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Abstract

During the last 5 years, there has been an important shift in the policy discourse around drugs issues. This article reviews the key changes and continuities in British drugs policy since the mid 1990s. It examines the crime reduction focus of the previous Labour government and the processes by which the recovery discourse came to dominate the current policy framework under the coalition government in 2010. The shifts in policy and practice will be explored in relation to how the drugs problem was framed and reframed over time and how shifts within the wider social, political, and economic contexts have impacted these developments. It is argued that although the moves toward a recovery-based policy represent significant changes, there are powerful continuities and remnants of previous policies and structures, which have endured and set the parameters for the current policy framework, particularly in relation to crime reduction priorities.

Keywords

drug policy, recovery, crime, Britain

Introduction

In December 2010, the coalition government published its new drug strategy. It was put forward as a "fundamentally different approach to tackling drugs and an entirely new ambition to reduce drug use and dependence" (HM Government, 2010b, p. 3). Rather than focusing on reducing the harms caused by drugs and the crime reduction benefits of treatment, the emphasis shifted to offering support to drug users to become "drug-free" and choose "recovery" as a way out of dependency. The previous Labour government had focused its efforts on attempting to break the so-called link between drugs and crime through the development of treatment pathways at every point of contact in the criminal justice system. A key question is how far the new drugs strategy represents a fundamentally different approach and new ambition within drugs policy. With this new emphasis on "recovery," what has happened to the crime reduction discourse developed by the previous government? Historical analyses have illuminated the longstanding tensions and conflicts between moral, medical, and penal ideologies within the development of British drugs policy (Berridge, 1999; Mold, 2008; Pearson, 1991; Smart, 1984; Stimson & Oppenheimer, 1982). Enforcement activities have always coexisted alongside harm and demand reduction

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strategies. The balance between treatment and punishment has changed over time and has been influenced by the nature and extent of drug use, the ways in which the drugs "problem" and drug users have been defined and by wider social, political, economic, and institutional contexts. Analyses of contemporary drug policy under the Labour government have indicated processes of "criminalization" of drug policy, a preoccupation with the link between drugs and crime, a growing merger between treatment and criminal justice, and a repositioning of treatment to serve crime reduction and public protection goals (see Duke, 2006; Parker, 2004; Seddon, Ralphs, & Williams, 2008; Shiner, 2012; Stevens, 2010a). However, within the various drug-related initiatives developed in the criminal justice system under Labour, harm reduction and methadone maintenance prescribing remained as key techniques in the treatment toolbox.

Another pervasive theme within drug policy analyses has been the pragmatism, compromise, and flexibility, which have characterized policy development throughout history. This dates back to the Rolleston Committee Report of 1926, which represented a process of accommodation between the Home Office and the medical establishment, a growing partnership between doctors and the state in the control of addiction and the control aspects of both the penal and medical views (Berridge, 1984). Similarly, the response to the heroin epidemic of the 1980s included both tough control measures and initiatives around harm reduction and treatment, which operated simultaneously. Pearson (1991) argues that, historically, there is a strong line of continuity within the development of British drugs policy, which is characterized by a flexible and adaptable approach to the drugs problem. Similarly, in her analysis of drugs policy development in the 1980s and 1990s, MacGregor (1998) points to the compromise that occurred between abstinence-based and harm-reduction policies:

> Policies were articulated in such a way as to appear to provide support for both positions at the same time in order to obtain a working compromise, provide a base on which something could be done. The willingness of the parties involved to accept this fudge, not to insist on a rigid adherence to principle, is one of the continuities in the British system, reflecting a broader political culture which pervades drugs policy as much as other public policies. (p. 132)

The aim of this article is to analyze the shifts and continuities in British drugs policy under the coalition government. There have been a number of analyses of the 2010 coalition drug strategy. McKeganey (2012) examines the possible futures for harm reduction with the rise of recovery and emphasis on drug-user abstinence. Wardle (2012) explores the 5-year period in the lead up to the coalition strategy, focusing on the influence and response of key actors and organizations in the drugs field to the recovery movement. Monaghan (2012, p. 30) focuses on the movement away from methadone maintenance toward abstinence and argues that this development is part of a "creeping moralisation" that emphasizes changing the behavior of "problematic" populations without acknowledging or tackling the underlying causes. Although these analyses have referred to the overwhelming emphasis on the drugs-crime link under the previous Labour government, they have not explored what has happened to the crime focus within the coalition strategy. This article will trace the key policy developments and legacy left by the Labour government from 1997 to 2010 and focus on the drugs strategy formulated by the coalition, with a particular emphasis on crime and the role of the criminal justice system. Drawing on the framework put forward by Rein and Schon (1993), the article will examine the framing and reframing of the drugs policy terrain during this period. It will explain these shifts in policy and practice by exploring how the drugs problem was defined and redefined, and how shifts within wider social, economic, and political contexts have impacted the reframing of drugs policy. In particular, the processes by which drugs policy became dominated by the recovery discourse will be examined

in detail. It will be argued that although there are significant changes and developments under the new drug strategy, there are also important continuities that have endured over the history of British drugs policy.

This commentary draws on an analysis of drug policy documents since 1995 to examine the shifts and continuities within policy development. The main questions to be addressed are, "How did the concept of 'recovery' become the dominating framework to organize the future developments in drugs policy?" "How does the strategy represent continuity with past policy frameworks, particularly in relation to the role of the criminal justice system?" "What are the key challenges to the recovery framework with respect to drug-involved offenders in the criminal justice system?"

