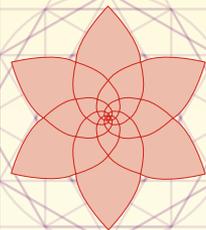# Stephen Bamber

Recovery writing:
Volume one,
2009-2010

Foreword by William L. White

What others are saying about this anthology

 "Most writers on recovery present an account that is narrow, lacking in intellectual rigour and unattractive to many, due to the judgements that are implicit in many areas of their work. Stephen Bamber's work is characterised by an inclusivity and a generosity of spirit that avoids most of these pitfalls. For my money, Stephen is the most interesting new thinker the UK drugs field has seen in some time."

Peter McDermott
Policy Lead
The Alliance (formerly The Methadone Alliance)

 "With admirable clarity Stephen Bamber's Recovery Writing is building an intellectual knowledge base for the fledgling UK recovery movement. There is much here that is challenging for the more traditional world of professional addictions knowledge. In these essays there is also the refreshing growth of new ideas and new relationships as we see recovery through the lens of those who for too long have been excluded from creating the discourse of their own lives."

Neil McKeganey
Professor of Drugs Misuse Research
University of Glasgow

 "Sometimes you read something, and even if interesting, it's just words. Stephen Bamber makes the words live. You can hear him talking to you. His writing has extraordinary clarity of thought. He has a capacity to communicate his ideas in a clear and logical way and you really feel that he doesn't just have a complete mastery of his subject, but that there is a passion burning within him, which enables him to be prolific as well as masterful. His section on recovery and harm reduction is the best I have read.

"There is something in me that doesn't like the word "recovery" in this context. I think it is something to do with experiences in the US with people who haven't touched a drug for 35 years describing themselves as

"recovering addicts". It seems very disempowering. For me, "recovery" is about having a decent life without stigma and marginalisation. That's why I like Stephen's sub-title, The Art of Life Itself. Brad Meldau did a wonderful series of recordings, the Art of the Trio, a few years ago. This is Stephen's masterpiece on the art of life. If you have ever been in his company, you will know that he is a special human being."

Professor Pat O'Hare
Honorary President
International Harm Reduction Association

"The concept of recovery in Stephen Bamber's hands is a means to explore the complex and contested world of drug treatment. His 'Recovery writing: Volume one, 2009-10' is a series of journeys designed to shed light on key issues in our rapidly changing field. Stephen's writing challenges existing disciplinary and individual boundaries and brings into play interlocutors from many different fields of enquiry. His work has a freshness and originality about it. He writes confidently and fearlessly and with an openess that demonstrates very clearly that he is in nobody's pocket."

Ian Wardle
CEO, Lifeline Project

"The writings of Stephen Bamber are a vital contribution to the collective history of the UK recovery movement. This collection has been produced as the UK Recovery movement moved from forming to storming. As we move into norming and performing, we should treasure and learn from Stephen Bamber's wise and compassionate words. Essential reading."

Mark Gilman
North West Regional Manager
National Treatment Agency for Substance Misuse
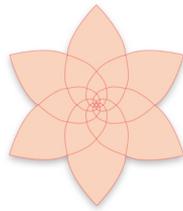
Recovery writing: Volume one, 2009-2010

Stephen J. Bamber

THE ART OF LIFE ITSELF

Citation:

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The unexamined life is not worth living.

- Socrates

Contents

Foreword

William L. White

 Recovering people and their families and allies are crafting numerous roles to support what is rapidly becoming a worldwide addiction recovery advocacy movement. The literature of this movement has until recently been restricted to confessional narratives, recovery guides, and brief histories of recovery community organizations. Distinctly missing has been a body of literature in which recovery is addressed as a subject of serious intellectual study. There have been only sparse references to recovery within the larger history of ideas and little writing on the political, economic, cultural and institutional contexts in which recovery flourishes or suffocates. That missing tradition is being filled by a rising vanguard of gifted thinkers and writers. Stephen Bamber is among the most eloquent of this vanguard.

Implicit in Bamber's growing body of written work is the premise that ideas about recovery and the language through which these ideas are expressed matter, and matter at personal and systems levels. His essays mark the blossoming of an intellectual tradition within the new recovery advocacy movement. This first collection of Bamber essays is an unspoken manifesto that recovering people have far more to offer the alcohol and other drug problems arena than their personal stories of self-destruction and rebirth. Members of a new generation of recovering people today possess or are obtaining advanced degrees and using their intellectual skills to examine recovery beyond their own personal experience.

Bamber is at his best when celebrating the growing varieties of recovery experience; extolling the role of community in long-term recovery; casting warnings about the commodification and commercialization of recovery; illuminating the transformations in personal identity so commonly experienced in addiction recovery; and challenging us to escape the stagnant and polarized drug policy debates that have long prevailed in the UK and the US. This collection of essays will find many

appreciative readers. I highly commend it.

William L. White

Author *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* and *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*

Preface

This anthology is drawn from articles and papers published on 'The Art of Life Itself' website over the past twelve months.[1] The site's tagline is 'Progressive thinking in addiction and recovery', and the content published on the site (and contained within this volume) is a critical exploration of some of the diverse theoretical and practical questions that have emerged during this formative interstice in the history of drug and alcohol treatment in the UK

The chapters are presented chronologically; i.e. in date order from when they were first published on the site. The publication date prefaces each chapter and a permanent link to the respective article is included in an associated footnote. Some chapters, although published on the site, were initially or simultanesouly published elsewhere. Where this is the case I have made it clear in the chapter preface. To maintain editorial integrity all of the chapters are published verbatim from their related articles. No changes have been made in any case.

The following text is taken from the 'About' page of the 'The Art of Life Itself' website,[2] and captures something of the site's spirit, which in turn pervades the writing contained within this anthology:

> The title [The Art of Life Itself] intimates that recovery requires an existential commitment; a commitment that is fulfilled through the creative engagement of the whole of one's life. It suggests that recovery, in a very real sense, is an *aesthetic* journey: one sculpts, shapes, forms and reforms the boundaries of ones being and through this self-cultivation enters into radically new relationships with the material world, other people, and ones own self.
>
> If recovery is an art of life, then it is also an art of government. Recovery is a meeting point of institutional technologies of domination and power, and individual technolo-

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[1] <http://www.theartoflifeitself.org>

[2] <http://www.theartoflifeitself.org/about/the-art-of-life-itself/>

gies of the self. As we define or redefine our own selves through new engagement with the world, we simultaneously assent to being defined by others: the pluralism of authorities with whom the social self negotiates in the process of self-constitution. Thus, recovery raises unexplored questions about how our conduct is governed by others, and how we govern ourselves.

This broad reading invites multidisciplinary scrutiny that is generally eclipsed by the medical and legal discourses that dominate the drug and alcohol field. Recovery reframes discussion on addiction, substance use, policy and treatment in a way that solicits, if not demands more comprehensive attention. The Art of Life Itself is a contribution to expanding the horizons of intellectual inquiry, and promoting dialogue in, between and beyond the traditional disciplines of our field.

the following have had an especial impact: My darling partner; all of my family; my close friends Andrew Mc, Roberto M., Martin L., Jean-Pierre A., Alex M. and Jo P.; Peter McDermott, Ian Wardle, Mark Gilman, Tim Leighton, William White and my colleagues on the board of the Recovery Academy. Thank you, friends.

Stephen Bamber, 3rd October 2010

Chapter 1

Introduction

> *'The past is always a rebuke to the present.'* - Robert Penn Warren

A few of years ago something strange started to happen in the UK. A number of different voices from various pockets of society began to query the effectiveness of the UK's drug treatment strategy. Simply put, a whole bunch of people began to ask the same question: "Couldn't we be doing things better?"

These voices of dissent - coming from different directions and with contrasting priorities, motives and moods - made themselves heard above the noise and chatter of everyday alcohol and drug treatment colloquies.

Some voices were those of parents or carers concerned by the lack of progress being made by their loved ones in treatment. Some voices were political; querying the incumbent administration's policies, demanding justification for an expanding treatment budget associated with seemingly poor outcomes. Other voices were those of practitioners frustrated by the increasing amount of time they were spending on paperwork and data collection rather than working directly with clients. Others were from academia who challenged the legitimacy of established truths of drug treatment, others still those of activists and a small number of vocal recovery advocates: the grass-roots of social

change who (echoing the resistance of those in earlier mental health recovery movements) highlighted a destructive imbalance in the dynamic of power in the professional/ client relationship. Independently and then collectively these voices asked: "Couldn't we be doing things better?"

The bureaucrats responsible for administering government strategy insisted repeatedly that treatment works. And yet something wasn't quite right. Treatment didn't seem to be working as well as we thought it could, and should. Individuals in treatment appeared to be *trapped* in services rather than *empowered* by them. Again and again treatment revealed itself to be a bleak and hostile place with minimal choices for the vulnerable men, women and young people who sought help and support for the very serious and highly differentiated problems they presented with.

People *did* recover from serious alcohol and drug problems: we just couldn't see them through the veil of therapeutic despondency that had descended on our service culture. The faces of recovery in the UK were unseen; their voices unheard. In one sense, this was the result of a purely structural, systems-level failure. The tiered arrangement of the National Treatment Agency's "Models of Care" separated services from one another both materially and ideologically, resulting in closed networks with narrow entry and exit points. Furthermore, these limited networks were completely divorced from the communities they served. In one oft-repeated and emblematic example: it was (and still is) common practice to physically export the few who are able to obtain funding for residential rehabilitation services to other parts of the country due to the absence of any clearly defined recovery cultures in which to embed these individuals locally.[1] For the same reason, those that successfully complete their residential programmes rarely return. Consequently, local communities do not see recovery success and local services do not see recovery success. Recovery advocates affirm the addict

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[1]Many individuals *choose* to re-situate themselves for their recovery as this is the surest way of severing intractable relationships within their local addiction culture. As a technology of recovery, this is valid and effective approach.

in recovery is a resource of immeasurable value. Their successes, when made visible, potentiate recovery in others. Recovery transmits virally through culture and the recovering addict is the source of infection. As has been realised, there needs to be sustained contact between those in recovery and those in need of recovery for the transmission to be effective.

This variegated critique began to self-organise into an open network of groups, organisations and communities centred around a number of influential and vocal recovery advocates and catalysed by a matrix of engaged practitioners and activists from the mutual aid community. Notable initiatives include: the North West Recovery pilot and associated regional fora; the UK Drug Policy Commission's Recovery Consensus Statement;[2] the Recovery Academy's inaugural symposia (2009) and first annual conference (2010), the Scottish Recovery Consortium, UK Recovery Federation's events; the online community Wired In, two impressively well-attended annual recovery walks and one recovery weekend in Glasgow to say nothing of the continuing emergence of highly motivated and energetic localised recovery groups. These elements serve as touch-points for engagement with what was becoming known as the 'recovery movement'. Academically, perhaps 'recovery milieu' more accurately represents the diversity of beliefs, attitudes and convictions contained within this heterogeneous assembly.

The National Treatment Agency responded positively and embraced recovery in its administrative discourse. The newly elected coalition government pledged to prioritise substance misuse and adopted an account of recovery ideology *simpatico* with their wider policy agenda, particularly a commitment to root-and-branch welfare reform. Even the most recalcitrant cannot deny the influence of recovery discourse, whatever their particular objections may be. Indeed, healthy scepticism must be welcomed as a valued commodity in the marketplace of recovery ideas.

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[2]UK Drug Policy Commission Recovery Consensus Group: A Vision of Recovery, UKDPC, 2008. Available:

<http://www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml>

Despite the prevailing economic uncertainty and impending cuts in public spending, the UK recovery movement is characterised by indefatigable hope and buoyed up by sparkling, joyful enthusiasm. It is this *espirit du corps* that inspired my own involvement, sustains my interest and will galvanize those who seek to answer the question "Couldn't we be doing things better?" not only with a "Yes!", but a "Here's how!" The journey to that place of clarity mirrors the journey of recovery itself: with its false starts, setbacks, obstacles and periods of doubt and incertitude. Which is why, for all of us who have the privilege to be involved in this field, "hope" is not merely an optional extra, but an absolute minimum requirement.

Chapter 2

Rethinking community: addiction, recovery and globalisation

Paper presented at the 12th International EWODOR Symposium, University of Stirling, October 18th-21st, 2009. Published on The Art of Life Itself*, November 6th, 2009. Published online on November 6th 2009.*[1]

Introduction

The notion of "community" is central to the thought, philosophy, and practice of the emerging recovery movement. This presentation explores how the processes of globalisation engender reconfigured conceptions of "community" and how this reconfiguration impacts on the recovery movement. To do this, I will argue that the capitalisation of the addict in the treatment economy (a corollary of the first-cause of globalisation, the free market) has resulted in the subjugation of "recovery knowledge" and that grassroots communities of recovery represent key sites of resistance against this totalising, reductive trend.

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[1]<http://www.theartoflifeitself.org/2009/11/06/rethinking-community-addiction-recovery-and-globalisation/>

The concept of globalisation encompasses a wide array of ideas and phenomena. It is also a somewhat hackneyed phrase - as Peter Berger wryly observes, the term globalisation now 'serves to explain everything from the woes of the German coal industry to the sexual habits of Japanese teenagers'.[2]

Broadly speaking, globalisation is used to describe the transformative effects of radical free-market trade on the global socio-economic landscape, and the increasing interconnectedness of individuals, nations, and states.[3] Globalisation indicates a reconfiguration of the relationships between the global and the local, the regional and communal, the state and the individual.

Although the origins of these global processes have been located as far back as the 16th century with the European conquest of the New World, it was the enthusiastic adoption neoliberal economic policies by the Thatcher and Reagan administrations in the latter half of the 20th century that set the economic stage for an accelerated increase in mobility of world trade, capital, and labour.

The free market and public health

The economic dream of globalization is a singular global space, with the competitive free-market the *in absentia* sovereign. The collapse of the Soviet Union was neoliberal capitalism's *coup de grâce*. There is, as has been repeatedly pronounced, no alternative to the free-market: production and consumption are the two poles between which all our realities are now framed.

