well within the narrative of Total Care and its practices, as detailed in this chapter. It is clear that Total Care had effectively interpreted the competition within Metropolis and had adopted strategies that would enable them to succeed. This was evident in the way in which Total Care had narrowly defined successful completion and the means through which workers were responsibilised to deliver outcomes. As has been argued, from a consideration of the NDTMS data, it appears that Total Care had been successful in achieving its aims.

The findings presented in this chapter have not only offered insight into some of the key concerns raised by drug policy commentators following the shift to recovery and
outcome-based commissioning, but it has also illustrated how the abstract concept of neoliberalism materialises at the level of practice. The following chapter seeks to continue this thread with an analysis of the third and final theme of this research: the employment of peer support workers within treatment.
Chapter 6 | Harnessing the ‘lived experience': The employment of recovering drug users in treatment services

6.1 Introduction

This chapter focuses on the employment of individuals with ‘lived experience’ of treatment and recovery into various peer support roles within services. As noted in Chapter 2, peer support for recovery has a long history, predating any form of structured treatment (see White, 2004, 2009). Throughout this history, peer support has predominantly been located in various MA societies, which have tended to exist independently and in parallel to mainstream treatment services (White, 2004; Measham et al., 2013:20). However, with the reorientation towards recovery, the government have stressed the important role that local MA groups can play in supporting people in their recovery, along with emphasising the need for treatment providers to recognise the benefits that those with lived experience of recovery can bring to the treatment workforce (HM Government, 2010; Home Office, 2012; Wardle, 2013; Bierge et al., 2015; Public Health England, 2015).

Whilst the employment of individuals with first-hand experience of substance use in treatment services has a history beyond the renewed emphasis on recovery (Mold, 2008; Mold and Berridge, 2010), in recent years, there has been a growing recognition of the ‘energies and inspirations’ that PSWs can bring (Wardle, 2013:16), based on the notion that they offer an effective means of inspiring and motivating others to enter recovery (White, 2009; Best and Gilman, 2010; Best, Rome, et al., 2010; HM Government, 2010; Home Office, 2012; Best, Loudon, et al., 2013; Public

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40 Peer support roles include titles such as peer advocates, peer mentors and recovery champions. For simplicity, unless otherwise stated, these roles have been grouped under the heading of peer support workers (PSWs).
Health England, 2015). Indeed, existing research has demonstrated the key benefits presented by the increase in PSW roles within treatment. Not only do PSWs offer an effective and authentic source of inspiration for those currently in treatment to achieve recovery, but the emphasis on peer support has also created increased job opportunities for recovering drug users, conferring an increase in self-esteem and thus further strengthening recovery (Best and Gilman, 2010; Best and Laudet, 2010; NTA, 2012a; Best, Loudon, et al., 2013; Measham et al., 2013; DrugScope, 2014, 2015b; Adfam, 2016; Best et al., 2016).

However, despite the stated benefits, key concerns have also been raised over the means through which recovering drug users are recruited into PSW roles, and the responsibilities bestowed upon them (White, 2009; Shapiro, 2012; DrugScope, 2015b; Roy and Buchanan, 2016). It has been argued that the drive to recruit PSWs in drug treatment services is representative of a much broader growth of SUI in a range of public services (Martin, 2011; Bach, 2012; Foot et al., 2014). However, with reductions to ‘professional’ staff and thus increased caseloads for service workers (as examined in Chapter 4; see also DrugScope, 2014, 2015b; Adfam, 2016), some have suggested (e.g. Duke, 2013; Measham et al., 2013) that the employment of PSWs is illustrative of a ‘deprofessionalisation’ of public sector roles and an increased reliance on voluntarism in line with neoliberal reform, responsibilisation and visions of the Big Society (see May et al., 2005; Bach, 2012; Rowson et al., 2012).

Whilst existing research has offered some useful insights into the benefits of peer support for recovery, research into the employment of PSWs and their roles and responsibilities in treatment services remains in its infancy (notable exceptions
include, for example, Best, Loudon, et al., 2013; Measham et al., 2013), with some key questions left unanswered. The findings presented in this chapter seek to bridge this gap in knowledge by addressing the following research questions:

i. Has there been an increase in the employment of recovering drug users in PSW roles within treatment?

ii. What responsibilities are PSWs given?

iii. What opportunities and risks are presented by their employment?

This chapter argues that, whilst the employment of PSWs provides benefits for both service users and PSWs, the speed at which recovering drug users are recruited into services and the responsibilities bestowed upon them have generated significant risks for their health and wellbeing. It is further argued that the employment of PSWs can be understood as an effective cost saving measure in times of increasing budgetary restraints, along with offering an additional means through which providers can demonstrate success to commissioners in a highly competitive treatment sector.

Building on the arguments presented in the preceding analysis chapters, it is demonstrated that an analysis of the PSW role offers further evidence of neoliberalism at the level of practice. Again, given the significance of the developments in Metropolis at the time of the research, whilst the views of participants from both research sites are incorporated, this chapter focuses primarily on the developments that were occurring in Total Care41.

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41 It should also be noted that whilst participants made reference to the existence and role of mutual aid in the community, this did not emerge as a significant theme throughout the research. Instead, participants were keen to draw attention to the opportunities and risks presented by the increased employment of PSWs in treatment.
6.2 The employment of PSWs in Total Care and Resicare

Both Resicare and Total Care employed people with lived experience of addiction and recovery within their services; however, the situation was markedly different in each service. For Resicare, the employment of people in recovery was a fundamental part of their ethos, with approximately three quarters of the staffing makeup in Resicare comprised of recovering drug and/or alcohol users. Of the five staff members interviewed in Resicare, all had a history of dependency, and considered it part of their role to draw on their experiences to support service users. In addition to their paid staff, Resicare also had a long history of volunteer support offered by past and present service users.

As with Resicare, some of the ‘professional’ staff in Total Care had first-hand experience of substance use. However, unlike Resicare staff, participants in Total Care explained that they were not encouraged to disclose their personal histories to service users, as Harold notes:

*I mean it's like the recovery champions, it's part of their job description to disclose, you know, because they're a recovery champion – ‘oh yeah, I'm in recovery’; but with us, we're encouraged not to disclose.*

Harold, Total Care service worker

Here, whilst Harold notes that Total Care workers with lived experience are encouraged to conceal their histories, he explains that disclosure was central to the role of a recovery champion. After taking over the contract in Metropolis in 2012, Total Care had specifically recruited service users into both voluntary service user representative roles and paid recovery champion roles. Service user representatives were service users who were nearing the end of their OST, and were tasked with discussing their experience of treatment and recovery with other service users who
had not yet started their recovery journeys. Similarly, recovery champions were individuals who had completed and exited treatment in recovery and were employed in paid positions in Total Care:

*We’ve now got four recovery champions, which weren’t in our original contract, but it’s for people that have got their own experience of services, had their own problems with substances and then come out the other end, obviously periods of drug free, they’ve done a lot of work, and then they come into the service as paid employees.*

Becky, Total Care manager

Two of the four recovery champions, Tony and Chris, were interviewed. When asked to describe their role, both Tony and Chris offered the following descriptions:

*...part of my role is to be visible in recovery – a visible presence of recovery in prescribing bases across Metropolis. And I guess the second part of my role, really, is to promote recovery: talk about recovery.*

Tony, Total Care recovery champion

*It involves supporting, guiding, motivating and empowering clients to take responsibility for their recovery and it also involves me supporting clients on a practical level on a holistic approach. So that could cover a range of things, you know, physical illnesses, emotional support, social support, things like debt problems, housing problems. Basically, any issues they’ve got...*

Chris, Total Care recovery champion

The above descriptions reflect the definitions of community recovery champions set out in the 2010 drug strategy (HM Government, 2010) and accords with empirical findings elsewhere (e.g. Best, Loudon, et al., 2013; Measham et al., 2013). The employment of ex-service users into the role of recovery champion within Total Care emerged as a highly controversial theme during interviews. Whilst PSWs were viewed as bringing a range of opportunities and benefits to the treatment sector, some participants viewed these opportunities in a cynical manner. The following section addresses this.
6.3 Opportunities presented through the employment of PSWs

In support of findings from existing research, this research identified clear benefits associated with the employment of PSWs. The key benefits identified by participants included the widely cited benefit of inspiring and motivating others to seek recovery (see White and Cloud, 2008; White, 2009; Best and Laude, 2010; Measham et al., 2013; Melick et al., 2013) and the opportunities to strengthen PSWs’ own recovery (see Cloud and Granfield, 2008; Measham et al., 2013; Best et al., 2016; Penn et al., 2016). However, in addition to these opportunities, the analysis of the data found evidence of other ‘benefits’, including the cost saving benefit (as detailed in Chapter 4) and the competitive advantage of employing PSWs. Whilst presenting the following four themes as ‘benefits’, it is important to recognise that each had been interpreted in more cynical terms by some participants, as will be highlighted.

6.3.1 The recovery benefit of employing PSWs

Participants from both Total Care and Resicare articulated consensus views of the benefit of employing people with lived experience in treatment services. In relation to the use of PSWs within Total Care, Becky offered the following view:

I see people that I key-worked years ago that are working alongside [me], that have got jobs or are volunteering with us … which is motivating for me as a worker. But then, for service users, you see that thing of ‘oh, bloody hell, I used to do whatever with you and now you’re working here or volunteering,’ … people get swept up in that energy.

Becky, Total Care manager

David, a former Total Care service user who was due to begin training as a PSW, expressed this from his perspective as an ex-service user:

I walked in here the first day and Tony, one of the recovery champions, I used to use with 20 years ago, and I absolutely couldn’t believe it. It’s a paid position and it’s that, sort of, turning people who’ve used [substances] into a tool to help other people stop using.

David, Total Care service user
Although David had been in recovery for two years and had not encountered recovery champions during his period in treatment, it was clear that witnessing somebody who he recognised as a peer gain paid employment was still highly motivating. Best and Gilman (2010:10, emphasis added) make this argument when discussing the social contagion of recovery: ‘seeing an individual recognised as a peer who has achieved significant recovery can act as a significant catalyst for change’. Interestingly, given the arguments presented in this chapter, David makes reference to turning recovering substance users into ‘tools’ to help others become abstinent. This will be returned to later in this chapter.

Along with service users highlighting the benefits conferred by PSWs, participants also explained that staff in senior or managerial positions who have first-hand experience of dependency also offer inspiration for change. As noted at the start of this chapter, the majority of Resicare staff were in recovery and considered it as part of their role to draw on their personal histories to support their clients. Service users in Resicare frequently made reference to the benefits of this:

*I tell you what’s the good thing about this place, Will, without a shadow of a doubt, is that 90 per cent of the people have been through it.*

Brandon, Resicare service user

*...look at him, where he’s come from … He’s told me, ‘Michael, I was fucking digging heroin in me fucking groin … if it wasn’t for Resicare, look at me now’. He’s the manager. He goes, ‘I’m big in the game now’, and he is, and he’s clean and he’s so happy and he’s got a family … This is what I mean, man, I look at him and I just think: I want all that.*

Michael, Resicare service user

Whilst many service users acknowledged that there were some ‘very good’ drug workers who have never had experience of addiction and recovery, most stated that the best workers are those who have this personal experience:
You can’t get a better drug person … than one who’s actually been there.