Identifying Frame Shifts

The drugs issue is a good example of a stubborn policy controversy with a long history. In some policy areas, disagreement and debate can be solved by reference to "facts" or evidence, but in areas of policy controversy, like drugs, this is difficult due to the value judgments involved. In these types of policy areas, Rein and Schon (1993) argue that actors "construct the problems of their problematic policy situations through *frames* in which facts, values, theories and interests are integrated" (p. 145). Framing refers to "a way of selecting, organizing, interpreting and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading and acting" (Rein and Schon, 1993, p. 146). This process can be problematic because different groups will have different views of the policy issue, which can lead to multiple social realities and frames that conflict. The various stakeholders in drugs policy have different frames that lead them to view and interpret drugs policy issues differently and to support different directions for policy and practice. Some actors emphasize the health aspects of drugs policy, while others focus on the crime elements and some focus on the moral aspects. There is a long history of debate in the drugs treatment field between those who advocate abstinence-based models and those who promote harm-reduction initiatives. This article is concerned with the reframing of drugs policy under the coalition government and the frame shift, which occurred toward a "recovery-based" policy discourse.

Rein and Schon (1993) argue that the framing and defining of a policy area take place within a nested context consisting of a number of levels, including the internal, proximate, macro, and global contexts. Shifts within this nested context impact one another and often result in the reframing of a policy issue. Reframing may occur as a result of changes within the internal context of the program or policy area, or changes within the proximate context due to interactions with other programs or adjacent policy areas. Drugs policy not only interacts with a number of adjacent public policy subsystems, including health and criminal justice policy, but also interacts with wider social policy areas such as social security, welfare, education, and housing. Macro changes at institutional, political, social, and economic levels can also affect the reframing process. Similarly, shifts within the broader global context can impact the reframing of policy terrains. Drugs policy and practice are affected by changes within these various contexts at micro-, meso-, and macro levels.

Shifts within these nested contexts do not necessarily set the conditions for policy reframing. This might lead to "symbolic" reframing (Edelman, 1971). Rein and Schon (1993) argue that "the rhetoric of disagreement may suggest a major reframing of policy while practice displays a remarkable continuity" (p. 155). Often, the political rhetoric around drug policy will be tough and punitive, but on the ground, practitioners will be delivering liberal, progressive treatment options. Similarly, the continuity and durability of policy and practice have been emphasized within many analyses. For example, Seddon (2010) urges us to explore the "residues," "traces," and "continuities," as well

as the new directions and changes within drugs policy development, while Berridge (1989) reminds us that many of the themes and discourses within contemporary policy have powerful historical antecedents. Historical analyses of the "British system" of drugs control and the subsequent development of harm-reduction initiatives demonstrate the enduring threads of stability within British drugs policy and practice (Berridge, 1991; Mold, 2008; Stimson & Lart, 1991). Throughout drug policy history, there has been a struggle between abstinence versus harm reduction within the debates about how to treat addiction. Moreover, the concept of "recovery" is not new, but has always been part of drugs treatment. Researchers exploring the history of recovery have traced it back to the early temperance and recovery movements in the first half of the 19th century in the United States and the United Kingdom (Berridge, 2012; Yates & Malloch, 2010).

The continuities in drug policy development link with new institutionalism, which emphasizes the importance of policy feedbacks or the ways in which inherited policies and structures shape subsequent policy development and processes (Skocpol & Pierson, 2002). Policy choices taken in the past can persist over time or become "fixed," altering the possibilities for future initiatives. New policies also affect the identities, goals, and capabilities of the various interest groups involved in policy-making, setting up established patterns of interdependence that constrain radical policy change. In some cases, groups will have a stake in the expansion and continuation of particular policies, while in others, groups may seek to repeal or reorient policies (Skocpol, 1992). This article will seek to analyze both the attempts to reframe drugs policy through the lens of recovery and how the previous policy frameworks that focused on treatment and crime reduction have set the parameters and laid the foundation for the development of the current policy discourse and structures.

The article is based on a qualitative analysis of all the official drug strategy documents published since 1995, with a particular focus on the 2010 drug strategy of the coalition government (HM Government, 2010b). The analysis begins with the Conservative government's 1995 drug strategy, *Tackling Drugs Together*, which marked the beginning of a shift toward a crime focus in British drugs policy (HM Government, 1995) and then focuses on the drug strategy documents and updates of the Labour government from 1997 to 2010 (HM Government, 1998, 2002, 2008; Home Office Drug Strategy Directorate, 2004). Alongside analysis of the current 2010 drug strategy document, the responses from the various agencies and organizations to the public consultation on the 2010 drug strategy are also included (see Home Office, 2010). The focus of the documentary analysis is to examine the dominant discourses surrounding policy development within each drug strategy document and to explore the relationships between it and subsequent strategy documents. The ways in which the drugs "problem" was conceptualized and framed, and the policy proposals as to how to deal with drugs issues are explored. The analysis emphasizes the temporal aspects of the strategies and their relationship to each other to explore any shifts and/or continuities in drugs policy over time.