And so, the unrestrained forces of the free market have penetrated spaces that have been traditionally immune to the direct influence of enterprise - education, security and defense, and public health. The

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[2] Peter Berger, "Four Faces of Global Culture", *The National Interest*, 49, 1997, p. 23 [23-30].

[3] Following Held et al. David Held, Anthony McGrew, David Goldblatt, Jonathan Perraton, *Global Transformations: Politics, Economics, and Culture*, Stanford University Press, Chicago, IL, 1999.

market colonization of public health by commercial enterprises has fostered the notion of individuals being consumers, rather than participants of health services.

To take illegal substance use as a case in point: the narcotic addict in the 21st century operates in one of two economies: as a consumer of substances in the illicit economies of global drugs trade, or as a conduit for economic gain in the licit bioeconomy of drug treatment. Irrespective of whether addiction is driven by irrational compulsion,[4] disordered desires,[5] excessive appetites,[6] or rational economic choice,[7] the totalizing effects of the neoliberal economics has resulted in a proliferation of markets that sell the non-consumption of substances, the "anti-markets" of addiction.[8]

The "anti-markets" of addiction are of course the ensemble of statutory and voluntary, private and public bodies, service providers, drug-treatment agencies, pharmaceutical conglomerates, funding bodies, and policy makers that seek to "deal with", in their various ways, the "problem" of addiction. In increasingly deregulated, privatised free-markets, each of these bodies has an interest in nurturing and maintaining the "addict" as a vehicle for the production of capital, just as the narcotic producers have an interest in sustaining the addict as consumer. It is a classic case of co-dependency. What we have failed to recognise is that contrary to all expectations the dysfunction in the co-dependency between service and addict is weighted towards the institutional side of

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[4]See for example Gerda Reith, "Consumption and its discontents: addiction, identity and the problems of freedom", *The British Journal of Sociology*, 2, 2004, pp. 283-300; Marianna Valverde, *Diseases of the Will: Alcohol and the Dilemmas of Freedom*, Cambridge University Press, Cambridge, 1998.

[5]See for example Pat O'Malley and Mariana Valverde, "Pleasure, Freedom, and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption", *Sociology*, 38:1, 2004, pp. 25-42; Helen Keane, "Disorders of Desire: Addiction and Problems of Intimacy", *Journal of Medical Humanities*, 25:3, 2004, pp. 189-204.

[6]Jim Orford, "Addiction as excessive appetite", *Addiction*, 96:1, 2001, pp. 15-31.

[7]Gary S. Becker and Kevin M. Murphy, "A Theory of Rational Addiction", *The Journal of Political Economy*, 96:4, 1988, pp. 675-701.

[8]Gordon C. Winston, "Addiction and Backsliding: A Theory of Compulsive Consumption", *Journal of Economic Behavior and Organization*, 1, 1980, p. 299 [294-325].

the relationship. As McKnight suggests in his critique of systems level approaches to social ills, the common enemy is not poverty, disease, or sickness... 'The enemy is a set of interests that need dependency masked by service'.[9]

This set of interests, the anti-markets of addiction capitalise the most marginalised and dislocated members of society. As Claude Kamoouh enigmatically states; 'In their squalor, the poor remain a source of potential profit in the globalizing sphere of consumption'.[10] As gold is sieved from rivers of human suffering by the anti-markets of addiction, the social environment is polluted by the toxic effluence of service affluence.

Following Winston, McKnight and others,[11] I am suggesting here that the opening of the free-market to public health creates anti-markets of addiction which capitalise the addict, fosters system and substance dependence, and further dislocates people from tradition sources of communal support. I will now explore whether the emerging recovery paradigm offers a more wholesome alternative to this somewhat depressing state of affairs.

The bifurcation of "recovery"

Recovery can indicate one of two things. In a governmental sense, it can refer to a nuanced and more refined normalisation of the addict-as-subject; the addict as a "disordered self" in need of regulation and control. This type of recovery discourse can be distinguished by its focus on social reintegration and citizenship, and it's interest in transferring the addict from a state of welfare to a state of economic productivity. Although harm-reductionists may bristle at the implicit moralism

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[9]John McKnight, *The Careless Society: Community and Its Counterfeits*, Basic Books, New York, 1995, p. 95.

[10]Claude Kamoouh, "Is the problem drug addiction or society? Amoral reflections on the postmodern", *Telos*, 108, 1996, p. 107 [105-117].

[11]Winston, 1980; McKnight, 1995; Bruce K. Alexander, "The Roots of Addiction in Free Market Society", Canadian Centre for Policy Alternatives, Vancouver, BC, 2001, pp. 1-31.

of such an approach, harm reduction itself as Miller has suggested– in theory and in practice - whilst claiming amorality and at first glance comprising an elegantly value-neutral ethic, is in fact implicitly moralistic – in that it promotes a prescriptive moralism based on the duty of individuals and populations to be healthy.[12]

As Keane points out 'government strategies which aim to produce a population of healthy, enterprising and productive citizens clearly require scrutiny and active forms of resistance because they subjectify individuals and limit the possibility of different forms of existence'.[13] Does then, "recovery" offer a point of ethical distinction, a discontinuity in this reductive trend? The answer, I suggest, is both yes and no. If, as Rose has compelling argued, we are governed through our freedom – if "freedom" must actively be cultivated for neoliberal governance to function effectively,[14] then the type of recovery that promotes freedom through a discourse of citizenship, autonomy and social reintegration can be viewed as an inevitable development of the governmental rationality of harm reduction. Furthermore "recovery" allows for the distribution of the cost of normalisation to be diffused through expansive new "anti-markets" of recovery – education, employment, training, pathways-to-work programmes etcetera: a bold new frontier for recovery enterprise. Although the modes and techniques of subjectification through which addicts are incited to transform themselves may vary - the result is more or less the same - a redeemed specimen of homo economicus, not simply "free to be" but merely "free to choose" and more

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[12]Peter G. Miller, "A critical review of the harm minimization ideology in Australia ", *Critical Public Health*, 11:2, 2001, pp. 167-178.

[13]Helen Keane, "Critiques of harm reduction and the promise of human rights", *International Journal of Drug Policy*, 14, 2003, pp. 231-232.

[14]Nikolas Rose and Peter Miller, "Political Power beyond the State: Problematics of Government", *The British Journal of Sociology*, 43:2, 1992, pp. 173-205; Nikolas Rose, "Government, authority and expertise in advanced liberalism", *Economy and Society*, 22:3, 1993, pp. 283-298. See also Nikolas Rose, "The Death of the Social? Re-figuring the Territory of Government", *Economy and Society*, 25:3, 1996, pp. 327-356; Nikolas Rose, Pat O'Malley, et al., "Governmentality", *Annual Review of Law and Social Science*, 2, 2006, pp. 83-104.

insidiously "free to consume". This type of "recovery", I suggest, is simply an extension of the logic of harm reduction but is aligned much more closely with the values and demands of neoliberalism. What differs is not the mode of this economic rationality, but the greater depth and extent with which it penetrates the being of addicts, shapes who they are, produces their identities, and normalises their selves.

There is, however, another type of recovery. The unknown psalmist writing his penitential lament in early Judaic times new well this as he pleaded: "Out of the depths I cry to you, oh Lord/ Lord, hear my prayer/ Let your ears be attentive to the sound of my pleading".[15] This primal scream of existential despair written over 3,000 years ago in Jerusalem or Babylon will ring true to anyone whose lives have been blighted by addiction and can be heard, in one form or another, in the countless testimonials, life-stories, and confessional narratives of those in recovery. It is the expression of the intense subjectivity of the addict-self, and the space where these voices are invariably expressed is community – be they secular, spiritual, or religious - and they sing out in laments as emotive as those of the exiled Jews, for they too had lost the one thing that systems cannot produce. A system cannot produce a community.

Communities of recovery: a grassroots response to unmet needs

"Community" as a key element in the new recovery discourse can be deployed in a number of different contexts. In its broadest sense, it can refer to "community" as a source of healing,[16] a repository of under-exploited resources and knowledge, a certain type of cultural ecology that fosters and supports the recovery process and the fabric in which psychosocial integration and identity reconstruction occurs.

In it's narrowest sense, it refers to discrete "recovery communities"

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[15] *De Profundis*, Psalm 129(130), Old Testament, version unknown.

[16] See William L. White, "The mobilization of community resources to support long-term addiction recovery", *Journal of Substance Abuse Treatment*, 36:2, 2009, pp. 146-158.

bounded by space, common interest, or identity. As Peter Cohen suggests,[17] the presence of similarity implies difference – the very ideas that act as symbolic referents for a shared identity of one community act as unseen boundaries that demarcate one community from another. Different recovery communities have different modes of being, different recovery epistemologies, different ways of knowing and being in the world. In contrast to the reductive economic algebra of addiction's anti-markets recovery communities allow for a comprehensive and polychromatic expression of human potential.

It is the glorious diversity of these recovery communities, combined with notion that community itself – as a value and localized space - is an underexploited source of knowledge that differentiates the emerging recovery movements and gives it its counter-cultural potency. But community in a globalizing world has been disrupted, and before I conclude, I will explore what impact these reconfigurations of community may have on the recovery movement.

Digital places

Community, Bauman suggests, is the 'kind of world which is not, regrettably, available to us - but which we would dearly love to inhabit and which we hope to repossess'.[18] The ephemeral territories of our globalising world have transformed social life and we would be forgiven for thinking we have been given an opportunity to repossess the romanticised past that Bauman alludes to. Communities have been de-placed: they extend beyond fixed locations, resist being tied to a shared physical territory and exist in virtual or hyperreal space. As communities are de-placed, so do they proliferate; individuals now have the mobility and technology to participate in numerous online communities in which they can assume unique identities and engage in highly plural,

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[17]Peter Cohen, *The Symbolic Construction of Community*, Tavistock, London, 1985.

[18]Zygmunt Bauman, *Seeking Safety in an Insecure World*, Polity Press, Cambridge, 2001, p. 3. See also Zygmunt Bauman, *Modernity and Ambivalence*, Polity Press, Oxford, 1991.

choice-driven relationships that stand in notable contradistinction to the largely instrumental relationships that dominate spatially embedded communities.

The exponential growth in communication technologies, a key characteristic of globalization, and the explosion of web-based social media platforms have enabled us to re-imagine community in any number of new ways.[19] These are dynamic but transient networks, flickering representations in a panoptic digital consciousness.

These new communal spaces lack critical elements of community-as-method – understood here in its most approximate sense. The raw transformative power, for example, of an encounter group, or that ineffable support yielded by a tender touch or empathic gaze simply cannot be replicated in the diaphanous dimensions of a digital space. Effective emotional communication, the lifeblood of recovery, requires the engagement of all of the senses - as anyone who has puzzled of the exact meaning of an ambiguous email or text message will attest. Furthermore, as Alexander intimates,[20] the growing dependence on the Internet for our social lives is in itself an expression of psychosocial dislocation, and the profusion of online social networks are limpid, eviscerated simulacra of their more visceral, earthly precursors. The efficacy of community-as-method depends, in no short degree, on the inability to choose ones peers. The confrontation with some uncomfortable truth about oneself, or the transmission of a priceless, personal pearl of wisdom would simply not transpire were they subject to the easy censorship allowed by the click of a mouse. That being said, it is information, not communication, that is the hard-currency of the digital age, and there can be no questioning the effectiveness of the internet as an empowering source of valuable recovery information. But information is

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[19]Three notable examples, each with a different emphasis and functionality: www.facebook.com - "Facebook helps you connect and share with the people in your life"; www.twitter.com - "Share and discover what's happening right now, anywhere in the world"; http://secondlife.com/ - "Second Life in an online, 3D virtual world imagined and created by its Residents". Retrieved 14.10.09, 07.34.

[20]Bruce K. Alexander, "The Globalisation of Addiction", *Addiction Research*, 8:6, 2000, pp. 501-526.

not knowledge, still less *self*-knowledge, which only arises with embodied praxis: reflective *action* in the world, reflective *being* in community. In short, online communities should be seen as incredibly valuable adjuncts to the recovery process, but not wholesale substitutions for it.

Conclusion

I have described how the forces of free trade and the ideals of neoliberal economics have colonized public health and produced an environment that produces profit from addiction and produces subjects who are orientated towards similarly monolithic ends. I have argued that in terms of the governance of individuals the emergent "recovery" movement can be mapped onto that continuum. I have suggested that although "community" can be expressed and supported in digital space, in terms of recovery from addiction, the true and enduring power of communities lies in their physicality, their materiality, their proximity, and their difference.

The energy and diversity of grassroots recovery communities resist the homogenous regimes of professional addiction services and can be seen as a grass-roots response to unmet needs – this is the radical idea that lies at the heart of the recovery movement. Grassroots communities of recovery, in all their colorful heterogeneity, expand the horizons of therapeutic space – they are places where identities can be nurtured to a fuller, more integrated extent – places that contrast sharply with the dull monochrome and clinical sterility of the community-drugs team, GP's surgery, or psychiatric consulting room.

Grassroots communities of recovery are places of potential, furnaces where self and selfhood are forged in the white heat of physical affinity, where the individual's acceptance of the group, and the groups' acceptance of the individual fortify the alloy of human uniqueness. The faces and voices of recovery represent far more than a simple victory of clean and sober living – they stand as a profound testament to the limitless possibilities of being for all of us. In the words of Patricia Deagan:

> The goal of the recovery process is not to become normal.

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> The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become [a] unique, awesome, never to be repeated human being... a question in search of an answer.[21]

In that spirit, I hope this paper can be seen as crudely grasping towards a few worthy questions, and perhaps even suggesting where some interesting answers may lie.