Geoff, Total Care service user

Some participants went further than this and argued that unless drug workers have first-hand experience, they simply cannot effectively encourage others to seek recovery, as expressed by Patrick:

...unless you know about recovery, unless you live and breathe it … It’s not something you can walk in a room and sell to someone unless you have experience of it. It’s not like selling a Mercedes - if you know a bit about cars, you could probably sell a Mercedes. To sell recovery, in my experience of both ways, you’ve got to kind of be in it.

Patrick, Resicare manager

Patrick was critical of drug service providers that have historically provided clinical interventions ‘rebranding’ as recovery agencies (see Chapter 4). Patrick explained that such organisations should ‘leave recovery to the people in recovery’, which was a view expressed by all of the Resicare staff interviewed. As demonstrated in Chapter 4, this is perhaps indicative of the competitive nature of the drug treatment sector with Patrick reflecting negatively on providers that are threatening Resicare’s existence as a ‘specialist’ provider.

The view that to ‘sell recovery … you’ve got to be kind of in it’ was also supported by service users. For instance, when discussing his experience of services, Jason explained that he was able to establish trust with workers who had experience of using, which could not be forced or ‘manufactured’:

Well it just builds trust straight away with other addicts, you know, you talk the same language. I’m not saying it’s not important people who learn it in university … it’s just a personal thing … You can’t buy it … You can’t manufacturer it, you’ve got to do it … I’m not saying there’s not a place for people who learn, because there is, it’s still the same message, but it’s how people take it … If you’ve got someone who learnt at university…talking about crack cocaine and heroin use, say, well, I haven’t done that, I fucking smoked
rock and smoked gear, you know what I mean? Talking to me about heroin and crack cocaine, you’re not using the same language as me.\textsuperscript{42}

Jason, Resicare service user

Harold also described this ‘automatic’ trust between worker and client. When working for a previous service provider in which he was encouraged to disclose his personal experience, Harold explained that he was often able to build more personal relationships with his clients, as he had the subjective knowledge of addiction:

...when I worked for [drug service], somebody came in the room and they had their head down like that, they’d be waffling away and then they’d look up to say, ‘oh, it’s you, well this is how it is’, you know what I mean? Because they know they can’t pull the wool over my eyes because I’ve been there, seen it, got the T-shirt. I know what it’s like to use puddle water to inject with ... I’ve been there ... I know what it’s like to live on the streets and inject in a phone box, and things. I’ve been there... So they find it harder to fool me than maybe somebody else who’s never lived there.

Harold, Total Care service worker

As has been demonstrated, there was a clear consensus within Total Care and Resicare that employing people with first-hand, lived experience of recovery offers a source of inspiration to current service users. Whilst recognising a worker as a peer who had once used in the same social circles was deemed most inspiring, it was evident that having knowledge of a worker’s personal history also provided inspiration to seek recovery.

Shifting the focus back to PSWs specifically, in addition to encouraging and supporting service users in recovery, being employed as a PSW can also help to strengthen a PSW’s own recovery. As discussed earlier, sustaining recovery from substance misuse has been shown to be highly dependent on the recovery capital possessed by an individual (Cloud and Granfield, 2008; Best and Laudet, 2010; Best et al., 2012, 2016; Duffy and Baldwin, 2013; Weston et al., 2017). The expansion of paid and voluntary roles within the drug treatment sector has been viewed as a key

\textsuperscript{42} This quote was also included in Chapter 3 when reflecting on the interview process.
opportunity for recovering drug users to gain employment and increase their recovery capital (Cloud and Granfield, 2008; Best and Laudet, 2010; Measham et al., 2013). Further, research has demonstrated that the sense of responsibility and self-esteem gained from supporting others in recovery and ‘giving something back’ can further increase an individual’s recovery capital (Pagano et al., 2004; Cloud and Granfield, 2008; Melick et al., 2013:195).

Both Tony and Chris reflected positively on their role and the opportunity they had to support others in recovery. As Tony explains:

_I could make more money somewhere else, so it isn’t just about money. Do you know what I mean? I used to make more money back in the day, than I do now. So if it was about just purely paying bills and making money, I could go and earn money, far more, somewhere else, so there’s definitely that element of just passing something on really._

Tony, Total Care recovery champion

Tony suggests that the key benefit derived from his role as a recovery champion is not the fact that he is in fulltime, paid employment, but that he has the opportunity to help others seek recovery as others had once helped him. Both Tony and Chris explained that their employment as recovery champions had increased their feelings of self-worth, noting that their roles had given them additional purpose. Interestingly, the suggestion from Tony that recovery champions are not paid a great deal for their role was discussed by a number of participants and feeds into the second ‘benefit’ to be addressed in this chapter: the cost benefit of employing PSWs within treatment.
6.3.2 The cost benefit of employing PSWs

The employment of PSWs within drug treatment can also be viewed as an effective cost saving measure in times of increasing budget reductions. As discussed in Chapter 4, this was particularly evident for Total Care and the employment of recovery champions and service user representatives. Sarah explained that, due to increasing numbers of service users completing and exiting treatment, keyworker caseloads had decreased. As such, rather than employing replacement keyworkers when existing staff had ‘left and moved on’, Total Care might instead have employed a recovery champion. Whilst Sarah framed this as a pragmatic response to an assessment of the changing level of need within the service, she also alluded to the associated cost savings:

...if we can reduce that [the cost of maintenance prescribing] by getting more people into recovery and abstinence then we can employ more recovery champions, employ more volunteers and pay volunteer expenses … So every time somebody's left, we’ve always sat down and thought ‘what do we need?’

Sarah, Total Care manager

As Sarah clearly indicates, the employment of recovery champions and volunteers in Total Care had generated significant cost savings. This was a view shared by other participants. For example, Damien explained that ‘professional’ drug workers’ salaries can be as high as £40,000 a year, with recovery champion salaries amounting to less than half of that amount:

I know recovery champions who are getting paid 15, 16 grand a year who are more effective than the actual drug worker who's getting paid 26, 27 grand a year ... When I say 26, 27 grand a year, that's the likes of Total Care, that. If you look at the likes of NHS, you've got members of staff there on, like, 35, 38 grand.

Damien, Resicare manager

As Damien points out, not only are the salaries of recovery champions much lower, but, as argued above, they are also perceived as more effective at supporting clients in
recovery than traditional drug workers. As such, whilst some participants argued that the increased employment of ‘unskilled’ PSWs in place of ‘skilled’ drug workers was primarily a means of reducing cost within Total Care, their perceived effectiveness in comparison to traditional drug workers was viewed by many as a positive development in response to a changing treatment landscape. This supports the arguments made by Wardle (2013) that those typically considered as ‘unskilled’ are now classed as the ‘experts’, providing the most inspiration to change.

However, whilst not denying the benefits that PSWs bring, some participants offered a more cynical account of the motivations for recruiting PSWs. Where Sarah explained that cost saving was an added benefit of PSWs, Alan argued that PSWs are increasingly being relied upon to compensate for the reduction in funding available:

...because of all these cuts, there’s been a tendency for … in tenders that come up, looking for peer mentors and volunteers to be delivering services … I do think that, within these tenders, it’s going too, just a bit too far to expect people to, as peer mentors and volunteers, compensate for the lack of resources that are available. And I think that’s what’s happened.

Alan, Resicare manager

Here, Alan argues that cost savings are the primary driving force, with contract tenders increasingly calling for PSWs to take on the roles traditionally delivered by qualified drug workers in order to reduce the financial cost of the labour force. Indeed, it is not difficult to imagine the extensive cost savings that can be made by replacing a £30,000-a-year worker with a £15,000-a-year recovery champion or even a volunteer worker for which only expenses must be paid43. The issue of PSWs taking on responsibilities of ‘professional’ staff is returned to in section 6.4.2.

43 Whilst there is currently no publicly available data on the cost savings made by employing PSWs in the drug treatment sector, existing research has detailed the savings that can be achieved through the recruitment of volunteers within other public sectors (see Rowson et al., 2012; Naylor et al., 2013).
In support of the above claim, commenting on the growth of low-paid and voluntary positions in the public sector, Bach (2012) has argued that cuts to public sector spending and the drive to achieve the Big Society have resulted in the substitution of volunteers in place of paid staff:

Although explicit policies may establish clearer expectations of volunteers, it is hard to avoid the conclusion that volunteers are being treated as staff members, with the important caveat that they are not being paid. Although organisations frequently express a commitment not to let volunteers substitute for paid staff, in practice, this principle is not always maintained. Consequently, statutory and voluntary organisations are making increased use of voluntary labour to manage or partially manage services being scaled back by local authorities. (Bach, 2012: 409; see also National Association for Voluntary and Community Action, 2011 (NAVCA))

The concern expressed by Alan above also feeds into broader debates with regard to the changing shape of the labour market in many western societies. Wardle (2013:17) discusses the emergence of the ‘hourglass economy’ in which high- and low-skilled jobs are increasing, but those in the middle are decreasing. Wardle expresses fear that the treatment workforce is at risk of being ‘hollowed out’ with the widespread ‘casualisation’ and deskillling of roles. Whilst Wardle argued that we have not yet witnessed this within the sector, this research supports the concern that the sector is at increasing risk.

In addition to the argument presented above, existing literature has also drawn attention to the issues that can arise between paid and unpaid staff, the inappropriate use of volunteers, and the ‘mismatch’ of volunteers’ skills and those required for their roles (London and Voluntary Service Council, 2011 cited in Bach, 2012:409–10).

When discussing the increasing employment of PSWs, Janet echoed this issue:

*There’s a bit ‘us’ and ‘them’ about recovery champions and drug workers. I think, if someone’s good enough: they’re not using, they’re healthy, they’re experienced, they should be a drugs worker, the same as everybody else, and*
they should be paid the same. And if they’re seen as not being able to do that, then they shouldn’t be employed at all. It’s worrying.

Janet, Total Care service worker

The feeling of ‘us’ and ‘them’ expressed by Janet was also found in other staff members’ accounts. Citing NAVCA (2011:254), Bach (2012:410) has demonstrated that the growing reliance on volunteers can also devalue the professional skills of paid employees, thus contributing to the challenging working relationships among staff. When considering Janet’s statement above alongside the increasing redundancies of ‘professional’ staff in Total Care – and the expectation of further redundancies as the treatment service in Metropolis becomes integrated in the new contract (see Chapter 4) – it was evident that the growth of PSWs in treatment services had generated anxieties over the security of some workers’ roles. This appears to be a growing concern within the treatment sector (see Measham et al., 2013:17).

As this section has demonstrated, the employment of PSWs within Total Care had generated significant cost savings at a time of reducing budgets. Whilst some participants viewed the primary motivation for employing PSWs as harnessing the recovery benefit they hold, others argued that a need to reduce the cost of the labour force was the key driving force. However, participants also added a third perspective, which was concerned with the competitive advantage of employing PSWs.