The Legacy of the Labour Government on Drugs Policy

When the Labour government came to power in May 1997, it inherited a drugs policy framework, *Tackling Drugs Together*, which had begun the process of reframing drugs policy away from the harm reduction and pragmatism that had characterized the HIV crisis of the 1980s and toward crime reduction (HM Government, 1995). Drug-related crime was highlighted as a key problem, and the discourses of "enforcement," "punishment," and "community safety" began to dominate the drugs policy arena. Drug Actions Teams and Drug Reference Groups, new multiagency structures that merged health, social services, and criminal justice agencies, were established to deliver the strategy on the ground at local level. Amid much controversy and debate, mandatory drug testing was introduced into the prison system for the first time (Duke, 2003).

Alongside this emphasis on drug-related crime and the role of the criminal justice system in dealing with drug users, there was renewed faith in the role of treatment. The overall conclusion of the effectiveness review of drug-treatment services was that "treatment works" in reducing harm (Department of Health, 1996). As MacGregor (2009b) argues, there were significant continuities between the Conservative and New Labour strategies, and the foundation for the focus on crime and treatment had been laid well before Labour gained power in 1997.

The 1998 drugs strategy, *Tackling Drugs to Build a Better Britain*, enhanced the focus on drug-related crime with the development of various treatment initiatives within the criminal justice system (HM Government, 1998). The transplanting of American ideologies and practices such as coerced treatment, drug testing, and drug courts began to gain acceptance within the drugs policy community. The centerpiece of Labour's drug strategy was the introduction of Drug Treatment and Testing Orders (DTTOs), which were probation-based court orders that combined drug testing and coerced treatment. Within the prison system, a new integrated treatment service was introduced (i.e., CARATS: Counselling, Assessment, Referral, Advice, and Throughcare Service). The criminal justice system became a major portal into drugs treatment and rehabilitation. Commentators began to refer to the "criminalization" of British drug policy (see Duke, 2006; Seddon et al., 2008) and the development of a new "industry" of treatment interventions in the criminal justice system (see Parker, 2004). The increasing merger between drugs and the criminal justice system was further intensified through the Criminal Justice and Court Services Act 2000, which introduced drug testing for defendants charged with trigger offences (i.e., property crimes and drugs offences) and for those under probation service supervision sentenced to the new Drug Abstinence Orders (DAOs) and Drug Abstinence Requirements (DARs).

In 2002, the government published its *Updated Drug Strategy*, which provided new funding for the development of the Drugs Intervention Program (DIP; HM Government, 2002). This program was set up initially as a 3-year program from 2003 to 2006 with a budget of £165 million per year. The aim of DIP was to get offenders "out of crime and into treatment." It provided opportunities for drugs testing and treatment at every point of contact with the criminal justice system from arrest and bail through sentencing and imprisonment or community supervision. Over time, the government's drug policy became increasingly focused on the most problematic drug users who were assumed to be committing crime to fund their habits, the "most dangerous drugs" (i.e., crack cocaine and/or heroin), and the "most damaged communities." The 2005 Drugs Act introduced further powers to drug-test arrestees and undertook mandatory drug assessments for those who tested positive. Between 2003 and 2009, more than 900 million pounds in total was invested in DIP (Home Office, 2009). In 2009-2010, between 4,000 and 4,500 problem drug users entered treatment in the community each month following referral from the program (National Audit Office, 2010).

The 2008 drugs strategy, *Drugs: Protecting Families and Communities*, extended further the role of the criminal justice system in treating problem drug users, but informal forms of social control were also emphasized. The themes of rights and responsibility ran throughout the initiatives proposed (MacGregor, 2009a). Families and communities were expected to take responsibility and get involved in drugs control. Drug users were seen to be responsible for engaging in drug treatment and threatened with benefit cuts if they did not cooperate. New forms of coercion into treatment were proposed through the welfare-to-work system. In relation to treatment, the key shift in focus under the 2008 drugs strategy was on the outcomes of treatment and successfully reintegrating drug users back into communities. The aim was to ensure that "those who do use drugs not only enter treatment, but complete it and re-establish their lives" (HM Government, 2008, p. 4). However, the strategy recognized that a range of treatment interventions would be necessary to deal with the diversity within the drug-using populations, including abstinence-based programs, methadone maintenance, and innovative treatment pilots of injectable heroin and methadone.

The 13 years of Labour government had a profound impact on the drugs treatment and criminal justice landscape. The discourses of "getting tough on crime" and "tough on the causes of crime" (i.e., drugs use) allowed both criminal justice and health to have an input into drugs policy that had universal political appeal. Most importantly, it enabled support for more resources and long-term investment in the drug treatment infrastructure. Over this period, spending on treatment increased dramatically. The pooled treatment budget, which combines funding from the Home Office and Department of Health, rose from £142 million in 2001/2002 to £406 million in 2009/2010 (Drugscope, 2009). Increasing numbers of drug users entered formal treatment. The National Treatment Agency (NTA) aimed to double the number of people in treatment from 100,000 to 200,000 by 2008. This target was exceeded with 207,580 adults in structured treatment in 2008/2009 (NTA, 2009). The drugs workforce also increased substantially from 6,754 in March 2002 to 10, 628 in March 2007 (NTA, 2009). The waiting times for treatment were reduced with 96% of users coming into the system waiting no more than 3 weeks to get treatment in 2010-2011 compared with 87% in 2006-2007 (NTA, 2011). Under the rhetoric of evidence-based policy, the Labour government also invested substantial sums of money in research, which expanded the knowledge and understanding of drugs treatment. A clear conclusion that emerged from various pieces of research was that "treatment works" (Donmall, Jones, Davies, & Barnard, 2009; Godfrey, Stewart, & Gossop, 2004). Research commissioned via the Department of Health's Drugs Misuse Research Initiative noted improvements in outcome measures 6 months after treatment. However, it was stressed that improvement does not necessarily mean "abstinence." Very few drug users achieve abstinence quickly, which indicates that a longer term view is required recognizing the chronic and relapsing condition of drug use, and that a wide range of service provision is needed (MacGregor, 2009a).