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[21] Patricia E. Deegan, "Recovery as a Journey of the Heart", paper presented at *Recovery from Psychiatric Disability: Implications for the training of mental health professionals*, Massachusetts State House, Gardner Auditorium, May 10th, 1995. Available:

http://www.aterhamtning.se/Recovery%20As%20a%20Journey%20of%20the%20heart.pdf, retrieved 03.10.2009, 11.41. Published as Patricia E. Deegan, "Recovery as a Journey of the Heart", *Psychiatric Rehabilitation Journal*, 19:3, 1996, pp. 91-97.

Chapter 3

In Search of Relative Pleasures

Published online on 12th November 2009.[1]

The conflict between the Home Office and the scientific community caused by Professor Nutt's dismissal as chair of the UK Advisory Committee on the Misuse of Drugs (ACMD) highlights a number of interesting theoretical questions surrounding the formation of drug control policy: Who has the right to speak truth about such matters? Under what conditions can statements about drugs and drug control said to be true or false? How are divergent forms of truth and knowledge reconciled in the discursive formation of policy?

Professor Nutt was not dismissed for 'crossing the line into politics', because policy, expertise, and advisory committees are instrumental loci in the apparatus of contemporary liberal government. Rather, Professor Nutt was dismissed for transgressing unspoken rules assented to by the various institutional actors in the truth-games of policy formation. As Zibbell has suggested, 'the language and poetics of drug policy, while they attempt to appear neutral, reflect certain values and rotate around specific parameters of what it means to say something correctly and what can actually be said on a given subject'.[2]

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[1] <http://www.theartoflifeitself.org/2009/11/12/in-search-of-relative-pleasures/>

[2] Jon E. Zibbell, "Can the lunatics actually take over the asylum? Reconfiguring sub-

Thus, from a critical perspective the role of the scientific expert is to constitute, not reflect reality. Mahmud alludes to this constitutive process in a recent study on ganja use in Bangladesh:

> Knowledge about the problem of drug use, about its causes and consequences, is accredited as "true knowledge", or is thought of as representing reality by virtue of being scientific. That is, such knowledge has been produced by disembodied researchers who adhere to the standards of scientific enquiry and thus comes to represent reality.[3]

A critical view of the role of the expert advisor problematises the positivist assumptions that lie behind this dominant reading. The government advisor is a special class of expert who has a key role in the constitution of social reality. Professor Nutt was not required, as one might expect, to provide independent evidence which is then assessed objectively by the State – but to passively collaborate in an effort to 'produce normative standards that support the enactment of policy that insures the general "well being" or security of populations in liberal societies'.[4]

In the heady atmosphere of drug control discourse, whose boundaries are constantly redrawn by the collusion of medical and legal institutional elements,[5] to unilaterally disrupt this process is to disturb a finely tuned balance of relationships and precipitate a tear in the fabric

jectivity and neo-liberal governance in contemporary British drug treatment policy", *International Journal of Drug Policy*, 15, 2004, p. 64 (56-65).

[3]Hasan Mahmud, "Drug addiction and identity politics: the spiritual use of ganja in Bangladesh", *Contemporary Justice Review*, 11:4, p. 442 (441-458).

[4]Jeremy Packer, "Disciplining Mobility: Governing and Safety" in Jack Z. Bratitch, Jeremy Packer, Cameron McCarthy (eds), *Foucault, cultural studies, and governmentality*, State University of New York Press, New York, 2003, p. 142 (pp. 135-164).

[5]This area has been well documented. For an influential example see Victoria Berridge, *Opium and the People: Opiate Use and Drug Control Policy in Nineteenth and Early Twentieth Century England, (revised edition)*, Free Association, London, 1999. Berridge coined the phrase 'medico-legal alliance' to describe British drug control policy after the infamous Rolleston Report of 1926.

of governmental reality. It is neither the veracity of Professor Nutt's pronouncements nor the independence of his voice that caused administrative distress – it was particular kind of truth he rendered visible: the asymmetries between popular, expert, and legislative truths that pervade this contentious area of governance.[6]

The Home Secretary may justifiably be accused of mismanaging this situation. However, opposition to government rationality from instruments of government themselves must be treated with a certain amount of circumspection, no matter how well intentioned that opposition may be. To claim that policy-informing bodies such as the ACMD are somehow dissociated from the mechanics of government invokes 'the myth of apolitical positivist science',[7] and misapprehends the 'mentality of rule' of liberal government.[8] Furthermore, such a claim ingeniously ignores the historical and cultural contingency of evidence-based practice and represents an 'anachronistic holdover from 19th century enlightenment thinking'.[9] As Holmes et al claim in their critique of evidence-based heath science:

> Those who are wedded to the idea of 'evidence' … maintain what is essentially a Newtonian, mechanistic world view: they tend to believe that reality is objective, which is to say that it exists, 'out there', absolutely independent of the human observer, and of the observer's intentions and observations.[10]

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[6]For the influence of popular truth/ knowledge on policy see See Toby Miller, *Technologies of truth: cultural citizenship and the popular media*, University of Minnesota Press, Minneapolis, 1998.

[7]Philippe Bourgois, "Anthropology and epidemiology on drugs: the challenges of cross-methodological and theoretical dialogue", *International Journal of Drug Policy*, 13, 2002, p. 266 (259-269).

[8]Pat O'Malley, Lorna Weir, Clifford Shearing, "Governmentality, criticism, politics", *Economy and Society*, 26:4, 1997, p. 502 (501-517).

[9]Bourgois, 2002, p. 260.

[10]David Holmes, Stuart J. Murray, Amélie Perron, Geneviève Rail, "Deconstructing the evidence-based discourse in health sciences: truth, power and fascism", *International Journal of Evidence Based Healthcare*, 4, 2006, pp. 182-183 (180-186).

This critique doe not to advocate a return to some mediaeval worldview, but suggests that a solely evidence-based worldview is 'dangerously reductive' in health science and negates the 'personal and interpersonal significance and meaning of a world that is first and foremost a relational world, and not a fixed set of objects'.[11]

Anyone familiar with the field will acknowledge that research into substance use rarely elicits consensus. We need to be constantly mindful of asking the right questions in the right way.[12] Recent events indicate we may be doing precisely the opposite by configuring our inquiries within a framework of harm and risk. Suggesting a more sophisticated method of classifying drugs based on relative harms may be lauded but does little to remove deleterious connotations of deviance, disorder, and disreputability that contribute to the intractable social immobility linked to certain modes of substance use.

O'Malley and Valverde point out that 'governmental discourses about drugs and alcohol... tend to remain silent about pleasure as a motive for consumption, and raise instead visions of a consumption characterized by compulsion, pain and pathology'.[13] Perhaps Professor Nutt and his insurgent colleagues could use any newfound freedom they have to work towards a classification of drugs based on relative pleasures: there would be no dearth of expertise – professional or otherwise – available for such an ambitious and worthwhile project.

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[11] *ibid.*, p. 182

[12] Jim Orford, "Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction", *Addiction*, 103:6, 2008, pp. 875-885. Cited for illustration.

[13] Pat O'Malley, Mariana Valverde, "Pleasure, Freedom, and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption", *Sociology*, 38:1, 2004, p. 26 (25-42).

Chapter 4

Revolution in the Head

Published online on Novermber 23rd, 2009.[1]

The discovery of recovery

> There should no longer be a single account of the illness experience, refracted through a medical perspective...The recovery movement, unlike some other user movements, is not fundamentally based on opposition or grievance and is not anti-psychiatry. It centres on an outward, pro-recovery approach, offering a broad, inclusive, humanistic philosophy that could unite professionals, service users and others in the collaborative project of working for better lives for those who experience severe mental health problems.[2]

As "recovery" gains traction in the ideas marketplace of drug policy and treatment provision those in the mental health field may look on with a little bemusement: recovery has been a key (but not uncontested) driver in mental health service development for the past 15-20 years, and has roots that lie deep in the reform movements of the 19th

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[1]<http://www.theartoflifeitself.org/2009/11/23/revolution-in-the-head/>

[2]Glen Roberts & Paul Wolfson, "The rediscovery of recovery: open to all", *Advances in Psychiatric Treatment*, 10, 2004, p. 45 (37-49).

century. Given the thematic overlaps mental health recovery movements represent rich sources of knowledge, and experience for their colleagues in addiction research and practice.

In the UK, recovery-orientated service reconfiguration draws largely on US experience in delivering recovery orientated systems of care in addiction services. However, socio-cultural differences between the US and UK alert us to the fact that this approach may have its limitations. In order for a robustly indigenous UK recovery ecology to develop and flourish, the grass-roots ethos that characterizes recovery movements will need to be tempered with multidisciplinary knowledge transfer and a reflective, critical approach at this formative interstice in the history of society's response to addiction and substance use.

Origins

In contrast to previous mental health reform movements (such as de-institutionalisation) which were predominantly informed by professional and organisational needs, mental health recovery emerged as a grass-roots critique of mental health services and resistance to the hegemony of professional power. The mental health recovery movement is not monolithic, but a diverse and evolving collection of ideas, beliefs, and practices. This heterogeneity reflects mental health recovery movement's manifold influences, which include:

- Institutional reform movements

- Early mental health self-help and mutual aid groups; e.g. "We Are Not Alone" (1940's), and Alcoholics Anonymous mutual aid groups.

- Civil rights, liberation, and social justice movements of the 1960/70's, e.g. women's rights movement, gay rights movements, disability rights movements.

- Anti-psychiatry movement (challenging the professional assumptions that lie behind the "psy" sciences – psychiatry/ psychology/

psychotherapy).[3]

- Consumer/ survivor movements and the emergence of voices of recovery; e.g. Network Against Psychiatric Assault, Mental Patients' Liberation Front (1970's).

- Growing evidence-base revealing positive outcomes challenges long-held assumptions that serious mental illness is an intractable, degenerating condition.[4]

Mental health recovery: key themes

A brief overview of some the key themes of mental health recovery movements illustrate how didactic these lines of thought and practice can be for the nascent addiction recovery movement.

- Self-empowerment and autonomy: taking responsibility and control.[5] This can be understood 'both systemically—as the power held by the state and the institution of psychiatry, and individually—as the consumer taking control and responsibility for his or her own life'.[6]

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[3]See Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, an abridged version of *Folie et déraison. Histoire de la folie à l'âge classique.* A full translation is now available: Michel Foucault, *The History of Madness*, trans. Jean Khalfa, Taylor & Francis, London, 2006

[4]See R. Warner, *Recovery from Schizophrenia: Psychiatry and Political Economy (3rd ed)*, Brunner-Routledge, New York, 2004. See also Kim T. Mueser et al., "Illness Management and Recovery: A Review of the Research", *Psychiatric Services*, 53: 10, 2002, pp. 1272-1284.

[5]After R. Andreson, L. Oades, and P. Caputi, "The experience of recovery from schizophrenia: towards an empirically validated stage model", *Australia and New Zealand Journal of Schizoprhrenia*, 37: 5, pp. 586-594.

[6]Nora Jacobson and Laurie Curtis, "Recovery as Policy in Mental Health Services: Strategies Emerging from the States", *Psychosocial Rehabilitation Journal*, Spring, 2000, p. 2 (1-14).

- Formation of a new identity or sense of self. Conversely, some mental health activists and theorists affirm recovery as the retrieval, reclamation, or integration of the self.[7]

- Recovery understood as both a process and an outcome,[8] a journey that can 'take people to a higher level of functioning than before'.[9]

- Building a meaningful life and gaining a mainstream social identity – a 'place of equality in society'.[10] Recovery from 'social exclusion, stigma, labeling, restrictions, civil rights, discrimination, guilt and shame'.[11]

- Multiplicity of individual perspectives ("survivor"/ "client"/ "consumer"/ "ex-patient") and the singularity of the experience: recovery as a unique, personal journey.

- Hope and optimism.

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[7]See Joseph A. Fardella ,"The Recovery Model: Discourse Ethics and the Retrieval of the Self", *Journal of Medical Humanities*, 29, 2008, pp. 111-126; P. Campbell, "It's not the real you", *Open Mind*, 111, 2001, pp. 16–17

[8]D.P. Liberman and A. Kopelowitz, "Recovery from schizophrenia: a concept in search of research", *Psychiatric Services*, 56, 2005, pp. 735–742.

[9]S. Bonney & T. Stickley, "Recovery and mental health: a review of the British Literature", *Journal of Psychiatric and Mental Health Nursing*, 15, 2008, p.141 (140-153). See P. Chadwick, "How to become better after psychosis than you were before", *Open Mind*, 115, 2002, pp.12–13.

[10]Bonney and Stickley, 2008, p. 148. See MIND, *Understanding Schizophrenia*, London, 2005.

[11]See W. Anthony, "Recovery from mental illness: the guiding vision of the mental health service system in the 1990s", *Psychosocial Rehabilitation Journal*, 16, 1993, pp. 11–23; P. Deegan, "Recovering our sense of value after being labelled mentally ill", *Journal of Psychosocial Nursing*, 31, 1993, pp. 7–11; L. Sayce, *From Psychiatric Patient to Citizen*, Macmillan Press, Basingstoke, 2000; S. Stanton, "Inescapable past?", *Open Mind*, 111, 2001. p. 15; C. Buckingham, "Schizophrenia – the biological and social", *Open Mind*, 111, 2001, p. 11; R. Hope, *The Ten Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*, Stationery Office, London, 2004; Chief Nursing Officer (CNO), *Chief Nursing Officer's Review of Mental Health Nursing Consultation*, Department of Health, London, 2005.

- Proactively challenging the "learned hopelessness" arising from negative clinical language.[12]

- Recognising diverse but positively perceived outcomes that exist along a continuum of equally valued possibilities.

- Attitudinal components of "hope":[13]

  - Recognition and acceptance.
  - Commitment to change.
  - Focus on personal strengths rather than pathologies.
  - Cultivating optimism.
  - Appreciation of incremental growth rather than instantaneous transformation.