6.3.3 The competitive advantage of employing PSWs

The third key theme to be addressed in this chapter relates to the competitive nature of the drug treatment sector at a time of fiscal austerity. It was suggested by a number of participants that Total Care was employing recovery champions because they offered a means through which they could look favourable to commissioners against their competitors at a time of retendering. This theme is an important one, as it can help to
make sense of some of the risks associated with the employment of PSWs, as will be discussed in the following section.

It was noted earlier that Total Care was not directly commissioned to employ recovery champions within their service. Instead, Sarah explained that cost savings made in other areas of the service had been redistributed into the employment of recovery champions. Whilst the benefits of their employment were clear for both Total Care and its service users, a number of participants explained that Total Care’s primary motivation for employing recovery champions was to increase its chances of winning the forthcoming contract in Metropolis. Peter articulates this position clearly:

*Total Care are doing that because they want to muscle in on the … there’s going to be a decision made, about one single provider, and I think Total Care are putting finances into recovery champions … We weren’t originally commissioned for that. And I think what they’re doing is they’re positioning themselves as a reliable provider – even in areas that they weren’t originally commissioned to do. So I think they just wanted to tick all the boxes.*

Peter Total Care service worker

As argued in chapters 4 and 5, in anticipation of the re-commissioning in Metropolis, Total Care wanted to demonstrate its ability as a provider to commissioners in order to be awarded the contract. In addition to the drive to achieve successful completions of treatment, a further means through which Total Care could demonstrate success to commissioners was by employing PSWs. Other participants also supported this assertion. As will be demonstrated further in the following section, participants often noted the ‘tokenistic’ way in which ex-service users were recruited into treatment services, with one participant in particular making reference to the way in which PSWs are ‘wheeled out’ for presentations or ‘put up on pedestals’ in order to demonstrate a provider’s worth. In accordance with this, Alan offered the following view:
They don’t really value experts by experience, it’s more of a tokenistic: ‘we’ve got these formal service users ... they’re big and they’re loud and they’re ex-offenders’. But they don’t really represent the population as a whole with people with drug and alcohol problems. But they get held up as poster boys [sic] and stuff like that, you know, and now that looks great to the commissioners.

Alan, Resicare manager

In support of this, Becky explained that Total Care would get extra ‘points’ in the commissioning process, as the employment of PSWs when not commissioned to do so would be considered ‘added value’. Moreover, the use of recovery champions and other PSWs to demonstrate success to commissioners is a phenomenon that has been observed by others in the field. In an article for *DrugScope*, Harry Shapiro (2012:10) refers to an interview with a PSW, James Gough. Gough argues that PSWs are being ‘parked’ in their roles, often for long periods of time, and often without being paid. This, Gough notes, is so that commissioners and services can ‘tick the right boxes’ (cited in Shapiro, 2012:10). Building on the arguments presented above, the following sections examine the key risks generated by the employment of PSWs in this climate.

6.4 The problems associated with the employment of PSWs

When discussing the employment of recovery champions and other PSWs with participants, a number of important issues arose. Concerns related to the way in which ex-service users were being recruited into treatment services, the responsibilities bestowed upon them, and the lack of training and support received within their roles. This section addresses each of these issues in turn.
6.4.1 The risk of recruiting too soon

The primary issue highlighted by participants related to the length of time that service users had been in recovery before being recruited back into services. A number of participants maintained that treatment providers are increasingly employing ex-service users very early on in their recovery journeys, as Charlie explains:

There was, and particularly within Resicare, but now same as Total Care, the huge reliance on volunteers, and the volunteers are people who’ve not been long out of treatment. Now, years ago, it used to be that you couldn’t work in treatment unless you’d been out of treatment for two years and gone off and done something completely different. That went out the window. So you had these volunteers, who were three, four months clean, again, sort of wheeled out for presentations, put up on pedestals...

Charlie, Resicare service user

Charlie makes a number of interesting and noteworthy points here. As noted briefly above, Charlie suggests that PSWs are being ‘put up on pedestals’ and ‘wheeled out for presentations’ within treatment services, thus pointing to the commissioning advantage that the employment of PSWs brings. Moreover, Charlie makes reference to what many refer to as the ‘two-year rule’. The two-year rule was never actually a rule, but rather guidance from the Standing Conference on Drug Abuse, which encouraged providers to refrain from employing ex-service users until they had been out of treatment for a minimum of two years (NTA, n.d.; Shapiro, 2012:10). This was a view held by a number of participants. Whilst it has been argued that the risk of relapse never fully disappears, research has discovered that it diminishes significantly over time (see Laudet and White, 2008), suggesting that providers should avoid recruiting individuals too soon after exiting treatment. Tony supports this view:

...some organisations, and I’m not going to name them, but I’ve seen it already … they’ll take people on that are kind of six months clean and kind of put them in a position of responsibility and kind of get used a little bit … On the one hand, it could be interpreted as, you know, you’re giving somebody a real opportunity, alright, but on the other hand … you’ve got somebody who’s kind of fresh out the wrapper, still acclimatising to life in the big wide world – they’re kind of like Bambi, you know what I mean, or like a rabbit in the
headlights – and along comes some organisation and says ‘Oh, you’re really good, you. Come on, get on board with us, we’ll do this, this, this and this’. And they’ll kind of really sell you that and, you know, poor little guy who’s kind of like, ‘Okay, yeah, yeah, brilliant, alright’...

Tony, Total Care recovery champion

Tony supports the assertion that treatment providers are recruiting ex-service users into paid and voluntary roles very soon after they have exited treatment. Though a recovery champion himself, at times during the interview, Tony was particularly sceptical about the employment of ex-service users into positions of responsibility when they were ‘fresh out the wrapper’ and ‘still acclimatising to life’. Interestingly, Tony points to the potential juxtaposition that the role of a PSW brings. As argued above, gaining employment increases an individual’s recovery capital and helps to strengthen their recovery (Pagano et al., 2004; Cloud and Granfield, 2008; Best and Laudet, 2010; Measham et al., 2013; Melick et al., 2013). As Tony notes, this is ‘a real opportunity’ for people in recovery. However, he then contrasts this with the suggestion of unscrupulous practices by treatment providers who are appearing to cajole service users into these roles and taking advantage of them in order to benefit their own objectives. The issue of PSWs being recruited very early on in their recovery journeys was a recurring theme and one that appeared to underscore many of the potential risks of employing PSWs. This included the pressures faced by PSWs in their roles, which the following section examines.

6.4.2 The pressures faced by PSWs in treatment

Existing literature has expressed concern over the pressure experienced by recovering drug users who are recruited into PSW roles too soon after exiting treatment for fear that the responsibility can be detrimental for the individual’s own recovery (White, 2009; Scottish Recovery Network, 2011; Shapiro, 2012). A number of participants
provided evidence for this concern. For example, Richard provides the following view:

For me, to be a recovery champion and get paid whatever, peanuts, I mean it’s lowish pay – 16, 17 grand. But for me, you need to be at least, I would say, two years clean to do it ... the risk otherwise is you take on everybody else’s shit and you haven’t learnt to cope with your own shit. And you’re just still learning to cope with that without taking everybody else’s stuff on, and then [it is] stressful – what do I do when I’m stressed? ‘Fuck it, I’ll get a bag; I’ll just switch off tonight and get a bag.’ That early period is still vital for them - being clean, getting used to paying bills, getting used to council tax - what’s that? That kind of stuff.

Richard, Total Care service worker

Again, like Charlie, Richard suggests that ex-service users should not be employed as PSWs until they have been in recovery for a minimum of two years. Existing research has demonstrated that stress is often a key threat to recovery (see Laudet et al., 2004; Laudet and White, 2008). As Richard notes, the risk of employing service users too soon after exiting treatment is that they might not be stable enough in their recovery to be able to deal with the stresses that ‘normal’ life brings, let alone the pressures associated with supporting other people in their recovery. Tony’s history as a service user and later PSW was particularly interesting in this respect. In an interview with a Total Care staff member44, it was explained that Tony had in fact been in a similar position to the one he describes in his earlier excerpt:

...one of the recovery champions ... a few years ago, tried to be a service user rep volunteer and then it really affected his mental health. He felt a lot of pressure. I don’t know whether he went back to using or not, but he really struggled with dealing with the emotions ... One of our manager’s manager, not in this agency, somewhere else, was using him in the most token way: it was just horrible. It was a bit like ‘look we treat our clients well’. Yeah, it was rotten ... he’d only just detoxed the week before, he came out of detox and started volunteering ... they were just, almost like grabbed like a vulture, and told ‘you better’, you know, ‘you detox soon ’cause when you detox, there’s a job waiting for you at the end of it’. For someone who hasn’t worked, who

44 Although all participants have been given pseudonyms, the participant who disclosed Tony’s history was wary of explicitly identifying him. At the end of the interview, after the voice recorder had been switched off, the participant identified him, as they felt it was important to stress this issue. Given the relatively small number of Total Care staff interviewed, to ensure that the participant’s anonymity is not compromised, the interviewee’s pseudonym has been omitted here.
hasn’t been trusted or hasn’t been believed [in], that’s lovely; and I mean, I think that’s nice to be nice to people, but the person was pushed into a severe depression and a suicide attempt, I mean, that’s how bad it got.

Total Care staff member

The passage above includes a number of interesting findings. Again, reference is made to the opportunities for employment that the PSW role brings for recovering drug users. However, as this participant notes, the speed at which Tony was recruited into his role was ultimately detrimental to his recovery, leading to a suicide attempt. Again, reference is also made to the tokenistic use of PSWs in an attempt to look favourable to commissioners.

Related to the above risk, and as alluded to earlier, a further concern expressed by participants was that ex-service users were being given too much responsibility within their roles. Annual State of the Sector reports have highlighted concern over the exploitation of volunteers by treatment providers that become dependent on them to adopt certain responsibilities, with individuals being expected to carry out tasks previously undertaken by ‘professional’ staff (DrugScope, 2014, 2015b; Adfam, 2016). During Charlie’s interview, he argued that volunteers’ roles have changed over recent years, with many taking on increased responsibility:

It used to be that a volunteer was a compliment to the paid staff – added value, and that changed over time to volunteers taking on much, much, you know, working on reception, front line, people walking through the door. And that’s, that’s quite heavy-duty stuff, ‘cause you don’t know who’s coming through that door.

Charlie, Resicare service user

Charlie supports the view that volunteers are increasingly taking on the roles and responsibilities of paid staff members in treatment services. Evidence of this was found within Total Care, as Peter explains:

Frank operates as a keyworker at the moment, as a mainline drugs worker … This week, he wasn’t around, so he asked the recovery [champion] to sit in
with the doctor for the doctor review … I’m not sure whether I think that’s an appropriate use of the recovery champion. I think it might be fine for the recovery champion to be there, but when you’re doing a clinical review of treatment and the recovery champion isn’t the keyworker, I’m not sure whether that’s leaning on them a bit …

Peter, Total Care service worker

As this section has demonstrated, the general view among participants was that PSWs were often recruited into services too soon, given too much responsibility within their roles and often relied on to compensate for a lack of professional staff. As noted above, one of the key concerns associated with PSWs being recruited too soon and given too much responsibility is the potential risk of relapse (White, 2009; Wright, 2010; Scottish Recovery Network, 2011; Shapiro, 2012). The following section considers this risk.