While at the level of the political rhetoric, Labour drug policy was portrayed as punitive and hard-line toward drug-using offenders, in practice, there were striking continuities between this phase of policy and the previous framework. The primary focus was on expanding treatment, and harm-reduction techniques (i.e., methadone maintenance) were still emphasized in defining the objectives of much of this treatment. However, the overriding goal of the new treatment interventions had become the reduction of drug-related crime and regulating the behavior of problem drug users. Within this criminal-justice-oriented framework, remnants of the pragmatism of the earlier phases of policy remained. Although the shift to the emphasis on crime reduction was very important and represented a fundamental change in responding to drug users, Seddon et al. (2008) argues that these changes were not "epochal," but rather were new developments that occurred within and alongside the existing parameters and arrangements. This links with the arguments of new institutionalism and highlights the persistence of established policy ideas, frameworks, and structures over time. The new drugs initiatives within the criminal justice system added additional layers to the existing system of drugs control.

The Coalition Drug Strategy

In the lead up to the general election in May 2010, there were few references to the development of drugs policy in the various political parties' manifesto statements. However, the Conservatives promised to deliver an abstinence-based drug strategy, benefit cuts for problem drug users, and compulsory residential drug treatment. The roots of these proposals can be found in the right wing Centre for Social Justice report titled, "Addictions: Towards Recovery," published in 2007. The report argues that the Labour policy on drugs with its harm reduction ethos had failed. It referred to the "entrenchment of addiction" and "intergenerational cycles of addiction" (Centre for Social Justice, 2007, p. 10). Methadone maintenance prescribing was blamed for perpetuating addiction and dependency. The report argued that the voluntary sector

had become "colonized" to promote harm reduction, which had stifled innovation and the development of holistic services. A new hard-line strategy underpinned by an emphasis on total abstinence was proposed.

The election in May 2010 led to the forming of a coalition government between the Conservative party and the Liberal Democrats. The broad program for this government was set out in the Coalition Agreement. There were only three specific commitments to drugs policy at this point in time. These were the introduction of a system of temporary bans on new legal highs, a review of sentencing policy to ensure that sentencing for drug use helps offenders come off drugs, and a commitment to explore alternative forms of secure treatment-based accommodation for mentally ill and drug offenders (HM Government, 2010a). By August 2010, a more detailed drug strategy consultation paper was disseminated for comment and debate. The overall themes of the proposed strategy included an emphasis on individual recovery; a holistic approach incorporating drugs, alcohol, child protection, mental health, employment and housing; devolvement of budgets and responsibility to the local level; and budgets and funding for drug treatment to become simplified and outcomes based (Home Office, 2010). Some of the most controversial proposals were benefit sanctions if individuals failed to address their drug and alcohol dependency, payment by results for drugs treatment, and the emphasis on abstinence. Although many of the aspects of the proposed strategy consultation were welcomed by the drugs policy community, such as the inclusion of alcohol and the holistic approach advocated, there were fears surrounding payment by results, time-limiting prescription medication such as methadone, and benefit sanctions for drug users who did not conform to treatment regimes (see, for example, Drugscope, 2010; United Kingdom Drug Policy Commission [UKDPC], 2010; Release, 2010). It appears that some of these concerns were taken on board. The new drugs strategy was published in December 2010 and stopped short of the overtly abstinence-based policy and the benefit cuts that were advocated by the Conservative party in the lead up to the election. The effect of the establishment of the coalition and the consultation process was inevitably a tempering of the more hard-line Conservative ideals with the values of the Liberal Democrat party. The outcome, as in many policy areas, was a compromise.

The overarching theme is "recovery" and signals a move away from a harm-reduction perspective and the previous government's obsession with the drugs-crime link. Although the strategy specifies that "recovery involves three over-arching principles—well-being, citizenship, and freedom from dependence," it concedes that recovery would not be explicitly defined: "It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people" (HM Government, 2010b, p. 18). However, the focus would shift from process-driven targets (e.g., accessing treatment) to outcome-based targets. All services would focus on a range of outcomes, including freedom from drugs and alcohol dependence, prevention of drug-related death and blood borne viruses, reduction in crime and offending, sustained employment, stable housing, improvements in physical and mental health, improved relationships with family and friends, and the capacity to be an effective parent. The strategy would be underpinned by a "whole systems approach" and would draw on a range of services including education, training, employment, housing, family support, health, prisons, probation, and youth justice. The system would be "locally led and locally owned" with the budgets and responsibility for drug services shifted to local areas that would design and commission services that meet the needs of all in the community. A system of payment by results would be introduced to reward those areas and providers who succeed in delivering outcomes.