- Freedom to make mistakes and take risks.13 Recovery is about 'potential and expectation, not the lowest common denominator of keeping everyone safe, taking no risk of failure'.[14]

Being comfortable with confusion: Implications for addiction recovery

What is striking about mental health recovery is its radically plural character: as has been discussed, given the manifold influences and developmental trajectories it is best understood as a collection of movements rather than a singular phenomenon. As Jacobson and Greenley note, this lack of specificity has led to a certain amount of confusion:

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[12]Bonney and Stickley, 2008, p. 149. See R. May, Understanding Psychotic Experience and Working Towards Recovery, Bradford District Community Trust, Bradford, 2001; P. Bracken and P. Thomas, "Hope", Open Mind, 130, 2004, p. 10.

[13]Adapted from Nora Jacobson and Dianne Greenley, "What Is Recovery? A Conceptual Model and Explication"", *Psychiatric Services*, 52: 4, 2001, pp. 482-483 (482-485).

[14]Bonney and Stickley, 2008, p. 148. See V. Gould, *A Carer's Perspective on the Recovery Journey*, Scottish Recovery Network, Glasgow.

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated – and how – are often not well understood either by the consumers who are expected to recovery or by the professionals and policy makers who are expected to help them.[15]

Rather than indicating any inherent conceptual weaknesses, this confusion can be attributed to the fact that mental health recovery 'is the product of the convergence of two very different forces':[16] namely, recovery as a complete amelioration of symptoms (based on longitudinal outcome studies) and recovery as an acceptance of symptoms and mental illness as being 'only one aspect of an otherwise whole person',[17] (based on consumer/ survivor voices). These oppositional forces contribute to a reification of "old" and "new" conceptualisations of recovery and the tension between them persists in an era of evidence-based health care.[18]

As the embryonic addiction recovery movement in the UK attempts to reconcile a univocal understanding of recovery inherited from the principal 12-Step mutual aid traditions (specifically AA and NA, which tend to affirm abstinence as the necessary starting point of recovery) with the realities of substance use and medically assisted recovery, the mental health recovery movement's accommodating approach to analogous concerns should be seen as instructive. Broadly speaking, mental health services have no trouble recognising a miscellany of positive

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[15]Jacobson and Greenley, 2001, p. 482.

[16]Larry Davidson et al., "Recovery in Serious Mental Illness: A New Wine or Just a New Bottle?, *Professional Psychology: Research and Practice*, 36: 5, 2005, p. 480 (480-487).

[17]*ibid.* p. 481.

[18]See Shulamit Ramon, Bill Healy, and Noel Renouf, "Recovery from Mental Illness as an Emergent Concept and Practice in Australia and the UK", *International Journal of Social Psychiatry*, 53, 2007, pp. 108-122.

recovery outcomes.[19]

Conclusion

"Recovery" is being positioned as a radical re-visioning of addiction service culture and delivery. In a climate of uncertainty precipitated by relentless service retendering, speculation over future funding, and an anticipated change in administration, drug and alcohol service providers and commissioners have every reason to look at alternative ways of delivering services. However, pursuing a solely top-down approach to reconfiguration risks replacing one regime of institutional truth with another, resulting in prolonged iatrogenesis and the continued exclusion, marginalisation, and stigmatisation of those who are directly affected by substance use.

Mental health recovery does not hold all the answers. One cannot import ideas or ideologies wholesale from the mental health field; its history and social context is quite distinct from the addiction field and key concepts and their associated theoretical milieux do not always translate well (the concept of "consumer" for example).[20] Nevertheless, as I hoped to have illustrated, mental health recovery discourse is suffused with congruent concerns and there is demonstrable value in pursuing bilateral knowledge transfer between the two fields. The most significant lessons perhaps come from the obstacles that are faced when implementing recovery-orientated changes.[21] For example,

[19]See Warner, 2004. Warner, whose analysis of 85 longitudinal studies dating back to the early 20th century revealed the reality of diverse outcomes for mental health recovery, distinguishes between 'complete recovery' (occurring in 20-25% of populations studies and indicating a 'loss of psychotic symptoms and return to pre-illness level of functioning'), and 'social recovery' (occurring in 40-45% populations, designating a regaining of 'economic and residential independence and low social disruption)'. Such a distinction is a useful starting point for advancing an inclusive and progressive account of recovery from addiction.

[20]See William White, A commentary on "consumer": Language, stigma and recovery representations., 2009. Published on www.facesandvoiceofrecovery.org, 2009.

[21]See Davidson et al. "The Top Ten Concerns About Recovery Encountered in Men-

Bonney and Stickley caution that:

> The notion of evidence-based practices and recovery-oriented services can work well together. However, if evidence-based practice research is to inform the development of recovery based services, then the concept of evidence-based practice must be broadened... Recovery-oriented system designers, programme planners and clinicians must be aware that their current efforts remain guided by the best available evidence, while we accumulate the best evidence possible.[22]

Whilst recovery researchers attend to the business of accumulating the best *possible* evidence, you don't have to look far to find the best *available* evidence.

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tal Health System Transformation", *Psychiatric Service*, 57: 5, 2006, pp. 640-645.

[22]W.A. Anthony et al., "Research on evidence-based practices: future directions in an era of recovery." *Community Mental Health Journal*, 39, 2003, p. 112 (101–114).

Chapter 5

Making sense of recovery identities

Published online on November 30th, 2009.[1]

Introduction

For anyone involved in the addiction and recovery field, questions surrounding identity have a particularly urgent quality to them: *Who are you? What is your history? Who do you want to become?* At each stage of the treatment journey we are incited to disclose ourselves: assessments are exercises in describing personal histories in terms of risk and disorder, and therapeutic partnerships aim for effective self-governance.

Sometimes the journey of recovery appears to orbit around a constellation of concerns relating solely to self and self-identity. As has been theorised, recovery is often modulated by the formation of a new identity – an identity embedded in new social and communal contexts, dissociated from previously problematic associations and circumstances. As Prussing suggests, recovery 'is not only a therapeutic transformation

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[1] <http://www.theartoflifeitself.org/2009/11/30/making-sense-of-recovery-identities/>

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but also a socially negotiated identity change [in] community'.[2]

The inessential self

Life in the early 21st century challenges the fundamental Judeo-Christian assumption – deeply embedded in the Western consciousness – that we have a stable, enduring self-identity. The vortex of modern life disturbs the foundations of this assumption. We are imbued, to varying degrees, with "choice" – choices about who we are, what we want to be, and who we want to become. Recovery presents a unique opportunity to transform oneself. This is life as art – an aesthetic process – the self sculpted, shaped, defined, and delimited – not just by material forces or the intentions of others, but by our own selves.

Christian or not – the myth of the essential self endures in the stories we tell of ourselves. We retrospectively organize our histories into a coherent narrative and narrate a similarly consilient history of our present. In other words:

> We come to know ourselves by interpreting our pasts and anticipating our futures according to the repertoire of culturally available "narrative strategies". These institutionally established strategies provide a context in which individuals can order their lives cognitively into a more or less "coherent assemblage".[3]

Through these narrative strategies we make sense of the world. For

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[2]Erica Prussing, "Reconfiguring the Empty Center: Drinking, Sobriety, and Identity in Native American Women's Narratives", *Culture, Medicine, and Psychiatry*, 31, 2007, pp. 499 (499-526). Where I use the term 'recovery', Prussing uses 'sobriety'. I don't think meaning is compromised by substitution in this instance

[3]Jenna Howard, "Expecting and Accepting: The Temporal Ambiguity of Recovery Identities", *Social Psychology Quarterly*, 69:4, 2006, p. 309 (307-324). See Leslie Irvine, *Codependent Forevermore: The Invention of Self in a Twelve-Step Group*, University of Chicago Press, Chicago IL, 1999, p. 5. For the narrative construction of identity see Anthony Giddens, *Modernity and Self-Identity: Self and Society in the Later Modern Age*, Stanford University Press, Stanford, CA, 2001.

those who choose to define themselves as being "in recovery", this often means retrospectively interpreting the past and describing the present through the lens of a socially mediated recovery identity.

As Berger and Luckman describe, people tend to 'retroject into the past various elements that were subjectively unavailable at the time' so that the past and the present may 'stand in continuous relationship" with one another'.[4] In terms of recovery, this means separating from a disordered past in the luminescence of a redeemed present. As Keane points out, 'the relationship between the addict and the recovering addict is one of distance and proximity, or to put it another way, difference and identity'.[5]

Thus, there is a rupture between historical fact and narrative fiction. Fragmented and incoherent events of the past – "status passages"[6] of highs, lows, crises, interventions, etcetera, are codified into a coherent mythos. This is not to undermine the legitimacy of this narrative construction: as Pillemer argues, 'narrative truth [is] just as valid as any other kind of truth'.[7] Historical and narrative expositions are equally cogent. The narrative accounts of our lives – the stories we create and tell about ourselves – are what give our lives meaning and significance. They allow us to relate to others and their histories, and help us to form a reflexive and functional relationship with our own ever-shifting selves in a polyatomic world and navigate the multiple territories of our times.

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[4]Peter Berger and Thomas Luckman, *The Social Construction of Reality: A Treatise on the Sociology of Knowledge*, Anchor, New York, 1966, p. 163. In Howard, 2006, p. 314.

[5]Helen Keane, *What's wrong with addiction?*, Melbourne University Press, Carlton South, Vic., 2002, p. 157.

[6]Anderson coins the term "status passages" to indicate these moments of therapeutic import. Tammy L. Anderson, "Drug Abuse and Identity: Linking Micro and Macro Factors", *The Sociological Quarterly*, 35: 1, 1994, pp. 159-174.

[7]David Pillmer, *Momentous Events, Vivid Memories*, Harvard University Press, Cambridge, MA, 1998, p. 10, in Howard, 2006.

Ambiguities of the recovery identity

A linear narrative trajectory oversimplifies a complex state of affairs. Whilst it is comforting, and perhaps even necessary to seek refuge in essentialist ideas about ourselves – enunciated in pronouncements like, "My name is Stephen and I am an addict", such statements offer an explicitly one-dimensional account of the self. This can be as restrictive as it is liberating: life in the early 21st century is dispersed across various axes and successful social mobility increasingly requires identity flexibility.

I am acutely aware of the politics of identity in my own life. I possess multiple identities –academic, addict, ex-addict, sibling, son, "person in recovery", "person with criminal record", musician, Buddhist, friend, partner – amongst others. Every one of these identities is imbued with myriad shades, textures, colours and moods: the boundaries between each are permeable and there is tension, movement, and arbitration between them.

Furthermore, each identity has it's own memory which is located externally as well as internally, and is anchored to the material conditions of society and culture. As Larkin and Griffith's point out, the 'psychological and the socio-cultural mesh together at the subjectively-experienced level of self-identity'.[8] Self-identity is the vehicle for mediating between these inner and outer worlds, and learning to negotiate between the two domains is an unspoken skill of recovery. Adopting a recovery identity can thus be viewed as one technique for traversing the craggy moraines of a life lived without problematic substance use: It may be time-limited, or it may evolve into a master-identity that serves as a reference point for steering one through the whole of one's life.[9]

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[8]Michael Larkin and Mark D. Griffiths, "Experiences of Addiction and Recovery: The Case for Subjective Accounts", *Addiction Research and Theory*, 10: 3, 2002, pp. 283-284 (281-311).

[9]A "recovery identity" may, of course, not feature at all. As Howard concludes, the recovery identity is 'both "useful" and "limiting"'. Howard, 2006, p. 309.

Conclusion: Self-identity and services

Whilst identity theory is reasonably well established and an accepted strand of academic discourse in addiction and recovery, there has been little dialogue on implications for policy and practice. In one exception, McIntosh and McKeganey argue that:

> If it is the case that an important part of the process of overcoming dependence upon illegal drugs is the capacity on the part of the recovering addict to construct or reconstruct a non-addict identity for themselves and, further, if one of the means through which this is achieved is through the process of providing a narrative of their recovery, there may be a need to ensure that drug agency staff are able to address issues of identity and narrative construction in their work with client... We would therefore recommend that particular attention be given to ensuring that drug workers receive appropriate training to enable them to work with clients in relation to these issues.[10]

This contribution is a welcome starting point for discussion. However, whilst it is clearly advantageous for drugs workers to be aware of identity issues the suggestion that the construction and reconstruction of identity is something that can be delivered by services represents a profound misunderstanding of this process.

Rather than needlessly burdening an already over-stretched workforce, forward thinking recovery-orientated services will form innovative alliances with other sectors. In contrast to the inward-looking nature of a predominantly biomedical treatment system, reciprocal partnerships with (for example) local education providers, community networks, and dynamic social enterprises represent an opportunity to acknowledge the pyscho-social dimensions of addiction recovery by em-

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[10]James McIntosh and Neil McKeganey, "Addicts' narratives of recovery from drug use: constructing a non-addict identity", *Social Science and Medicine*, 50, 2000, p. 1509 (1501-1510)

bedding individuals who choose to change in environments conducive to identity reconstruction and personal growth. Recovery is not delivered, it is supported, and narratives of recovery emerge naturally when people are given opportunity to make meaningful choices outside the claustrophobia of service-orientated systems.

Chapter 6

The Spiritual Self

Published online on 7th December 2009.[1]

It's January 2008. I'm walking out of a large Liverpool supermarket and pass the magazine and tobacco concession. Something catches my eye: amongst the arrangement of daily newspapers, magazines and periodicals there is a large, brightly coloured display stand promoting a new magazine. I am drawn to the neon orange signage, stylish font, and the promise of free gifts. My heart quickens as I pick up the shrink-wrapped glossy and survey the contents. Breathless, I read on: I will be taught how to summon angels (using the free angel power cards), balance my chakras (with the aid of the crystal chakra bracelet), decipher my dreams (using, one supposes, a combination of the enclosed dream catcher and dream dictionary), and find guidance with the (also enclosed) I-Ching coins. I will be able to learn how to meditate, 'start afresh for the new year', discover my life number and explore my psychic powers. And all of this in the first issue...