6.4.3 The risk of relapse

As noted above, it was indicated that Tony had experienced a breakdown and suicide attempt as a result of the pressures he faced in a previous PSW role. When discussing the risks of employing PSWs with Tony, he offered the following view:

_They have to be careful as well because there will be an element of, for some people, this could go drastically wrong. You’ve got someone who has come out of that life, and is suddenly in this life, in employment, say recovery champion, and all of a sudden, there’s this real pressure and you’re now dealing with real lives, other people’s lives and there’s all this kind of pressure and there’s a lot of relying … There’s a lot of pressure now for people to kind of, you know, for people that have had rocky pasts… To be in that position of responsibility? Yeah._

Tony, Total Care Recovery Champion

It is entirely possible that Tony is reflecting somewhat on his own experiences here. During his interview, Tony made references to a number of challenges that he has faced whilst being in recovery. The following passage relates to a previous experience Tony had whilst working for a homeless support service:
The guy, he’s subsequently passed away, he died on the streets. So that’s how hard it can be. And I still think about that guy today, and think, sometimes, not all the time – I’m not consumed with it – but sometimes I stop and think, what could I have done differently? But I was the last in a long line of people that are probably all asking, what could we have done differently? And I guess, maybe nothing could be done differently. I don’t know. I haven’t got the answer, do you know what I mean? But it’s really hard.

Tony, Total Care Recovery Champion

Although Tony is not reflecting on an experience he had whilst working in drug treatment, it is indicative of some of the pressures recovering drug users can face when placed in positions of responsibility and when ‘dealing with real lives’. During Charlie’s interview, he suggested that he has known of a number of PSWs relapsing as a result of being recruited into positions of responsibility too soon, with too much expectation placed on them:

...they were dropping like stones, you know, these people

Relapsing?

Yeah, because its too much pressure on them too soon, you know, they just weren’t ready for it. They hadn’t acquired the skills that you need for life, you know? … Too much expectation, too much responsibility

Charlie, Resicare service user

Tony again supports this observation:

I’ve seen it go badly wrong.

What happens when it goes wrong?

Well, relapse or, you know, or relapse then followed by, again that, ‘fuck what’s wrong with me, I had this opportunity – I had it, I had it’ … but they’re being told and encouraged and kind of having their egos massaged, ‘Oh yeah, get on board with us’. Somebody somewhere has to keep an eye on that stuff.

Tony, Total Care Recovery Champion

The point Tony makes about providers massaging the egos of ex-service users reaffirms his earlier argument that ex-service users are often enticed into positions of responsibility by treatment providers who want to take advantage of them. Tony also supports a point made in the previous chapter regarding one of the implications of relapse following successful completion of treatment: the view that ex-service users who relapse often feel responsible for failing to maintain their recovery (McLellan et
al., 2000; White and Cloud, 2008). However, when in a position of responsibility within treatment – either voluntary or paid – the negative feelings from relapse are often amplified. As Shapiro (2012:9) notes in reference to recovery champions, ‘They have flown higher and have further to fall’.

Janet also provided support for the above arguments. At the time of her interview, Janet had two clients who had both been recruited into treatment services very soon after completing treatment. Along with gaining employment within drug treatment, both clients also had stable accommodation. Given the available evidence, it could be argued that both individuals had high recovery capital and would therefore be more able to maintain their recovery (Cloud and Granfield, 2008). However, Janet explains that they were perhaps still not ready to take on the responsibility they were given:

*I’ve got two clients that used to be drugs workers because I think they were part of the recovery movement and they got pushed very quickly into getting into drugs work and they’re now back on the other side of the desk … one person actually had some bereavements, the other person had end of relationship, lost job, lost housing, and both went back on drugs … It’s worrying that people might have been pushed into this field sooner than they were ready.*

Janet, Total Care recovery worker

The data presented so far within this chapter has demonstrated the key risks with recruiting recovering drug users into services too soon following their own treatment completion, along with being given too much responsibility within their roles. Given the issues identified, it is important that recovering drug users are given adequate training to take on the role of a PSW and are constantly monitored and supported throughout their employment (Wright, 2010; Shapiro, 2012; Public Health England, 2015; Roy and Buchanan, 2016). However, Peter noted that PSWs in Total Care are not given adequate training to take on their role:
...to be honest, they’re not given a huge amount of training to take on some of the responsibilities they have in my opinion ... some of the things that you’re seeing can trigger emotions for you; you can see distressing things.

Peter, Total Care service worker

This has also been identified as an issue within the mental health field, with peer workers often affected by other people’s experiences, particularly as those experiences frequently resonate with their own (McLean et al., 2009; Scottish Recovery Network, 2011). Given the above findings, it was important to establish whether Tony and Chris felt that they were adequately supported in their roles. When questioned on this, Chris noted the following:

_We have team meetings, we have recovery champion meetings where I get to discuss – it might be something where I felt like I didn’t know what to do, you know, a new experience, I didn’t know how to handle it properly and other recovery champions do. And then talk about that and discuss it ... It’s like a full-day counselling session really and I get to feel like I’m not the only one learning, developing, progressing. I learn off other people’s experiences when they’re talking about how they felt. Yeah, I know I can go and speak to my manager any time and they treat me like a professional._

Chris, Total Care recovery champion

Tony offered a similar response and emphasised that he felt secure in his role. As such, despite Tony’s previous history as a PSW, it was encouraging that both he and Chris felt that they were adequately supported in their employment. Notwithstanding this, it is evident from the findings presented in the preceding sections – and especially those from Tony – that the employment of PSWs within treatment carries significant risks, which continued support and training are vital to guard against. A further issue that both Tony and Chris raised, however, concerned their title of ‘recovery champion’, as the following section demonstrates.
6.4.4 The label of recovery champion

As already demonstrated, participants expressed consensus views that, due to their first-hand experience of addiction and recovery, PSWs are able to establish a genuine and empathetic connection with their clients, and offer effective inspiration to seek recovery. In addition to this, it has been argued that the employment of peer support workers within drug treatment presents an opportunity to redress the unequal power balance of the traditional prescribing model in services (Measham et al., 2013; Roy and Buchanan, 2016). However, when discussing their roles within Total Care, both Tony and Chris pointed out that being labelled as a ‘recovery champion’ sets up a barrier between their clients and them:

*It implies that I’m some type of champion and I’m not, I’m just a person, I’m just Chris. And I feel like it’s a barrier.*

Chris, Total Care recovery champion

*I just think that the minute I walk into a room with someone who’s ... on a script or still using, and still living that life, the minute I say, ‘hi, my name’s Tony and I’m a recovery champion’, it’s kind of setting up a bit of a barrier. ... I’m uncomfortable with it, because ... I remember sitting in that seat, and I already felt less than, and I already felt that I was no good, and I already felt that I was worthless, and that my life was finished and over. And I think if I’d have met somebody who came in and said, ‘hi, I’m a recovery champion’, I would have been intrigued as to what they do, and ... once I got past the title, I probably would have bought into it and been quite inspired, but I think some people can’t get past that, and for me, it’s setting up: I’m a champion, you’re not.*

Tony, Total Care recovery champion

It is evident that, whilst Chris and Tony both felt their roles as peers within treatment had value, the label they were assigned within Total Care somewhat undermined the benefits of their role. As noted in Chapter 2, a fundamental aspect of peer support is the bi-directional, mutual relationship between individuals (White, 2004; Bassuk et al., 2016:2). However, with the recruitment of recovering drug users into paid positions with a certain title, it can be argued that they have been co-opted into this power dynamic rather than redressing it (see Roy and Buchanan, 2016). This is a
phenomenon that has been witnessed in the mental health field. Rather than the reciprocal relationship found in naturally occurring support and MA groups, PSWs in mental health services are co-opted into the less symmetrical relationship of ‘giver’ and ‘receiver’ of care (Davidson et al., 1999; Repper and Carter, 2011). This feeds into a broader issue concerning the apparent ‘professionalisation of recovery’ (Duke et al., 2013; Bjerge et al., 2015), which is returned to below.

6.4.5 The potential risk to service users

Along with the risks for PSWs detailed in the preceding sections, participants also highlighted potential risks that the PSW role brings for current service users. With the increasing ‘deprofessionalisation’ of roles within health and social care services (Bach, 2012; Duke, 2013; Measham et al., 2013), concerns have been raised over unqualified staff working with vulnerable populations (Measham et al., 2013:19). However, with regard to the PSW role in drug treatment – and recovery champions in particular – the nature of the role and its responsibilities give cause for some concern. For example, Steve points to the risks associated with recovery champions ‘forcing’ clients into recovery:

So institutions, whether it’s a university, a hospital, a drug treatment agency, it’s a pyramid: there’s a chief exec at the top and there are workers at the bottom, and maybe volunteers underneath them ... Recovery is a circle - it couldn’t be more different. Recovery is a circle where everybody is equal. So when you go to a meeting of Alcohol Anonymous, it doesn’t care whether you’re prince or pauper, king or queen, if you come there from a cardboard box or in a Rolls Royce, you’re exactly the same within that circle ... When a hierarchal pyramid ... tries to embrace recovery and do recovery, it gets it horribly wrong. So, for example, what does it do? It forces people out of treatment and into recovery when they’re not ready. You get self-appointed moral guardians who themselves are often in recovery of a sort and say ‘well I’ve done it, you can do it’ and they are positively dangerous because they force, they can interpret targets so, you know, you have an institution who sets targets, pushes people out and it can’t be a coincidence that the deaths have gone up.

Steve, national policy stakeholder
This quote from Steve speaks directly to a number of key issues raised throughout this thesis. Importantly, Steve supports the findings presented in Chapter 5, arguing that service users are being forced out of treatment prematurely in order to hit targets, which he viewed as having contributed to the recent increases in DRDs. Most pertinently for the current discussion, however, Steve explicitly notes that PSWs recognise the need to get as many clients as possible into ‘recovery’ and so use their status to ‘force’ others into detoxing and exiting treatment, noting that ‘I’ve done it, you can do it’. Steve’s comparison of the natural ‘circle’ of recovery (White, 2004; Bassuk et al., 2016) and the ‘hierarchy’ of treatment also relates back to the unequal power dynamics that PSWs are co-opted into (Measham et al., 2013; Roy and Buchanan, 2016) and exemplifies the ‘professionalisation of recovery’ and the extension of medical dominance that has been reported elsewhere (see Duke et al., 2013; Bjerge et al., 2015).