As argued in the paragraphs above, the focus on the drugs-crime link and the development of treatment initiatives within the criminal justice system dominated previous drug strategies since the publication of *Tackling Drugs Together* in 1995. The references to crime reduction and criminal justice responses are still present in the current strategy, but appear to lose their prominence

within the new recovery discourse. However, there were new proposals to develop and evaluate options for alternative forms of treatment-based accommodation in the community; provide liaison and diversion services in police custody suites and at courts; divert young people away from the youth justice system; and pilot wing-based, abstinence-focused drug recovery services in prisons (i.e., drug recovery wings). The emphasis remains on ensuring that offenders seek treatment at the stage of contact with the criminal justice system through the Drug Interventions Program (DIP) and diverting drug using offenders out of prisons into community penalties. However there is a renewed focus on making community sentences more "robust" and ensuring that these forms of punishment are "visible" to the community, by combining drugs and alcohol requirements with other sentencing options, such as Community Payback. In many ways, these developments represent an intensification of the crime-reduction discourse (Stevens, 2010a).

A key component to successful recovery is the building of "recovery capital." The strategy draws on the work of Best and Laudet (2010) who define recovery capital as "the sum of resources necessary to initiate and sustain recovery from substance misuse" (p. 2). This can be broken down into four forms of capital: social, physical, human, and cultural. Social capital refers to the resources derived from relationships with family, friends, and peers. Physical capital is linked to tangible assets such as property, income, and investments, which may provide access to a greater range of recovery options. Human capital refers to education, skills, and physical and mental health, which may help with recovery problem-solving and goal attainment. Cultural capital refers to values, beliefs, and attitudes, and the ability to adapt and fit in with dominant social norms (Cloud and Granfield, 2008). The plan within the drugs strategy is to "support services to work with individuals to draw on this capital in their recovery journey" (HM Government, 2010b, p. 19). These aspects of recovery capital are dominated by a focus on the individual in recovery and individual-level factors. Best and Laudet (2010) also emphasize the importance of recovery capital at community level. They refer to the social transmission of recovery capital and the roles of recovery champions within the community. The strategy refers to "networks of recovery champions" and the contagion of recovery. These networks would involve three levels of champions at the strategic level (i.e., drug and alcohol commissioners and Directors of Public Health), the therapeutic level (i.e., those delivering services who have early success), and the community level (i.e., individuals who have gone through recovery and are able to act as mentors to their peers).

The new emphasis on recovery represents a fundamental shift in the way in which problem drug use has been framed and defined. The next sections of the article will look at why this reframing occurred and how changes in the wider contexts have impacted this process. It will also examine the key continuities that have endured within the policy development.

Crime, Recovery, and Responsibility: Shifting and Stable Policy Terrains

Labour drug policy rested on the premise that there is a direct and causal relationship between drugs and crime. However, as Stevens (2007) has effectively argued, evidence supporting causality between drug use and crime was exaggerated and overshadowed an alternative explanation, which acknowledges a "relationship" between the two, but suggests that the issue of causality is complex and mediated by a number of underlying socioeconomic factors such as inequality, deprivation, and unemployment. Research findings were used selectively to support the crime-driven drugs policy agenda, and this had a profound impact on the form of drugs treatment provision. With the importance of crime reduction as a clinical goal for drug treatment, Mold (2008) argues that a significant shift in the type of treatment offered to heroin users occurred. More users were being prescribed methadone. Overall, the total number of methadone

prescriptions increased dramatically from 970,000 in 1995 to 1,810,500 in 2004, with an increased use of methadone specifically for the treatment of substance dependence (from 81.1% in 1995 to 95.1% in 2004). Findings from a national survey of drug services indicate that on average 66.2% of clients who were prescribed methadone were on a maintenance prescription (NTA, 2007). Mold (2008) links this development to three issues. The first was the continuity with the previous phase of policy around HIV and harm reduction where maintenance had become a key priority. Second, methadone was seen to be part of a cost-effective strategy; with every £1 spent on treatment, a saving of £9.50 was made in crime-related costs. Third, methadone maintenance was effective in reducing drug-related crime. In the NTORs study, acquisitive crime fell by one third for methadone patients compared with one quarter for drug-free residential rehabilitation patients. She argues that "the apparent increase in methadone maintenance suggests that the purpose of addiction treatment has moved away from helping addicts achieve abstinence and towards other goals, principally the reduction of crime" (Mold, 2008, p. 153).

One of the key reasons for the shift toward recovery in British drugs policy was the growing disillusionment with methadone maintenance, which began to surface in some sectors of the drug policy community from 2004, reaching the crisis point in 2007. As McKeganey (2011) argues, confidence in the treatment works discourse "evaporated virtually overnight and a definite sense of crisis descended" (p. 46). Although the Labour government had been successful in expanding drug treatment and building up an infrastructure for treatment in the criminal justice system, drug users had been accessing treatment and stabilizing their drug use through substitute prescribing in many cases, but not necessarily exiting treatment successfully, fully overcoming their addiction and reintegrating into the community. 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."

The process of reframing was aided by influential Scottish research, which showed that the majority of drug users themselves said that their goal for treatment was to become drug free, rather than to receive harm reduction support (McKeganey, Morris, Neale, & Robertson, 2004). As we have seen in the section above, the right wing think tank, the Centre for Social Justice, also fuelled the debate by vigorously criticizing the harm reduction and use of methadone maintenance under the Labour administration (Centre for Social Justice, 2007). Although advocating a harm reduction stance, there were also reports from the Royal Society for the Arts and the UKDPC, which critiqued the focus within policy on numbers in treatment, rather than treatment outcomes (Reuter & Stevens, 2007; RSA, 2007). The media began to pick up on this unrest within the drugs field, and more fuel was added to the fire with a report from the BBC's Mark Easton, which revealed that only 3% of drug users had left drug treatment free of all drugs (including methadone) in 2006/2007. The drug treatment system was seen to be a costly failure among some politicians and sections of the media. Hayes and Dale-Perera (2010) argue that this "sparked an abstinence versus maintenance" (p. 9) civil war in the sector reflected in the wider political and media debate. There was a renewed faith in abstinence-based programs growing with the rise of what Mike Ashton has termed the *new abstentionists* (Ashton, 2007).