A confession: I bought the magazine. It's sitting next to me as a type this. I bought it not because I am a sucker for free gifts (although I am), or have a particular desire to discover my life number or be guided by angels, but because I believe this an exquisite and compelling example

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[1] <http://www.theartoflifeitself.org/2009/12/07/the-spiritual-self/>

of one of the most significant phenomenon of our time – the explosive growth of spirituality in 21st century culture.

The re-enchanted world

The new spiritual landscape is not monolithic; it is a colourful and heterogeneous environment characterised by themes of inwardness, pluralism, subjectivity, personal experience and creative expression.[2] Contemporary spirituality is often framed in opposition to organised, or institutional religion. As Sandra Schneiders observes this contradistinction is 'often expressed in statements such as "I am a spiritual person (or on a spiritual journey), but I am not religious (or interested in religion)."'[3] Spirituality is 'celebrated by those who are disillusioned by traditional institutional religions and seen as a force for wholeness, healing, and inner transformation... [it] provides a liberation and solace in an otherwise meaningless world'.[4]

Life in a globalised era is fragmented, lacks depth, and is dominated by the constant demand to be economically efficient and ever more productive. Spirituality is seen as counterpoise to that nihilistic, reductive trend – the universe is regarded not as a 'dead mechanism, but a living organism permeated by a spiritual force'.[5]

The spiritual self exists in a holistic relationship with other selves and the universe as a whole – a vast, organic nexus of interconnectivity. Spirituality sings a hymn of praise to the self: no longer need the quest for meaning be mediated by the 'dead hand of the church'.[6] We,

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[2]See Wade Clark Roof, *Spiritual Marketplace: Babyboomers and the Making of American Religion*, Princeton University Press, Princeton, New Jersey, 1999, esp. pp. 3-4

[3]Sandra Schneiders, "Religion vs. Spirituality: A Contemporary Conundrum", *Spiritus*, 2003, pp. 163-64.

[4]Jeremy Carrette and Richard King, *Selling Spirituality: The Silent Takeover of Religion,* Routledge, Abingdon, Oxfordshire, 2005, p. 1

[5]Wouter J. Hanegaaff, "New Age Religion and Secularization", *Numen*, 47:3, 2000, p. 291.

[6]Carrette and King, 2005, p. 1.

and we alone, take on this responsibility. Where traditional religion involves subjecting ourselves to a higher, transcendent authority, the new spirituality 'invokes the sacred in the cultivation of a unique subjective-life'.[7] The transcendent authority we defer to – our higher power – is now intensely personal. The 'God of our own understanding' is precisely that – whatsoever we choose to make divine.

A "fuzzy" concept

This may sound like a healthy state of affairs – spirituality as a form of creative resistance to the oppressive forces of organised religion and a recuperative tonic for life in a meaningless world. However, if we scratch the surface of the contemporary spiritual self – if we go beyond the rhetoric of individualism and positivity we find the situation is a little more complex.

First, the very concept of 'spirituality' is problematic – it is a term that is surrounded by ambiguity and confusion. Scholars have claimed it is a '"fuzzy" concept that embraces obscurity with passion',[8] and that it is simply a 'necessary pseudoconcept we don't know how to replace'.[9] Even within the disciplines of religious studies, conceptions of spirituality are nothing if not diverse.[10] As Burton-Christie points out, 'questions concerning the very meaning of the term spirituality, as well as what constitutes the primary subject matter of the field and the most useful methodological approaches for interpreting spiritual experience remain highly contested'.[11]

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[7] Paul Heelas et al., *The Spiritual Revolution: Why religion is giving way to spirituality*, Blackwell, London, 2005, p. 5.

[8] B. Spilka, "Spirituality: Problems and directions in operationalizing a fuzzy concept", *American Psychological Association Annual Conference*, 1993, p.1

[9] Gustavo Vinay, "'Spiritualita': Invito a una discussione", *Studi Medievali,* 2, 1961, p. 706.

[10] Brian J. Zinnbauer et al., "Religion and Spirituality: Unfuzzying the Fuzzy", *Journal for the Scientific Study of Religion*, 36: 4, 1997, p. 549.

[11] Douglas Burton-Chrisite, "Spirituality: Its Uses and Misuses", *Spiritus*, 7, 2007, p. 74.

To talk of spirituality as if it were a specific category with clearly defined boundaries is disingenuous; it is a term that encompasses such a diverse collection of ideas, beliefs, and behaviours that it is arguably meaningless.

The spiritual economy

Second, whilst contemporary spirituality has surface associations with the sacred and the divine, this glorification of the spiritual is intensely materialised. The eruption of new religious movements and spiritualities has been catalysed via the market colonisation of the religious sphere by the aggressive, unrestrained forces of free-market capitalism. Cultural elements from non-Western, non-Christian cultures and faith traditions are appropriated and transformed into consumable products and services for the lifestyle sector of the Western economy.

In the early 21st century the principal pathway to pursue 'spiritual meaning and cultural identification [is] through acts of purchase'.[12] The world has become a cultural supermarket and Western consumers can buy their way to spiritual enlightenment. The close relationship between spirituality and consumerism calls into question some of spirituality's ideological claims.

Third, whilst life-long spiritual practices of traditional religion are orientated towards some transcendent object and dissolution of the boundaries of the self, many forms of contemporary spirituality appear simply to develop a more effective, a more defined self. It appears that the telos – or goal – of modern spiritual life is simply to become a better producer, better consumer, or better citizen.

The machinery of government has subsumed spirituality, aided by humanistic psychology's regimes of empowerment, self-actualisation, and human potential. As Carrette and King suggest, Maslow's famous 'hierarchy of needs' can be read as a 'hierarchy of capitalist wants'

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[12]Lisa Aldred, "Plastic Shamans and Astroturf Sun Dances: New Age Commercialization of Native American Spirituality", *American Indian Quarterly*, 24: 3, 2000, p. 329.

for the privileged Western elite. This subsumption explicitly separates spirituality from its roots in faith and tradition and recasts it as a function of the psychological self. 'After Maslow, spirituality became the new addiction for the educated, white middle classes . . . this was a spiritual message for a culture of excess and one that rejected the shared expression of communal religious faith'.[13]

Spirituality is put into service of the very forces it is commonly assumed to oppose. Disguised by a seemingly innocuous language of emotional health, self-efficacy, and wellbeing, spirituality becomes a means to discipline and normalise the modern workforce and yield increasingly optimal modes of efficiency and productivity.

Conclusion

This brief critical look at the modern spiritual self should elicit some healthy scepticism and cause us to question some of the assumptions that surround spirituality contemporarily. In fact, a reflective, critical approach to the spiritual journey is a common characteristic of traditional religious life.

On one hand, spirituality appears to 'be an escape route from the demands of committed faith, a throwback to self-indulgent pietism, and religious experience tailored to the consumer. It turns the life of faith into a shopping excursion in the Great Mall of the Spirit, where everyone gets to pick up whatever gives them some religious feeling and the assurance they are "spiritual"'.[14] On the other hand, rejecting the formality and dogma of traditional religion, spirituality helps engender a sense of divinity and wholeness in a globalised world stripped of all meaning bar neoliberal ordinations of free enterprise.

The problem here, as I hoped have illustrated, is that spirituality has become locked in a symbiotic relationship with apparatuses of production and consumption that religious life has traditionally (though not

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[13]Carrette and King, 2005, pp. 77, 76.

[14]William C. Spohn, "Spiritual Practices: The True Test of Spirituality", *Dialog: A Journal of Theology*, 40:1, 2001, pp. 277.

always) tended to subvert.[15] In this dynamic cultural and economic milieu it is difficult to distinguish between authentic expressions of spiritual practice and empty, eviscerated religious products of the spiritual marketplace. We should exercise our right to purchase with care.

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[15]The relationship between religion and capitalism is not newly observed. See, for example, Max Weber's classic *The Protestant Work Ethic and the Spirit of Capitalism*, Charles Scribner & Sons, New York, 1958.

Chapter 7

Education: The Missing Link in the Recovery Chain

Published online on 27th January 2010.[1]

In fifty years time, when future historians of the UK's drug treatment system come to write their analyses of this formative period, they will be struck by a glaring absence in the landscape of early 21st century provision – the lack of any integrated system to facilitate access to mainstream education for those in recovery from addiction.

Education is an effective yet under-exploited route to recovery. Indeed, education itself can be regarded as a *method* of recovery. Education raises expectations, creates opportunities and catalyses the profound process of self-transformation that is recovery from addiction, putting greater distance between the addict-self and the recovered-self.

Whilst the role of social/ recovery capital is gaining increasing attention, it is generally discussed in elliptical and abstruse terms. Education is of particular interest as it directly and pragmatically addresses the question: "How can recovery capital be increased?"

Education creates a space where a new mode of being can flourish

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[1] <http://www.theartoflifeitself.org/2010/01/27/education-the-missing-link-in-the-recovery-chain/>

and grow. Education re-situates the self in unfamiliar yet beneficent social contexts, allowing new material and interpersonal relationships to form, thus providing the framework for a more constructive way of relating to the world: a potential fast-track to social reintegration.

In addition to the primary benefit of education – the opportunity to increase social mobility and quality of life through the acquisition of skills, learning, and qualifications, the educational environment is implicitly therapeutic. It supports, nurtures, challenges, and encourages – a perfect adjunct to the recovery process. What will perplex those future historians most of all is why we didn't make this connection sooner and leverage the vast pedagogic resources our communities have at their disposal.

The answer is, of course, that we persist in treating addiction within the highly restrictive binary system of public health and criminal justice, and education remains a peripheral concern for those in the treatment industry, perceived as a wrap-around service or a minor component of aftercare. Rather, education should be privileged as a principal pathway to recovery and social reintegration.

In the coming years, progressive service leaders will develop creative, regenerative, and mutually advantageous partnerships with centres of educational excellence. We'll see innovative practice at the community level – drug and alcohol teams partnering with local universities, colleges and further education institutions. Eventually, we'll see recovery-orientated supported education as a front-line option for those coming into contact with addiction services.

If we're really serious about transforming our approach to addiction, let's make sure we know our A-B-C's.

Chapter 8

When Addiction Becomes Visible

Published online on February 3rd, 2010.[1]

Recovery can only occur when addiction is made visible. Addiction is made visible when a certain set of material conditions is met, a set of conditions created by the interaction of complex ensemble of forces: laws, legislation, regulatory enactments (i.e. governance), social conventions, various scientific truths, ascribed levels of dysfunction and disorder and, as a corollary of this, the extent to which a particular drug-using behaviour incapacitates ones rationality, autonomy, and ability to function in consumer society.

For example, heroin addiction is highly visible as heroin has been a stringently controlled substance for roughly a hundred years. Those who choose to use it are subject to strict disciplinary regimes that have evolved over during time. Heroin/ opiate use has been exhaustively researched and studied, so there is a surfeit of scientific statements and truths about heroin and heroin addiction.

Significantly, heroin addiction is regarded as having a notably detrimental effect on ones rationality and autonomy. Liberal societies do not tolerate individuals who behave in a chaotic manner, who evidence

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[1]<http://www.theartoflifeitself.org/2010/02/03/when-addiction-becomes-visible/>

a compromised ability to self-control, self-regulate, and who are unable to operate effectively within a matrix of production and consumption.

Heroin addiction is highly visible because it penetrates innumerable areas on the surface of social and political concern. Thus, the most visible forms of addiction receive acute (and of course stigmatizing) attention. In the UK, individuals who fall into this deviant category are labelled Problem Drug Users (PDU's). Resources will always be privileged to measure, evaluate and ultimately normalize the most aberrant members of drug using populations.

Because heroin addiction is highly visible, recovery from heroin addiction is made possible. In fact, it is demanded by the political economy. But what of less discernible addictions? We are living through a period of history that is bearing witness an accelerated increase in the visibility of highly differentiated forms of addiction.

An important and instructive case that illustrates this process of rendering the invisible visible can be seen in the UK in addiction to over the counter (OTC) medicines, particularly those containing low levels of the opiates codeine and dihydrocodeine.

In 2007/08, the All-Party Parliamentary Drugs Misuse Group (APP-DMG) heard evidence from a range of sources for the Inquiry into Physical Dependence and Addiction to Prescription and Over-the-Counter medication. This was a defining moment in the process of making OTC addiction visible, as it was at this inquiry that politics intersected with research (albeit scarce), anecdotal evidence, patient testimonials, public concern, popular reportage and commentary. This intersection of forces dramatically increased the visibility of this issue.

In response, in September 2009 the MHRA reenforced the governance of these products. Pharmacies were given new guidelines and exhorted to monitor sales of these drugs. New labelling and information on Patient Information Leaflets (PIL) explicitly indicated these drugs for moderate, chronic pain, to be used for a maximum of three days, with a clear warning that they have the potential cause addiction.[2] We can ex-

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[2]Simply re-licensing such products Prescription Only Medicines (POM) is not an option, as it runs counter to the government's drive to diffuse the burden on GP

pect to see further studies to gather reliable evidence on the prevalence of OTC medication addiction, further guidelines, reports, committees, recommendations; all of which will contribute to an increase in visibility.

How does one recover from OTC medicine addiction? Generally – by yourself. There are a couple of well-established online support groups, Codeine Free Me, and Over-Count.[3] Drug and Alcohol Action Teams (DAAT's) have no provision to offer support for this type of substance addiction. In fact, the APPDGM report recommended that people be treated in Primary Care rather than referred to DAAT funded projects.[4]

Unless OTC medication addiction develops into a disabling social problem that threatens the population's productivity, it is unlikely we will any specialist care in this area. It has not yet crossed, and perhaps never will cross, the threshold of visibility that triggers the type of provision given to Problem Drug Users.

To recover from addiction to over-the-counter medicines, peer-support is the only really viable option. One can access reduction protocols, obtain information and advice, and can plug-in to the power of shared experience. Unless we want to introduce people to the potentially suffocating, stigmatising environment of our drug treatment system, perhaps this isn't such a bad thing.