In support of Steve’s argument, it was evident from Tony’s interview that he was aware of the need to get service users into ‘recovery’:

*I guess it’s a good thing that people are being, I don’t want to say forced, ‘cause no one’s forced, but people... It is quite obvious, encouraged, it’s quite obvious that you’re not going to be sitting on a script forever. You will be introduced to recovery options. It will be spoken about. It will be something that is a topic of discussion.*

Tony, Total Care recovery champion

Particularly interesting here is the choice of words by Tony. Although not wishing to state that people are ‘forced’, Tony explicitly notes that service users will be ‘encouraged’ to consider recovery and will be ‘introduced to recovery options’. Whilst spending time in Total Care, a conversation between Tony and Bobby, a

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45 Whilst this quote could have been used in either of the preceding analysis chapters, it was considered most appropriate when discussing the problems associated with PSWs.
service user, was observed. Tony was asking Bobby about his daily routine revolving around acquiring and using drugs, and was attempting to encourage Bobby to consider becoming abstinent. During this interaction, Tony was being quite direct with Bobby, which was considered at the time as falling on the side of coercion rather than encouragement. The interaction with Tony was raised in Bobby’s interview later that day:

*I think they’re trying to, I think government and that are trying to force people to get off drugs and all that, and that just won’t work, you know? …

…You talked about treatment services trying to get people off drugs … when Tony was talking to you upstairs about wanting to get clean, do you think that’s a pressure on you…

Yeah, yeah, yeah, sometimes yeah. ‘Cause you’re ready when you grow out of it, you know; I think I can do it myself.

Bobby, Total Care service user

It is evident from the quotes above that Tony was aware of the pressure to get service users into recovery, and this had manifested in his working practices. Whilst the role of the recovery champion in Total Care was to ‘be a visible presence of recovery’ there is a conflict here between being an inspiring presence in the background and being a driving force for recovery in the foreground, as appears to be the case.

This raises broader questions about the role of the PSW within treatment services. The findings presented in this chapter suggest that ex-service users are being cajoled into PSW positions and ‘used’ by treatment providers for their ability to more effectively encourage people to complete and exit treatment. This can be interpreted as further evidence of the strategic coherence that has existed in drug treatment, designed to persuade drug users into making prudential choices (Seddon, 2010a, 2011; Seddon et al., 2012). Further, the arguments presented in Chapter 5 concerning growth of new managerialism and its effect on the drug treatment sector can once again be made here. With PSWs co-opted into the unequal power dynamic found in
the traditional treatment model, it appears that they too are responsibilised for producing outcomes. Given the significant risks presented in the previous chapter, this raises further cause for concern. The following section considers the final issue with the employment of PSWs in treatment.

6.4.6 Marketization of PSWs

When discussing the employment of PSWs within services, Damien explained that ex-service users from Resicare who had been trained as volunteers within the service were being recruited by large providers to work as paid PSWs:

*But we found recently that other drug services have been actively sort of approaching our volunteers, offering them work, because they know how skilled they are and how competent they are when they've come to Resicare and we've trained them up.*

Damien, Resicare manager

The active recruitment of Resicare’s volunteers by other drug services is again indicative of the nature of competition. Within the competitive treatment environment in which the employment of PSWs is a way for providers to ‘tick the right boxes’ (Shapiro, 2012:10), PSWs become commodities to be traded and utilised to gain a competitive advantage. This ‘commodification’ is central to neoliberal forms of governance, as Clarke (2004:35) pertinently notes:

*The economic calculus of neo-liberalism expels that which cannot be counted – but it seeks to bring more and more of human activity within the economic calculus. Most things – even those previously decommodified or uncommodified – can be brought to market.*

Clarke (2004:35–6) contends that this can occur in a variety of ways, including the direct privatisation of services, organisations and resources, to the creation of internal markets that have characterised health and social care over recent decades. In addition, however, Clarke (2004:36) also highlights the creation of ‘new conditions for competitive success’. As has already been established, the introduction and
expansion of new managerialism within the public sector can be understood in these terms. However, it can also be argued that a consequence of the formal introduction of PSWs in treatment has been the commodification of those with lived experience as ‘tools’ to demonstrate success. Offering further support for this notion, Steve asserted that the issue of ex-service users being recruited into treatment services has also extended into mutual aid groups in the community:

Some people in NA say that the rise of recovery-oriented treatment has had a negative effect on the fellowship because it’s basically perverting the natural course of recovery. Because what would tend to happen is you’d come into NA, you’d get a sponsor, you’d do the steps, you’d do service under direction of your sponsor and you’d do it all for free. Whereas now because the third sector not-for-profit organisations are coming along and saying you can be a recovery champion with us, people expect to get paid for what they would once have done for free.

Steve, national policy stakeholder

As Steve contends, the formal introduction of PSWs into treatment services has disrupted the natural process of recovery. One of the proverbs of mutual aid is that ‘we keep what we have only by giving it away’ (NTA, 2010c:1). In other words, those in recovery can only remain in recovery by volunteering their time to support others to achieve recovery. However, Steve suggests that with the introduction of paid recovery champions, this has undermined the fundamental notion of mutual support, as people now expect to be paid to support others. This feeds back into Steve’s earlier argument concerning the discord between the natural ‘circle’ of recovery and the hierarchal model of treatment. This issue is returned to in the following chapter.

6.5 Chapter summary and conclusion

In line with the arguments presented in the previous two chapters, this chapter has demonstrated some of the key risks that can arise from a highly competitive drug treatment system. Whilst in support of existing literature (White, 2009; Best and Gilman, 2010; Best, Rome, et al., 2010; Best and Ball, 2011; Best, Loudon, et al.,
2013; Measham et al., 2013), this research found that the employment of PSWs offers an effective source of inspiration for existing drug users and can help to strengthen a PSW’s own recovery, their employment within services might be more appropriately viewed as a concerted cost saving measure at a time of reducing budgets in an increasingly competitive drug treatment environment. The view expressed by frontline workers within Total Care was that the employment of recovery champions was part of an effort to strengthen Total Care’s chances of being awarded the contract for the integrated service in Metropolis. Not only did their employment allow Total Care to ‘tick all the boxes’ with commissioners, participants also viewed their employment as a means of increasing the number of successful completions due to their ability to effectively encourage service users into detox.

In line with the above argument, there was widespread recognition among participants that ex-service users were often recruited into services too soon after exiting treatment, ‘wheeled out for presentations’, and given too much responsibility within their roles. Participants suggested that PSWs are often relied upon to fulfil the responsibilities of ‘professional’ staff, exemplifying the ‘deprofessionalisation’ of public sector roles and the increased reliance on voluntarism in line with neoliberal reform, responsibilisation and the achievement of the Big Society (May et al., 2005; Bach, 2012; Rowson et al., 2012; Duke, 2013; Measham et al., 2013).

Participants explained that PSWs were often not ready to take on the responsibility associated with working in drug treatment, with anecdotal evidence of PSWs relapsing as a result of the pressures associated with their employment. Moreover, both Tony and Chris viewed the title of ‘recovery champion’ as setting up a barrier
between themselves and their clients, thus suggesting that they had been co-opted into the power dynamic that the introduction of PSWs within treatment aims to redress. Taken together, the findings presented in this chapter highlight a fundamental conflict between the notion of recovery as it exists independently of treatment and the conception of recovery found in the hierarchical treatment pyramid. The following chapter synthesises the key findings presented in the preceding analysis chapters and highlights the key contributions to knowledge.
Chapter 7 | Conclusion: Delivering recovery at a time of reform and economic austerity

7.1 Introduction

This thesis has explored the impact of the shift towards recovery in British drug policy on local level policy and practice during a time of economic austerity and widespread public health reform. With the reorientation towards recovery, many drug policy commentators have speculated about the impact of this shift on drug treatment services at the local level (e.g. Roberts, 2009, 2011; Stevens, 2011a; DrugScope, 2012, 2013; UKDPC, 2012b; Watson, 2012; Duke, 2013; McKeganey, 2014; Best, De Alwis, et al., 2017). Whilst existing research has offered some useful insights (e.g. Roy and Buffin, 2011; UKDPC, 2012b; Measham et al., 2013; Neale et al., 2013; DrugScope, 2014, 2015b; Bjerge et al., 2015; Adfam, 2016), there was a profound need for further research to better understand the impact of these developments. This thesis helps to address this gap in knowledge. The following three, overarching research questions were established:

1. How has the reorientation towards recovery in British drug policy influenced local level policy and practice?
2. To what extent have the recent public health reforms impacted on drug treatment services at the local level?
3. How have drug treatment services been affected by pervasive government austerity measures?

Following a critical examination of the 2010 drug strategy and a review of existing literature, key issues were raised and further, subsidiary research questions were identified. Guided by the overarching research questions detailed above, this research employed a qualitative research design. This consisted of in-depth interviews (N=36)
with drug service commissioners, staff and service users from two drug treatment services in the north of England, and an interview with a national policy stakeholder. Interview data were analysed thematically, allowing for the identification of common patterns – or themes – within participants’ accounts. These themes were discussed in chapters 4, 5 and 6. The key findings of this research are presented in the following section.

7.2 Key findings

This section details the key findings of this research and, in so doing, provides answers to the research questions. Whilst many of these findings are interlinked, for the sake of clarity, they are discussed below in the sequence of the analysis chapters.

7.2.1 The shift to recovery in local level policy at a time of economic austerity and widespread reform

This research found that a clear reorientation in policy had occurred at the local level. The treatment system in both local authorities had been re-commissioned in 2012 with a direct focus on improving recovery outcomes for service users. This had been met with a shift from process-driven targets to the outcome-based target of successful completion of drug treatment. For Resicare, due to their history as an abstinence-focused recovery service, the shift to recovery served only to align their philosophy with national and local priorities. For Total Care, however, participants had witnessed a marked change in local policies and practices following this shift. Despite a lack of consensus among participants about how recovery should be defined, it was found that recovery had been conflated with abstinence and treatment completion at the level of practice.
Alongside the shift to recovery, this research found that both Total Care and Resicare had experienced or were anticipating reductions to their budgets. Whilst cuts to funding were not reported to have negatively affected service provision, there were concerns over the security of funding and the impact on future service provision. Perhaps unsurprisingly, it was evident that Resicare was facing significantly greater challenges in responding to cuts than Total Care. As a result of reductions to funding and changes to the qualifying criteria within contract tenders, Resicare was not only finding it more difficult to compete for contracts with larger organisations, but was also subcontracted less often by lead providers.

For Total Care, although anticipating a reduction of 15 per cent to their funding, it was noted that the service redesign in Metropolis had allowed for substantial cost savings to be made without impacting service provision. In addition, as a result of the focus on recovery, greater numbers of service users had exited treatment, thus reducing the caseloads of workers. This had allowed for changes to be made to the staffing makeup of the service, with keyworkers being replaced by other members of staff, such as social workers or recovery champions, thereby generating further cost savings. Whilst this was presented as a pragmatic response to a changing level of need within the service, staff maintained that reductions to the workforce and a ‘deprofessionalisation’ of roles had adversely affected the quality of the service provided.