The moves to a recovery-based framework with abstinence as the overarching goal for drug policy were well underway, and traces of this ideology can be seen in the development of the 2008 drugs strategy with its emphases on outcomes and reintegration. By the time of the 2010 general election, the foundation had been laid for a new discourse around the drugs problem. Another key reason for the adoption of recovery as the new frame for drug policy was its political attractiveness as a concept. Its elasticity and multiplicity means it can be framed in different ways for different people in different contexts. It can be defined in terms of complete abstinence or sobriety, which appealed to the Conservative party because of the clear moral message that any form of drug use would not be tolerated. For example, the Betty Ford Institute Consensus

Panel (2007) defines recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship" (p. 222). Similarly, William White (2007) argues that recovery has three elements, including sobriety or abstinence from alcohol, tobacco, and unprescribed drugs; improvement in global health (physical, emotional, relational, and ontological—life meaning and purpose); and citizenship or participation in and contribution to communal life. However, recovery can also be defined in terms of a more harm reduction-oriented approach that recognizes controlled or stabilized substance use within a recovery framework. An example is the United Kingdom Drug Policy Commission (UKDPC) Consensus Group's definition of recovery, which acknowledges a range of routes to recovery that may include "medically maintained abstinence." Their conceptualization of recovery is defined as "voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society" (UKDPC, 2008, p. 6). Moreover, recovery is politically attractive because it goes beyond the drugs and drug use to include wider goals such as improved health, citizenship, and most importantly, economic contribution to society. As Mike Ashton (2008) argues, the term *recovery* "provides a benevolent rationale for an entirely non-medical imperative—to save money by getting patients out of treatment, off welfare benefits, back to work, and paying taxes" (p. 1).

At the macro and global levels, the reframing process was also influenced by national and international policy frameworks. For example, similar to the response to HIV crisis in the 1980s, Scotland was several years ahead of England and Wales in terms of the commitment to "recovery." In 2008, the Scottish government put forward a new drug strategy titled, "The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem" (Scottish Government, 2008). Within this document, recovery is defined as "a process through which an individual is enabled to move on from their drug use towards a drug-free life and become an active and contributing member of society" (Scottish Government, 2008, p. vi). Just as the previous drug strategies under the Labour government had been influenced by the American ideas and practices, such as drug testing, coerced treatment, and drug courts, the current U.K. strategies have also been underpinned by the recovery movements emanating from the United States. This includes the work of George DeLeon on recovery-oriented integrated systems (De Leon, 2007) and the influential work of William White (2007) on the recovery "revolution."

The reframing of drugs policy toward recovery has taken place alongside shifts within the wider political, economic, and social contexts. In 2010, David Cameron put forward his Big Society agenda with its underlying emphases on neoliberalism, empowerment, freedom, citizenship, and responsibility. The three strands of the agenda are social action (i.e., voluntarism and philanthropy), public sector reform (i.e., removing centralized bureaucracy and opening up public services to new providers), and community empowerment. This is to be achieved through three techniques: decentralization (i.e., pushing power down from central government to local communities, neighborhoods, and individuals), transparency (i.e., provision of information to communities), and financial provision (i.e., connecting private capital to investment in social projects; Cameron, 2010).

These ideas fit easily within the recovery agenda, which places emphasis on the role of families, communities, and volunteers in supporting the recovery process. The introduction of payment by results within drug treatment will enhance the role of the market with public-, private-, and third-sector providers competing for funding. Drugs policy interfaces with other policy subsystems, such as health, criminal justice, and welfare, which are undergoing many changes, including the reform of NHS and the development of the Public Health Service, the review of sentencing policy, the "rehabilitation revolution," and the reform of social security/welfare-to-work programs. Under the new recovery framework, which stresses the importance of broader life issues and the building of recovery capital, these adjacent policy areas and structures become

increasingly important. There will no longer be a separate agency dedicated to drug treatment. The NTA will cease to exist, and its key functions will be transferred to the Public Health England (PHE). Under the plans for the rehabilitation revolution in criminal justice, prisons will become places of hard work and industry, and payment by results will ensure that only those providers who succeed in punishing offenders, protecting the public, and reducing offending will be rewarded (Ministry of Justice, 2010). All of this reform and restructuring will affect the direction and development of the "recovery" agenda within drugs policy as well as how services are delivered to individuals and communities on the ground. More importantly, these initiatives are occurring in a context of massive cuts to public sector funding and global recession, which will constrain their development.