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[3]<http://www.codeinefree.me.uk/>; <http://www.over-count.org.uk/>

[4]I have heard of two instances of people presenting with codeine addiction and being initiated on a methadone maintenance program. Clinicians' hands are tied when it comes to opiate substitution prescribing. There are only two universally licensed options – preparations containing methadone or buprenorphine – both heavy-duty opiates that are arguable innapropriate for treating codeine addiction. Although GP's can prescribe off-licence (e.g. prescribing codeine or dihydrocodeine for opiate addiction), in a litigious climate of restrictive clinical governance, most are reluctant to do

Chapter 9

Recovery: The Epitome of a Cross-cutting Issue

Published online on February 10th, 2010.[1]

The National Treatment Agency's February Parliamentary Briefing points to a recent Institute for Government report (Shaping Up: A Whitehall for the Future, January 2010) that singles out the NTA as an exemplar of interdepartmental government co-operation.

The IfG report critiques the highly compartmentalised nature of government as a structural weakness that impedes action on cross-cutting issues. (A cross-cutting issue is one whose governance extends across multiple governmental departments. Examples of cross-cutting issues include child welfare, social mobility, domestic violence, the environment, and human rights).

Substance abuse treatment is a particularly robust example of a cross-cutting issue, as it has an extensive history of inter-departmental administration between the Department of Health, Home Office and latterly the Ministry of Justice.

Progress has been hampered in the field as the fiscal benefits for

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[1]<http://www.theartoflifeitself.org/2010/02/10/recovery-the-epitome-of-a-cross-cutting-issue/>

spending on drug treatment – traditionally from the Department of Health budget – are accrued in another department – the Home Office, in the form of reduced crime. As the IfG report points out:

> . . . spending on drug-abuse treatment programmes in the NHS can generate large savings, but mostly in the form of reduced crime rates, which means that the Department of Health may not have a strong incentive to spend on this activity.

And:

> One specific problem is that drug treatment is a health intervention, so must be delivered within the health service. But the numbers who die or become ill each year from Class A drug addiction are small relative to the numbers whose health is harmed by alcohol, tobacco and diet problems. Thus, the Department of Health has an incentive to deprioritise drug treatment as expenditure.

Although aligned primarily with the Department of Health, the NTA was formed to administer pooled resources from discrete governmental departments and budgets in order to increase the efficacy and availability of drug treatment, fill the vacuum between local and central government provision, and obviate obstructive wrangling between the Department of Health and the Home Office. The NTA has achieved positive outcome in terms of more effective mobilisation of resources. These notable successes in effectuating joined-up government must now be revised and developed as we enter a new era of provision and an uncertain political and economic climate.

In the same parliamentary briefing, the NTA affirms their commitment to creating recovery-orientated treatment systems across England. This shift in focus dramatically illuminates "recovery" as a more extensively cross-cutting issue than "substance abuse treatment". By displacing the medical and criminological gaze with a more panoramic perspective, the horizon of opportunity expands.

Unlike a substance abuse treatment intervention, a recovery intervention does not necessarily have to be a health intervention, which paves the way for more radical and progressive programs. However, maintaining the binary governmental logic of health and criminal justice precludes involvement of other governmental departments, and arguably inhibit the fullest expression of recovery-orientated treatment and support.

A truly recovery-orientated governmental agency would co-ordinate and pool resources between the Cabinet Office, Treasury, Department for Communities and Local Government, Department for Children, Schools and Families, Department for Innovation, Universities and Skills, Department for Work and Pensions, as well as the triumvirate of the Home Office, Department of Health, and the Ministry of Justice. The problem, as the IfG report demonstrates, is how to persuade these departments to invest in recovery-orientated programs when there is no immediate fiscal benefit to them.

Or is there?

Short answer – we simply don't know. The key fiscal metrics we use to quantify the value of drug and alcohol treatment are framed in terms of reduced health and criminal justice costs. Until we develop ways of quantifying financial and social benefits of recovery in other areas, a stronger case is unlikely to be made for a far-reaching recovery-orientated agency.

The archetypal recovery equation contains two structural components: top-down governance and bottom-up, grass-roots, community activism. "Recovery" casts a spotlight on the ambiguous and yet to be defined relationship between these components. The NTA has an opportunity demonstrate how a dynamic interface between community and diffused, coordinated government can lead to the best quality provision for those who enter our services.

It may be that top-level governance needs a radical root-and-branch reform to bring about a more comprehensive system of recovery deliv-

ery suggested above. Until that transpires, grass-roots recovery organisations must take the lead in providing reflexive and responsive recovery that reflects the cross-cutting nature of recovery in our times.

Chapter 10

The role of needle and syringe programmes in a recovery-orientated treatment system

I was invited by Nigel Brundson, author of Injecting Advice to write a piece on recovery and NSP's.[1] *The article was published online on both Injecting Advice and The Art of Life Itself on March 3rd 2010.*[2]

    The UK is moving inexorably towards recovery-orientated treatment for drug and alcohol problems. In February 2010, the National Treatment Agency affirmed its commitment to developing recovery-orientated treatment systems in England, and recently published a twenty-page "Commissioning for Recovery" guide for service commissioners and joint commissioning groups, exemplifying the NTA's re-visioning of the 2008 drugs strategy within the conceptual idiom of recovery. This is a welcome response to the diverse grass-roots, academic, and political

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[1] Injecting Advice: <http://injectingadvice.com/>
[2] <http://bit.ly/NSPsRecovery>; <http://www.theartoflifeitself.org/2010/03/03/nsps-in-recovery-orientated-treatment-systems/>

critiques of the UK's provision.

There can be no question that recovery is now a fixture of mainstream discourse and is set to become a defining and instrumental feature of the policy and treatment landscape in the UK.

Whilst there is absolutely no suggestion that needle and syringe programmes [NSPs] and other harm reduction initiatives will disappear under recovery-orientated modalities, this article argues that although NSPs are rarely discussed in contextual relationship with recovery, their low-threshold, open-access structure position them as fundamental and critical elements of a recovery orientated treatment system.

Recovery digested

"Recovery" has multiple associations and manifold influences. UK readings of US experience tend to identify "recovery" as synonymous with abstinence and 12-step mutual aid. The embryonic UK recovery movement, although significantly influenced by this account of US experience, is in the process of negotiating the boundaries of its own conceptualization of "recovery".

Definitions of recovery are notoriously (and perhaps unavoidably) tendentious. The following formulation utlised by the Department of Behavioral Health, Philadelphia, US, is a usefully inclusive reference point:

> Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members.

What is emerging in the UK is a robust and extensive end-to-end

vision of recovery that seeks to consolidate the superabundance of statutory and 3rd sector treatment services with a wider network of reintegration and community provision and independent grass-roots recovery movements.

Recovery and harm reduction

It is impossible to discuss NSPs without considering the ideological driver for their inception and development into a distinct field of professional practice– the harm reduction paradigm. NSPs were the beating-heart of early harm reduction initiatives, which, in a radical discontinuity with past treatment modalities, focused on the attraction and retention of injecting drug users and providing services that promoted safer injecting practices with a view to reducing the risk of HIV/ AIDS (and latterly other viral and bacterial infections) which were seen as a greater harm than drug use itself. Drug dependency was not challenged and abstinence, although a key influence for individuals entering treatment and the gold-standard of harm reduction goals, slowly slipped beyond the horizon of expectations

Catalyzed by the HIV/ AIDS crisis of the 80's, a robust public health approach developed that privileged the minimization of the multiple harms associated with injecting drug use. Recovery and harm reduction are often polarized as oppositional ideological paradigms. This is neither useful nor accurate. For the purposes of this discussion, I suggest that *recovery is best understood as an organizational attitude that seeks to maximize the positive outcomes of harm reduction.*

Integration

One of the key principles of a recovery-orientated model is it is integrated. That is, all of the constituent parts, all the various elements of a local system are co-coordinated, speak the same language, communicate with each other and have a congruous set of values and principles that orbit around the affirmative and empowering possibilities of re-

covery. Every part of the system is involved in a collaborative effort to increase positive outcomes and take a long-term view with respect to developing the quality of life for individuals who access their services and disrupting negative therapeutic expectations where they occur.

This contrasts markedly with the tiered system of the NTA's "Models of Care", which, coupled with a dynamic if bellicose competitive commissioning/ tendering cycle has engendered a fragmented treatment system with individual tiers and their respective providers separated from one another both materially and ideologically. Each tier, sector, and service is compelled to privilege its own interests above the needs of service users, who may not necessarily benefit from being locked into a single service or artificially created strata of provision.

Recovery-orientated treatment systems (which we can expect to replace "Models of Care") re-situate the individual at the heart of provision and encourage vibrant inter-service partnerships. A local recovery-orientated treatment system allows greater flexibility and non-linear movement between system elements. Thus, it should be possible (where appropriate) for a user to move from NSP engagement to in-patient or community detox, residential or community re-hab, supported access to mutual aid groups, and direct referral to reintegration services such as housing, education, employment, training, and welfare.

Building on strengths developed over 25 years, recovery focused NSPs will ensure responsive, needs-based placement to the most appropriate service from locally available choices. This will depend on apposite and effective assessment, the responsiveness of the local system, and the vision, drive, and leadership of NSP staff.

Low threshold, high expectation

From the perspective of integration, the principle value of NSPs in a recovery orientated model is that they offer open-access, low-threshold point of entry into the system for populations with the greatest needs – those with high problem severity and low recovery resources. In a significant number of cases, NSPs are often the only touch-point that

members of this drug-using population have with local drug-treatment services.

Although NSP outcomes tend to be framed in a negative discourse of risk minimization, the real-world benefits of NEPs are overwhelmingly positive. As a corollary of promoting harm reduction goals of safer using, stabilization, and use-reduction, and without locking service users into restrictive and obstructive disciplinary treatment regimes, NSP engagement:

- Contributes to a better quality of life.

- Removes barriers to health care access.

- Promotes self-control and self-efficacy

- Encourage autonomy and personal responsibility.

- Provides opportunities to increase knowledge and self-awareness.

Thus, NSPs are directly linked to key recovery-orientated goals in terms of facilitating the accumulation of vital recovery resources, particularly within the domain of personal recovery capital. Recovery success can be directly linked to increases in recovery capital – that is, resources in the personal, social, and communal domains of an individual's life that can be drawn on to support and sustain long-term recovery. Small incremental gains in the area of physical and mental health, wellbeing, and self-efficacy at this stage are significant as they can act as catalysts and triggers for long-term accrual of capital in other recovery domains.

Self-change: the heart of recovery

Gaining control over one's injecting practices demonstrates that injecting drug users can be effective agents of self-change. Self-change is the heart of recovery: the notion that an individual can radically transform their relationship with their own selves, others, and the world. From this perspective, NSPs should be considered, and positioned as,

recovery outposts; and NSP workers as vanguards on a terrain of recovery choices. Highlighting and celebrating the reality of supported self-change is vital in a recovery-orientated treatment system in order to raise aspirations and create opportunities to further self-change and personal development.

The therapeutic *milieu*

A recovery focused NSP will be driven by a vision that creates a therapeutic space conducive not only to safer injecting practices, but also to actively promoting and supporting engagement for long-term recovery from problematic substance use. Ideally, this means making visible recovery successes and articulating a robust, realistic narrative of recovery that is meaningful and appropriate to the injecting population. This is not something that can be determined centrally, but requires local dialogue and consultation amongst service users, providers, and recovery mentors.

The therapeutic milieu of a recovery focused NSP would evolve locally and be determined by the quality of:

- The local service ecology and its commitment to recovery-orientated provision

- NSP/ pharmacy teams and their leadership

- Local mutual-aid and grass-roots recovery communities

- Wider community attitudes and partnerships

- Local recovery champions and recovery mentors

- The local spirit and ethos of recovery innovation and collaboration

Making recovery success visible

Those with the most chronic problems often exist in a world of perceived hopelessness and negative self-expectations. Taking advantage of their access to difficult to engage populations, recovery focused NSPs will pro-actively make visible recovery success – for example, through employing workers or volunteers in recovery (the therapeutic power of a positive encounter between a drug user and an ex-drug user should not be underestimated), promoting local recovery champions and mentors, encouraging reciprocal working relationships with other recovery and reintegration services, and providing access to recovery information and resources that demonstrate the reality of long-term recovery from addiction.

Conclusion

The bottom line of recovery can be expressed in three words: recovery is possible. If recovery is possible; that is, if there is an authentic, realistic possibility of recovery then there is arguably an ethical imperative to promote and provide access to services that deliver recovery orientated change. Whilst NSPs have a very specific remit that focuses on the reduction of harm associated with drug use, their services can be delivered in a recovery-aware environment that is engaged with the full range of local recovery and reintegration provision, and firmly, authentically rooted in community. The journey towards a full and meaningful life that is recovery can begin in the most unlikely of places. Why not through the doors of a needle exchange programme?

Chapter 11

Recovery, power and resistance

Published online on March 10th, 2010.[1]

One of the benefits of being located within the field of philosophy, theology and religious studies is that one develops an especial appreciation of the arts of critique. "A critique", Foucault suggested, "does not consist in saying that things aren't good the way they are. It consists in seeing on just what type of assumptions, of familiar notions, of established and unexamined ways of thinking the accepted practices are based".

Insofar as recovery scrutinises professional and popular assumptions, received knowledge, and the various material practices of "treatment", it can be regarded as a multivalent social critique of extant modes of provision – an attempt to to 'disrupt the taken-for-grantedness of the present and to show how things could be different'.[2]

With a penetrating appraisal, "recovery" discloses the stagnant politics of prevailing institutional practices. Recovery reveals the correlated discursive production of myriad addict identities. Recovery challenges the hegemony of expert knowledge, strips naked a finely arrayed body

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[1] <http://www.theartoflifeitself.org/2010/03/10/recovery-power-and-resistance/>
[2] A. Petersen & R. Bunton, *Foucault, Health and Medicine*, Routledge, London, 1997, pp. 3-4.

of truth-claims and lays bare its emaciated, desiccated physique.