Issues were also identified with joint working in both local authorities. Despite the changes introduced through the public health reforms providing greater opportunities for interagency working, participants believed that partnership working had worsened
over recent years as a result of cuts to local authority budgets, particularly with regard to housing and mental health support. This was considered to have severely affected the extent to which hard-to-reach clients were presenting to treatment, along with negatively impacting the opportunities for service users to accrue the capital necessary to initiate and sustain recovery.

This research found evidence of substantial changes to the commissioning and tendering of treatment services within the two local authorities. Following the introduction of the public health reforms, the budget for spending on drug treatment had been merged with wider public health spend in both local authorities, allowing for the commissioning of a combined drug and alcohol service. Participants viewed this as a necessary and positive development due to the extent to which service users had co-dependency issues. However, by combining the drug and alcohol budgets in Southside, it was reported that funding previously ring-fenced for spending on drug treatment had been diverted into the alcohol service, thus appearing to support concerns over disinvestment. Notwithstanding this, as drug use was not one of the key public health priorities in Southside whereas alcohol use was, the commissioning of a joint service had, in effect, provided security for drug treatment funding in the local authority.

Other changes to commissioning practices included shorter contracts and changes to the content of contract tenders. Shorter contracts and thus frequent retendering of services was found to create significant disruption and anxiety for service providers, service staff and service users. Significantly, concerns were raised over an increasing weighting on cost within tenders, with a consensus among Resicare staff that the
suitability of providers was increasingly being judged on the cost rather than the quality of their service. With decreasing budgets for service delivery and an increasing weighting on cost within tenders, Resicare staff reported that elements of ‘strategic commissioning’ had entered the sector. This included providers submitting unrealistic bids in order to win contracts and commissioners awarding contracts to providers that would make significant staff redundancies in order to reduce the overall cost of service delivery.

Taken together, the above findings demonstrate that the reorientation towards recovery in local level policy during a time of substantial reform and economic austerity had generated a number of significant challenges to the continued provision of support for drug users. Largely as a consequence of the changes to the tendering and commissioning of services, it was found that treatment providers are operating in a highly competitive environment in which the success of future funding bids is increasingly contingent upon demonstrating success to commissioners by recording successful completions of drug treatment. The following section presents the findings relating to this drive to demonstrate success.

7.2.2 The drive to demonstrate success: the successful completion of drug treatment

This research has established that the successful completion of drug treatment is now the key target set by commissioners, and the primary means through which the worth of providers is measured. Using Total Care as a case study, this research has provided in-depth insights into the impact of the shift to outcome-based commissioning on local level treatment practice, and the risks that have been generated for both staff and service users.
In the competitive environment in which Total Care was operating, there was a heavy focus on ensuring that service workers were continually encouraging their clients to enter detox. Moreover, workers were instructed by their managers to close clients’ cases on the same day of finishing their detox in order to ensure that they could be recorded as having completed and exited treatment. Significantly, the performance of each worker was being measured by the number of completions they could record, which managers monitored through a ‘tracking system’, with instances of underperforming being raised in supervision meetings.

The introduction of such overt employee performance monitoring within Total Care had placed significant pressure on workers to achieve successful completions or else face reprimand by their managers. This pressure had generated perverse incentives and had given rise to a number of risky practices performed by treatment staff. Such practices included the slowing down or speeding up of clients’ detoxes in order to hit targets, as well as ‘gaming’ the system by ‘creaming’ (cherry-picking) clients with fewest barriers to recovery and thus most likely to succeed, and ‘parking’ (neglecting) clients with more complex needs.

In line with the above practices, the drive to achieve successful completions had raised concern among workers that many service users had been completing and exiting treatment prematurely, which had resulted in high rates of relapse. This had also generated fears over the increased risk of overdose among clients who relapse after exiting treatment, with the introduction of take-home naloxone within Total Care viewed by some staff members as a direct response to this risk. Importantly, as a result of the above issues, some participants believed that the focus on successful
completion of treatment was contributing to recent increases in drug-related deaths. For Total Care’s performance, however, the issue of death following treatment completion was not viewed as problematic, with one participant explaining that clients who die after exiting treatment are still recorded as a successful completion.

A further technique used by Total Care to increase successful completions was through the employment of PSWs within their service. The following section presents the key findings in relation to this development.

### 7.2.3 Harnessing the ‘lived experience’: The employment of recovering drug users in treatment services

The research found that both Resicare and Total Care employed ex-service users in a variety of roles within their services. Whilst this was not a novel development for Resicare – with approximately three quarters of ‘professional’ staff having histories of drug and/or alcohol dependence – after taking over the contract in Metropolis in 2012, Total Care had specifically employed a number of PSWs, which included four recovery champions. Closely matching the description of community recovery champions in the 2010 strategy, recovery champions in Total Care were expected to act as ‘visible examples’ of recovery and to promote recovery to other service users.

The increased employment of ex-service users into PSW roles within treatment services emerged as a controversial theme, with participants viewing this development as bringing both benefits and risks for providers, staff and service users. It was widely accepted that those with first-hand experience of addiction and recovery could effectively inspire and motivate others to follow the same path; participants expressed such sentiments in relation to both PSWs and other ‘professional’ staff.
members who draw on their personal histories throughout their work. In addition, as articulated by the two recovery champions in Total Care, the role of a PSW brings with it benefits such a sense of responsibility or importance, increasing self-esteem and thus strengthening recovery.

Whilst the service manager in Total Care explained that the employment of recovery champions was a pragmatic response to a changing level of need within the service, other participants were more cynical about the reasons for their employment. Some participants viewed the increasing employment of PSWs as a concerted cost saving measure by providers in a constrained financial climate. In addition, as Total Care was not commissioned to employ recovery champions within Metropolis, staff viewed their employment as a further means through which Total Care could look favourable to commissioners against their competitors during a period of contract retendering.

Along with reference to the tokenistic employment of recovery champions and other PSWs, participants also raised a number of serious concerns with regard to the speed at which recovering drug users were being recruited into treatment and the responsibilities bestowed upon them. It was suggested that ex-service users were being recruited into services too soon into their own recovery, and were given too much responsibility, often being expected to perform the duties of ‘professional’ staff. Participants expressed that this was placing PSWs at risk of relapse, with the relapse of one of the recovery champions in a previous PSW role serving as a useful illustration of this risk.
Lastly, it was found that the employment of PSWs raised a number of issues for current service users. This included the extent to which the label of ‘champion’ co-opts PSWs into the traditional power dynamic between service worker and service user and the extent to which PSWs cajole current service users into recovery in order to contribute to the overall performance of the service. With regard to this, it was argued that the lived experience of PSWs is being harnessed by treatment providers and used as a tool to encourage others into detox and treatment completion, thus further demonstrating a provider’s worth.

As the preceding sections have demonstrated, this research has provided important insights into the impact of the shift to recovery on local level policy and practice at a time of widespread reform and economic austerity. Taken together, these findings offer an original contribution to knowledge, as the following section demonstrates.

7.3 Contributions to knowledge

This research has made two significant contributions to knowledge. First, this research has provided in-depth, empirical evidence of the impact of the reorientation towards recovery on local level policy and practice. Second, this research has contributed to understandings of neoliberalism by offering empirical insights into the manifestation of abstract notions of competition, risk, choice and responsibility at the level of practice within the drug treatment sector. This section discusses these contributions in turn.
7.3.1 Providing empirical insights into the impact of the shift to recovery

Since the introduction of the recovery agenda in 2010, there has been a great deal of speculation over the impact of this shift on local level drug treatment policy and practice. However, to date, there has been a dearth of empirical research in this area. This research offers an original contribution to knowledge by providing in-depth, empirical insights into the impact of the shift to recovery, as experienced by those working on the ground.

Most importantly, this research has demonstrated that the recovery-focused treatment system, with its emphasis on individuals successful completing treatment, has led to providers pushing service users prematurely into detox and treatment exit, placing them at risk of relapse and overdose. Since the introduction of the recovery agenda and the shift to outcome-based commissioning, many have expressed concern over this risk (Release, 2010; Hunter, 2011; Roberts, 2011; Roy and Buffin, 2011; UKDPC, 2011; DrugScope, 2012; Neale et al., 2013; Roy and Buchanan, 2016; Best, De Alwis, et al., 2017); however, empirical research has thus far largely failed to offer any conclusive evidence. Whilst existing empirical research has found that this issue appears to be occurring in some treatment services (e.g. Roy and Buffin, 2011; DrugScope, 2015a), and others have recognised that this risk is evident elsewhere (e.g. Measham et al., 2013; Neale et al., 2013; Roy and Buchanan, 2016), this research is one of the first in the field to demonstrate not only that these risks are being realised, but, more importantly, to offer in-depth explanations for how and why such issues arise. This is the most important contribution of this research, and provides a number of important policy considerations, as will be addressed in the following section.
This research has also made an original contribution to knowledge by providing detailed insights into the risks that can arise from the employment of recovering drug users in the treatment sector. Whilst this research found evidence in support of the benefits that those with first-hand experience can bring to the treatment system (see also Cloud and Granfield, 2008; Best and Gilman, 2010; Best and Laudet, 2010; Best, Rome, et al., 2010; Best, Loudon, et al., 2013; Measham et al., 2013; Penn et al., 2016), it has also substantiated concerns that PSWs are being recruited into services too soon after exiting treatment and are being given too much responsibility within their roles, often being relied upon to compensate for a lack of available resources. It has been shown that the pressures placed on PSWs can increase the risk of relapse, thus undermining their recovery.

The findings of this research suggest that providers are recruiting ex-service users into treatment in order to further demonstrate value to commissioners. Evidence was provided of the ‘tokenistic’ way in which providers employed recovering drug users, along with the extent to which PSWs were being exploited as an effective means of encouraging service users into recovery, thus further demonstrating success to commissioners. Connected to this was the idea that those with lived experience of recovery have become commodities to be traded and utilised by treatment providers to gain a competitive advantage. This research has not only documented the risks that PSWs can face, but has made an original contribution to knowledge by examining the factors that serve to produce these risks.

Importantly, this research has contributed to knowledge of the impact of austerity and the wider public health reforms on drug treatment provision. Whilst existing research
has offered useful insights into the extent of reductions to treatment budgets (see DrugScope, 2014, 2015b; Adfam, 2016), research has thus far failed to provide in-depth knowledge of the impact of cuts to funding from the point of view of commissioners, staff and service users. In doing so, this research has demonstrated that, whilst the shift to recovery offers greater opportunities for drug users to make positive improvements to their lives and to move on from treatment (Best and Laudet, 2010), the climate in which the recovery agenda has emerged has resulted in these opportunities being missed. Significantly, this research contributes to literature on recovery capital by demonstrating how cuts to funding to treatment services and wider support services make it increasingly difficult for drug users to accrue the capital necessary to initiate and sustain recovery (Cloud and Granfield, 2008; Best et al., 2016). When considered alongside the drive to achieve successful completions of drug treatment, this research has demonstrated the detrimental consequences that this can have.