Although these shifts in the nested context have resulted in changes to the framing of drugs policy, there are powerful continuities remaining. There are threads of continuity between David Cameron's Big Society agenda and Labour's ideas surrounding voluntary activity and shifting responsibility for welfare away from the state and toward the "community." The Labour government had already been promoting the concepts of social capital, personalization, co-production, community empowerment, and voluntary and civic action. The responsibility for social problems, such as crime, drug use, and antisocial behavior, is viewed as not resting with government, but with citizens and the civil society. The key difference is that the Big Society agenda is being put forward with much greater intensity within the current context of public spending cuts and recession (Kisby, 2010). The "community" will be expected to fill the gaps left by the cuts to public sector funding. These developments intersect neatly with the recovery agenda and its emphases on fostering mutual aid and peer support within "recovery communities." Many of these mutual aid groups do not require public funding, which is an important explanation of the appeal of recovery in the current economic conditions. In relation to funding recovery-oriented treatment, Best et al. (2010) argue that "the model of peer engagement and community focus means that much of the resources required are already out there in the form of graduates of services and members of mutual aid groups" (p. 278). It could be argued that drug policy has shifted its emphasis from harm reduction to crime reduction to resource reduction.

There is also continuity between Labour drugs policy and that of the coalition in relation to the focus on crime and the role of the criminal justice system. The infrastructure for drug treatment within criminal justice remains in place, and crime can be readily incorporated into the recovery discourse. Crime reduction is a key outcome of recovery, and the criminal justice system is viewed as an important pathway to recovery (Stevens, 2010b). Key turning points, such as arrest or conviction, are often used as opportunities to develop incentives and motivation to address drug use and offending behavior, and begin the recovery process. There are clear parallels between recovery and the desistance literature within criminology. In particular, the work of Laub and Sampson (2004), which is based on a life course or developmental perspective to assess offending careers, is cross-referenced in the recovery literature to illustrate the analogies between problem drug use and criminal careers. Here, long-term outcomes or pathways are determined not by treatment or interventions, but by life course transitions and turning points, such as employment and educational opportunities, new relationships, becoming a parent, and moving to new homes and communities. These transitions and trajectories are influenced by broader social environments and relationships, and by the availability of social capital. McSweeney (2010) emphasizes that recovery and desistance are complex processes for drug-involved offenders, rather than discrete events, and that a longer term perspective over many years is needed.

The emphasis on crime reduction was also reiterated by the NTA in the summer of 2012 with a report that highlighted the crime reduction benefits of drug treatment and recovery (NTA, 2012). In the context of the removal of "ring fence" around drug-treatment funding in 2013, the

NTA estimated that drug treatment in England may have prevented 4.9 million crimes in 2010/2011, with an estimated saving to society of £960 million in costs to the public, businesses, the criminal justice system, and the National Health Service. During the spending review period (2011/2012-2014/2015), they estimated that 19.6 million crimes may be prevented, with an estimated saving to society of £3.6 billion. A further 4.1 million offences (estimated value of £700 million) may be prevented from 2011/2012 to 2019/2020 due to an estimated 13,702 people who left treatment in 2010/2011 will be successful at long-term recovery. If spending on drug treatment continues over the spending review period, this would result in an estimated 54,000 recovered clients, which may prevent up to 16.6 million more offences estimated at £2.6 billion by 2023/2024. The potential impact of disinvestment in treatment was also estimated. For every £1 million removed from the system, this could result in an increase of approximately 9,860 drug-related crimes per year estimated at a cost to society of more than £1.8 million (NTA, 2012). Amid fears that drug treatment funding will not be prioritized in local budgetary decisions, these figures provide ammunition to the argument for continued dedicated spending on drug-treatment services. The report also represents the continued prominence of crime prevention debates in local and national drug policy debate and formulation.

Seddon (2010) argues that there is "strategic coherence" in the drugs field from the 1960s onward connected with the transition to neoliberalism. Drug users are viewed as rational actors with the capacity to act autonomously and make responsible choices. This can be seen in the harm reduction discourse that emerged in the 1980s in response to the HIV crisis. Drug users were no longer seen as passive patients, but as active clients with the capacity to choose healthy and less harmful options. Although this view may promote a sense of empowerment and resilience, it ignores the material disadvantage and sociostructural constraints and barriers on choice (Fraser and Moore, 2006). Rather, seeing the transition to crime reduction in the late 1990s and into the millennium as a critical juncture in British drugs policy, Seddon (2010) argues that there are important continuities in the ways in which the two policy phases frame the drugs problem, that is, "drug users as threats to the community who should be urged and empowered to act responsibly in the behaviour choices they make" (p. 89). Seddon focuses on the Tough Choices program, which was a series of provisions within the Drugs Act 2005 as an example of this neoliberal form of governance. These measures used a risk-based logic by testing and selecting the most problematic users and by promoting a strategy of responsibilization where individuals were encouraged to act responsibly to minimize risk and make the "correct" choice in relation to treatment. The language of responsibility and autonomy is prominent within the coalition strategy document. The new recovery focus 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.

Conclusion

Building Recovery in an Age of Austerity

During the last 5 years, there has been a shift in the policy discourse around drugs issues in the United Kingdom. The obsession with drug-related crime and crime reduction has eased to some degree, while the emphasis on recovery and reintegration has come to dominate policy discussions. However, whether these developments constitute a complete reframing of the drugs problem and policy priorities is a matter for debate. As the new institutionalists argue, such policy shifts are gradual based on processes of incremental adjustments, rather than revolutionary reform (Pierson, 2004). Within the recovery-oriented framework, the criminal justice system remains in a pivotal position. Moreover, the institutional arrangements and structures for the

delivery of drug treatment and testing via the criminal justice system remain unaltered. The various professionals and practitioners who were recruited and trained to manage and deliver these initiatives also have a stake in the continuation of the drugs-crime discourse and the involvement of the criminal justice system in drugs treatment. The health and crime discourse have coexisted and reinforced each other throughout the history of British drugs policy. Treatment providers will continue to work alongside and in partnership with those working within the criminal justice system. The priority of crime reduction has also been reiterated and further emphasized by the NTA in a bid to ensure the continuation of dedicated drug-treatment funding (NTA, 2012). Recovery is compatible with crime reduction and appears to be a logical extension of this focus.