Above all, recovery resists. Recovery resists the powers of domination and subjugation that produce governable order out of ungovernable chaos – the forces that regulate disorderly misuses of pleasure and mold, shape and transform the most unproductive members of the population into compliant and docile bodies.[3]

Those entering drug treatment programmes are subjected to potent disciplinary biopower mediated by miscellaneous institutional actors and framed within the logic of harm reduction and risk management – from rigourously controlled substitute prescribing regimes where subjects become "violently, physically disciplined – if not fully controlled – by manipulations in their dosage levels",[4] to the surveillance of drug consumption through NDTMS/ TOPS monitoring, to the use of cognitive behavioural therapies (CBT) as a "psycho-social intervention" to foster neoliberal ideals of productive self-efficacy and personal responsibility.

In the UK, although harm reduction initiatives emerged locally as a site of resistance against the dominant ideologies of the time, they rapidly became subsumed by the apparatuses of government. This was largely due to the consonance between harm reduction and the preventative approach of public health, the HIV/ AIDS crisis of the eighties, and the emergence of post-welfare, neo-liberal economics which shifted the burden of responsibility for being a healthy, autonomous citizen from the State to the individual.

As a consequence of this institutionalisation, many proponents of harm reduction became assimilated into the very system of power they were trying to overcome.[5] For those exploring the ideological horizons

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[3]According to Foucault, a docile body "is one that may be subjected, used, transformed, and improved… and that this docile body can only be achieved through strict regiment of disciplinary acts".

[4]Phillipe Bourgois, "Disciplining addictions: The bio-politics of methadone and heroin in the United States", *Culture, Medicine, and Psychiatry*, 24, 2000, p. 183 (pp. 165-195).

[5]See Brent L. Pickett, "Foucault and the Politics of Resistance", *Polity*, Volume XXVIII, Number 4, 1996, p. 447 (pp. 445-466).

beyond harm reduction it's vital to acknowledge and learn from this historical point.

The mental health recovery movement has retained an authentic grass-roots spirit of resistance whilst simultaneously informing policy and engaging in expert discourse. Similarly, the success of AA/ NA can be attributed in part to the organisational consistency (codified in the "12 traditions") which insists upon complete independence from all statutory/ voluntary services and organisations. One doesn't have to become institutionally anonymous to engage in an ongoing project of reflective practice – however, one should always be able to step back and critique one's position. This is especially true for those recovery activists currently shaping and forming the field. Failure to resist administrative assimilation means we'll simply replace one regime of institutional truth with another: a net gain of zero.

Chapter 12

Addiction and consumption

Published online on April 16th, 2010.[1]

Any discussion of recovery contemporarily must take into account the fabric into we incite individuals to recover to: the free market of global consumer culture. Whilst addiction is defined in terms of dysfunction and disorder, consumerism is overwhelmingly normative. However, viewed from certain perspectives, there is little to distinguish consumer behaviour from the behaviours associated with problematic substance use. Just as heroin or crack addiction is driven by the circular motion of need and fulfilment, as Bauman suggests, "In the consumer society, consumption is its own purpose and so is self-propelling".[2]

Addiction, in its chronic stages, becomes a way of life. The language of addicts reflects this: they graft, have pay-days, work over-time: maintaining an addiction is a full time occupation. As Isidor Chein reflects:

> The life of an addict constitutes a vocation—hustling, raising funds, assuring a connection and the maintenance of supply, outmanoeuvring the police, performing the rituals

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[1]<http://www.theartoflifeitself.org/2010/04/16/addiction-and-consumption/>

[2]Zygmunt Bauman, "Consuming Life", *Journal of Consumer Culture*, 1:2001, pp. 12-13.

of preparing and of taking the drug—a vocation around which the addict can build a reasonably full life.[3]

It is a myth to suppose that the addict lives in a world of isolated, abject misery. For many, it is the best choice to be made from a limited set of options. The world of addiction and correlated lifestyles is replete with their own social conventions, rules, networks, co-operatives and so forth. Rowe and Wolch note from their studies of homeless women in Los Angeles:

> Homeless people share their locales with other homeless individuals, facilitating the formation of peer networks within the homeless population. Peer networks are comprised of homeless acquaintances, friends, family, lovers, and spouses; some peers will live in informal street communities or encampments of the homeless which often arise in vacant lots, park and sidewalks in Skid Row. In many ways these peer networks replace the function of the home-base in the maintenance of time-space continuity, identity and self-esteem for the general homeless population. The formation, utilization and importance of peer networks appear to vary between homeless men and women.[4]

There is then, contrary to popular lore, a rational dimension to chronic drug use. Addicts operate under the same economic principles as the rest of the consuming population. They are autonomous, make cost-benefit analyses and seek to maximise utility. Becker and Murphy, with

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[3]Isidor Chein, "Psychological Functions of Drug Use", in Hannah Steinberg(ed), *Scientific Basis of Drug Addiction*, Churchill, London, 1969 cited in Stanton Peele, Archie Bordsky, *Love and Addiction*, Taplinger, 1975; available: <http://www.peele.net/lib/laa3.html>. Retrieved 15.11.09. See also Isidor Chein, Donald L. Gerard, Robert S. Lee, Rosa Rosenfield, *The Road to H: Narcotics, Delinquency and Social Policy*, Basic Books, New York, 1964.

[4]Stacy Rowe and Jennifer Wolch, "Social Networks in Time and Space: Homeless Women in Skid Row, Los Angeles", *Annals of the Association of American Geographers*, 80:2, 1990, p. 191.

their controversial but compelling rational choice theory of addiction were the first to explore this hypothesis which precipitated an extensive body of literature on the subject.[5]

Positing the addict as an autonomous individual commensurate with any other kind of consumer creates a new vista with which to explore addiction and recovery. Both licit and illicit economies depend on the consumer for their existence:

> The consumer is essential for the culture of capitalism. Not only must consumers buy, they must buy more every year, and still more the year after that. Without perpetual consumption, the economy would either decline or collapse.[6]

The harms associated with the perpetual consumption of illicit substances are visible to us: in our communities, in our social networks, in our daily lives. What is less visible is the harm engendered at a global level by aggressive, unrestrained forces of the consumer culture we invest so much time, energy, and effort to integrate the marginalised into.

The waste, pollution and ecological and human costs of rabid consumerism are displaced to poorer countries, moved out of sight and safely beyond the boundaries of our consciences:

> Some parts of the earth—places like Africa and the Arctic—are having to pay a disproportionate share of the costs of rising consumption as the globalization of corporations, trade, and financing shifts, intensifies, and casts ecological shadows into more remote regions.[7]

We, the privileged global elite, consume at the expense of others. The cult of consumerism is a global religion, and recovery offers salva-

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[5]Gary S. Becker and Kevin M. Murphy, "A Theory of Rational Addiction", *The Journal of Political Economy*, 96:4, 1988, pp. 675-701.

[6]Richard Robbins, "Readings on the Consumer", <http://faculty.plattsburgh.edu/richard.robbins/legacy/consumer_readings.htm> accessed 15th April 2010, 08.34.

[7]Peter Dauvergne, *The Shadows of Consumption: Consequences for the Global Environment*, MIT Press, Massachusetts, 2008, xiii.

tion to those who have fallen from economic grace and consume outside the frontiers of the legitimate marketplace.

The emphasis on social reintegration that characterises much of contemporary recovery discourse is an attempt to curb public spending and reduce the drain on our national resources. The depletion of global resources by the recovered and those that support them is an as yet unexplored dimension in our field. If we are to collectively heal ourselves from this mass psychosis, perhaps we should begin to ask if there are wrong and right ways to consume.

Chapter 13

The Rhetoric of Abstinence

Published online on April 21st, 2010.[1]

A brief post this week on the dangers of employing a rhetoric of abstinence when discussing the future of drug treatment in the public domain. This post comes as we witness the inevitable accentuation of the politicisation of drug treatment policy in the approach to the general election.

As the Conservative party notably claims ownership of a unidimensional account of recovery expressed in an idiom of abstinence, coercion and criminality, and suffused with anti-methadone sentiment, advocates of recovery-orientated change need to secure the ownership of recovery for those to whom it rightfully belongs.

The following five points highlight the problems associated with an account of recovery rooted in a rhetoric of abstinence.

1. "Abstinence" evokes a retrogressive conceptualisation of addiction which is at variance to a mature, progressive and inclusive account of recovery. Indeed, it could be argued that the rhetoric of abstinence is antithetical to authentic recovery orientation.

2. It is a basic category error to equate abstinence with recovery. Ab-

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[1]<http://www.theartoflifeitself.org/2010/04/21/the-rhetoric-of-abstinence/>

stinence is a condition, recovery is a process. By focussing on the condition of abstinence, our collective attention is drawn away from the much more important process of recovery.

3. A rhetoric of abstinence suggests addiction is a choice or function of deviant moral character. The reality is that addiction is a multidimensional phenomenon with a complex etiology and broad range of recovery pathways indicated.

4. Those with severe addiction problems are often (though not always) the most marginalised and dislocated members of society, many of whom who have experienced severe trauma in early life. Valorising abstinence will further disenfranchise those with high problem severity and low recovery resources, and increase the stigma associated with those populations who benefit from methadone maintenance therapy (MMT) in the short or long term.

5. An authentic recovery-orientated treatment system acknowledges a broad spectrum of positive outcomes. Privileging abstinence over and above other recovery indicators (such as quality of life, self-change, well-being and empowerment) reifies a restrictive and outdated understanding of addiction that fosters short-term thinking for chronic, long-term problems.

Abstinence is of course a key target for those embarked/ embarking on journeys of recovery. In some cases, it may be the only target. The point I have made here, evidenced by the countless internecine conflicts the term continues to provoke in the field is that abstinence is a problematic and perhaps even redundant term in recovery discourse. Recovery is a political issue: a politics of self and identity as much as a politics of governance and freedom.

Chapter 14

Recovery: A Journey of Self-Transformation

Who are you?

Are you the same person as you were yesterday?

How about a year ago? Two years?

Am I the same Stephen Bamber as I was aged 16?

What's different? What's changed? What elements of our self-identity have remained the same?

The cluster of questions that orbit around the concepts of self and self-identity are acutely significant when considering addiction recovery. The shift towards long-term thinking taking place from top-to-bottom throughout the UK's treatment ecosystem provides a valuable opportunity to creatively re-vision our understanding in fresh, unconventional ways (although there is a modest body of literature on addiction and identity, there is little on recovery and identity). Positing recovery as a journey of self-transformation is an approach that can help stimulate innovation and foster new understanding. It is particularly congruent with the conceptual foundations of mainstream recovery thought, which emphasise empowerment, individualisation and long-term, holistic change. The addict self is a particularly well-defined subjectivity (experience of ones own self) that has developed over the past

200-300 years, evolving into a distinct variety of the deviant identities formed in opposition to the normative post-Enlightenment ideal of the autonomous, self-determining individual able exercise restraint and self-control; regulating their behaviour without disturbing the delicate balance of the social contract.[1]

The modern "addict-self" (reified contemporarily as the Problem Drug User, or PDU) refers to a genus of non-productive individuals who require particular kinds of moral, medical, and juridical interventions in order to subjugate, analyse, control and ultimately reform them into economically productive individuals capable of maintaining the levels of self-control demanded by advanced liberal societies. In this sense recovery is simply an extension of a governmental logic that seeks to maximise the productive and consumptive efficiency of the populace.[2]

For those tied to this addict identity and the cultures and discourses that produce them, the journey of recovery represents a profound reclamation, or transformation of the self. As Alexandre Laudet -friend of the Recovery Academy and distinguished scholar - observes of the Pathways Project: "A recurrent theme was that recovery is [the process of] regaining an identity (a self) lost to addiction".[3]

We may quibble over definitions and competing accounts of recovery yet there appears to be a theoretical subtext running through all expositions of recovery: we sacrifice an old self and lay claim to a new self in the making.

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[1]Harry Gene Levine, "The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America", *Journal of Studies on Alcohol*, 39:1, 1978, pp. 143-173. Cf. Jessica Warner, ""Resolv'd to Drink No More": Addiction as a Preindustrial Concept", *Journal of Studies on Alcohol*, 55:6, 1994, pp. 685-691 and Roy Porter, "The Drinking Man's Disease: The 'Pre-History' of Alcoholism in Georgian Britain", *British Journal of Addiction*, 80, 1985, pp. 385-396

[2]Stephen Bamber, "Rethinking community: addiction, recovery and globalisation", 12th International EWODOR Symposium, University of Stirling, October 2009. Available <http://www.theartoflifeitself.org/articles_and_papers/Rethinking_Community_Stephen_Bamber.pdf

[3]Alexandre Laudet, "What does recovery mean to you? Lessons from the recovery experience for research and practice", Journal of Substance Abuse Treatment, 33:3, 2007, pp. 243–256.

We tend to assume we have stable, enduring, self-identity, yet the continuity of this can be disputed. The journey of recovery from addiction is an exquisite example of how individual selves can, and do, change over time. Although we sense there is some connection with the person we are today and the person we were when living in the chaotic tempest of full-blown addiction, it is difficult to isolate and identify the elements that connect or separate these two diametrically opposed ways of life.

We have memories of course, and external fixed points that re-enforce our sense of self: our living space, our habits and proclivities, our commitments, our community, family and friends: in short, our way of life. We find ourselves reflected in other people and places as much as we do in the mirror of our own self-awareness. The greater the difference in our relationship between these exterior sources of the self - the wider the gap between addiction as a way of life and recovery as a way of life - the greater our chance of solidifying recovery into a concrete mode of being capable of propelling us safely through the fragmented and ephemeral territories of 21st century life.

Translating the abstract sphere of recovery identity theory into meaningful guidelines for practice is no easy task. However, viewing recovery from the perspective of identity transformation opens up valuable new ways of thinking about the initiation and sustainment of recovery in groups, communities and individuals. For example, recognising, as pioneers in the field of natural recovery did, that re-situating the self in new social contexts hastens and supports the construction of a non-addict identity, we immediately see the value of identifying and demarcating the boundaries of local recovery cultures and orientating ourselves towards them.