Corroborating findings from existing research (DrugScope, 2014, 2015b; Adfam, 2016), the research has demonstrated the impact of changes to the tendering and commissioning of services. Importantly, as noted above, the research has demonstrated how shorter contracts, coupled with an increasing focus on the cost of service delivery can create a highly competitive environment in which providers are acutely conscious of demonstrating success to commissioners in order to win contracts. Whilst this research did not find evidence of disinvestment within the two local authorities studied, it has shown that this risk is still apparent.
7.3.2 Examining neoliberal notions of competition, risk, choice and responsibility in drug policy and practice

In addition to the contributions to knowledge discussed above, this research has also contributed to the body of literature examining the effects of neoliberalism within public sector services (e.g. Deem, 1998; Clarke, 2004; O’Malley, 2004; Teghtsoonian, 2009; Bach, 2012, 2016; Damm, 2012; Krachler and Greer, 2015; Juhila et al., 2017; Räsänen and Saario, 2017). This research has demonstrated how the reorientation towards recovery and its impact on local level policy and practice can be understood through a consideration of neoliberal notions of competition, risk, choice and responsibility.

Most significantly, this thesis has examined the existence and impact of competition within the drug treatment sector. As noted above, the research has demonstrated how reductions to budgets, changes to commissioning practices and a focus on outcomes within the sector had generated significant competition between treatment providers in the research sites. The impact of this competition was most clear when considering the emergence of ‘strategic commissioning’ by providers and commissioners, the drive to achieve successful completions, and the tokenistic employment of PSWs within services.

Notwithstanding the above issues, existing neoliberal theorising suggests that these findings are not particularly surprising, and in fact are to be expected in competitive environments. It has been established throughout this thesis that, within neoliberal societies, public and third sector organisations are expected to act in a more business-like fashion and to engage in practices that serve to increase efficiency, maximise
profits, and minimise losses (Clarke, 2004). Indeed, with the emergence of neoliberalism, we have witnessed the introduction of ‘new managerialism’ within public sector services, which has been characterised by practices that serve to increase efficiency and decrease cost. Such practices include: the introduction of quantifiable target setting and a monitoring of employee performance; an emphasis on output over input; the introduction and monitoring of league tables; and the establishment of punishments and rewards (Harlow, 2003; Connell et al., 2009; Diefenbach, 2009; Ward, 2011; Harlow et al., 2012; Siltala, 2013; Juhila et al., 2017; Lynch, 2017; Räsänen and Saario, 2017).

The above techniques were found to be evident within this research. Most clearly, the shift from the process-driven targets of attracting and retaining drug users in treatment to the outcome-based, quantifiable target of successful completion of drug treatment can be understood as central to new managerialism. The monitoring of this target through the NDTMS, and the comparison of local completion rates against the national average, provides further evidence that such processes have expanded within recent years. Moreover, as was explicit in the 2010 drug strategy, it was clear that only providers that demonstrate success to commissioners through the delivery of these outcomes will be ‘rewarded’ (HM Government, 2010). Evidence of such techniques and their effect was most clear at the level of practice. Examining the day-to-day working practices in Total Care, it was clear that techniques of new managerialism were extensive, and can be understood as having resulted in many of the risks that have been identified. Most significantly, the monitoring of employee performance and the threat of reprimand for workers who fail to achieve successful
completions had generated significant pressure on workers to hit targets, consequently giving rise to the risky practices identified throughout the thesis.

Again, however, existing neoliberal theorising reveals that this is not particularly surprising. The introduction of new managerialism has also transformed the role of the public sector workforce; public sector workers are responsible for producing quantifiable outcomes, and are held accountable when they fail to do so (Deem, 1998; Banks, 2004; Connell et al., 2009; Le Bianic, 2011; Juhila et al., 2017; Räsänen and Saario, 2017). Indeed, the actions of Total Care staff can be understood as the outcome of this responsibilisation (Rose, 1996, 1999; Garland, 2003; O’Malley, 2004, 2009). Total Care staff are viewed as ‘enterprising selves’: rational actors who behave in ways that will maximise their personal utility (Ogus, 1994; Rose, 1996, 1999; Harvey, 2005).

Further, as has been argued elsewhere (Seddon et al., 2008, 2012, Seddon, 2010a, 2011), the same conception can be made of drug users: as rational choice-makers who, given a range of options, can be cajoled into making ‘responsible’ decisions. As has been argued by others in the field, the drive to achieve recovery can be understood as a means of cajoling service users to become abstinent, find employment and stop claiming benefits (Seddon et al., 2012; Duke, 2013; Monaghan and Wincup, 2013; Wincup and Monaghan, 2016). In support of this argument, this research has demonstrated how this was evident in practice. The introduction of certain policies and practices within treatment services illustrate this ambition, with the ‘late pod’ in Total Care providing perhaps the most useful example of this.
In addition, this research has provided support for the argument that the shift to recovery can be understood as a means of responsibilising individuals and communities to address societal problems (Monaghan, 2012; Duke, 2013; Monaghan and Yeomans, 2016; Roy and Buchanan, 2016). The finding that commissioners are placing greater emphasis on prevention and early intervention within drug treatment contracts can be understood as a means of responsibilising services and communities to manage ‘risky’ populations (Rose, 1999; Teghtsoonian, 2009; Juhila et al., 2017). Similarly, the discovery that Total Care was planning to train individuals in communities, such as barbers and hairdressers, to deliver brief interventions provides clear evidence of this development.

In summary, through an examination of existing neoliberal theorising, Total Care and its workforce was operating as one would expect in a highly competitive environment, and was performing optimally as a result. As demonstrated, the NDTMS data show that Total Care was consistently performing above the national average for the percentage of clients successfully completing treatment and not re-presenting within a six-month period. Despite the claim from workers that large numbers of clients were re-presenting after the six-month window had passed, this is not important when considering the means through which Total Care’s performance was being measured. The following section offers policy recommendations in response to the findings of this research.
7.4 Policy recommendations

The overarching recommendation of this thesis is that there is a palpable need to shift the focus of treatment towards an emphasis on producing outcomes rather than simply recording outputs. To do so, this thesis also makes a further four, supplementary recommendations. The recommendations of this thesis can be summarised under the following headings: (i) shift from outputs to outcomes; (ii) investment in treatment; (iii) investment in wider support services; (iv) focus on quality over cost in commissioning decisions; and (v) continued investment in OST and harm reduction. These recommendations are discussed below.

7.4.1 Shift from outputs to outcomes

Most importantly, there is a vital need for a shift from focusing on outputs to a focus on outcomes of treatment. It has been argued that measuring the success of providers through treatment completion and non-re-presentation has prohibited a more realistic assessment of the effectiveness of treatment. It is widely accepted that recovery encompasses more than the control or cessation of substance use, and instead comprises positive life changes, such as improvements to health and wellbeing (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; White, 2007; UKDPC, 2008). Despite this, it is clear that conflating recovery with detoxification and treatment completion risks resulting in many service users exiting treatment without having built the foundations necessary for recovery, thus placing them at greater risk of relapse (Cloud and Granfield, 2008; Laudet and White, 2008; White and Cloud, 2008; Best et al., 2012).
It is recommended that the successful completion of drug treatment indicator be replaced with a more appropriate measure of recovery that comprises more than just treatment completion and non re-presentation, and instead represents a truer picture of recovery, as those working in the field have defined it. Whilst improvements in quality of life are more difficult to quantify, it is ultimately counter-productive to continue incentivising providers to pursue goals that place the health and wellbeing of service users at risk. This recommendation is particularly important considering the recent increases in DRDs (ONS, 2017).

As discussed briefly in Chapter 5, Total Care staff viewed the drive to achieve successful completions as having contributed to the recent increases in deaths. Since 2012, there have been substantial, year-on-year increases in DRDs (ACMD, 2016; Public Health England, 2016c, 2016d). Deaths involving heroin and/or morphine have doubled in the last three years and are now the highest on record (ONS, 2017). Responding to the increase in deaths, independent investigations have been carried out by PHE (2016d) and the ACMD (2016). Following their investigation, PHE concluded the following:

Matching death and treatment data had not produced any evidence that a focus on recovery and on successful treatment completion has had a negative impact and led to more drug deaths, though it will be important to maintain vigilance, both to clinical and commissioning practice and to analysing emerging data, to identify any early evidence of such an impact and respond appropriately. (Public Health England, 2016d:29)

In addition, both PHE (2016d) and the ACMD (2016) found that the majority of DRDs had occurred among individuals who had not been in contact with treatment services in the years leading up to their deaths. As noted in Chapter 5, in respect of these findings, it was concluded that the key factors responsible for the increases in DRDs included an increased availability and purity of heroin following somewhat of
a ‘drought’ in recent years, along with the ageing cohort of heroin users that are now developing complex health issues (ACMD, 2016; Public Health England, 2016d).

However, despite this conclusion, drawing on the findings of this research, along with unpublished evidence elsewhere (Dennis, 2016 cited in ACMD, 2016), the ACMD (2016:27) recognised that ‘some drug treatment services may not be providing services in a way that will enable both the reduction of drug-related harm and the achievement of recovery’. In support of this, anecdotal evidence has also surfaced over recent years that suggests that the issues identified in this research have been occurring elsewhere (see Release, 2015; BBC News, 2016; Buchanan and Pollock, 2016; Stevens, 2016; The Alliance Forum, 2017). Significantly, in 2016, a drug service provider in the north of England reported that 74 service users had died over an 18-month period (Buchanan and Pollock, 2016). Whilst the organisation claimed that the deaths were due to the ageing cohort of service users, service staff maintained that service users were being pushed for abstinence when it was not in their best interests, thus supporting the findings presented in this thesis.

Given the suspicions that significant numbers of service users are relapsing after successfully completing treatment, Release (2015) have advocated the introduction of a ‘drug-related deaths sub-indicator’, which would provide a better insight and evaluation into the extent to which recovery has indeed been ‘successful’. In addition, given that the majority of deaths are of people who are not engaged in treatment, Release (2015) note that the introduction of a drug-related death sub-indicator would also incentivise providers to better engage with this population of drug users. This research supports this recommendation. With the publication of the long-awaited
2017 drug strategy, the non-re-presentation requirement has been extended from six to 12 months (HM Government, 2017). Whilst a step in the right direction, more needs to be done to alleviate the problems that have been created by the obstinate focus on this measure.

7.4.2 Investment in treatment

In order to improve the outcomes of those in treatment, it is essential that local authorities continue to invest in drug treatment. Whilst this research found that significant disinvestment had not occurred within the two local authorities studied, it was evident that this risk remained. This research has demonstrated the clear challenge that budget reductions are creating for the continued provision of adequate support for substance users. Cuts to funding have led to staff redundancies, increased caseloads for workers and a reliance on PSWs to plug the gaps. With further cuts of approximately £22m planned for drug treatment by the end of 2018 (The King’s Fund, 2017b), it seems that, unless further investment is made in the sector, the situation will only get worse.