The key question is whether these developments will make a significant impact on practice at ground level. At the level of political rhetoric, recovery is often promoted as a tough, total abstinence-based approach. The coalition's strategy document is presented more "neutrally" with harm reduction and methadone prescribing as possible options. However, at the level of practice, it will be interesting to examine how day-to-day practice develops and changes with drug users under the new framework. Rein and Schon (1993) argue that policy may *appear* to be reframed in areas where there has been intense debate and far-reaching changes within the nested contexts, while at the level of practice, there may be remarkable continuity and stability. In the initial consultation for the drug strategy, many key players in the drugs field argued that it was necessary to build on what had achieved thus far and the need to respect clinical judgment and evidence-based provision. The fusion of harm reduction and recovery was seen to be possible. Paul Hayes (Chief Executive of the NTA) insisted that harm reduction would remain "the bedrock of what we do. Our challenge is adding recovery, not subtracting harm reduction" (quoted in Barnes, 2010, p. 7). In 2010, the NTA appointed Professor John Strang to chair an expert group to review the evidence base and develop a clinical consensus around the use of substitute prescribing within a recovery-oriented framework. Their final report preserved the place of opioid-substitution treatment within the drug-treatment toolbox and concluded that it "has an important and legitimate place within recovery-orientated systems of care" (Strang, 2012, p. 5). The group argued for no time limits on prescriptions, but equally there would be more emphasis on continual reviewing, auditing, and checking treatment plans and progress to ensure a balance was achieved between promoting overcoming dependency and promoting reduction of harm. From this document, it would appear that the pragmatism that has characterized British drugs policy and treatment over history is likely to continue. The report could be viewed as a compromise to satisfy both those who advocate a harm reduction-based treatment framework and those who argue that the goals of treatment should be abstinence and full recovery from dependency.

There are huge challenges and constraints to building a recovery-based framework within the current political, economic, and social context. It is clear that recovery needs to be adequately funded and supported, yet no new funding is being made available. Given the chronic, relapsing nature of problem drug use and the intensive support over long periods of time needed to become drug free, there is a danger that there will not be sufficient funding to ensure that treatment services can deliver the recovery framework (McKeganey, 2011). The key components for successful recovery are found in the community (i.e., housing, employment, family, health services, education, and training). These are the elements needed by recovering drug users to build recovery capital, but these are precisely the areas that are being subjected to unprecedented funding cuts. Under the Big Society initiative, advantaged, middle class communities with high levels of social capital may be able to take advantage of these new opportunities to develop approaches around community empowerment, but this is more problematic for disadvantaged, deprived communities that do not have access to such forms of capital. In most cases, recovery capital in its four forms (i.e., social, physical, human, and cultural) needs to be developed and built up over

time, particularly for groups like problem drug and alcohol users who may have had experience of the criminal justice system.

There is a need to explore the sociostructural factors that help or hinder recovery, particularly for offender populations. Sung and Richter (2006) examined community-level pressures and how they affected recidivism rates for drug-involved offenders who had completed lengthy mandatory treatment. The key finding was that recovering offenders who began their reentry during times of high unemployment were found to be more likely to reoffend during their 1st year back in the community. They concluded that environmental support was as important as individual effort in ensuring the successful reintegration of recovering offenders. Due to the various legal, social, and economic barriers that blocked access to employment, there was a need for programs that helped to make recovering offenders "job ready" by increasing their human capital (i.e., their skills and qualifications) and their social capital (i.e., creating networks and referrals/placements). Moreover, community advocacy was important for stereotypes and stigma to be addressed so that communities were prepared to receive recovering offenders on release and help to reintegrate them (Sung and Richter, 2006).

Within British drugs policy, there has been a history of setting unattainable objectives and targets within short time periods such as eradicating the drugs problem or cutting drug-related offending. The House of Commons Committee of Public Accounts (2010) criticized drugs policy under Labour because it had failed to conduct adequate evaluation of the program of measures in the strategy and to verify that the strategy was directly reducing the overall cost of drug-related crimes. Under the current recovery framework with its emphasis on payment by results, there also will be pressures to demonstrate effectiveness in delivering outcomes where individuals have made a "full recovery" (i.e., drug-free, crime-free, gainfully employed, housed in permanent accommodation, etc.). Rein (2006) argues that "secondary reframing" can occur with such problematic policy areas. The policy terrain is renamed to mask the problem and possibly shift it to another institution. Mechanisms that might come into play include professional or institutional "creaming" whereby professionals retain the clients they want and feel they can help, and the "offloading" or "reclassifying" clients with multiple and overlapping problems to other agencies or institutions. Concerns have been expressed by various commentators that payment by results in relation to drug treatment would result in services cherry picking clients with the greatest chance of full "recovery" being chosen for treatment. The danger is that those with the greatest needs would be excluded. It would be unlikely that drug-involved offenders with multiple social problems would be the winners in the race for treatment.

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