Perhaps the most notable benefit of an identity-transformation approach is it allows us to move beyond the weary dualism of medical and moral accounts of addiction and recovery. Focusing not on the perceived rights and wrongs of particular decisions or behaviors, but instead taking a long-term view in terms of the choices we have with respect to our identity. Rather than asking, "What should I do?" we can

engage with the much more profound question: *"Who do I want to become?"*

Chapter 15

Mutual aid groups

Published online on April 9th 2010.[1]

Definition

> *Mutual aid groups (sometimes known as self-help or peer support groups) provide non-professional support to those who identify as sharing a similar problem. Members of mutual aid groups both give and receive support in regular group meetings that supplements or replaces the support offered by professional services. Mutual aid groups are independent, self-governing and institutionally autonomous; they may be local and unaffiliated, or part of a larger organisation. Mutual aid groups do not provide treatment.*[2]

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[1]<http://www.theartoflifeitself.org/recovery-glossary/mutual-aid-groups/>

[2]Bamber, S. 2009. *Mutual Aid Groups.* The Art of Life Itself:. <http://www.theartoflifeitself.org/recovery-glossary/mutual-aid-groups/>, accessed 7th October, 2010. 01.50. Published April 9th.

Discussion

Mutual aid and institutional anonymity

Organisationally, mutual aid groups maintain independence from professional treatment services, although some meetings are hosted by various institutions and services. This organisational independence, or institutional anonymity is critical in terms of the efficacy of mutual aid as it:

- Permits mutual aid groups to exist outside the political and economic influence of the free market.

- Promotes independence by facilitating liberation from restrictive treatment regimes and prescriptive clinical governance.

- Provides an alternative source of recovery knowledge emerging from the mutuality of shared experience.

- Redresses the balance in the dynamics of power inherent in client-professional relationships.

Fig. 1: Independence of mutual aid groups
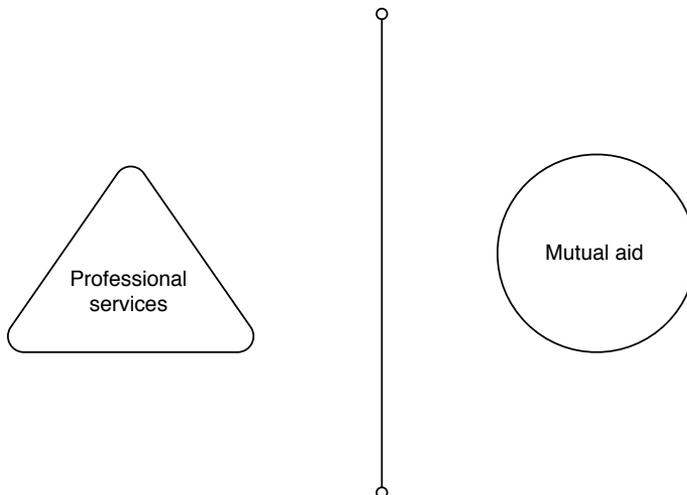
Mutual aid groups do not compete in the treatment economy, so they are unencumbered by the corporate pressure to generate revenue, meet targets and compete for funding and resources. The subjection of treatment services to the demands of the free market effectively establishes individuals who access services as conduits for economic gain in the licit bioeconomy.

The capitalisation of the addict in the treatment economy binds those who cross the threshold into treatment to a system that does not privilege their interests. Rather, the need of the service or system to be profitable is paramount, and will tend to supersede the interests of the client.[3] Mutual aid groups undermine this client-system interdependence and provide an alternative to the structures of power and knowledge that underpin professional services in the open market.

Mutual aid groups in the mental health recovery movement

The mental health recovery movement is now decades old yet continues to guide policy and practice. Mental health recovery has been a significant influence on emerging addiction recovery movements and the practice of mutual aid is privileged in both movements.[4]

Within mental health, mutual aid groups emerged as a point of resistance against the hegemony of professional knowledge wielded by the elite caste of psychiatric specialists. As Stewart notes:

> Disenchanted with professional experts and perceiving both elitism and ineffectiveness within formal professional sectors, self help groups aimed to demystify and demonopol-

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[3]Stephen Bamber, "Rethinking community: Addiction, recovery and globalisation", Paper presented at the 12th International EWODOR symposium, Stirling, 2009, pp. 2-4 (1-8).

[4]See Stephen Bamber (2009), "Revolution in the Head", *The Art of Life Itself*, <http://www.theartoflifeitself.org/2009/11/23/revolution-in-the-head/>, accessed 9th April 2010, for an overview of the thematic links between the mental health and addiction recovery movements.

ize professional expertise by shifting power to consumers and altering traditional roles of lay people and professional people.[5]

A rupture appeared in the fabric of mental health care. Vocal consumer and survivor mutual aid groups challenged the sovereignty of professional knowledge and in many cases rejected it outright. Dismissing institutional knowledge, people began to look to each other for support, nurturing, and healing. Mutual aid groups are the material expression of that turn to communal support. The singular uniqueness of the recovery journey is magnified when re-situated in a group context.
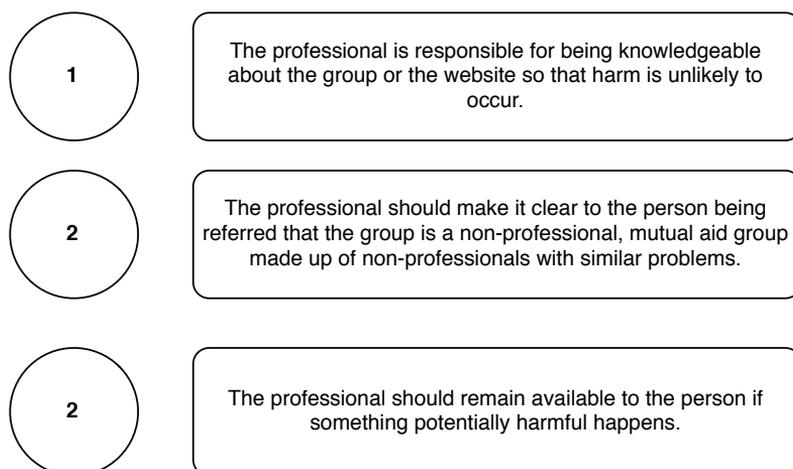
Referring to mutual aid groups

The independence and autonomy of mutual aid groups raises a number of questions for professionals wishing to refer their clients to them. Being independent, non-professional and self-governing, mutual aid groups are not required to accede to the same codes of accountability as public services and professional organisations.

The perceived risk of referral can be managed by nurturing a clear understanding between the client and professional as to the roles and responsibilities of the various elements in the referral pathway. The following protocol is a pragmatic and usefully simple starting point.[6]

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[5]Miriam J. Stewart, "Professional Interface With Mutual Aid Groups", *Social Science and Medicine*, Vol. 31, No. 10, 1990, p. 1143 (1143-1158

[6]For more detailed expositions see Keith Humphreys, *Circles of Recovery*, Cambridge University Press, Cambridge, 2004, Chapter 5. Humphreys also offers a thorough review of the diversity and effectiveness of mutual aid groups in this volume.

Fig. 2: Protocol for referring to mutual aid groups[7]

1	The professional is responsible for being knowledgeable about the group or the website so that harm is unlikely to occur.
2	The professional should make it clear to the person being referred that the group is a non-professional, mutual aid group made up of non-professionals with similar problems.
2	The professional should remain available to the person if something potentially harmful happens.

Referring clients to mutual aid groups is an opportunity for the interface between professional services and mutual aid groups to become more permeable, fortifying the integrity of the local recovery ecosystem. The following models illustrate two possible implementations at a service level.

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[7]Linda Kurtz and Ernie Kurtz, "Guide to the development of mutual aid groups", available <http://www.bhrm.org/Guide.htm>, accessed 13th February 07.43.

Fig. 3: Referal model 1

Keyworker attends first session with client. [Note: the rules regarding attendance of those not directly seeking support will vary from group to group.]
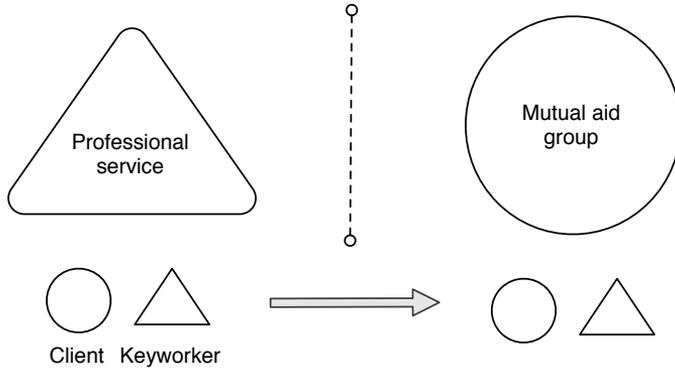

Fig. 4: Referal model 2, part 1

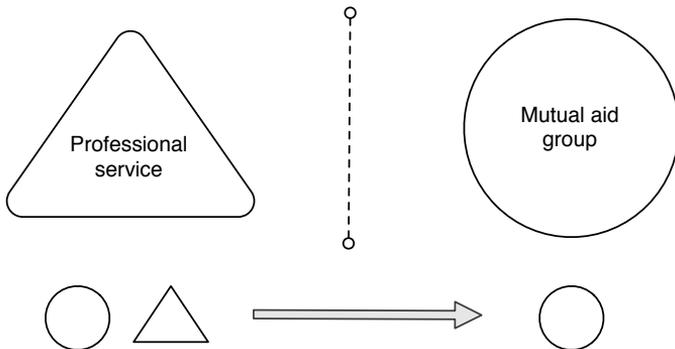i) Keyworker refers client, client attends alone.

Fig. 5: Referal model 2, part 2

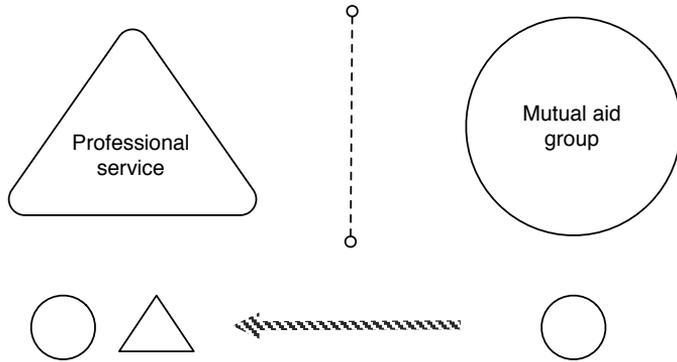ii) Client feeds-back and discusses experience with keyworker.

Fig 6: Referal model 3, part 1

i) "Assertive referal": Keyworker contacts mutual aid group volunteer to arrange for client to be met before meeting.
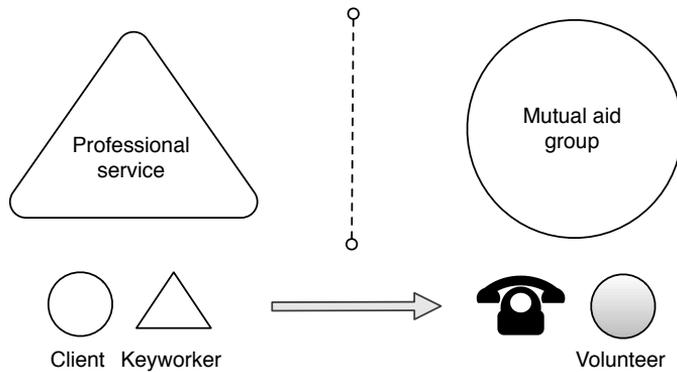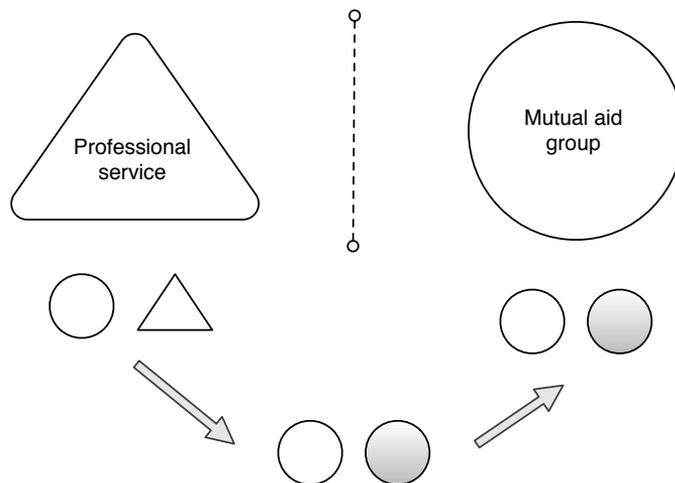
Fig. 7: Referal model 3, part 2

ii) Volunteer meets client in a neutral location and escots client to meeting. (Client then feedsback to keyworker: not shown).

Conclusion: working together

Mutual aid groups and professional treatment services offer very different kinds of support for people with drug and alcohol problems. The limitations of professional services in the treatment of alcoholism was acknowledged as early as 1927.8 Although the quality and nature of treatment has evolved, there are domains of recovery that remain outside the purview of statutory and third sector provision. The nascent recovery movement in the UK is burgeoning in that exterior space.

   The energy and diversity of grassroots recovery communities resist the homogenous regimes of professional addiction services and can be seen as a grass-roots response to unmet needs – this is the radical idea that lies at the heart of the recovery movement.

    Grassroots communities of recovery, in all their colorful heterogeneity, expand the horizons of therapeutic space –

they are places where identities can be nurtured to a fuller, more integrated extent – places that contrast sharply with the dull monochrome and clinical sterility of the community-drugs team, GP's surgery, or psychiatric consulting room. Grassroots communities of recovery are places of potential, furnaces where self and selfhood are forged in the white heat of physical affinity, where the individual's acceptance of the group, and the groups' acceptance of the individual fortify the alloy of human uniqueness.[8]

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[8]Bamber, 2010, p. 8.

Appendix A

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