7.4.3 Investment in wider support services

With the centrality of recovery capital well-established in the literature (Cloud and Granfield, 2008; Laudet and White, 2008; White and Cloud, 2008; Best and Laudet, 2010; Best et al., 2012) it is critical that local authorities also invest in the wider support services that are vital for drug users to build the foundations necessary for recovery. The shift to the local planning and commissioning of public services through the health reforms provides greater opportunity for joint working in local authorities. Further, with devolution agreements being made in many areas (Local Government Association, 2017), there is greater potential to develop a local health care system that can address the whole needs of citizens. However, this research has
demonstrated that, despite the shift to local commissioning, partnership working has suffered as a result of insufficient funding, particularly with mental health and housing support.

As with the 2010 strategy, the 2017 drug strategy plainly cites the importance of joint working and the need for wider support for drug users: ‘We know recovery is only achievable through a partnership-based approach with action taken across a range of services, particularly housing, employment and mental health’. However, despite this rhetoric, the government are, once again, failing to support this ambition with the funding it requires (The King’s Fund, 2017a, 2017b; Winstock et al., 2017). Whilst it is recognised that drug addiction is a relapsing condition, and even those with substantial levels of recovery capital are not immune to relapse, pervasive cuts to housing and mental health support funding risk setting up drug users to fail.

7.4.4 Focus on quality over cost in commissioning decisions

There is a need to address commissioning practices that have been found to generate competition between providers. The increase weighting on cost within contract tenders was viewed as having resulted in providers submitting unrealistic bids in order to undercut competitors and win contracts, and subsequently failing to deliver an adequate service. As such, there is a need to place greater emphasis on quality rather than cost when making commissioning decisions. Further, awarding contracts of longer duration would give providers greater opportunity to establish themselves in an area without the constant pressures generated from frequent commissioning cycles. Coupled with altering the means through which success or progress is measured, this would allow providers to better focus on the needs of their service users.
7.4.5 Continued investment in OST and harm reduction

Finally, despite the focus on recovery, echoing the recommendations of the ACMD (2016) and PHE (2016d) it is important that commissioners continue to invest in OST of optimal quality, dosage and duration. It must be recognised that abstinence is not a goal for everybody and that harm reduction is not the antithesis of recovery (Best, Rome, et al., 2010; ACMD, 2016; Wincup, 2016). The obstinate focus on recovery in treatment with little acceptance of alternative aspirations is forcing service users into changes that they are not comfortable with and that do not meet their individual needs. This research has offered examples of the issues that can arise when involuntary and arbitrary changes are made to clients’ treatment plans. Drug treatment has, and will always need to be, a personalised service.

It is therefore important that treatment services continue to engage in practices that reduce the harms associated with problem drug use (ACMD, 2016; Public Health England, 2016d). The developments made in the British drug treatment system over the past five decades have made it one of the best in the world (Roy and Buchanan, 2016). However, this thesis demonstrates that the emphasis on recovery in a highly competitive environment appears to be creating rather than reducing harms for service users, and thus a change in policies and practices is vital.

Ultimately, the current treatment system is failing to recognise the intricacy of recovery and the importance of adequate, continuing support for individuals after exiting treatment. Discharging service users from treatment with little, if any, continued support and follow-up fails to recognise the vulnerability of many recovering drug users, with relapses viewed as the failure of the individual rather than
their treatment (McLellan et al., 2000). Drawing on the arguments made by Laudet and White (2008:45–6) in the US, it is important that the current system in Britain moves away from the acute treatment model that is comprised of assessing, admitting, treating and discharging clients, to a treatment model that acknowledges the chronicity of recovery and the need for continued support. To return to the arguments made in Chapter 6, it is evident that the adoption of recovery by the ‘hierarchal’ treatment system has resulted in a ‘professionalisation of recovery’ (Duke et al., 2013; Bjerge et al., 2015) with detrimental consequences for treatment providers, staff and, most importantly, service users. Whilst a certified solution to the issues that have been raised through this research lie beyond the scope of this thesis, the above recommendations hope to go some way in redressing the challenges currently facing the sector. The following section considers key areas for future research.

7.5 Future research agendas

The findings of this research, whilst providing empirical insights into some of the key questions following the shift to recovery, also signal important areas for further research. Although the findings of this study cannot be generalised, the emergence of anecdotal evidence elsewhere in support of this research (see, for example, Release, 2015; Buchanan and Pollock, 2016; Stevens, 2016; The Alliance Forum, 2017), demonstrates the need for additional examination in other geographical areas to establish whether similar issues are in fact occurring. Moreover, with evidence of similar changes to the tendering and commissioning of services in other local authorities (DrugScope, 2014, 2015b; Adfam, 2016), it is likely that the issues presented through this thesis are not unique to the research sites studied.
In addition, whilst the two treatment services recruited for this research offered useful insights into the policies and practices of providers in the current climate, the situation in Metropolis was particularly noteworthy. Given the issues reported by Total Care staff concerning the treatment system in Metropolis, it would have been useful to engage with the other providers operating alongside Total Care in order to glean a more complete picture. Whilst the commissioning of an integrated service means that this is no longer possible, it would be interesting to return to Metropolis to establish whether the newly commissioned system provides a better level of care for its service users.

Lastly, it is important to conduct further research into the security of providers in the current climate. As shown through this research, there is a growing concern that the commissioning environment in local authorities is marginalising smaller providers, with large, prime providers continuing to dominate. Nevertheless, recent developments have also demonstrated the vulnerability of some of the largest providers in the sector. In May 2017, it was reported that one of the largest not-for-profit drug and alcohol providers, Lifeline Project (hereafter Lifeline), had gone into administration following concerns of ‘critically weak financial controls’ (Brindle, 2017). In its 2016 financial statement, Lifeline noted that the majority of its funding comes from statutory sources and, as such, reductions to drug and alcohol budgets had presented a major financial risk (Lifeline Project, 2016:10). In addition, the report also makes reference to the competitive commissioning environment in which Lifeline was operating and the need to increase capacity in order to meet future challenges (Lifeline Project, 2016:10).
Following its closure, the contracts for Lifeline’s services were transferred to another provider, Change Grow Live (CGL). CGL is the largest not-for-profit drug and alcohol provider in the UK (Brindle, 2017). As has been demonstrated through this thesis, in a constrained financial environment in which commissioners are increasingly requiring providers to deliver greater efficiency at lower cost, there is a concern that the most powerful providers such as CGL will continue to dominate the sector whilst those who fail to keep up fall by the wayside. With the marginalisation of smaller, specialist service providers, there is a concern that vital expertise of these providers will be lost, raising important questions over the potential monopolisation of power and the future of service provision, which is worthy of further investigation.

7.6 Final thoughts

This thesis has highlighted clear risks that have emerged through the shift to recovery in local level policy and practice. Whilst the focus on recovery has the potential to transform the lives of individuals, families and communities (Best and Gilman, 2010; Best, De Alwis, et al., 2017), the climate in which it has been introduced, and the way in which it is being defined and delivered in practice, has fallen short of these ambitions. Those committed to improving outcomes for drug users – including academics and those working in the field – have consistently demonstrated that, for recovery to be successful, it is crucial that sufficient support and resources are available. Whilst the 2017 drug strategy, like its predecessor, promotes optimism, it is clear that the government are continuing to pay lip service to the ambitions of recovery. To echo the argument of Winstock et al. (2017:2): the 2017 drug strategy ‘lacks honesty, coherence, and realistic financial support. It is based on false claims and is full of empty promises’. It is hoped that the findings of this research can contribute to the on-going campaign for a more effective, safer drug treatment system.
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Appendix A: Interview guides

Commissioners

1. Role and responsibilities

2. Tendering and commissioning
   a. Process
   b. Changes over recent years
   c. Contract lengths and commissioning cycles
   d. Key priorities for [LA]

3. Impact of recovery agenda
   a. Commissioning for recovery
   b. Targets for drug and alcohol services
   c. Changes over recent years
   d. Structure of treatment service in [LA]

4. Public health reforms
   a. Impact of Health and Social Care Act
   b. Public Health England
   c. DsPH/JSNAs/JHWSs/CCG
   d. Opportunities and challenges
   e. Joint commissioning
   f. Disinvestment/prioritisation

5. Budget allocation in [LA]
   a. Current allocation
   b. Increase/decrease/same
   c. Cuts to budgets
   d. Disinvestment/prioritisation
   e. Impact

6. Evaluation of treatment services

7. Challenges faced

8. Other comments/thoughts/questions
Service manager(s)/workers/PSWs

1. Role in service
   a. Current role and responsibilities
   b. Changes to role and responsibilities over recent years
   c. Emphasis on recovery
   d. Definition of recovery
   e. [PSWs] history/background

2. Service
   a. Services provided by [service]
   b. Brief history of [service]
   c. Staff and client numbers/demographics
   d. Key targets
   e. Focus on recovery

3. Challenges
   a. Main challenges facing treatment and/or [service]
   b. Challenges faced as a manager/worker/PSW

4. Substance use in [local authority]
   a. Substances currently being used
      i. Changes in recent years
   b. Substances users presenting to services with
      i. Challenges/risks

5. Public health reforms
   a. Changes witnessed
      i. Health and Social Care Act 2012/Public Health England
   b. Budget allocation in [LA]
      i. Is funding allocated differently? If so, how?
   c. Tendering and commissioning
   d. JSNAs/JHWSs – involvement in wider processes
   e. Impact of changes

6. Austerity
   a. Current state of funding
   b. Cuts or potential cuts to funding
   c. Cuts to other public services
   d. Cuts to LA budgets in general
   e. Impact of cuts to funding

7. Evaluation
   a. What does [service] do well?
   b. Service users’ needs adequately addressed?
   c. [PSWs] adequate support/training
   d. Improvements
   e. Future

8. Other comments/thoughts/questions
Service users

1. Background
   a. Upbringing
   b. Relationships
   c. Education
   d. Living environment (past and present)
   e. Age

2. Employment history
   a. Employment status
   b. Periods of past employment
   c. Benefit claimant status

3. Substance use
   a. Age of first use
   b. Substances used
   c. Reasons for use
   d. Progression
   e. Substance presenting to [service] with
   f. Periods of abstinence

4. Recession
   a. Experience of recession
   b. Benefits
   c. Availability of support services

5. Experience of services
   a. Length of time in treatment/[service]
   b. Past periods of treatment
   c. Evaluation of service
   d. Changes to services over recent years
      i. Impact
      ii. Reasons for change
   e. Support available
   f. Access to wider support services

6. Substances used (general)
   a. Substances witnessed being used
      i. Changes in recent years

7. Other comments/thoughts/questions
National policy stakeholder

1. Impact of public health reforms
   a. Health and Social Care Act
   b. Public Health England
   c. Local commissioning
   d. Opportunities
   e. Challenges

2. Budget allocation at LA level
   a. Opportunities
   b. Risks

3. Tendering and commissioning
   a. Process
   b. Changes

4. Austerity
   a. Impact
   b. Cuts to drug and alcohol funding
   c. Potential
   d. Challenges
   e. Cuts to wider support
   f. Future

5. Recovery agenda
   a. Focus on recovery
   b. Reasons (political, economic, social)
   c. Changes to treatment
   d. Key targets
   e. Harm reduction

6. Other comments/thoughts/questions